An investigation into the care and treatment of Mr B

A report for NHS Yorkshire and the Humber

March 2013

Authors:
Sue Bos
Liz Howes

Peer reviewers:
Chris Brougham
Derek Mechen

Expert advisor:
Dr Mostafa Mohanna

© Verita 2013

Verita is a management consultancy that works with regulated organisations to improve their effectiveness and levels of service. It specialises in conducting independent investigations, reviews and inquiries.

Verita
53 Frith St
London W1D 4SN

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

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

Contents

1. Introduction

1.1 NHS Yorkshire and the Humber (the SHA) commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of a mental health service-user (Mr B).

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

1.3 The purpose of this independent investigation, as detailed in the terms of reference, is to comment on the suitability of the care and treatment provided and how this reflected national and local requirements. The purpose is also to identify things that were done well, causes of the incident and learning points for improving systems and services'.

The incident

1.4 Mr B, a 21 year old man, fatally stabbed his nine-year-old brother and wounded his 19-year-old sister at her home in February 2010. He was convicted of manslaughter and was given a hospital order for an indefinite period.

Background to the independent investigation

1.5 At the time of the incident Mr B was receiving care and treatment from Bradford District Care Trust (BDCT) and Bradford and Airedale Community Health Services (BACHS).

1.6 BACHS carried out an internal management review as part of the serious case review undertaken by Bradford Safeguarding Children's Board for Mr B's brother.

Overview of the organisation

1.7 BDCT provides mental health and learning disability services to the communities of Bradford, Airedale and Craven, a population of 500,000. Services include: adult mental health, substance misuse, older people's mental health, learning disabilities, child and adolescent mental health and forensic services.

1.8 At the time of Mr B's care and treatment, the early intervention in psychosis service was provided by BACHS (the provider arm of NHS Bradford and Airedale) and was not the responsibility of BDCT. BACHS has been part of BDCT since April 2011. Acute inpatient mental health care is provided on two sites, one of which includes an eight-bed self-contained psychiatric intensive care unit. Mental health services have been commissioned by NHS Airedale, Bradford and Leeds (the PCT cluster) since October 2011.

2. Terms of reference

2.1 The terms of reference for this independent investigation have been set by NHS Yorkshire and the Humber, in consultation with NHS Bradford and Airedale, Bradford and Airedale Community Health Services, Bradford District Care Trust and Verita.

2.2 The aim of this independent investigation is to examine the care and treatment provided to the service user and to comment upon the following.

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

- The extent to which the care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies, notably in respect of the appropriateness and quality of care and treatment of the service users in relation to:

    - referral to the EIP (Early Intervention in Psychosis) service and EIP service standards
    - use of the care programme approach
    - use of the Mental Health Act (1983)
    - discharge planning
    - risk assessment
    - referral to social care
    - carer assessments
    - information sharing - interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs
    - records management – including access to previous notes (i.e. CAMHS records).

2.3 The purpose of the investigation is also to:

- identify aspects of the service user's care and treatment which was of good quality or commendable practice and through appropriate analysis, root and contributory causes of the incident and, where appropriate, learning points for improving systems, processes and services in particular:

  - causes of any system failure not previously acknowledged
  - any additional actions for organisations in the health and social care economy

- make realistic, measurable and specific recommendations for action in conjunction with NHS Bradford and Airedale, to address the learning points not previously identified.

3. Executive summary and recommendations

Introduction

3.1 NHS Yorkshire and the Humber (the SHA) commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of a mental health service-user (Mr B). 'We' in this report refers to the Verita investigation team.

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

3.3 The purpose of this independent investigation, as detailed in the terms of reference, is to comment on the suitability of the care and treatment provided and how this reflected national and local requirements. The purpose is also to identify things that were done well, causes of the incident and learning points for improving systems and services.

The incident

3.4 Mr B, a 21-year-old man, fatally stabbed his younger brother aged 9 and wounded his elder sister aged 19 at her home in February 2010. He was convicted of manslaughter and was given a hospital order for an indefinite period.

Background to the independent investigation

3.5 At the time of the incident, Mr B was receiving care and treatment from two separate organisations: Bradford District Care Trust (BDCT) and Bradford and Airedale Community Health Services (BACHS).

3.6 BACHS carried out an internal management review for inclusion in the Bradford Safeguarding Children's Board serious case review for the victim.

3.7 Significant improvements have been made within BDCT and we have identified further learning from our examination of Mr B's care and treatment.

Overall conclusions of the independent investigation

3.8 We had serious concerns about the overall management of Mr B's care. Nobody who took charge of his treatment had a clear overview of his problems and needs.

3.9 Despite our concerns, we found good practice in some areas and Mr B was generally seen by skilled and conscientious staff. Mr B was referred to the adult team and the early intervention in psychosis (EIP) service. He was given intensive practical support with valuable contributions from other agencies but there was no agreed overview of the link between his mental health and substance misuse. There are also questions about the diagnosis and the overall formulation of the case.

3.10 Mr B had a difficult childhood. In 2008 he had been assessed as having a low IQ. He only sporadically showed any commitment or motivation to participate in the treatment or support offered by workers both as an inpatient and in the community. He was admitted to an inpatient unit after violent behaviour towards his sister. We could not see what was achieved during the time Mr B spent on the ward and in intensive care, other than a period of containment. It did not result in any clearer understanding of Mr B's problems.

3.11 From the evidence we have seen we cannot conclude that any particular course of action would have prevented a serious incident.

3.12 BDCT has made significant improvements and we identify further learning, in relation to good practice and managing patients in the future, from our examination of Mr B's care and treatment.

Summary of Mr B's contact with mental health services

3.13 Mr B was under the care and treatment of child and adolescent mental health services (CAMHS) between December 1994 and June 2002. The case was closed in June 2002 because the family had not attended appointments.

3.14 Mr B was seen by a clinical psychologist at the Bradford Magistrates' Court at the request of Mr B's solicitors on 16 October 2008 and a report was written on the 3 November 2008. The psychologist recorded in the report that Mr B had a below average IQ of 68.

3.15 Mr B was referred by his GP, to the adult mental health team in September 2008 and first seen in outpatients in November 2008.

3.16 In April 2009 Mr B was referred to EIP.

3.17 On 8 May 2009 a Mental Health Act assessment was undertaken prompted by increasing violence to the family. He had assaulted his sister the day before, giving her a black eye. Mr B was admitted to ward 1 at hospital A on Section 2[1] of the Mental Health Act.

3.18 Mr B was transferred to the psychiatric intensive care unit (PICU) at hospital B on 8 June 2009 for a period of assessment without illicit drugs. He returned to ward 2 at hospital A on the 22 June.

3.19 The family reported on 17 August 2009 that overnight leave had gone well with no violence or aggression. Mr B was re-graded to informal status and discharged with a seven day follow-up appointment arranged with the EIP service.

3.20 Mr B was in regular contact with the EIP service and with his outpatient consultant between August 2009 and February 2010 apart from two periods in December 2009 and January 2010.

3.21 On 18 February the EIP service made an urgent visit to Mr B in answer to a message left on the team's answer phone. He later went to see his GP.

3.22 On the same day Mr B fatally stabbed his younger brother, aged 9, and wounded his elder sister, aged 19, at her home.

[1] Assessment up to 28 days

Diagnosis and treatment

3.23 Mr B only sporadically showed any commitment or motivation to participate in the treatment or support offered by both inpatient and EIP staff and went absent without leave (AWOL) from the ward on several occasions. It appears that the CAMHS notes were never received by adult services and there were some inaccuracies in the history given by the family. We have concerns over the formulation of the case, that the relationship between the substance misuse and apparent psychotic symptoms was not sufficiently or adequately explored and that the significance of the history of violence going back years had been missed. The risks were not conveyed to the GP in the outpatient letter sent in February 2009 or the discharge summary sent in October 2009. It was unclear what the overall plan was for his care and treatment and it may have been a missed opportunity not to have spoken to Mr B's grandfather on 18 February 2010.

Early intervention in psychosis service

3.24 EIP staff provided intensive practical support to Mr B which colleagues regarded highly. EIP staff tried to engage with Mr B and worked hard to address his needs but there was no documented agreed overview of his problems and no system to coordinate it.

3.25 The EIP clinical lead now attends all team meetings on a weekly basis and is systematically involved in regular case reviews and clinical supervision.

Risk management

3.26 Risk profiling was in place for Mr B in the adult service and a great deal of relevant information was recorded. A reliable overview of the current risks to inform his care plan was missing.

3.27 EIP now has a robust system to monitor risk assessments and management plans. Clinical managers in all teams should monitor the content of risk summaries.

Care programme approach and discharge planning

3.28 We found the discharge arrangements in August 2009 overall fell short of good practice in view of the risks. The CPA process was not used to determine a meaningful care plan for Mr B after discharge from the ward. The EIP team visited him regularly but it is difficult to see what they were trying to achieve.

3.29 BDCT has revised its care coordination policy and has made considerable improvements to CPA and care planning.

Carer assessment

3.30 The notes show that staff had a great deal of contact with Mr B's family, both while he was an inpatient and living at home. A carers assessment was never offered to either of the parents.

3.31 The EIP service has improved systems for documenting the involvement of families and carers and for recording carer assessments.

Use of the Mental Health Act

3.32 We considered the use of the Mental Health Act for Mr B was appropriate on the two occasions it was used.

Referral to social care

3.33 During Mr B's admission in May 2009 information about Mr B's history and past behaviour was not shared by social services until 30 June. This delay left gaps in the knowledge available about Mr B's past.

Interface, communication and joint working

3.34 Formal systems for the interface and communication within mental health services and with partner organisations were adequate. CPA and care planning systems were not used to facilitate the interface with partner agencies, which relied heavily on the good relationships established by workers in the team.

3.35 We found no evidence that the quality of written communications from junior medical staff to the GP was monitored or overseen by the relevant consultants. The trust has informed us that they have since developed a memorandum of understanding with local clinical commissioning groups which clearly describes standards pertaining to timeliness and quality of written letters by medical staff in BDCT. This will be audited within the CPA audit.

Records management

3.36 The standard of handwritten case notes was generally good but there were some problems with legibility. This diminished the value of some entries, as we were not sure we, or anyone else, could identify the key issues. Other problems with record keeping included: the failure of some staff to identify themselves legibly; gaps in the EIP records; poor CPA documentation and the absence of some correspondence from the case file. The RiO patient information system will have made a big difference to the quality of the single patient record. This should enable staff to access a clear and comprehensive overview for each service user.

3.37 It is unclear whether the CAMHS notes were ever received by the adult services although CP3 was clear he had never seen them. The CAMHS notes contained details of unusual and abnormal behaviours displayed by Mr B from as early as five-years-old. The behaviour in his childhood was fundamentally different in its nature from the later antisocial behaviour. This information would have informed those caring for Mr B.

3.38 Problems with tracing some of the documentary evidence for our investigation meant we spent more time than expected requesting and examining documents. The arrival of batches of disparate documents at different times further complicated our

analysis. The full set of evidence collated for the internal management review undertaken by BACHS was not retained for future reference.

3.39 BDCT has undertaken significant development work but we did not see a comprehensive update of progress on all the recommendations from BACHS's internal investigation. We wondered how this could be monitored effectively.

Recommendations

R1 BDCT should continue to explore the capacity and acceptance criteria of the EIP service to ensure it can adhere to its key objectives, as well as the requirements of the trust, whilst providing added value for service users.

R2 BDCT should review the effectiveness of the current model of specialist clinical leadership for EIP staff in CMHTs. The arrangements should provide a robust focus on the formulation and review of the service user's diagnosis, risk profile, treatment and objectives throughout the period of EIP involvement, as they move between inpatient and community care.

R3 BDCT should ensure clinical managers in all teams monitor the content of summaries in risk profiles. Summaries must provide a reliable overview of current risks.

R4 BDCT should audit care plans to check: a) the care plan can be understood by staff who do not know the service user and b) the care plan is copied to all those involved.

R5 BDCT should ensure registration/admission forms and care plans identify a) if there is a carer and b) what support is being offered to the carer and c) what contact there is with the family if there is no carer. BDCT should ensure all teams, including CAMHS and EIP, identify carers and the involvement of families in accordance with trust policy.

4. Approach and structure

Approach of independent investigation

4.1 The investigation team (referred to in this report as 'we') comprised Sue Bos and Liz Howes, senior investigators with Verita. Chris Brougham and Derek Mechen were peer reviewers. Professional psychiatry advice was provided by Dr Mostafa Mohanna, a consultant psychiatrist and until recently the medical director at Lincolnshire Partnership NHS Foundation Trust. Biographies for the team are given in appendix A.

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

- Openness – the investigation should provide an open, transparent, factual and independent account of the circumstances leading up to the incident and relevant associated matters.

- Learning lessons – finding out what has gone wrong and proposing improvements while balancing individual accountability with criticism of organisational systems and processes.

- Creating the circumstances for change and service improvement – making recommendations that help NHS organisations improve and develop in order to offer better services. Creating a climate in which organisations and individuals accept and act on the findings of the report.

4.3 The SHA wrote to Mr B and asked for access his clinical records. He gave his consent in September 2011 and our independent investigation started in December 2011, once we had received the first batch of documents from BDCT. The SHA had to seek consent for a second time in April 2012 because the original consent had expired. We received most of the documents we needed by the end of May 2012. We outline in relevant sections of this report the problems with tracing documents and we include a summary in the section on records management.

4.4 We examined documentary evidence, listed in appendix B including:

- relevant BDCT and BACHS policies and procedures
- copies of Mr B's mental health records
- Mr B's electronic GP records
- BACHS's internal management review
- statements and transcripts of interviews for the internal management review
- GP internal management review
- psychiatric court reports.

4.5 All the evidence about Mr B's care and treatment in our report is taken from these documents. Where we use information provided by staff in statements or at internal interviews, we say this was recalled or said later.

4.6 BACHS carried out an internal management review (IMR) as part of the serious case review relating to the death of Mr B's brother. It included a detailed review of some aspects of Mr B's care and treatment. However, we found no reference to his diagnosis or the care and treatment he received as an inpatient. A trust internal investigation would have had different terms of reference and been undertaken by a multi-disciplinary team. This may have considered further issues such as those we have identified which could have been considered sooner if they had been included.

4.7 Our investigation was commissioned as a documentary review and we did not originally plan to interview any of the people directly involved with the care and treatment of Mr B. We were asked by the SHA to meet with the consultant psychiatrist involved with Mr B's care in the community in relation to his formulation of diagnosis. We also had questions about the documentary evidence and actions plans so, in agreement with the SHA, we met three senior representatives of the early intervention in psychosis service and a representative from the PCT.

4.8 We sent our draft report to the SHA, the PCT and BDCT on 15 October 2012 for comments on factual accuracy.

4.9 We met Mr B as a matter of good practice at the outset to explain the purpose and process of the independent investigation and we shared the terms of reference with him. We also shared our findings with him once we had completed our investigation.

4.10 We offered to meet with Mr B's family to explain the purpose and process of the independent investigation and to explain the terms of reference to them. We also offered to meet with them to share our findings. They choose not to meet with us on both occasions and we respect their wishes.

4.11 We have analysed all the evidence and comments received and made independent findings and recommendations to the best of our knowledge and belief.

Report structure

4.12 We investigated the care and treatment Mr B received from the start of his contact with the adult mental health service in October 2008 until the incident in February 2010. We include some background information from the time Mr B was receiving care from the CAMHS but we have not examined in detail the care provided because it was outside of our terms of reference. We examined the suitability of the care and treatment in view of Mr B's history, vulnerability and assessed health and social care needs.

4.13 We considered Mr B's care and treatment under these key themes:

- diagnosis and treatment
- early intervention in psychosis service
- risk management
- care programme approach and discharge planning
- carer assessment
- use of the Mental Health Act 1983
- referral to social care
- interface, communication and joint working
- records management.

4.14 The terms of reference required us to consider the extent to which Mr B's care and treatment corresponded with statutory obligations and relevant guidance from the Department of Health at that time and how local operational policies and practices conformed with such guidance. We considered the key themes in relation to the specific policies and guidance set out in the terms of reference and we detail our findings under the relevant heading.

4.15 We identify throughout this report aspects of Mr B's treatment and management that were good or commendable.

4.16 The analysis and comments of the investigation team in this report are in ***bold italic*** script.

5. Diagnosis and treatment

5.1 In this section we outline what we know about Mr B's background and examine his diagnosis and treatment while he was in contact with the mental health services. We consider this in five chronological episodes of care: December 1994 to June 2002 when Mr B was under the care of CAMHS for information only; November 2008 to January 2009 when Mr B was seen in outpatients; April to May 2009 when Mr B was treated in the community; May to August 2009 when Mr B was an inpatient at hospital A, including a period of psychiatric intensive care; August 2009 to February 2010 when Mr B was treated in the community.

Background

5.2 Mr B was born in 1989 to a family living in West Yorkshire. He is the eldest of four siblings. Mr B's family had various problems and had moved house a number of times when he was a child. He used cannabis from the age of 13. He had lived an isolated life since the age of 17.

5.3 Mr B was under the care and treatment of the CAMHS between January 1995 and June 2002. The case was closed in June 2002 because the family had not attended appointments.

5.4 In 2006, when Mr B was 17, he was subject to an ASBO[1] whose conditions he repeatedly breached. He attended a Young Offenders Institute (YOI) on two occasions and he attended a YOI for a breach of probation for a robbery. At 18, he received a four-month prison sentence for burglary which he served at Doncaster Prison. He stole throughout his teens to fund his cannabis habit.

5.5 Mr B was seen by a clinical psychologist at the Bradford Magistrates' Court at the request of Mr B's solicitors on 16 October 2008 and a report was written on 3 November 2008. The psychologist recorded in the report that Mr B had a below average IQ of 68 which falls within the mild learning disability range.

[1] Anti-social behaviour order

December 1994 to June 2002

5.6 Mr B received care and treatment from the CAMHS in Bradford and Scarborough. We did not examine the care and treatment provided by the CAMHS as this was not part of our remit. We include some keys aspects of that period because they provide a background and context to Mr B's future care.

Evidence

5.7 Mr B was referred to the CAMHS service in Bradford for the second time on 16 January 1996 by general practitioner 1 (GP1). Mr B was described as being uncontrollable, naughty, fidgety and aggressive and was fighting with his sisters. He was living with his mother and sisters at their grandparent's home as his mother and father had separated: there had been violence in the marriage.

5.8 CAMHS told the family in a letter on 27 February 1996 that there was a long waiting list and that they would contact them again when an appointment became available. A letter offering an appointment for 18 June for an initial assessment was sent to the mother on 10 June that year.

5.9 Mr B was reviewed by senior registrar 1 (SR1) on 13 August 1996 as at the initial assessment with the social worker a query about hyperkinetic disorder a term that describe the problems of children who are hyperactive and have difficulty concentrating, also known as attention deficit hyperactivity disorder (ADHD) had been raised. At the appointment on the 13 August Mr B had talked about an episode where he had urinated on his sister in response to being teased.

5.10 A letter to GP1 of 19 August says that SR1 found no evidence of hyperkinetic disorder but that Mr B's behaviour could be the result of growing up in a troubled environment. The letter explains that social services were no longer involved and that Mr B had never been on the child protection register in spite of previous concerns.

5.11 A letter to GP1 dated 19 December 1996 said the CAMHS had seen the mother and grandmother once since August and that two appointments had been missed by the family. CAMHS had decided to remain involved despite this. The letter explained that Mr B's head

teacher was contacting social services because she was concerned about his general wellbeing.

5.12 The family failed an appointment with CAMHS on 3 March 1997. A letter was sent to the mother explaining that if there was no further contact Mr B would be discharged back to the GP. Mr B was discharged on 14 April 1997.

5.13 Mr B was then seen by Scarborough, Ryedale and Whitby CAMHS Service for approximately two years between 1997 and April 1999 whilst he was living in Scarborough. He was diagnosed as having ADHD and was treated with methylphenidate, also known as Ritalin, with good effect until it was stopped by the family who said that the drug was causing Mr B to lose weight and was turning him into a 'zombie'.

5.14 A referral letter from Scarborough CAMHS from consultant psychiatrist 1 (CP1) to Bradford CAMHS on 20 April 1999 asked that they take over the management of Mr B who was now living back in Bradford. He had been living in Scarborough for two years. He was described as a young man with ADHD.

5.15 Bradford CAMHS sent an appointment for 24 June 1999.

5.16 CP2's letter dated 30 June 1999, to CP1, copied to GP2 after this appointment said that Mr B had always lived in an unsettled environment and that his behaviour was explicable in these terms but Mr B also met the criteria for ADHD. Mr B was taking Ritalin 10mgs.

5.17 An appointment took place on 19 October as part of the ADHD clinic with CP2. Mr B had stopped taking Ritalin because of concerns over poor appetite and weight loss. CP2 recorded in the notes that they could not support the diagnosis of ADHD because they had not been able to observe Mr B at school or home and his behaviour was different when he was with his paternal grandfather. Three further appointments were arranged in November and December 1999.

5.18 A letter from CP2 dated 23 May 2002 to the mother said that Mr B had not been seen for some time and had failed to attend an appointment on 12 March 2002. He had been seen at the end of 2001 when things were going well. If no contact was made Mr B would be discharged from the CAMHS. Mr B was not on medication at this point.

5.19 Mr B was discharged from the CAMHS on 18 June 2002.

5.20 During the period January 1995 and October 2001 various abnormal behaviours on the part of Mr B were recorded. He had banged the dog's head against the wall until it bled; urinated over his younger sister and on his toys; smeared dog faeces over his face and that of his sibling; and played with his genitals and otherwise exposed himself to his siblings.

5.21 Consultant clinical psychologist 1 (CCP1) saw Mr B in October 2008 at Bradford Magistrates' Court at the request of Mr B's solicitors. He found Mr B had an IQ of between 55 and 70, the age equivalent of a child of 8 or 9, which would put him in the mild learning disability range. We saw no evidence that any reasonable adjustments were considered necessary or made to Mr B's care as a result of this report.

November 2008 to January 2009

Evidence

5.22 Mr B attended three outpatient appointments in the adult service after being referred by his GP during this period.

5.23 Mr B was first referred to adult mental health services on 22 September 2008. The GP had made a referral to CAMHS but this was passed onto the adult services because Mr B was now 19.

5.24 Mr B's mother and grandmother were increasingly concerned about his behaviour.

5.25 Mr B was seen by senior house officer 1 (SHO1) on 25 November 2008. He was accompanied by his mother and grandmother. The notes say he was becoming increasing socially isolated and withdrawn and often aggressive at home, with poor concentration. His condition had deteriorated over the last 12 months. No plan is recorded in the case notes.

5.26 Mr B attended another appointment with SHO1 on 4 December, this time with his mother and younger brother. Mr B's behaviour is reported by his mother as still being

difficult and the plan is: to wait for blood results: CT and MRI results: refer to neuropsychologist: next appointment in three weeks.

5.27 He attended another appointment with SHO1 on 29 January 2009 with his mother. His behaviour was still difficult. He was aggressive, spitting and swearing at his mother and on one occasion punched her. The notes say that Mr B turns off lights before he goes into a room, that he has problems with his memory and he is taking less pride in himself. Mr B denies his mother's story of events and of him taking drugs.

5.28 SHO1 wrote to the GP3 on 27 February.

Analysis and Comment

5.29 ***The SHO saw Mr B three times between November 2008 and January 2009. He wrote a detailed assessment letter to the GP but the level of violence in the home was not included and the letter focused on Mr B's neurological needs. We would have expected the SHO to have sought advice from his supervising consultant given the unusual and violent history with this case. We discussed this with consultant psychiatrist 3 (CP3) who said he could not initially recall the SHO coming to discuss the case with him. He recalled the SHO did regard Mr B's case as unusual, he could not recall whether the case was discussed in weekly supervision sessions or the ad hoc supervision sessions. Later on in the interview it was established that CP3 prepared a case summary which was initially created on 25 November 2008 and was last modified on November 2009 CP3 accepted that to prepare this he must have obtained information from the SHO and the notes that already existed. CP3 also said towards the end of the rotation the SHO tended to act independently despite having regular supervision with CP3 and this had been raised with his vocational training scheme (VTS) supervisor at the time.***

5.30 ***The trust has informed us that they have since developed a memorandum of understanding with local clinical commissioning groups which clearly describes standards pertaining to timeliness and quality of written letters by medical staff in BDCT. This will be audited within the CPA audit.***

February 2009 to May 2009

5.31 The community mental health team (CMHT) and EIP service saw Mr B during this episode.

Evidence

5.32 Police phoned the CMHT duty worker on 4 February 2009 to say that Mr B was in custody for slapping his mother. They asked for an appropriate adult to be allocated in line with national guidelines for safeguarding the rights and welfare of young people and vulnerable adults in police custody.

5.33 The IMR shows that the plan was to discuss this at the team meeting but there is no evidence to suggest the CMHT took any further action.

5.34 Mr B's grandmother phoned the CMHT on 4 February expressing concern about the wellbeing of Mr B and his brother. She said CAMHS had seen Mr B in the past and had prescribed Ritalin. The family wanted help. The plan was to discuss the case at the CMHT referral meeting.

5.35 A referral from the GP for Mr B was faxed to the CMHT on 21 April 2009.

5.36 Two community psychiatric nurses (CPN1 and CPN2) undertook a home visit on 22 April 2009 at the request of gateway worker 1 (GW1) due to increase in violence against the mother. The father had moved back into the family home. The notes state that "[Mr B] *was responding to unseen stimuli and was displaying poverty of speech.*"

5.37 The assessment was discussed with CPN1, CP3 and early intervention in psychosis 1 (EIP1). They agreed that Mr B's case was appropriate for the EIP service. They planned that CP3 would review Mr B after the EIP assessment.

5.38 EIP2 phoned Mr B on 28 April to arrange an initial visit from the EIP Team. EIP2 left a message arranging a visit for 2.30pm on 30 April.

5.39 EIP made a telephone call to the General Practice to clarify if a referral had been made to a neuropsychologist following the recommendations of CCP1 in November 2008. The only referrals the surgery knew about were to the CMHT in November 2008 and February 2009.

5.40 The notes show that EIP called CAMHS on 29 April to request their notes.

5.41 EIP2 and GW2 visited Mr B at home as arranged in the message left on his mobile. He was in bed and neither the family nor Mr B was expecting them because he had not received the message. He came down but he was reluctant to talk and kept saying *"I'm alright"*. A further visit was arranged for 6 May at 15.30. Mr B and his mother were aware of the appointment.

5.42 EIP2 and clinical psychologist trainee 1(EIPCPT1) visited Mr B at home on 6 May. He sat with them for 20 minutes but said little except *"I'm fine"*. It was explained to Mr B by EIP2 what the EIP could offer young people. The notes show that Mr B stared suspiciously at his visitor but he agreed for them to visit again and for EIPCPT1 to meet his mother on 13 May.

5.43 Mr B's mother rang the CMHT on 7 May to say that Mr B had hit his sister and the police had been called. She did not feel it was a crisis but she wanted to talk to someone. This information was passed to EIP by the CMHT by phone at 13.00 on the same day.

5.44 At 13.45 EIP2 phoned Mr B's mother and left a message about wanting to talk.

5.45 On 8 May at 10.30 a telephone call was made by EIP2 to the mother. The mother said things were very stressful she reported that Mr B had not been himself since he left prison in Doncaster in the summer of 2008. She described details of Mr B's violence to family members. She said this had calmed down over the last month but that Mr B had been violent to family members at least once a week. Sometimes it was after an argument, sometimes it was unprovoked. Three weeks earlier Mr B hit her and threw an ashtray at his sister. He had pressed his hands on the head of his sister's seven-month-old baby. Mr B's mother said they were all living in fear and were hiding from him. She expressed her worries that she could not cope much longer.

5.46 After the phone call EIP2 texted the mother to say she would be at the family home by noon which was a prompt response.

5.47 EIP1 and EIP2 visited the family home at noon on 8 May. Mr B seemed distracted and glanced around the room. They asked about the incident on 7 May. Mr B said "*he had apologised and it was fine"*. He said he wanted to stay at home and a number of strategies to allow that were put to him this included: medication; informal admission; input from the crisis team. Mr B firmly refused all of them. Due to the risks the EIP staff explained to the mother that Mr B should be assessed under the Mental Health Act for formal admission and she agreed. EIP1 and EIP2 explained to Mr B that they would return with other people to assess him later.

5.48 EIP1 phoned Mr B's mother at 14.30 to tell her the assessment had been arranged for 17.30 Mr B's mother expressed concern that he would not go to hospital willingly.

5.49 The actions of EIP on the 8 May were prompt and appropriate.

5.50 EIP2 phoned child protection at 15.30 to say that police had already made a referral after an incident on 14 April 2009 when Mr B had punched his sister and mother.

5.51 At 16.00 the same day social care 1 (SC1) phoned EIP2 explaining that she needed to know that Mr B would be removed from the family home to protect the children from violence. She asked that EIP2 ring with the outcome of the Mental Health Act assessment.

5.52 The outcome of the Mental Health Act assessment was that Mr B was admitted to hospital under Section 2 of the Mental Health Act.

Analysis and comment

5.53 ***We could not find any assessment documentation completed by the EIP team. It appears that Mr B was accepted for the service after the discussion with CP3, CPN1 and EIP1 after the CMHT assessment on 2 April.***

5.54 ***The EIP team responded promptly to this discussion and saw Mr B initially on 30 April. They again responded promptly and appropriately on 7 May when Mr B's***

mother rang to tell them of the violence to his sister. 0n the 8 May EIP responded appropriately and promptly in relation to the events and Mr B's subsequent admission.

May 2009 to August 2009

5.55 During this time Mr B was an inpatient at hospital A and the PICU at hospital B under the provisions of Section 2 but later converted to a Section 3 and was discharged to the EIP Service.

Evidence

5.56 BDCT had a draft operational policy dated January 2008 for the PICU at hospital B. Updated versions were issued in March and September 2011. The January 2008 version sets out the referral criteria:

> *"Service users admitted to the PICU will have behavioural difficulties which seriously compromise their physical or psychological well being or that of others and which cannot be safely assessed or treated in an open acute inpatient facility."*
>
> *"Service users will be admitted if they display a significant risk...in the context of a serious mental disorder..."*
>
> *"There must be mutual agreement between referrer and admitting unit on the positive therapeutic benefits expected to be gained from the time limited admission including a clear rationale for assessment and treatment."*
>
> *"If beds are available, short admissions for drug-free assessments will be considered dependent on assessment of need and risk."*

5.57 Under 'joint assessment with ward staff' the policy says:

"Arrangements will be made for a joint assessment to take place between referrer, PICU staff and service user where possible. At this meeting the CPA care plan will be reviewed and a FACE[1] risk assessment completed and/or amended ... Interventions to be implemented during the admission will be discussed and the therapeutic aim of the PICU admission will be identified. The final decision to admit will be determined by the PICU consultant."

5.58 Under 'admission' the policy says:

"Service users admitted to the PICU will be detained under the Mental Health Act 1983."

"Referrer, PICU staff and where possible the service user will jointly agree on the aims of PICU admission, an objective measure of when those aims will have been met and an anticipated timescale for admission."

5.59 Mr B was admitted under Section 2 of the Mental Health Act to ward 1 at hospital A on 8 May 2009. This was his first admission to a psychiatric hospital.

5.60 The EIP Team requested that he be assessed free from illicit drugs.

5.61 Mr B was made aware of his rights under Section 2 of the Mental Health Act on 9 May 2009 and offered the right of appeal.

5.62 The named nurse (NN1)recorded in the notes on 10 May that Mr B has no problem with information being shared with his family.

5.63 NN1 spoke with Mr B's mother who said that the violence had increased recently to once a week.

5.64 A CPA review was arranged for 11 May at 10.00am. Mr B's mother, EIP1 SC1 and SC2 were made aware.

[1] Functional assessment of the care environment.

5.65 EIP1 visited Mr B on the ward on 11 May. Mr B did not want to see him because he was sleeping. Mr B agreed to a visit on 12 May.

5.66 On 11 May at 18.10 Mr B was offered time by a ward nurse but Mr B declined saying he was too tired. A member of the ward team later observed him chatting and watching TV. The ward nurse asked him not to take the communal CD player into his room.

5.67 On the same day Mr B was seen by consultant psychiatrist4 (CP4). The plan was to observe patient medication-free apart from PRN[1].

5.68 He was offered one-to-one time on 12 May but refused again. He refused all hospital meals but ate crisps in his bed area. He was observed dancing in his room and spent time in the arts and craft area.

5.69 EIP2 visited Mr B on the ward at 15.30 on 12 May but Mr B said he could not be bothered to talk. EIP2 said she would return later in the week.

5.70 Mr B was playing the ward stereo loudly in his room at 16.00 on 12 May. Staff came to remove it and noticed smashed cups on the floor, which they cleared up. Mr B could not say why the cups were in his room.

5.71 At 20.20 on the same day Mr B denied breaking an arm and leg off a chair in the payphone. The broken pieces were found in his room but he denied he had touched it. He accepted 1mg lorazepam. The notes show that Mr B was acting bizarrely, looking through the annexe window where the chair was being stored.

5.72 At 20.40 the same day Mr B intimidated a fellow patient Mr B declined time with staff. He was pre occupied and was observed muttering.

5.73 Mr B was offered one-to-one time with ward staff on 13 May, which he again refused. He refused to eat food from the hospital, remained guarded and rarely sat still. He played music loudly but turned it down when requested.

[1] Medication that should be taken only as needed

5.74 CP4 met with Mr B on 14 May. Mr B refused to be seen in the interview room and the meeting took place in his room. CP4 recorded in the notes that Mr B said:

> *"'I'm fine. I'm alright' He declined to discuss how he was; he had no plans for the day. Isolates himself in his room. Motivation seems poor. He denies there is a problem. Not asking to leave at present. Evidence of psychosis since November 2008 and history preceding this, since out of Doncaster jail."*

The plan was to hold a CPA meeting on 15 May and to discuss medication and the appropriateness of Section 17[1] leave.

5.75 At 18.40 Mr B refused one-to-one time with ward staff. He was observed responding to unseen stimuli. He had also been found smoking on the ward and was asked to go outside. The ward smoking policy was explained to him. He accepted 1mg lorazepam when he asked for a sleeping tablet. He ate a small amount of food at tea time.

5.76 At 20.25 Mr B went to the recreation hall and interacted with patients and staff.

5.77 The CPA review took place on 15 May. The meeting was attended by CP4, EIP1, SC1, SC2, Mr B's mother and grandparents. His mother was happy to have Mr B home for leave.

5.78 The plan agreed was: "*Home leaves after social services had undertaken assessment: escorted leaves to shop up to 30-60 minutes: prescribed olanzapine 5mg: ECG and chase bloods*". Mr B was told by CP4 he should not drive for three months after his psychotic episode had settled.

5.79 Mr B was more interactive with ward staff at 16.40 on 16 May.

5.80 Mr B refused one-to-one time with ward staff at 17.55 on 17 May. He continued to push boundaries by smoking in the music room and playing loud music. Mr B agreed to turn down the music but continued to smoke and his interaction with patients and staff was limited.

[1] Section 17 of the Act allows for the responsible clinician to grant short periods of leave from the ward whilst on a section of the Mental Health Act 1983

5.81 EIP2 visited Mr B on the ward at 14.30 on 18 May. He refused to see EIP2 saying that he was 'fine'. Mr B continued to smoke on the ward and refused to engage with staff or family members when they visited.

5.82 Mr B punched a fellow patient in the face at 23.30 on 19 May. Others patients said that the patient who Mr B had punched had spat on Mr B and had invaded his space. Mr B accepted 1mg lorazepam. An incident form was completed and the FACE risk assessment and Honos[1] score updated.

5.83 CP3 discussed Mr B's presentation with ward staff and saw Mr B. CP4 wrote in the notes "*evidence of ongoing psychosis still seen. Accepting Lorazepam*". The plan was: limit Section 17 leave escorted leave to only 1 hour: risk assessment from social services still awaited: continue low dose olanzapine: continue observing mental state.

5.84 Mr B decided to appeal against his Section 2 on 20 May.

5.85 Mr B was seen again by CP4 on 22 May. CP4 noted that Mr B's mother did not feel that Mr B should be at home when he was better and that he should not appeal his against the Section 2. The plan was: social services risk assessment still awaited: Section 17 leave with staff 1 hour only.

5.86 CP4 also records that Mr B had been found smoking cannabis on the ward and that he tried to obtain cannabis on 20 May.

5.87 CP4 told Mr B on 23 May that a further period of assessment may be needed after the 28 days of the Section 2. Mr B accepted this and agreed to work with staff. Until this he had thought that he would be discharged after 28 days.

5.88 On 25 May Mr B undertook a drug-screening test which came back positive for cannabis.

5.89 Ward staff phoned social services on 26 May to ask for progress on the risk assessment. A message was left for SC2 because she was not available.

[1] Health of the Nation Outcome scales measure the health and social functioning of people with severe mental illness

5.90 A further CPA review was held on 26 May. The plan is recorded in the notes as:

"*advise* [Mr B] *to avoid cannabis; support him with his appeal against Section 2; await child social services; two hours Section 17 leave with father: EIP to support other leave if possible: mother not yet feeling able to have* [Mr B] *home: advise* [Mr B] *and family that* [CP4] *will be suggesting move to Section 3: Olanzapine to 10mg."*

5.91 On 27 May CP4 reviewed Mr B and wrote in the notes

"Working diagnosis: "Psychotic episode likely relating to cannabis use (paranoid schizophrenia but until cannabis free for period of weeks this diagnosis cannot be reliably applied)."

5.92 CP4 wrote a report for the tribunal on 28 May advising that Mr B remain sectioned under the Mental Health Act. The report said:

"his personality seems to have been changing"

"has a "history of change in behaviour, personality and cognitive function since leaving school at the age of sixteen."

5.93 CP4 also says Mr B *"was seen by a neuropsychologist who also noted the cognitive decline".*

5.94 The Section 2 tribunal was held on 1 June. Mr B gave his evidence and left. He did not acknowledge the previous incidents of violence before his admission to hospital. The tribunal decided that Mr B should remain on section. CP4 completed the Section 3[1] recommendation.

5.95 Mr B threw his Walkman against the wall in his room and left the ward without permission on 2 June at 21.00. The police, his mother and grandmother were informed by ward staff.

[1] For treatment after assessment

5.96 Mr B returned to the ward with his brother at 23.35. His brother said Mr B had gone home. Mr B accepted that he may be hearing voices after a discussion with ward staff about his unauthorised departure.

5.97 Mr B was detained under Section 3 of the Mental Health Act and he refused to have his rights of appeal read to him when this was offered by a the ward nurse.

5.98 On 5 June Mr B was made aware of his right to appeal against his section, which he declined to do and he also refused an independent mental health advocate.

5.99 Mr B was found smoking in another service-user's bedroom.

5.100 Mr B was seen in the ward garden area on 7 June area smoking cannabis with another patient. Mr B became aggressive. He was asked to return to the ward, which he did eventually. An incident form was completed.

5.101 CP4 reviewed Mr B on 8 June. The outcome of the review was that Mr B to be transferred to the PICU to be assessed illicit drug-free.

5.102 The risk assessment and care plan were faxed to the PICU by staff on ward A on 8 June at 19.40. It was planned that Mr B would be transferred the following day at 9.00.

5.103 Mr B was admitted to the PICU for a period of assessment without illicit drugs. The purpose of his admission to the PICU is clearly written in the notes. On admission Mr B denied taking cannabis recently and said he had been in prison three times for anti-social behaviour. The plan was: "*continue olanzapine 10mg nocte: observe behaviour/psychotic symptoms: Level of observations 1: to be reviewed by team*".

5.104 Mr B's risk management plan was updated on 10 June. He was approached about his rights under Section 3 of the Mental Health Act. Mr B declined to receive his rights. He was encouraged to visit the day area by staff.

5.105 On 11 June Mr B was observed by staff shadowboxing. He stopped when requested by ward staff. He was encouraged to attend the day centre but was reluctant to do so. There was no evidence of low mood agitation or odd behaviour. Mr B was read his rights,

which he accepted. His sister visited, and he behaved appropriately. At times on the ward he was seen to be responding to unseen stimuli.

5.106 On 12 June he had shown patience waiting for staff to be available for him when he had requested cigarettes. It is recorded in the notes that he had not been a management problem and had asked about going out with his parents. Ward staff explained to him that Section 17 leave would be considered when he was settled and back on the acute ward. Mr B said during one-to-one time at 13.00 that he hoped he could return to hospital A and look for work. He was difficult to engage but showed no obvious signs of responding to unseen stimuli or any unusual or inappropriate behaviour.

5.107 CP5 reviewed Mr B on 12 June. He denied using cannabis at all and denied any hallucinations. Mr B became subdued during the interview and smiled for no apparent reason.

5.108 A fellow patient said Mr B had been rude to him on 13 June. Mr B apologised.

5.109 Mr B tested positive for cannabis on 15 June.

5.110 CP5 and the multidisciplinary team reviewed Mr B on 22 June. It is written in the notes that Mr B was doing well, compliant with medication, and that there had been no aggression or violence. Mr B was to be transferred back to ward 2 at Hospital A the next day.

5.111 Mr B's stay at the PICU had been from 9-23 June.

5.112 The discussion at the review is recorded in the notes but there is no link to the original objective of Mr B's admission on the PICU, i.e. that he be assessed free from illicit drugs. Neither is there any evidence of formal handover back to the open ward.

5.113 On 22 June CP4 recorded in the notes that a letter had been received from social services advising of the outcome of their assessment and stating that the mother was anxious about Mr B returning home. The case on the family was closed to social services as his mother did not feel she needed help. Social services requested that they be informed when Mr B was to be discharged.

5.114 CP4 saw Mr B at 15.00 on 22 June. He was unconcerned about the transfer back to hospital A, he remained unwell in presentation but less paranoid about food. The outcome of the social services assessments had been received. The plan was: "*CPA to discuss Section 17 leave, letter from social services states that mother still not happy to have him at home, no leave until CPA, mother and EIP to be invited: Olanzapine 15mg".*

5.115 On 23 June CP4, and EIP2 agreed two hours Section 17 leave to assess his engagement with staff outside of the hospital environment. CP4 made EIP aware of the letter from social services.

5.116 A CPA review was held on 26 June attended by CP4, EIP2, SC2 mother and father and younger brother. The plan was: "*escorted 2 hours leave with family or EIP not to visit home: urine screen for drugs*".

5.117 Mr B went on leave with his father at 19.36 on 26 June. His father reported to the ward that Mr B had gone AWOL. Mr B returned to the ward several hours later.

5.118 CP6 saw Mr B at 11.25 on 30 June. He was distracted and muttering. CP6 made a note to ask EIP about his improvement.

5.119 At 16.00 the same day EIP2 rang the ward to explain:

> "*that social services had been withholding information about* Mr B.. *The information is about previous violence towards the family since the age of 5. He was at the time banging his dogs head against a wall until it bled and urinated on his sister."*

Nursing staff revoked section 17 leave as a result of this message.

5.120 EIP 2 explained to ward staff that Mr B had been known to EIP for only three months and they were unaware of his pre-morbid personality. The family had reported that his mental health had deteriorated since he came out of prison and that he had been normal until then. Also there had been instances of domestic violence in the family. The plan was for EIP to take Mr B out most days that week. A professionals' meeting was arranged for 7 July.

5.121 At 17.30 on the same day recovery coordinator (RC1) from the EIP service visited Mr B on the ward and arranged to take him out on 3 July. Mr B asked what early intervention was and said "*I'm fine*".

5.122 EIP2 visited Mr B on the ward on 1 July and suggested going out but Mr B declined. EIP2 arranged that a colleague would visit and take him out on 2 July.

5.123 Mr B's grandparents and parents visited separately on 1 July. Mr B took what they had brought for him, demanded money and told them to go away. He was seen by ward staff to be responding to unseen stimuli and was guarded and suspicious.

5.124 On 3 July Mr B attended a managers hearing which upheld his Section 3.

5.125 RC1 visited Mr B on 3 July, as arranged, but Mr B said he was not feeling well enough. A discussion took place about how he would like to use these visits. Mr B said he would like to go to bingo. RC1 arranged to visit again on 10 July to go to bingo. RC1 said Mr B was laughing and responding to unseen stimuli throughout the conversation.

5.126 Mr B was seen by ward staff smoking in his room at 18.40 on 3 July. He was challenged and he denied this and that he had a lighter. He was strongly advised not to smoke in his room and he agreed.

5.127 Mr B was not in his room when staff made their hourly check at 18.30 on 5 July. They could not find him in the hospital so the AWOL procedure was instigated. They contacted police and Mr B's family who said they would return him to hospital if he went home. Mr B returned to the ward 11.00 on 6 July. He said he had gone out with his uncle and admitted to smoking cannabis.

5.128 CP6 saw Mr B at 11.15am on 6 July at. The notes say:

> "[Mr B] *said he had spent the weekend with his uncle and he had seen the whole family. He said he had a spliff while he was out and that his father had brought him back today.*"

The plan was for EIP to take him because the risks '*were unchanged patient came to no harm*'.

5.129 On 7 July EIPCPT1 rang CAMHS and requested the notes for Mr B. The secretary had to request them from a different base where they were centrally held.

5.130 A professionals' meeting was held on 7 July attended by social services, EIP2, CP6, EIP3, EIP4 and EIPCIP1. SW2 told the meeting that in April 2009 Mr B had punched his sister in the head. She did not press charges, EIPCPT1 reported that she had lost engagement, and the family had worries of isolation.

5.131 The notes say:

> "*Confidential risks were shared by social services*; *Level of verbal aggression is very high: Parents relationship is unclear- father in the house for protection against* [Mr B]: [Mr B] *often stealing to fund cannabis habit."*

5.132 The conclusion was that Mr B was a risk to everyone at home. His brother was frightened of him. His mental health issues started in July 2008. The family were not working with social services while Mr B was not at home. His mental health had improved since his admission to PICU from where he had been discharged on the 23 June. He was much less aggressive although he became agitated when probed. The plan was to:

- *"organise a carers assessment* [SW2] *to be involved if family re engage*
- *meeting to observe sibling violence whilst supervised in hospital*
- *still not to visit home*
- *leave with EIP and family as long as staff are present*
- *risk assessment to be distributed*
- *EIP to chase CAMHS notes*
- *case needs to be re referred to children's services before unescorted leave starts by care coordinator*
- *if discharged from section at tribunal in August children's services to be informed*
- *family meetings to be planned."*

5.133 Mr B was asked several times to provide a sample for a drug screen on 7 July after he had been seen smoking on the ward. He refused to provide a sample. At 21.00 the alarms rang on the ward. Mr B and another patient had absconded by opening the fire doors. AWOL procedure was instigated. Mr B's father called the ward at 22.25 to say Mr B

had arrived at home and that he would return him to the hospital. Mr B returned to the ward at 22.50. He refused a drug screen.

5.134 The IMR states that on 8 July EIPCPT1 received a phone call from CAMHS explaining that the Mr B's notes were not in archive. The tracer card indicated that these had been sent to the CMHT in October 2008.

5.135 Mr B's grandparents visited him on 8 July. They thought he was better than he had been.

5.136 Mr B was playing loud music on the ward at 18.00 on 9 July. Staff took away the hi-fi. No evidence of psychotic symptoms was noted by ward staff.

5.137 Ward staff spoke with CP6 at 8.40 on 10 July and it was agreed to stop Section 17 leave until he was reviewed by CP6. EIP were informed by voice message.

5.138 Mr B later asked for the hi-fi system to be returned. Staff asked him to wait while they discussed his request. Mr B went to his bed area and then the alarms sounded. Mr B was found to have absconded and the AWOL procedure was instigated. Mr B returned to the ward at 12.45 on 11 July. He said he had been with his family and denied taking any illicit substances. He apologised and said he would not do it again.

5.139 A family meeting was held with CP6, EIPCIP1, EIP4 and ward staff on 13 July. The family said Mr B was not back to normal. He had been bright and fun-loving. He had begun to deteriorate after being in Doncaster prison. They also said Mr B's sister tormented him and that he was probably violent to her in retaliation. CP6 explained that anyone harbouring Mr B was breaking the law because he was on a section of the Mental Health Act. The family said they had no concerns about Mr B meeting with his siblings. They were advised by CP6 of the suggested supervised meeting with EIP at their home. The plan was: "*to try and develop greater rapport with intensive support from EIP and family: 2 hours Section 17 leave with family or EIP, The family promised to contact the ward if Mr B went AWOL again: continue Olanzapine: agreed with professional meeting plan that contact with children should be escorted with staff member*".

5.140 Staff on another ward reported at 18.15 on 14 July that someone had climbed on the roof and absconded. Mr B was found to be AWOL and the AWOL procedure was

instigated. Police, social services and family were informed. Discussion with CP6 resulted in: "*Section 17 leave to be stopped: Level 2 observations on return: CP6 to refer to Forensic Team to seek expert advice: to monitor his mental health*".

5.141 The family phoned to say Mr B was at home and they would return him to the ward. He came back at 22.25 and said he had drunk two cans of lager. Staff explained to him that he was on level 2 observations which meant someone should be with him at all times.

5.142 CP6 reviewed Mr B on 15 July. He had been AWOL four times in the past week and showed no remorse. It was agreed that the most productive way to manage the risks was to pursue a therapeutic approach and to continue one-to-one nursing observations. Leave with EIP was to continue but only with authorised leave. The forensic team were also asked to provide advice on risk management. Mr B's grandparents visited and told staff he was getting worse. At 20.40 Mr B was found to be smoking in the shower room, which set off the alarms.

5.143 Mr B told staff on 16 July that he wanted to go home. He showed them letters from his sisters saying they were missing him. He had been more communicative and polite since staff had advised him to work with them to achieve his discharge. There had been no management problems. He remained on one-to-one observations.

5.144 CP6 discontinued one-to-one observations on 17 July. Mr B had Section 17 day leave to home with EIP. No problems were noted. His father was encouraging him not to go AWOL and to work with staff. Mr B returned to the ward where he spent most of the time with fellow service-users and participated in making pizzas, which he enjoyed. He was then seen making sexually inappropriate movements and staff asked him to stop.

5.145 Over the next two days Mr B declined to engage with staff and on 20 July at 7.45 he was observed pretending he had a gun in his hand shooting at people on the ward. Later that day he went on leave with EIP to his home which appeared to go well but the atmosphere between him and his mother was strained.

5.146 CP6 could not review Mr B at 9.40 on 21 July because he was ill in bed. The plan was to continue as before.

5.147 The ward manager saw Mr B walking down the road at 16.45 the same day. Mr B had apparently left the ward via the roof and absconded. Police, Social Services and his father were informed. He returned to the ward at 21.30. His father had dropped him off. Mr B smelled strongly of alcohol. He denied drinking or taking illicit drugs but then admitted drinking two cans of beer. He was placed on one-to-one observations. He refused to supply a urine sample. This was the fifth time he had been absent without leave. CP6 saw him on 22 July.

5.148 The letter from the forensic service dated 23 July described Mr B as "*presenting with schizophrenia of undifferentiated sub type and traits consistent with dissocial personality, his mental state will deteriorate in the context of cannabis misuse.*" The service made a number of recommendations, including that Mr B's niece and his siblings should never be alone with him. The forensic service also noted their concerns over the support the family would provide in helping him to maintain his engagement with mental health service on discharge.

5.149 Mr B's siblings visited him on 27 July and no untoward occurrence was reported.

5.150 A CPA meeting was held on 28 July attended by CP6, SC1 EIP4, EIP2 and mother, father, grandparents and sister. All reported that his mental state had improved, that he was warmer with greater rapport and more emotionally reactive. The family wanted him to have leave at home. Social services advised that unescorted leave would need children's social service approval. The plan was: "*take off one-to-one observations: aim for increased time away from hospital: escorted leave up to 6 hours with EIP or ward staff, if with family no contact with children unless accompanied by EIP or ward staff: referral to social services re authorisation for unescorted leave*".

5.151 Mr B went out with his parents for a couple of hours in the afternoon. When he returned, he appeared slow, his eyes were red and he smelt of alcohol. He denied taking any alcohol or drugs. The conditions of his leave were explained to him and he admitted having drunk two cans of lager. Staff contacted his father to explain that he was not allowed alcohol.

5.152 Senior care manager social services wrote to EIP2 on 29 July acknowledging the home visits by Mr B and saying his father would be present. The parents had been made aware that they were responsible for the siblings. The letter also said children's services

had no role in this case after this point so EIP should make contact if there were any further concerns.

5.153 Mr B had leave again on 29 July. He returned to the ward at 21.00 as arranged and when asked for a urine sample said he had had some cannabis, which he had left in his room at home.

5.154 Mr B had leave again on 30 July with his family. He returned at the stipulated time and denied taking any illicit substances. He did not supply a urine sample.

5.155 EIP2 phoned the ward on 31 July and told staff that social services had sent an email confirming that Mr B could have overnight leave. A copy of the email was faxed to the ward. The father was happy for Mr B to go on overnight leave and would collect him next day.

5.156 CP6 reviewed Mr B on 31 July and agreed to six hours' unescorted leave and to review for overnight leave next week. Leave took place on the 1, 2, 3, 4 and 5 August with no problems reported. On 6 August he went to the cinema with EIP4.

5.157 Mr B was assessed and deemed appropriate for overnight leave on 7 August. He was due to return to the ward on 10 August. He returned as planned and was reviewed by CP6. EIP4 said Mr B's father had found Mr B a job. The father reported that leave had gone well. Mr B did not take medication while on leave because he did not feel comfortable with it. Mr B went on a week's leave.

5.158 CP6 reviewed him when he returned from leave on 17 August. His father said the leave had gone well but that Mr B could not hold down a job. There had been no violence or aggression, relationships with family had been okay. Mr B had not taken medication for two days while on leave because he was using cannabis. The plan was: regrade to informal[1] status; EIP4 to follow up in a week: seven days medication for discharge: diagnosis of paranoid schizophrenia F20. Mr B's section 3 was rescinded and he went on overnight leave until 18 August, when he was to collect his discharge medication. A message was left for EIP4 to undertake the seven day follow up appointment. He was off sick but an EIP worker agreed to inform him on his return.

[1] Without use of the Mental Health Act 1983

5.159 The junior doctor dictated the discharge letter to the GP on 29 September. It was typed on 12 October and stamped as being received by the GP on 15 October, two months after Mr B was discharged from the ward.

Analysis and comment

5.160 ***A significant aspect of this case is the unusual and abnormal behaviour, including unusual violence, displayed by Mr B from a young age, whilst still a child. This behaviour was described by the family and documented in the CAMHS notes, whilst Mr B was under their care. It is our view that the behaviour indicates serious personality issues that preceded any use of illicit substances and which cannot be ascribed to a mental illness such as schizophrenia. It is important to distinguish this behaviour from the antisocial behaviour that made its appearance later in the teenage years. Furthermore, the antisocial behaviour made its appearance certainly before the age of 16 years, again indicating personality issues.***

5.161 ***Prior to his admission the EIP service had not received the CAMHS notes despite them being requested.***

5.162 ***The trust has informed us that they now have single points of access for both community and inpatient services these identify as part of the information gathering details of a service user's GP, previous contact with mental health services, probation and the criminal justice system. Systems exist to ensure requests are made and followed up. This system should now ensure that all relevant information is available in a timely way.***

5.163 ***On 30 June EIP were informed by social services of the history of abnormal behaviours, including violence, since the age of 5 and the ward were immediately informed. We recognise that the information provided by social services about past behaviours is likely not to have been as detailed as that recorded in the CAMHS notes. This led to Section 17 leave being revoked.***

5.164 ***It appears that this was the first time EIP had been made aware of these behaviours and violence which, having made their appearance in early childhood, indicated an abnormal 'pre-morbid' personality. At the professionals meeting on 7***

July social services advised of past history and risks and Mr B was only allowed escorted leave.

5.165 *On 15 July he was referred to the forensic service for an opinion in relation to the risks he posed, this request was acted on in a timely way and a comprehensive letter offering advice on his management was provided. For the first time he was described in the letter from the forensic services as having 'traits consistent with dissocial personality'. It is our view that this was a most significant statement and that the conclusion was fully justified given the evidence available. However, the conclusion – that there was evidence for a dissocial personality disorder – appears not to have taken a hold in the subsequent overall understanding of this case.*

5.166 *The trust have since told us that CP3 did consider that he had early conduct disorder, with traits of antisocial personality disorder as he matured (as described by the forensic report), possible comorbid traits of ADHD, comorbid substance misuse and evidence of comorbid psychosis we could find no evidence of this recorded in the notes.*

5.167 *The trust also later said that CP3 and EIP had a clear understanding as above that his antisocial personality traits played a part in his behaviour and presentation along with the other comorbid issues above. We do not consider that the management of Mr B subsequent to the forensic report reflected a grasp by all those involved that he had a personality disorder of the antisocial type. What was foremost in any care plan and comments was the mental disorder which was being treated with medication.*

5.168 *It was in our view appropriate – indeed necessary – that Section 17 leave was suspended on receipt of this significant information regarding the long-term nature of the violence and its extent. This would have been to allow further probing and exploration of this area and to re-assess the risk posed to others, particularly to his younger brother (and to any other young people with whom Mr B might come into contact). However, we do not find evidence that any such further work was carried out. Within a short space of time, the Section 17 leave to home and family was again allowed. We do not see that this reversal of plan regarding the leave was based on any objective construction of the situation. There is mention that Mr B's behaviour*

according to the family had improved, but this is not looked into further and was in our view an insufficient reason to reverse the leave plan indefinitely.

5.169 *We acknowledge however that the history was confused due to the family giving information to the services that was misleading. The family repeatedly implied that Mr B's behaviour, including the violence to the family, was of more recent origin (for example, "by age ten his mum described him as a normal hyperactive boy"). This was clearly not the case. What prevailed in the overall construction of the case was this latter version: that Mr B had developed normally as a child and teenager and that the violence made its appearance much later than was in fact the case. This allowed the violence to be construed by the professionals as either induced by the cannabis and any other illicit drugs or as caused by the occurrence of mental illness.*

5.170 *Furthermore, the family stated that Mr B was different on the ward from how he normally was: that he was withdrawn and not engaging in activities which had previously interested him. The report dated 28 May 2009 prepared by CP4 for the tribunal hearing into the Section 2 is a critical document in that it establishes well the information known of Mr B up to that point. In this report, the consultant states: "His personality seems to have been changing" and states further that Mr B has a "history of change in behaviour, personality and cognitive function since leaving school at the age of sixteen". This was the impression that finally prevailed.*

5.171 *The evidence that was accrued to support the diagnosis of the major mental illness, schizophrenia included the following: "throwing things for no reason"; "often plays music very loudly"; and "increasingly irritable and short-tempered". These findings are generally "soft" and non-specific and do not, in themselves, carry much diagnostic significance. Then there is the following: "conversation skills have declined": this would have been conjecture based on what the family were reporting of recent changes in Mr B. There are also the following: "appears to be responding to auditory stimuli; apparently talking to himself" and "observed whispering and muttering to himself": again, these are non-specific. Such behaviour could well be explained, for example, in the context of using cannabis (and indeed, consuming alcohol). It is also significant in our view that Mr B denied hearing voices. As for any possible delusions, the consultant herself states in her report that "Mr B did not discuss the content of his thoughts".*

5.172 *In terms of risk the report refers to Mr B's aggressive and violent behaviour: "Episodes of physical violence towards family members began in 2009". This is based on what the family reported. However, there was already enough to show that Mr B's aggressive and antisocial behaviour started much before then. CP4 states in the report that: "Since the age of thirteen Mr B had been smoking skunk cannabis and is reported to have stolen things to fund his habit" and adds: "Various acquisitive offences led to 'ASBO's' and eventually a custodial sentence". CP4 elaborates: "In 2006 Mr B was given a five year 'ASBO' the conditions of which he has repeatedly breached and has attended a young offenders institute on two occasions."*

5.173 *In our view this information was sufficient to lead to a suspicion that Mr B's disruptive and aggressive behaviour goes much further back than the family would have the staff believe. Whilst we recognise that the five year ASBO was put in place primarily for acquisitive offences and other non violent misbehaviour, a five-year ASBO is not suddenly imposed, but is almost certain to have been preceded by chronic misbehaviour going back for some time. Further questioning might well have revealed just how young Mr B was when he started displaying such behaviour.*

5.174 *The tribunal report details what are considered symptoms of mental illness and the mostly recent aggressive and violent behaviour. But the two - the illness on the one hand and the violent behaviour on the other – are not overtly looked at in their possible associations. Rather, what is implied is that Mr B is mentally ill, that his violent behaviour is a consequence of his illness, and if the illness is treated then the behaviour will subside.*

5.175 *The report argues for the existence of a discrete mental illness but at this point all CP4 will commit to is a diagnosis of 'psychotic disorder in relation to cannabis use.' This is not inappropriate, even though there was little to suggest with any certainty the presence of any delusions or hallucinations, and can be supported to some extent by some of the observations.*

5.176 *A second ('addendum') report dated 2 July 2009 was prepared for the tribunal hearing into Section 3 by a different consultant (CP5) who cared for Mr B whilst he was at the PICU from 9 June to 22 June 2009. Throughout that time Mr B was on Section 3.*

5.177 *The report is dated almost two weeks after Mr B had been transferred back to the open ward at hospital A and five weeks after the earlier report by CP4. In the report CP5 comments not only on the period of Mr B's stay on the PICU but also on Mr B's "progress since transfer back to the open psychiatric unit" and states that he reviewed Mr B on 30 June.*

5.178 *In this report CP5 states: "The overall impression … was that his psychotic symptoms were perhaps less prominent on the PICU." There is very little evidence to support such an observation.*

5.179 *As for risk, the report does not comment directly on any risk that Mr B might pose to others, but does acknowledge past episodes of physical violence to the family and recommends continues detention in hospital for treatment in the interests of his own health, safety and with a view to the protection of others. The report states: "I remain concerned about his own safety and vulnerability".*

5.180 *In neither report, whether the initial one prepared by CP4 or the subsequent 'addendum' by CP5, is there any reference to the unusual and abnormal behaviours documented by the CAMHS services or the information imparted by social services to the EIP staff on 30 June 2009 (and we assume that this was information that included the long history of abnormal and violent behaviour going back to early childhood) It appears that this information was not known to CP5.*

5.181 *The trust has since told us that in line with Bradford District Care Trust's Inpatient Business Plan discussion has commenced with the commissioners regarding the provision of complex care/personality disorder pathway inclusive of the recruitment of additional psychological therapists. Acute Care has a lead for NICE guidance that will utilise service governance processes to disseminate newly published and updated information around mental health disorders.*

5.182 *Mr B went AWOL on several occasions and was placed on one-to-one observations. He occasionally attended the day centre but engaged only sporadically at these sessions. He continued to have access to drugs while on the ward and often refused requests to provide a sample for drug screens.*

5.183 *He was reviewed regularly by medical staff and the plan for his care was recorded in the case notes.*

5.184 *Mr B was transferred to PICU to provide an environment where he could be assessed free of illicit drugs. We accept that, even on a PICU, it can be difficult to prevent all access to illicit drugs. However, we were surprised there was no routine of regular drug screens to support an assessment, particularly around those times when Mr B managed to abscond from the ward, and when on several occasions it became clear that he had taken cannabis whilst off the unit. After all, access to drugs was now greatly reduced and it was crucial to understand the link between Mr B's presentation and his substance misuse.*

5.185 *BDCT told us later that when PICU transfers a service user to an acute ward it: a) provides an updated risk assessment; b) updates nursing notes on RiO (including reasons for transfer) and c) updates the care plan. In addition staff are required to complete an internal or external multi-disciplinary transfer plan. All of this has a weekly nursing audit.'*

5.186 *BDCT now has a system to update risk assessments, nursing notes and care plans on transfer from PICU and to complete a multidisciplinary transfer plan. These are excellent developments and BDCT may wish to reassure itself that the new system stipulates timescales and includes confirmation of the achievement of the aims of admission to PICU and the outcome of any assessment.'*

5.187 *The family reported successful periods of Section 17 leave at the CPA meeting on 17 August and it was agreed with the family that Mr B could be discharged. Representatives of the EIP team were not at this CPA but undertook the seven days follow-up after discharge.*

5.188 *The discharge letter sent to the GP was dictated by the junior doctor on 29 September and typed on the 12 October; it is stamped as being received on the 15 October by the GP. This is clearly an unacceptable delay in the dictation and subsequent typing of the letter. Whilst the discharge letter details the various events and progress on the ward, it does not deal with risk whether directly or indirectly and, significantly, does not mention the information shared by social services regarding Mr B's past abnormal and violent behaviour going back many years. Nor*

does it refer to the involvement of the forensic services and the advice given by them.

Conclusion

5.189 We do have concerns over the formulation of Mr B's case. It is unclear whether the adult services had access to the CAMHS notes that contained details of past risks and behaviour.

August 2009 to February 2010

5.190 Mr B received care and treatment from the EIP service which was part of BACHS during this time.

5.191 On 18 August it is recorded by EIP4 that CPT1 had informed him that Mr B has become:

> "*increasingly aggressive since his discharge not being reasonable with family requests. Level of stress in the home have increased. They have cancelled the holiday they had planned and feel* [Mr B] *needs to move*. [Mr B] *had stolen cannabis from his sister's boyfriend and laughs in their faces*."

EIP5 had offered family mediation, which was declined. The family would prefer Mr B to move into supported housing accommodation and a housing needs assessment was planned for 21 August.

5.192 EIP4 phoned the home to remind them of the housing appointment but Mr B had gone out. His mother agreed to contact EIP4 if he returned.

5.193 EIP4 visited the home on 24 August to find Mr B smoking skunk outside. His mother said she did not think he would survive living independently. She said she would prefer him to stay at home. Mr B declined to do anything with EIP4 because he was busy with his sister.

5.194 On 26 August Mr B's father told EIP4 during a visit that Mr B was still disrespectful to the family and that he needed to move out. His mother did not want him to go because she felt he would not survive. This demonstrates a conflict within the family. EIP4 and the father agreed that the father would collect a repeat prescription from the GP for Mr B's medication.

5.195 RC1 accompanied Mr B and his sister to Housing Advice for an assessment on 28 August. In the case notes she described Mr B as uncooperative and agitated and he deliberately gave false information about benefits and criminal history. He denied any problems at home that required him to find alternative accommodation. RC1 wrote a letter to housing advice which was sent on 1 September.

5.196 RC1 contacted housing advice for an update on 7 September; they were still to contact probation but would send an application for supported housing.

5.197 RC1 visited Mr B on 14 September to complete a DLA form. Mr B was found to be agitated and keen to get to his friends house. He said things at home were okay but that he still wanted to move. RC1 also asked him about his drug use and he said it was not a problem. RC1 called housing advice after the visit and left a message.

5.198 RC1 accompanied Mr B to a job centre for a formal interview on 15 September. As a result Mr B was to have a monthly mandatory meeting with a view to finding him work. RC1 spoke with Mr B about his drug use and the effect this had on his psychosis. RC1 also spoke to him about supported housing options. Mr B said he preferred to be nearer his home. RC1 spoke with housing advice who were to make a referral to a supported hostel.

5.199 Mr B failed to attend an appointment at the learning disability service for a psychology assessment on 23 September. EIP4 had phoned Mr B's home to remind him of the appointment. Mr B had gone out.

5.200 RC1 tried to visit Mr B at home on 24 September as planned but no one was in. She had been told that there was a vacancy coming up at a supported living establishment and she wanted to discuss this with Mr B.

5.201 RC1 accompanied Mr B on a visit to a supported hostel on 29 September. Mr B said he did not want to live in a hostel. RC1 spent some time discussing this and his plans. Mr B

became aggressive when he returned home, saying he did not want contact with EIP and did not want his medication. RC1 agreed with Mr B to not go to the job centre as planned and to fax risk assessment to the hostel.

5.202 RC1 called to see Mr B's mother on 8 October after not being able to contact his father by phone and text. She was advised that the father's phone was not working and was given the mother's mobile number. She said she was concerned that Mr B had spent the last four days in his bedroom and was responding to unseen stimuli. He was talking to himself and was being increasingly verbally aggressive. He had had problems with his prescription so he had not taken his medication for four days and he was now adamant that he did not want to go back onto the medication. The parents were bribing him with tobacco to take it. Today was the first day he had been out, so they felt he was a little better. RC1 arranged to visit the next day.

5.203 Mr B's father phoned EIP4 on 12 October to say they had had enough of him. He had been reportedly stealing bicycles from neighbours. The police had arrested him and were requesting the CMHT to provide an appropriate adult for him because his parents were refusing responsibility. The victim of the theft had apparently offered him labouring work. Mr B was encouraged by this and said he would apologise for stealing the bike.

5.204 EIP4 attended a housing options assessment with Mr B on 15 October. Mr B appeared distracted throughout and admitted smoking cannabis. EIP4 asked if he had apologised to the neighbour. He appeared amused by this. They went to the housing office for the assessment but it was closed.

5.205 A supported housing organisation phoned EIP4 on 16 October to tell him they would not be able to offer Mr B the required level of support and recommended another option. EIP4 had an appointment with Mr B at the job centre. Mr B was not at home and his father was asked to confirm whether Mr B wanted this appointment to be rearranged. His father reported that things were much the same. He said *"When he has money we don't see him"*.

5.206 Mr B was not taking his medication on 26 October when EIP4 visited. EIP4 discussed possible admission under the Mental Health Act with Mr B and said that he would discuss the situation with CP3.

5.207 On the same day Mr B and his mother attended an outpatient appointment with CP3. It was reported that he stopped his medication for the last few weeks the mother said it made him sick. She reported that he stayed in bed watching TV and could be heard muttering and laughing. He had a poor appetite and would go for two days without eating. Mr B denied smoking cannabis. CP3 describes him as sullen and had an uncooperative manner, blushed for no reason, laughs for no reason, became irritable with mother about medication and became intimidating at this point. The plan was: "*to see again in one month: to have a low threshold for detained admission but to admit now would create more disengagement than at present: risk slightly lower?? Because not smoking cannabis: need to be watchful to threats to the family*". EIP4 was informed that Mr B had agreed to accept medication.

5.208 EIP4 visited Mr B on 2 November and delivered his medication, which had been halved. He had stopped staying in bed; he was eating and going out.

5.209 EIP4 visited again on 6 November. Mr B had improved since taking his medication. His parents confirmed he was more settled.

5.210 Mr B attended an outpatient appointment with CP3 on 23 November, accompanied by his father. He denied taking cannabis. CP3 recorded an improvement in his mental state and that it was early in treatment resumption. He told his father Mr B might continue to improve if he took his medication regularly.

5.211 EIP4 visited Mr B again on 9 December. He had been in court for sentencing. EIP4 visited again on 10 December. Mr B said he was taking his medication daily and had no side effects.

5.212 There was then a gap in contact until 21 December, when EIP4 faxed a risk assessment to a housing organisation. Mr B had an assessment planned for 8 January.

5.213 EIP4 did not visit again until 12 January. Mr B barely communicated, he was slow to respond. He appeared to be responding to unseen stimuli and looked confused.

5.214 The probation service phoned EIP4 on 18 January. Mr B had been placed on a community order with supervision. He was to meet with probation weekly. EIP4 agreed to accompany Mr B to the next appointment.

5.215 The appointment took place on 25 January. Mr B was obliged to attend for 16 weeks. He responded appropriately to questions, with some incongruous laughter. EIP4 accompanied him to the appointment.

5.216 EIP3 and EIP6 visited Mr B on 18 February. They were responding to a message on their answer phone picked up early afternoon of the 18 February from Mr B's grandfather. The Trust have told us that rather than return the call they felt it was more appropriate to visit the family directly and an immediate plan was made to visit Mr B's family that afternoon. Workers spoke to Mr B's mother regarding grandfather's concerns and had intended to speak to grandfather also but events took over before workers had an opportunity to do so.

5.217 The notes written up soon after the visit say: *"Seen after call to office saying EIP needed to call to see Mr B urgently- this call it later transpired came from his Grandfather'* The Trust have since told us that "*The EIP worker referred to his call when he was talking to Mr B's mother that afternoon and she left him with a sense that she was telling him (*the worker*) as much as he* (the grandfather*) had intended to. He recalls her saying she had been over to see her Dad at midday that day, and on the basis of her conversation with him he had phoned the team".*

5.218 The electronic records show that when EIP3 and EIP6 saw Mr B he was cooperative and amenable to talking. He was not overtly distressed or agitated. His mother reported some signs of increased emotional upset. He was tearing up and burning old photographs of himself and old poems he had written as a child to his mother. Mr B would not say why, but he agreed with his mother that he did not like pictures of himself in the house. He seemed cooperative and denied any problems. He was muttering. He did not like doors shut and he preferred to sit in the dark. He denied being frightened. He admitted a recent binge on alcohol and cannabis. The mother did not report any violence to others or any self harm. He was taking his medication although sometimes argued with his father taking it. Mr B accepted a visit from CPN3 on 22 February. His mother agreed with this plan.

5.219 Mr B visited his GP with his mother at 16.27 the same day to request a sick note. The GP recorded in the patient summary we saw that he had seen a CPN that day and that Mr B was the same as before: "*not much change, no eye contact, quiet. His mother reported no behavioural problems".*

5.220 At 22.34 on the same day the consultant in charge of A&E told the EIP team that a ten-year-old boy had been stabbed to death and his sister had been seriously injured. The assailant was alleged to be their brother Mr B who was in police custody.

Analysis and comment

5.221 ***The IMR notes that the family sent texts to EIP4 during the week he was away and that Mr B's grandfather left a message on the EIP answer phone requesting an urgent visit. We have seen no evidence other than that in the IMR of the text messages, nor can we find any evidence that attempts were made to speak with Mr B's grandfather to more understand his request for an urgent visit. The trust have since informed us of the rationale for not contacting the grandfather. We are aware that the recording of text messages was a feature of the BDCT action plan.***

5.222 ***We feel that not having spoken with Mr B's grandfather may have been missed opportunity to gain a better understanding of his and the family's concerns. We recognise that when EIP visited Mr B his mother was present and she did not raise any concerns with EIP.***

Overall conclusion

5.223 Mr B only sporadically showed any commitment or motivation to participate in the treatment or support offered by both inpatient and EIP staff and went AWOL from the ward on several occasions. It appears that the CAMHS notes were never received by adult services and there were some inaccuracies in the history given by the family. We have concerns over the formulation of the case, that the relationship between the substance misuse and apparent psychotic symptoms was not sufficiently or adequately explored and that the significance of the history of violence going back years had been missed. The risks were not conveyed to the GP in the outpatient summary sent in February 2009 or the discharge summary sent in October 2009. It was unclear what the overall plan was for his care and treatment and it may have been a missed opportunity not to have spoken to the grandfather on 18 February 2010.

6. Early intervention in psychosis service

6.1 In this section we examine the role of the EIP service in Mr B's care and treatment, both in the community and as an inpatient.

6.2 The EIP service was initially set up in 2005 to provide three years of intensive input for young people aged 14–35, following a first episode of psychosis. At the time of Mr B's care and treatment the service was provided by BACHS. It transferred to BDCT in April 2011. The operational policy covering most of the period of Mr B's care and treatment was dated October 2007. We saw versions dated May 2009, September 2009 and May 2012. The operational policy for October 2007 said the EIP service was based on the model recommended by the Department of Health's implementation guidance published in 2001 and followed the approach to implementation proposed by the Sainsbury Centre for Mental Health. The purpose was:

> *"EIP services provide quick recognition of the first onset of a suspected psychotic disorder and appropriate treatment and support in the early years. We provide age and phase-specific interventions to minimise the severity of an initial psychotic episode and to facilitate as full a recovery in an individual as is possible."*

6.3 Under 'aims and objectives' the policy says:

> *"We expect and enable individuals to recover rather than render them dependent on services and we view the restrictive and stigmatising nature of hospitalisation as an undesirable necessity in which earliest possible discharge is imperative."*

6.4 Under 'service standards' the policy says each person and their family will be offered a comprehensive assessment. The core assessment consisted of:

- positive and negative syndrome scale (Sci-PANSS) within two months of referral
- pre-morbid adjustment scale within six months
- pathways to care within six months
- duration of untreated psychosis calculation within six months.

6.5 The policy says:

"Information gathered from the assessment will be drawn into an individual formulation of the person's vulnerabilities, protective factors, needs, strengths, and goals. A in service formulation outline has been developed entitled 'Your Story' (see appendix 2). We aspire that each service user will have an initial formulation within 6 months of referral. This ... will be developed collaboratively with the person and their family ... drawing from the multidisciplinary team for guidance and supervision. The formulation will inform care planning and prioritisation of needs. Each person and key worker will jointly develop a formulation driven care plan ... within 6 months of referral ... as a minimum care plans will be reviewed collaboratively with the person and their family every 6 months."

6.6 We did not see appendix 2 - the formulation outline entitled 'Your Story' – but the operational policy dated May 2012 included a document with this title in appendix 8.

6.7 Under 'acute care and ward liaison' the operational policy of October 2007 says:

"In order to build on and improve our working relationships with the wards and to maximize benefits to service users who are in hospital it is vital for the team to be as fully involved as possible in the process of admission, assessment and care planning in hospital and discharge planning. This is emphasized as crucially important in the CPA procedures and also in literature focusing specifically on early intervention."

"EIP should in most cases be the initiators of admission in discussion with the individual experiencing psychosis…"

"EIP needs to be involved also in the process of admission. This may involve accompanying the service user to hospital, helping them through the admission process, facilitating communication with the ward staff and helping the service user to feel comfortable."

"At this stage the team will bring a copy of the current care plan, risk assessment and details of current medication. It is also important to make an entry in the hospital record regarding our involvement and the reasons for admission. Every effort will be made to present this information in person to ward handover within 48 hours of admission…"

"Assessment and care-planning. Our input is very important here … care-planning on the ward will be more consistent with our overall plan which has been developed with the person … The key task here is regular liaison with the named workers on the ward. This should take place either by visiting or … telephone contact. When appropriate EIP workers will attend weekly ward liaison meeting, which will enable them to work collaboratively with the service user and the ward staff … and we may be involved in accompanying the person to town, to the bank or to plan for overnight leave. All EIP team members will make an entry into the ward notes for the particular service user following any contact."

"Discharge Planning. Our collaboration with ward staff will facilitate discharge planning. Generally meetings to plan discharge will have a formal status i.e. they will be a CPA review and/or an S 117 meeting … Planning should take place well in advance of discharge and a date set for discharge."

6.8 The EIP service lead said later that he expected care coordinators to maintain contact with inpatients and to drive early discharge. He said:

"However … when somebody is in hospital under the care of another team, our role becomes secondary to the care team in charge for the period of acute care. As a minimum we would expect to be involved in discharge planning and ward based CPA meetings but there is a formal transfer of responsibility for someone who is an inpatient."

6.9 Under 'communication – record keeping' the policy says:

"The single patient record should be held by the care coordinator…"

"All staff must ensure that an accurate and up to date account of all service user contact (direct or proxy) is detailed in the case notes."

"All contacts must be logged on the Totalcare[1] activity log-sheet for inputting onto the database by administrative staff."

"Team member's diaries (which are the property of the PCT) should be kept up to date and legible."

"Entries should be clear in content and legible and should, where possible be made immediately after a contact by/on behalf of a service user."

6.10 The policy described the hub and spoke model of service delivery with a central EIP hub providing specialist support, supervision, training, work allocation and leadership. Eleven whole-time-equivalent EIP care coordinators at the time of writing are based in CMHTs, delivering care in partnership with BDCT medical staff using EIP and BDCT policies and procedures. At the time of writing these care coordinators have case loads of 12 to 15 service-users and are supported by a total of 18 team leaders, recovery coordinators, support workers and service user development workers.

6.11 An external review of the EIP service reported in September 2010. This review considered national guidelines and concluded that the service followed a philosophy of care that had been adopted both nationally and internationally. The recommendations were included in the service's composite action plan drawn up in response to several other reviews, including the internal investigation into the care and treatment of Mr B. The review did not comment on individual cases but concluded that the model of delivery, service standards, clinical governance and clinical supervision compared favourably with national guidance and other similar services. We saw the update of this action plan for June 2012 and referred to it when considering our own recommendation.

6.12 We asked representatives of the EIP service if they distinguished between people whose psychotic symptoms appeared to be based on an underlying mental illness and those whose symptoms appeared to be based on substance misuse. They explained that they worked on understanding the development of the psychosis and any link with substance use. They took people who used substances if they continued to experience psychosis. They felt they had an inclusive view of psychosis and took people who might not have a diagnosis of schizophrenia. About two thirds of their clients had a dual diagnosis. They had recruited staff with this expertise and provided in-service training.

[1] Electronic patient record in use within the trust until May 2009.

6.13 We asked the EIP representatives about medical staffing. They said when the service was set up they were told not to expect commissioners to fund more psychiatrists but to work in partnership with BDCT. So they organised EIP services around CMHTs and their doctors. However, funding has now been provided for a doctor to work with the central EIP assessment team. This appointment followed a recommendation of the external review that *"consideration should be given to the appointment of a designated and dedicated psychiatrist, competent in EIP".*

6.14 BDCT told us later that the EIP service aims to continuously improve its triage, assessment, acceptance and decision-making processes to ensure these are as reliable as possible. Where formulations are more challenging, assessment continues while service users are offered needs/strengths led service and appropriate treatment. EIP works with diagnostic uncertainty with an extended assessment (six months) before a reliable and meaningful diagnosis can be offered. The EIP Decision making matrix is derived from nationally approved inclusion criteria and endorsed by the multidisciplinary team. BDCT said:

> *"EIP's aims are to reduce the number of people ever receiving a diagnosis of schizophrenia by offering timely interventions to facilitate recovery. EIP acknowledge that in order to include all of those individuals they should be working with, they will inevitably take some individuals into the service that later are found not to need it and some who might have more appropriately have received a service elsewhere. EIP have recently initiated a personality disorder pathways project and a recent audit of service users who are viewed as having interpersonal/personality issues suggests that approximately three quarters of those who were considered to have some personality issues were appropriately within EIP as they also clearly had episode(s) of psychosis."*

6.15 BDCT also told us that the clinical lead in EIP is a consultant psychologist with responsibility for clinical governance, supervision, training and supporting the team's clinical practice. BDCT said:

> *"The model of clinical leadership in EIP has been strengthened since the time of this incident with the clinical lead providing supervision to all team leaders and the majority of care coordinators in the service and attending all team meetings*

on a weekly basis so being systematically involved in case discussion, formulation and risk management."

6.16 Bearing in mind the need for a multidisciplinary approach and the issue of diagnostic uncertainty in early psychosis, the trust resists 'diagnostic' leadership but would value increased and more systematic medical input into the MDT, where a shared and consistent approach to formulation and care planning can be assured. This has been achieved in the service hub with the recent appointment of a consultant psychiatrist and there is an opportunity to strengthen medical leadership in the CMHT based EIP teams as part of the current CMHT transformation project.

6.17 Mr B was originally referred to EIP in April 2009. He was seen on 30 April and again on 6 May. On 8 May after a violent episode towards his sister, EIP offered Mr B input from the crisis team or EIP worker or informal admission. He declined these options so EIP were then involved in arranging for Mr B to be assessed under the Mental Health Act and he was admitted to hospital under Section 2 of the Act.

6.18 EIP workers regularly visited Mr B on the ward, contributed to CPA reviews and escorted him on Section 17 leave. The notes of their intervention appear in the inpatient notes.

6.19 EIPCPT1 said at a professionals meeting on the ward on 7 July that she had lost engagement with the family. We can find no record of this in the notes.

6.20 Communication between the EIP team and the ward was good, particularly when the information about history and risks became available.

6.21 EIP were not invited to the CPA meeting on 17 August, where discharge was agreed, but we have no evidence that they would have objected to the discharge.

6.22 EIP saw Mr B regularly after discharge in August 2009, sometimes two or three times a week between August and February 2010. Regular visits did not take place in two periods - one in December 2009 for 22 days and another in January 2010 for three weeks.

6.23 Mr B was seen twice between August 2009 and February 2010 by CP3 on the 23 October and 23 November 2009. EIP staff were not present at the appointments. CP3 told

us that the EIP cluster team were based in the same building as he was and the team members were always coming to speak to him about patients, including Mr B, giving him feedback on what was happening, asking him questions. There would have been regular contact with the EIP Team before and after the appointments. The case notes contain no record of these discussions. CP3 also attended the EIP weekly meetings.

6.24 BDCT have since told us that Mr B was discussed regularly in local (cluster) EIP team and group meetings. It is accepted records of these meetings were not routinely kept all the time. These meetings are now minuted to ensure there is a paper trail of team discussions and where appropriate a summary is entered on to RiO. All cases are now reviewed systemically and high risk cases are being formally reviewed at least weekly. The EIP service clinical lead, a consultant clinical psychologist who has specialised in EIP provides clinical leadership at these weekly meetings. Meetings are supplemented by managerial supervision and separately by clinical supervision, both of which are highly valued in the service.

Analysis and comment

6.25 ***Mr B was referred to the EIP service on 21 April 2009. The referral and assessment process was unclear. We asked EIP representatives about referral and assessment documentation for Mr B. They said he was referred just before the EIP service set up the central hub.***

6.26 ***EIP care coordinators and other members of the team provided frequent and intensive input for Mr B although visits did not happen so regularly in December 2009 and January 2010.***

6.27 ***The EIP staff involved with Mr B were working as a team and supporting each other and were diligent in visiting him and trying to engage with him. There appears to have been no real overview and objective to his care plan. However, other reviews identified concerns about handover and cover and changes were made to the operational policy to address this.***

6.28 ***Communication and discussion between the EIP team members and the consultant psychiatrist working in the CMHT spoke were good.***

6.29 *We saw no records of any discussions about Mr B either within EIP or the wider mental health service.*

6.30 *The EIP records contained many gaps: referral and acceptance documentation, formulation, and psychology notes. Senior EIP staff had not noticed some of these gaps.*

6.31 *We saw no evidence of the assessment documents listed in the operational policy.*

6.32 *EIP staff had a vital role providing practical support to Mr B and indeed to other staff. We were less clear about the role EIP played in Mr B's mental health treatment. CP3 told us that both he and the team were trying to manage his antisocial tendencies by engaging with him.*

6.33 *The EIP care coordinators regularly recorded their discussions with Mr B and his family about his mental illness and behaviour but they did not record any discussions about this with anyone else including CP3 who had explained that he regularly spoke to the EIP team about Mr B.*

6.34 *We remain puzzled about the role of the EIP psychologist. EIP CPT1 reported at a CPA review on the ward that she had lost engagement with the family but we saw no clinical notes or evidence that supported this statement.*

6.35 *Overall, we found the EIP service made an impressive practical contribution to Mr B's care, especially while he was in the community, but what the service was trying to achieve for Mr B in the longer term was not clear. We found plenty of evidence of hard work and dedication, particularly from the care coordinators, but no record of any discussion between colleagues, either within EIP or the wider mental health service. We expected to see evidence of EIP's contribution to Mr B's diagnosis, treatment plan and objectives, but we did not find it.*

6.36 *We could not resolve the question of how EIP assessed and accepted Mr B and why documentation is so limited. We do not know why there was no collaborative formulation to support the care plan, as described in the operational policy. This*

could have made a vital contribution to understanding the link between Mr B's mental illness and substance misuse and influenced thinking about his best interests.

6.37 *Given the level of scrutiny following this incident and the commitment to the single patient record, we were surprised EIP senior staff had not noticed the limited referral and assessment documentation, or the absence of a clear formulation or the lack of psychology notes and CPA documentation in the case files.*

6.38 *We appreciate the challenge of writing up notes if staff are not in the same building as the file. However, the care coordinator was supposed to hold the file except, presumably, when the service-user was in hospital. So we do not know why there were gaps in EIP CPT1's notes. The RiO information system has made it easier for all staff to enter their notes daily into the single patient record and to see what their colleagues have written, but the proper filing of paper documents remains a challenge.*

6.39 *We highlight various gaps in the EIP service records. We wanted to emphasise the importance of accurate records rather than to criticise individual members of staff unfairly, especially the care coordinators who worked closely with Mr B.*

6.40 *We understand the rationale for EIP working in small teams within CMHTs instead of working separately with a dedicated consultant psychiatrist. This model is economical and offers continuity for service-users; the opportunity to share expertise across the CMHT and the convenience of tapping into local links with other agencies. The EIP team and CP3 were based in the same building and this facilitated regular discussion and contact. However, the discussions that took place are not recorded on the notes. The EIP staff were, in addition, accountable to a separate management and supervision structure in a separate trust at the time. We hope the transfer of EIP to BDCT has bridged this gap but we do not know if it has facilitated the development of an agreed clinical overview for each service-user.*

6.41 *We acknowledge the value of the broad inclusivity of the EIP service. It is commendable to offer assessment and treatment to a wide range of service users but there could be a risk of losing fidelity to the core principles if the service becomes overwhelmed by numbers. The EIP service will always need to concentrate on a manageable caseload where they can best add value.*

6.42 ***EIP services were established across the country on the premise that early intervention could play a significant role in either aborting or substantially reducing the development and severity of psychosis. The intention was also to provide this client group with a specialised assertive outreach service. The EIP representatives we met were concerned about the future of the EIP service in the current economic climate. We believe the future of the service will depend on the value other senior clinicians put on it. In addition to providing excellent practical support, EIP staff must be seen as clinical specialists making a vital contribution to discussions about clinical presentation, formulation and treatment for the service-users who need it most.***

Conclusion

6.43 EIP staff provided intensive practical support to Mr B which colleagues regarded highly. EIP staff tried to engage with Mr B and worked hard to address his needs but there was no documented agreed overview of his problems and no system to coordinate it.

6.44 The EIP clinical lead now attends all team meetings on a weekly basis and is systematically involved in regular case reviews and clinical supervision.

Recommendations

R1 BDCT should continue to explore the capacity and acceptance criteria of the EIP service to ensure it can adhere to its key objectives, as well as the requirements of the trust, whilst providing added value for service users.

R2 BDCT should review the effectiveness of the current model of specialist clinical leadership for EIP staff in CMHTs. The arrangements should provide a robust focus on the formulation and review of the service user's diagnosis, risk profile, treatment and objectives throughout the period of EIP involvement, as they move between inpatient and community care.

7. Risk management

7.1 In this section we examine the risk management process followed for Mr B. We also consider his vulnerability, which was mentioned in his risk profiles.

Evidence

7.2 The Department of Health issued *Best practice in managing risk* in 2007. This guidance set out a framework of principles covering self-harm and suicide, violence to others and self-neglect. It provided a list of tools to structure risk assessment and management. The intention was to balance care needs against risk, emphasising positive risk management; collaboration with the service-users and others; recognising and building on the service-user's strengths and assessing changing as well as static risk factors.

7.3 The Department of Health's guidance document *Refocusing the care programme approach* was published in March 2008. It reminded trusts about the 2007 guidance on managing risk and said:

> *"Risk assessment is an essential and on-going element of good mental health practice and a critical and integral component of all assessment, planning and review processes."*

7.4 BDCT's policy on risk management for the period of Mr B's care and treatment was included in the care coordination policy of November 2007. It described the use of the FACE risk management tool and said FACE was an integral part of care coordination. It said the FACE form should not duplicate the information in the care plan or contingency plan and the latest risk profile should be kept with the care plan at the front of the clinical file, as well as being available on Totalcare. The policy set out the triggers for a review of the risk profile, including: initial assessment; every care coordination (CPA) review; admission to and discharge from hospital; before transfer to other areas or agencies; after any major incident or change of circumstances; when serious concerns are raised by carers, family or other agencies.

7.5 BDCT updated the *Care coordination policy* in May 2009 as the *Care programme approach policy*. This version said the trust was using the RiO risk profile.

7.6 The Department of Health and Home Office issued *No secrets: guidance on developing and implementing multiagency policies and procedures to protect vulnerable adults from abuse* in 2000. It used the definition of a vulnerable adult from the 1997 consultation paper *Who decides?* issued by the Lord Chancellor's Department:

> *"a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation."*

7.7 This guidance was replaced by two Department of Health guidance documents issued in 2011: *Safeguarding adults: the role of health service practitioners* and *Safeguarding adults: the role of health service managers and their boards.*

7.8 BDCT issued *Safeguarding adults policy and procedures* in November 2007. It used the definition of a vulnerable adult quoted above. It focused on dealing with specific situations of actual or suspected abuse and on raising concerns initially within the trust.

7.9 We saw a revised version of BDCT's policy with no date of issue but with a review date of November 2009. This version used the same definition as before. The policy was revised and reissued in August 2009 and July 2011. The July 2011 version included a set of principles in appendix 10, one of which said: *"There is a duty to support all patients to protect themselves. There is a positive obligation to take additional measures for patients less able to protect themselves."*

Mr B risk assessment

7.10 We saw evidence of six risk assessments being completed during Mr B's care and treatment. Three of these were FACE assessments and three were recorded electronically on RiO.

7.11 The FACE risk assessments were completed on 9 May, 20 May and 31 May 2009 while Mr B was an inpatient on ward A. The score on all of the assessment for domestic violence is two and three for violence to others on 9 May, two on 20 and 31 May.

7.12 The RiO risk profiles were completed on 12 June. 11 July and 21 December 2009. The risk profiles are set out in areas of risk: harm to self; harm from others; harm to others; accidents; other risk behaviours; factors affecting risk and a summary. The sections for each area of risk included information about past and recent events. Most entries remained unchanged on the profile.

7.13 A copy of the risk assessment was faxed to the PICU on the 8 June 2009 when Mr B was transferred to their care.

7.14 A risk assessment was completed on the 12 June while Mr B was on ward A. It was updated on 11 July while he was still an inpatient.

7.15 Some of the entries were undated and stayed on the profiles when they became less relevant or even inaccurate.

7.16 No section allows for all this information to be brought together into a risk management plan.

7.17 Mr B was referred to forensic services on 15 July when information about his past behaviour became apparent from social services. The advice was taken into account in relation to Section 17 and to being left alone with his siblings

7.18 A list of risks in the case notes typed on unheaded paper details past risks between 1995-April 2009. It is undated and unsigned and it is unclear where it came from.

7.19 We found no evidence that the EIP team carried out risk assessments until 21 December 2009, when EIP4 updated the risk assessment to support Mr B's housing application. This falls short of good practice.

7.20 The IMR says Mr B was regarded as a high-risk in the EIP 'hub' but in the EIP community 'spoke' he was not considered one of their high risk clients. Given Mr B's lack of engagement, family history, violence and aggression to family members and non-compliance with medication we are surprised that he did not remain a high risk.

Analysis and comment

7.21 ***Nursing or EIP staff always completed Mr B's risk assessments. The only involvement from medical staff seemed to have been at ward reviews. The lack of involvement from medical staff was also illustrated by the absence of an overview of risk in the discharge letters to the GP.***

7.22 ***We gained the impression that nursing staff were doing their best to update the risk profile at appropriate times with relevant information but not stepping back to consider the content as a whole. Anyone who did not know Mr B needing to check his risk profile on the electronic system would struggle to get a clear picture of the situation.***

7.23 ***We found no update of Mr B's risk profile on discharge in August 2009. Such an update would have informed a more coherent care plan.***

7.24 ***EIP did not update the risk profile during the four months that Mr B was in the community. The probation service would have been another source of information but we could not see from the records if they had made a contribution to the risk profile. In addition, the probation service should have been asked for a definitive forensic history because the nature and extent of Mr B's previous offences was unclear in the case file.***

7.25 ***We found that Mr B's two weeks on PICU made no discernable contribution to his risk assessment. It should have been reviewed weekly as part of CPA, according to the PICU operational policy.***

7.26 ***CP5 had cared for Mr B while he was on the PICU. He/she wrote a tribunal report in July 2009 that described him as 'vulnerable'. The report does not comment directly on any risk that Mr B might pose to others, but does acknowledge past episodes of physical violence to the family and recommends continues detention in hospital for treatment in the interests of his health, safety and with a view to the protection of others. CP5 said in the report "I remain concerned about his own safety and vulnerability".***

7.27 ***We do not fully agree with the statement about his vulnerability but it was not explored further with the wider team caring for Mr B. The outcome of that discussion should have influenced his management plan.***

7.28 ***We criticise several aspects of risk management but the main problem was the failure to think about the bigger picture. The risk profiles and case notes contained references to incidents of aggression in the past and intimidating incidents while Mr B was an inpatient but many staff did not experience aggression or violence from him. They did not perceive a risk of serious violence and saw no obvious signs that Mr B could be as violent as he was on the day of the incident.***

7.29 ***In fact, a comprehensive assessment of risk was not possible without a better understanding of the possible link between Mr B's drug use, his psychotic symptoms and his pre-morbid personality. This meant a plan to manage the risks could not be consolidated.***

7.30 ***We asked BDCT if EIP team leaders and other clinical team leaders specifically monitor the summaries in risk profiles to ensure they provide a reliable overview of current risks. BDCT explained how the EIP service monitors risk assessments and management plans but did not provide information about the system used by other adult teams to monitor the standard of risk summaries.***

7.31 ***The EIP service now has a robust system to monitor risk assessments and management plans but we do not know if other teams, especially inpatient teams, have improved their systems to ensure there is a reliable overview of current risks for each service user.***

Conclusion

7.32 Risk profiling was in place for Mr B in the adult service and a great deal of relevant information was recorded. A reliable overview of the current risks to inform his care plan was missing.

7.33 EIP now has a robust system to monitor risk assessments and management plans. Clinical managers in all teams should monitor the content of risk summaries.

Recommendation

R3 BDCT should ensure clinical managers in all teams monitor the content of summaries in risk profiles. Summaries must provide a reliable overview of current risks.

8. Care programme approach and discharge planning

8.1 In this section we examine how CPA was used to plan Mr B's care, including his discharge from hospital to the community.

Evidence

8.2 CPA is the process mental health services use to coordinate the care of people with mental health problems. The concept was introduced in 1991, and in 1999 *Effective care coordination in mental health services – modernising the care programme approach* set out the arrangements for all adults of working age under the care of secondary mental health services. The key elements of CPA are:

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

8.3 The Department of Health published *Refocusing the care programme approach* in March 2008. This document updates the guidance and emphasised the need to focus on delivering person-centered mental health care. It also confirmed that crisis, contingency and risk management are an integral part of assessment and care planning.

8.4 CPA was originally targeted at adults of working age requiring specialist psychiatric services. The guidance of 2008 said:

> *"CPA should be used to plan transition, for example when children and young people are discharged from in-patient services into the community and when young people are transferred from child to Adult services, their continuity of care is ensured by use of the care programme approach."*

8.5 The 2008 guidance also said: *"Where a criterion of complexity applies in CPA, there is theoretically no lower age limit for the use of CPA".*

8.6 BDCT reissued their CPA policy in November 2007 as their *Care Coordination Policy.* This document explained that CPA would be referred to as 'care coordination' as this was the foundation of good care. It said care coordination was:

> *"a model of assessing, planning, implementing, delivering care and then evaluating the effectiveness of that care or intervention. It aims to promote effective liaison and communication between agencies, thereby managing assessed risk and meeting the individual needs of people with mental health problems so that they are better able to function in society."*

8.7 The policy said in paragraph 1.7: *"the principles of CPA are relevant to the care and treatment of younger people with mental health problems."* It confirmed the requirement for everyone to have a copy of their care plan and for the care plan to be available to carers.

8.8 The policy set out in section 14 the principles of good practice for people on enhanced CPA. These included the requirement for reviews to be held within six months or within one month of discharge. Section 15 sets out the arrangements for discharge.

8.9 BDCT's draft operational policy for PICU of January 2008 said under 'admission' that an initial care plan covering the first 48 hours would be prepared and CPA documentation would be completed: *"A full review of immediate care needs will be made at least weekly with the full involvement of relevant care professionals … This meeting will be formally documented within the Care Programme Approach".* This version of the policy gave no guidance on transfers from PICU but the September 2011 version said on page 10: *"When a service user is ready to be transferred back to a BDCT acute ward a pre transfer CPA will be held".*

8.10 BDCT updated the *Care coordination policy* in May 2009, August 2009 and March 2011 as the *Care programme approach policy*. The updated versions included much less guidance on discharge planning than the 2007 version. BDCT told us there was no separate policy on discharge planning.

8.11 BDCT told us later that care plan audits are now completed weekly within ward audits, including a check that care plans are copied to service users and carers. BDCT compiles a CPA audit quarterly which entails two peer review audits and two reviews by the CPA office. BDCT told us: *"The CPA audit asks if a service user has been meaningfully included in their assessment and care plan. RiO facilitates and ensures that all entries are dated and are in chronological order."*

Evidence

8.12 Mr B was referred to the EIP team in April 2009 and within 16 days of referral he was admitted to an inpatient ward, which prevented a CPA meeting from taking place before his admission.

8.13 CPA meetings were held on the ward at regular intervals on: 11 May, 5 May, 26 May, 26 June and 28 July 2009. All relevant parties were present at the meeting, including family members. The case notes state who was present and the plan that was agreed.

8.14 A professional meeting was held on 7 July 2009 when social services attended.

8.15 The CPA meeting held on the ward on 28 July 2009 was the last before discharge. The EIP team were not invited to the review on the ward on 17 August when it was agreed with the family that Mr B would be discharged.

8.16 The only CPA documentation we have seen is for the CPA review on 28 July, when three care coordinators are recorded - two from the EIP hub and one from the CMHT.

8.17 No CPA meeting was held after discharge from the ward while the EIP team were caring for Mr B. This is clearly not in line with trust policy at the time.

8.18 EIP 4 visited the home on the day of Mr B's discharge, in line with good practice and the seven-day discharge arrangements.

Care Planning

8.19 A care plan with a print date of 1 June was developed which details his presenting problems. It also details his history, risks observation level and medication.

8.20 This plan was updated on the 8 June and again on the 26 June 2009.

8.21 A further copy is available with a print date of 14 July, which has also been written across 'updated on the 14 July 2009'. We have not seen this updated care plan. A section for a crisis plan and a contingency plan should have been completed.

8.22 The care coordinator named in the care plan is EIP2.

8.23 Section 5 of this report shows that the EIP team visited Mr B regularly and monitored his behaviour, that they had considerable contact with the family, supported him to attend appointments about housing and with the probation service. None of these interventions is recorded in the care plan.

8.24 We are aware that the action plan from the internal management review included care planning and risk assessment.

Analysis and comment

8.25 ***CPA and care planning were reasonable during Mr B's admission. CP4's notes of the ward reviews clearly record the decisions and a plan for care and treatment but these do not appear to have been transferred to CPA documentation.***

8.26 ***The lack of a CPA review before discharge in August 2009 prevented a robust care plan being put in place.***

8.27 ***We found that no CPA review took place while Mr. B was on PICU, despite the requirement in its operational policy for full weekly reviews to be documented under CPA. CPA reviews should have involved staff from other services. They should have focused on risk and progress with assessment and treatment.***

8.28 ***CPA was not used at all while Mr. B was in the community and his care plan was never updated. CPA documentation was particularly poor, and there was no care plan.***

8.29 ***BDCT has made considerable improvements to CPA and care planning systems, with regular audits.***

Conclusion

8.30 Overall we found the discharge arrangements fell short of good practice in view of the risks. The CPA process was not used to determine a meaningful care plan for Mr B after he was discharged from the ward. The EIP team visited him regularly, but it is difficult to see what they were trying to achieve.

8.31 BDCT has revised its care coordination policy and has made considerable improvements to CPA and care planning. The trust intends to provide guidance on discharge planning for homeless people by February 2013.

Recommendation

R4 BDCT should audit care plans to check: a) the care plan can be understood by staff who do not know the service user and b) the care plan is copied to all those involved.

9. Carer assessment

9.1 The Carers (Recognition and Services) Act 1995 was the first piece of legislation recognising the role of informal carers and providing for the assessment of the ability of carers to provide care.

9.2 The Carers and Disabled Children Act (2000) extended carers' rights to support services, giving them the right to an assessment of their needs.

9.3 The Carers (Equal Opportunities) Act 2004 gave services the duty to inform carers of their rights and to undertake a carer assessment, taking into consideration if they work, or wish to, and also their education, training and leisure needs.

9.4 The Department of Health carers' leaflet advised that most carers had a legal right to an assessment of their own needs. It is their chance to discuss what help they need with caring. It said:

> *"Carers can discuss any help that would maintain their own health and balance caring with other aspects of their life, such as work and family. Carers should be able to have a separate assessment in the following situations:*
>
> - *Where you're providing regular and substantial care to someone.*
> - *As part of the process of assessment when the person you're looking after is being discharged from hospital.*
> - *When you're looking after someone with mental health problems who is on the Care Programme Approach*
> - *As a parent carer of a disabled child under 18. In this case, you have a right to a separate assessment of your own if the assessment for the child under the Children Act does not fully take account of your needs."*

9.5 The BDCT's *Care coordination policy* dated November 2007, in place at the time of Mr B's care and treatment, said:

> *"All carers must be identified and offered a carer's assessment of their need. If they do not require this service, this should be recorded on to the Care Coordination form. If they do require an assessment, they should be given a copy*

of the Bradford Carers Assessment. On its completion, a Carers Care Plan should be completed with them and a record of this recorded with the Care Coordination documentation. This should normally be done by the care coordinator unless there is a clear conflict of interest. These details should be recorded on the Database."

9.6 The BDCT's *Care programme approach policy* dated May 2009 contained appendix 7 describing the process of carer assessments in more detail, including:

"The assessment is the responsibility of the statutory services to arrange, usually through the Care Coordinator. The assessment should include:-

- *Current support provided by the carer and others for the service user*
- *Current support to the carer (formal and informal)*
- *The participation of the carer's own GP*
- *The carer's views: and*
- *The carers needs including financial/benefits advice: domestic or personal assistance: respite: emotional support: accommodation: social and recreational: employment: health: advocacy: transport: information."*

9.7 The BDCT had a pro forma for carer assessments dated December 2006. In November 2010 BDCT issued *Involving You (2) service user and carer engagement and involvement strategic vision and action plan refresh*. This indicated that information on carers should be recorded on service-user records and that the needs of carers should be taken into account in care planning.

9.8 One of the recommendations from the internal investigation was to consider how carers could be better supported to cope with a person with serious mental illness and ensuring carer assessments were undertaken. The proposed action was to audit the completion of carer assessments and develop an improvement plan to bridge identified gaps. The action plan for EIP dated April 2011 said audit within EIP showed 16 per cent compliance with carer assessments in November 2010 and *"improvement plan developed."* We asked EIP representatives about the improvement plan. They said they had not identified any specific problems to work on. They also said work with families was a foundation of EIP but not in the way a carer would be seen for a person with a disability – EIP was more informed by the CAMHS approach.

9.9 We received details of EIP audits of carer involvement in 2010 which showed an average of 17.25 per cent carer assessments on RiO but 86 per cent of families and 90 per cent of carers had *"meaningful involvement in assessment and care planning."*

9.10 EIP representatives said they had not been carrying out carer assessments but these were now recorded as third party information on RiO for identified carers. They said they also ensured that work with the family was included in the CPA care plan and made clear if there was a carer or not. The update of the EIP composite action plan for June 2012 described work on documenting the involvement of families and carers in assessment and care planning, including the reasons if they are not involved. The EIP representatives told us a regular meeting took place for EIP staff to review and develop expertise in working with families. A further audit of carer assessments in June 2012 showed an average of 46.25 per cent of cases had an identified carer and of those, 80 per cent had been offered a carer assessment.

9.11 We looked at the role of Mr B's family while he was with the adult service. He was first admitted to hospital on 8 May 2009 under Section 2 of the Mental Health Act. His father is named on the section forms as the nearest relative. On the admission details his mother is recorded as next of kin. This form did not ask if there was a carer.

9.12 When Mr B was transferred to Section 3 on 4 June 2009 his father was named on the section papers as the nearest relative.

9.13 On the discharge planner dated 17 August 2009 and addressed to the GP Mr B's mother is listed as the next of kin.

9.14 Mr B had been admitted from home. He had been violent and aggressive to his family but both his mother and father visited regularly and both attended CPA reviews on the ward. Their initial concerns over Mr B not returning home were listened to by ward staff. Discussions about Mr B having Section 17 leave always included either his mother or father and they were always informed when he absconded from the ward. On several occasions when he did so, his father took him back to hospital.

9.15 A relative assessment interview for first episode psychosis appears in the case notes, which includes questions about the relatives' understanding of psychosis. Answers

to the questions have been written on the form. It is not dated or signed but 'July-August 2009' is written on the top.

9.16 As a result of the professionals meeting held on 7 July a carer's assessment was to be organised but there is no documentation in the notes to indicate that this ever took place.

9.17 The decision to discharge Mr. B on 17 August 2009 was made at a CPA meeting, which both his mother and father attended. Both supported the discharge.

9.18 The EIP service visited and engaged with Mr. B's mother and father regularly while he was living at home after discharge from the ward.

9.19 Mr. B's grandfather left a message on the EIP team answer phone on the day of the incident requesting that EIP visit Mr. B urgently. A visit was made to Mr. B by the EIP team at the family home the same day.

9.20 The care plan in use during Mr. B's admission was last updated on 14 July 2009. It was not updated when he was discharged. The care plan did not ask if there was a carer and said nothing about contact with Mr. B's family.

Analysis and comment

9.21 ***We were surprised the admission forms the adult service used and the personal details form EIP used did not ask for a carer to be identified. The BDCT policy should have been well established by that time but we could not see how carers were formally identified. Mr B's mother and father were named as his next of kin but not as his carers. They were both involved in his care and concerned about his wellbeing. They were in close contact with the ward staff and appeared to have a good relationship and frequent contact with the EIP team.***

9.22 ***The term 'carer' was used on only one occasion: at the professionals meeting on 7 July where a carer's assessment was to be organised. We found no evidence that a carer's assessment was offered to Mr. B's mother or father at any stage. EIP has now put in systems to document the involvement of families and carers.***

9.23 ***We were encouraged by EIP's work on documenting the involvement of families and carers. A system now operates for recording carer assessments on RiO but we are still not sure if carers are being identified in accordance with trust policy.***

Conclusion

9.24 The notes show that staff had a great deal of contact with Mr. B's family, both while he was an inpatient and living at home. We found no evidence that a carer's assessment was ever offered to either of the parents.

9.25 The EIP service has improved systems for documenting the involvement of families and carers and for recording carer assessments.

Recommendation

R5 BDCT should ensure registration/admission forms and care plans identify a) if there is a carer and b) what support is being offered to the carer and c) what contact there is with the family if there is no carer. BDCT should ensure all teams, including CAMHS and EIP, identify carers and the involvement of families in accordance with trust policy.

10. Use of the Mental Health Act 1983

10.1 In this section we examine the use of several sections of the Mental Health Act 1983 in the care and treatment of Mr B.

10.2 Section 2 of the Act allows for assessment for up to 28 days.

10.3 Section 3 of the Act allows for treatment following assessment.

10.4 Section 17 of the Act allows for the responsible clinician to grant short periods of leave from the ward whilst on a section of the Mental Health Act 1983.

10.5 Community Treatment Order (CTO) is a legal order issued by a doctor which sets the conditions under which the person with a serious mental health problem may live in the community.

10.6 The act requires information to be given to the nearest relative in writing unless the service-user objects.

Evidence

10.7 Mr B was assessed under the act on 8 May 2009 and admitted to ward 1 - an open ward at hospital A - under Section 2. The Section 2 was due to expire on 4 June. This assessment was prompted by increasing violence to the family. The day before Mr B had assaulted his sister, giving her a black eye. He was stealing from the family. Mr B declined crisis or EIP worker and an informal admission to hospital.

10.8 A Section 2 appeal hearing was held on 1 June 2009. CP4 completed a report for the hearing dated 28 May 2009 and recommended that Mr B should remain detained under the act.

10.9 Mr B was re-graded to Section 3 on 4 June 2009. The Section 3 was rescinded on 17 August one day before Mr B's discharge from inpatient care.

10.10 CP3 completed one of the two medical recommendations for the Section 2 and on form A4 deleted the statement that he had previous knowledge of the patient.

10.11 The second medical recommendation for the Section 2 was completed by another medical practitioner working with a different community mental health team. This doctor like CP3 had no 'previous acquaintance' with the patient.

10.12 Mr B had several periods of Section 17 leave while he was on ward A. The decision for these is recorded in the notes and the Section 17 leave of absence forms were completed and available in the case notes.

10.13 The letter from the forensic service dated July 2009 giving advice to his management said they would not use a Community Treatment Order after his first admission but this could be considered in the future.

Analysis and comment

10.14 ***On 8 May when Mr B was placed on Section 2. CP3 deleted the statement on form A4 that he had previous knowledge of the patient, despite the fact that his SHO who saw Mr B in the outpatient clinic in November 2008. Mr B therefore would have been formally under the care of CP3. Acquaintance with the patient does not necessitate having seen the patient before.***

10.15 ***Given Mr B's increasing risk of violence, that he had assaulted his sister and his refusal to be seen by the crisis team or be admitted informally to hospital, use of Section 2 was appropriate.***

10.16 ***The report completed by CP4 for the Section 2 appeal hearing was written three weeks into Mr B's inpatient stay. We think it is an excellent report describing the clinical presentation and how this influences the diagnosis.***

Conclusion

10.17 We consider the use of the Act for Mr B was entirely appropriate each time.

11. Referral to social care

11.1 EIP2 called child protection at 15.30 on 8 May 2009 to make a referral in relation to Mr B's violence to his siblings. EIP2 was told that police had already made a referral after an incident on 14 April 2009 when Mr B had punched his sister and mother.

11.2 SC1 phoned EIP2 at 16.00 the same day and said information in the earlier call raised the question of whether Mr B would be removed from the family home. She asked that EIP2 phone with the outcome of the Mental Health Act assessment.

11.3 The CPA review which social services attended on 15 May 2009 agreed that home leaves would start after social services had undertaken an assessment.

11.4 On 22 June CP4 noted the receipt of a letter from social services saying Mr B's mother was anxious about his returning home and that the case on the family was closed because she did not feel she needed help. Social services requested that they be informed when Mr B was to be discharged.

11.5 A CPA meeting with social services was held on 26 June when they disclosed that there was significant risk history about the family but that they were reluctant to share this.

11.6 On 30 June a telephone call to social services was made by EIP2 to SC1 to encourage sharing of information and EIP2 asked that Mr B's case be reopened. It was agreed that a professionals meeting would take place on 7 July.

11.7 Information in the IMR states that on 30 June EIP2 phoned the ward to share the information about the past risks. On the 2 July a referral was made to child protection.

11.8 The professional meeting took place on 7 July. SC1 and SC2 attended and information about Mr B's past history and risks were shared. The meeting agreed: "*case needs to be re referred to children's services before unescorted leave starts by care coordinator*; *if discharged from section at tribunal in August children's services to be informed*".

11.9 The senior care manager wrote to EIP2 on 29 July acknowledging the home visits by Mr B and that his father would be present. His parents had been made aware that they were responsible for his siblings. The letter also said children's services had no role after this point and that EIP should make contact if they were concerned.

11.10 Social services sent an email to EIP2 on 31 July confirming that Mr B could have overnight leave.

11.11 We found no evidence that social services were involved with the case after Mr B was discharged on 17 August 2009.

Analysis and Comment

11.12 ***EIP staff took appropriate action to obtain information from social services and EIP2 contacted the ward once they were aware of the history. Mr B's Section 17 was reviewed and rescinded because of the new information.***

11.13 ***The BDCT IMR made a recommendation about inter-agency working and information sharing.***

Conclusion

11.14 There was a delay in sharing information about Mr B's history and behaviour coupled with the difficulty in accessing the CAMHS notes, which we describe earlier. This left gaps in the knowledge about Mr B's past.

12. Interface, communication and joint working

12.1 In this section we consider the collaboration within mental health services and with other agencies, with references to matters covered earlier in this report.

Evidence

12.2 BDCT was party to the *Bradford health and social care partnership interagency protocol for sharing information* of November 2003. This protocol was between local NHS trusts and the local authority social services department.

12.3 The Bradford district partnership issued a multi-agency *Information exchange charter* in March 2011. This included NHS trusts, local government, the university and college, the probation service, Yorkshire Water, the police, the fire and rescue service and the chamber of commerce. The charter reminded partners about the need for compliance with legal, regulatory and ethical requirements. It said partner agencies agreed to develop information-sharing agreements and provided a template. The charter emphasised the duty of confidentiality not to disclose information *"without the consent of the data subject, unless there are statutory grounds and/or an overriding justification for so doing"*.

12.4 We asked EIP representatives about the interface with other agencies. They said that as a new service they knew they needed to engage actively with local agencies for two reasons. First because the agencies were often in a position to identify people in the early stages of developing psychosis. Second, because EIP and the agencies needed to understand each other's responsibilities. The EIP service prepared a briefing sheet after the internal investigation as part of a road show for local agencies. This outlined the care coordinator's role and the value of sharing information. The EIP representatives recognised the need for continuing work by frontline staff, as colleagues in other agencies changed, to maintain effective working relationships so that vital information could be shared. For example, EIP staff were encouraged to discuss mutual expectations when they met new colleagues and the EIP team manager now attended a monthly referral meeting at the drugs project.

12.5 We have seen no information sharing agreements between BDCT and individual partner agencies.

Interface within mental health services

12.6 Mr B was transferred to the PICU on 9 June for a period of assessment without illicit drugs. The purpose of the admission is clearly recorded in the notes. The risk assessment and care plan were faxed to the PICU the day before. It was planned that Mr B would be transferred at 9.00 the next day. The plan was: "*continue olanzapine 10mg nocte: observe behaviour/psychotic symptoms: Level of observations 1: to be reviewed by team.*"

12.7 He was reviewed on 22 June by CP5 and it was agreed that he should return to the open ward. The impression of the multi-disciplinary team was that his psychotic symptoms were less prominent. His medication had been increased while he was on the PICU.

12.8 Mr B was referred to the forensic service on 15 July 2009 and a written response was received on 23 July giving advice on his management.

12.9 We examine the interface between EIP, the CMHT and the inpatient teams in section 6.

Interface with GP practice

12.10 Mr B was first referred to adult services in 2008 and was seen three times by SHO1 between November and January 2009. The SHO's outpatient letter to the GP did not give details of the violence in the home.

12.11 EIP made a telephone call to the General Practice to clarify if a referral had been made to a neuropsychologist following the recommendations of CCP1 in November 2008. The only referrals the surgery was aware of were to the CMHT in November 2008 and February 2009.

12.12 Mr B was discharged from the ward on 17 August 2009. The discharge letter to the GP was dictated by the junior doctor on 29 September and typed on 12 October. It is stamped as having been received by the GP on 15 October. It does not focus on the risks associated with the case nor refer to the history and risks that had been shared by social services about Mr B or the advice of the Forensic service.

12.13 We could find only one letter from EIP team to the GP - from EIP2 dated 28 April 2009 explaining that they would make contact with Mr B as soon as possible and would inform the GP of progress in one month's time. We found no evidence of any further letters.

12.14 CP3 wrote to the GP on 26 November after having seen Mr B on 26 October and 23 November 2009. The letter requested that the GP alter his prescription to olanzapine 10mgs and to continue prescribing we assume that this was the first time the GP had been asked to prescribe this medication for Mr B.

12.15 We make a recommendation earlier in this report about written communication by junior medical staff.

Interface with probation

12.16 Probation phoned EIP4 on 18 January 2009 explaining that Mr B had been placed on a community order with supervision as a result of his stealing the neighbour's bicycle. Mr B was to meet with probation weekly. EIP4 agreed to accompany Mr B to the next appointment with probation.

12.17 EIP4 accompanied Mr B to the appointment on 25 January 2010. Mr B was obliged to attend for 16 weeks.

12.18 The probation service was involved with Mr B for a few weeks before the incident but we saw little information in the mental health case notes about the work and risk assessments of the probation service. We saw no complete record of Mr B's forensic history.

Interface with other agencies

12.19 The EIP team referred Mr B to housing associations after discussing options with Mr B. Information and risks appear to have been shared appropriately but he was never offered any accommodation so further joint working did not take place.

12.20 The EIP team also offered support and accompanied Mr B to the job centre.

Comment

12.21 ***The delay in dictating and typing the discharge letter is unacceptable. AS described in section 5 the trust has informed us that they have since developed a memorandum of understanding with local clinical commissioning groups which clearly describes standards pertaining to timeliness and quality of written letters by medical staff in BDCT. This will be audited within the CPA audit.***

Conclusion

12.22 Formal systems for the interface and communication within mental health services and with partner organisations were adequate. CPA and care planning systems were not used to facilitate the interface with partner agencies, which relied heavily on the good relationships established by workers in the team.

12.23 BDCT had no system for monitoring the quality of written communications from junior medical staff to the GP. The memorandum of understanding that has now been put in place will have rectified this.

13. Records management

13.1 In this section we set out the problems with accessing some of the documents for our investigation. We also pull together evidence from other sections about the recording and management of clinical information.

13.2 BDCT's *Trust-wide patient records policy* was issued in October 2007. The policy said professional staff were accountable for making and keeping patient records *"which is an integral part of patient care and not a distraction from its provision"*. It sets out in section 3 standards for making records, starting from *"the accuracy, legibility and timeliness of entries in patient records is extremely important to the trust"*. It specifies that all entries must include the signature, printed name and designation of the writer and be dated and timed. Section 17 says progress notes can include a record of discussions with the patient, carers or family members, doctors, other health professionals and other health or social care providers. It also says the records should contain: *"all letters and reports relating to the patient including a record of where these...were sent"*.

13.3 The policy covers the use of the electronic patient administration system in use at the time and refers to national guidance and legal responsibilities.

13.4 BDCT's *Records management policy* was issued in June 2009 and updated in February 2011. These are overarching policies without the detailed guidance provided in the policy of October 2007.

13.5 BDCT had difficulty tracing some of the documents we needed to see. We sent our original document request to BDCT in September 2011. We sent a second request in February 2012, confirming what was outstanding and asking for some additional items. After further requests we received by the end of May 2012 most of the items we felt were essential, including versions of the policies, Mr B's electronic records and updated action plans. We did not receive the notes of the EIP psychologist.

13.6 BDCT told us later that it now has a system to retain a full set of documents reviewed and created for the internal investigation of a serious incident so they can be accessed later. BDCT said it "*adopts the same system of document retention regardless of the level/nature of the internal investigation.*"

13.7 We received the electronic GP records for Mr B which comprised of letters the GP received from 1990 – 2010, copies of Mental Health Act assessments and a patient summary. Mr B's other GP records had been archived but the facility where they had been stored could not find them.

13.8 We examined eleven documents with recommendations and action plans relating to the serious case review following the death of Mr B's brother. We have included an analysis of these documents in appendix B. The documents did not provide a full update of progress on all the recommendations with clear evidence of completion. We understand the action plans are being monitored by the EIP governance group and by Bradford Safeguarding Children Board.

13.9 We had difficulty following the updates and agreed to meet representatives of the EIP service to discuss progress. We include in the relevant sections of this report the information they provided.

13.10 The police contacted the CMHT on 4 February 2009 requesting an appropriate adult for Mr B. The CMHT could find no record of Mr B having been seen by adult services even though SHO1 saw him in November 2008.

13.11 We have described elsewhere the lack of clarity of when the CAMHS notes were received despite them being requested. At interview with CP3 he made it clear that he had never seen the CAMHS notes. The BDCT IMR says EIP were told that the notes were not in archive and that the tracer card showed they had been sent to the CMHT in November 2008. We have no other evidence of this.

Analysis and comment

13.12 ***BDCT's guidance of October 2007 set out standards for the quality of record keeping but this guidance was not included in later versions.***

13.13 ***The records by ward nurses, especially the named nurses, were generally clear and full. The names and designations of staff were sometimes illegible and we saw no composite list showing the name, designation and sample signature of people making entries in the case file.***

13.14 ***Risk profiles contained appropriate information but no clear overview. CPA documentation was adequate during the admission but poor during the episode of care in the community.***

13.15 ***We do not know if the EIP service ever received the CAMHS notes, even though they had asked for them and followed up the request.***

13.16 ***The EIP records lacked information on referral and acceptance documentation and formulation.***

13.17 ***We were concerned that the full set of evidence collated for the internal investigation was not retained for future reference.***

13.18 ***EIP has a composite action plan from several reviews and has clearly undertaken significant development work. There is also a combined health action plan following the serious case review. There is considerable overlap between these two main action plans and the many additional action plans with evidence of extensive improvements. However, we found a few gaps and contradictions and there is no comprehensive update on all the recommendations.***

Conclusion

13.19 The standard of handwritten case notes was generally good but there were some problems with legibility. This diminished the value of some entries, as we were not sure we, or anyone else, could identify the key issues. Other problems with record keeping included: the failure of some staff to identify themselves legibly; gaps in the EIP records; poor CPA documentation and the absence of some correspondence from the case file. . The notes of the outpatient appointments in November 2008 were not readily available to the CMHT when police contacted them.

13.20 The RiO patient information system will have made a big difference to the quality of the single patient record. This should enable staff to access a clear and comprehensive overview for each service user.

13.21 We do not know if adult services ever received the CAMHS notes but CP3 had evidently never seen them. The notes contained details of Mr B's risks and perverted behaviours from the age of five that would have informed those caring for him.

13.22 Problems with tracing some of the documents for our investigation meant we spent more time than expected requesting documents and examining them when they were received. Receiving batches of unrelated documents at different times also complicated our analysis. We were concerned the full set of evidence collated for the internal management review was not retained for future reference, but BDCT now has a system to ensure the retention of documentary evidence.

13.23 BDCT has undertaken significant development work but we did not see a comprehensive update of progress on all the recommendations from BACHS's internal investigation. We wondered how this could be monitored effectively.

14. Overall conclusions

14.1 We had serious concerns about the overall management of Mr B's care. Nobody who took charge of his treatment had a clear overview of his problems and needs.

14.2 Despite our concerns, we found good practice in some areas and Mr B was generally seen by skilled and conscientious staff. Mr B was referred to the adult team and the EIP service. He was given intensive practical support with valuable contributions from other agencies but there was no agreed overview of the link between his mental health and substance misuse. There are also questions about the diagnosis and the overall formulation of the case.

14.3 Mr B had a difficult childhood. He had been assessed in 2008 as having a low IQ. He only sporadically showed any commitment or motivation to participate in the treatment or support offered by workers both as an inpatient and in the community. He was admitted to an inpatient unit after violent behaviour towards his sister. We could not see what was achieved during the time Mr B spent on the ward and in intensive care, other than a period of containment. It did not result in any clearer understanding of Mr B's problems.

14.4 From the evidence we have seen we cannot conclude that any particular course of action would have prevented a serious incident.

14.5 BDCT has made significant improvements and we identify further learning, in relation to good practice and managing patients in the future, from our examination of Mr B's care and treatment.

Appendix A

Team biographies

Sue Bos

Sue is based in the north of England and is a graduate of the NHS national training scheme. Sue spent most of her career working in hospitals in senior operational roles, and was director of specialist services at Leicestershire Partnership NHS Trust for many years. In this role she was responsible for a group of clinical directorates, which included forensic psychiatry, drug and alcohol services and child and adolescent services. Throughout this time, she was a member of the trust's senior management team and undertook many investigations and reviews. She has also carried out work as an independent consultant at the National Patient Safety Agency and for the Health Service Commissioner. Sue has completed a number of investigations for Verita, most recently, two independent investigations for NHS Yorkshire and Humber.

Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its most high-profile mental health reviews. In addition to her investigative work, Chris regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations. As head of training Chris has developed and delivered courses on different aspects of systematic incident investigation. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people. Chris heads up Verita's office in Leeds.

Liz Howes

Liz Howes has 20 years' experience of senior management in the NHS, specialising in mental health and learning disabilities. Liz led on a service improvement project in mental health services as part of a national pilot with the National Institute for Mental Health in England, and was responsible for leading a multi-agency project plan for the reprovision of homes for people with learning disabilities. This involved providing alternative accommodation and ensuring mainstream services for residents that promoted social

inclusion and personalised care. Her previous posts have included interim director of learning disabilities and specialist services and head of services redesign and information services at Leicestershire Partnership NHS Trust; and director of mental health services at Leicestershire and Rutland Healthcare NHS Trust.

Derek Mechen

Derek has been involved in healthcare for over 30 years, holding senior operational management positions in both the NHS and independent sector. He has also worked for the National Audit Office where he led value-for-money studies and spent a year on exchange at a teaching hospital in Chicago. As director of client work for Verita, he has overall responsibility for the quality of all investigations, and heads up Verita's joint training initiative with Capsticks on maintaining high professional standards.

Mostafa Mohanna

After graduating from medical school with an MB, BCh, Mostafa went on to get his basic training in psychiatry at Leicester and subsequently, after gaining membership of the Royal College of Psychiatrists (MRCPsych), became a lecturer with the Leicester Medical School. From there he went on to become a senior registrar in the Cambridge rotation. Mostafa then took up a consultant post in Lincoln in 1990 and has been in that position since. Mostafa, during his consultant tenure, became the clinical tutor organising the junior doctor rotation and from there went on to become the clinical director for the mental health services. He then became the medical director for the newly formed Lincolnshire Partnership Trust in 2001 but has recently vacated that post. He currently continues to practice as a consultant psychiatrist within the same trust. His role as medical director involved, amongst other things, investigating untoward incidents and complaints and liaising with external bodies coming into the trust to investigate incidents. As medical director, Mostafa was joint lead, with the director of nursing, on clinical governance and quality, and had the lead on research and clinical effectiveness. Mostafa is a Fellow of the Royal College of Psychiatrists (FRCPsych).

Appendix B

Documents reviewed

Clinical records

- CAMHS records December 1994 to June 2002
- Adult mental health records November 2008 to February 2010
- Electronic records from Totalcare and RiO
- General practitioner summary and copies of correspondence

BACHS internal investigation documents

- BACHS's internal management review
- Five statements and transcripts of interviews for the internal management review
- GP internal management review

1. SCR executive summary – composite list of recommendations including sections for:
    a. EIP
    b. CPA within EIP
    c. risk assessment within EIP
    d. assertive outreach within EIP
    e. interagency working
    f. BACHS community services
    g. BDCT

2. BACHS action plan for Bradford BSCB – undated, actions on f

3. BACHS action plan for Bradford BSCB – undated, actions on a

4. BDCT action plan for Bradford BSCB – undated, actions on g [except for 10.10.5 - prompts for CPA meetings on RiO and 10.10.6 - section 17 leave/discharge planning]

5. Combined health action plan for Child J SCR – undated, actions on a [item 5 interagency information sharing protocols only completed for children's services], f, g [except for 10.10.5 - prompts for CPA meetings on RiO and 10.10.6 - section 17 leave/discharge planning] and an appendix with actions from audit of EIP case notes on documentation of:
    h. safeguarding

i. domestic abuse
j. dual diagnosis
k. family/carer involvement in CPA
l. GP involvement in CPA
m. carers' care plan
n. suicide checklist
o. regular review of client
p. electronic records within 24 hours
q. contingency plan for unplanned discharge

6. BDCT action plan for EIP from IMR – undated, actions on a [item 5 requires gaps in information sharing to be addressed and an information exchange charter requires information sharing agreements to be developed - we have seen none but the action says 'completed December 2012' – see also 10 below]

7. BDCT action plan for EIP from audit of case notes – dated 01/11/2010, actions on h - q

8. Update of 7 – also dated 01/11/10 – received 20/07/12 from PCT

9. EIP composite action plan – dated April 2011, actions on a [item 2 requires review of risk assessment processes and action says 'see addendum' which does not mention risk assessment; item 3 requires review of treatment package of all dual diagnosis clients - this is not mentioned here and not clear in 6 above that completed; item 5 says EIP will cooperate with PCT led process to develop single information sharing agreement, meetings with substance providers planned 2011 and protocols for information sharing with police completed November 2011 but we have seen no outcomes – see also 7 above], b [10.7.8.1 requires competencies for staff in risk assessment – this is not mentioned here but 6 above indicates completed/ongoing], c, d [10.7.8.3 requires benchmark of assertive outreach approach in EIP – this is not mentioned here but 6 above indicates completed], e [items on information sharing as above], p, q + addendum with h – o

10. Update of 9 – dated December 2011 but no addendum, without evidence or date of completion on 'completed' items

11. Update of 10 – dated June 2012 with addendum, without evidence or date of completion on 'completed' items

BACHS policy documents

- EIP operational policy October 2007, May 2009 & September 2009

BDCT policy documents

- EIP operational policy May 2012
- EIP information sheet on CPA & care coordination - undated
- PICU operational policy January 2008, March 2011 & September 2011
- Care coordination policy November 2007
- Care programme approach policy May 2009, August 2009 & March 2011
- Individual carer assessment and support plan December 2006
- Safeguarding children guidelines August 2007 & August 2009
- Safeguarding children joint protocol May 2011
- Safeguarding children supervision procedures April 2011 - April 2013
- Safeguarding adults policy November 2007, undated, August 2009 & July 2011
- Bradford health and social care partnership interagency protocol for sharing information November 2003
- Bradford district partnership information exchange charter March 2011
- Trust-wide patient records policy October 2007
- Records management policy June 2009 & February 2011

Other documents

- External review of EIP service September 2010
- Psychiatric court reports