Independent Investigation into the Care and Management of Mental Health Service User 2004/487

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

The Investigation Team members were:

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- Dr Mark Potter, Consultant Psychiatrist, South West London Mental Health Trust
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Acknowledgements:
The Investigation Team wish to thank all of the staff at North East Lincolnshire Care Trust Plus who gave willingly of their time to assist us in understanding the full context of the care and management of the mental health service user involved in the homicide incident on the 26 February 2004.

The Investigation Team also extend their thanks to the Independent Service Users and Carers Forum in North East Lincolnshire, and to the daughter of the deceased, and her husband, for the information shared with them.

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EXECUTIVE SUMMARY

Intention

This report sets out the findings of the independent Investigation Team following its analysis of the care and treatment of a mental health service user (MHSU) who was convicted of murdering his stepfather on 26 February 2004.

Purpose

The purpose of the work commissioned was:

- To undertake a detailed and analytical timeline charting the MHSU's contacts with the mental health service.

- To critically analyse the documented care of Doncaster and South Humber NHS Trust and to identify any areas that appeared weak or unsatisfactory, and then to determine the significance of these features in relation to the subsequent course of events and incident that resulted in the death of the MHSU's stepfather.

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

Outline of the review process

An initial review of the MHSU's clinical records suggested that in this case service wide root cause analysis was not required. Therefore a targeted investigation of the MHSU's care and treatment only was undertaken.

The primary activities were:

- Documentation review
- Interviews and round-the-table meetings with staff involved in the care and treatment of the MHSU and their local and senior managers.
- Liaison with the MHSU's family
- Liaison with the MHSU
- Liaison with Humberside Police

Main conclusions

As a result of this review the main conclusions are:

- The analysis of the case notes suggests that the MHSU's care and treatment by mental health services up to and including his discharge from mental health services in April 2002 was reasonable.

- The Care Coordinator assigned to the MHSU in May 2003 supported the MHSU appropriately in achieving stable accommodation and in liaising with the North East Lincolnshire Housing Department to try and find suitable accommodation.

- It was reasonable to maintain the MHSU on oral anti-psychotic medication following his admission to hospital in May 2003. Furthermore the outline plan of providing an Associate Nurse to work with the Care Coordinator to monitor medication compliance was a good one.

- Unfortunately there were a number of aspects of the MHSU's care that fell below par. The primary underpinning reason for this was the lack of effective systems and processes in North East Lincolnshire at the time to ensure that inexperienced staff were appropriately supported and supervised in their work. Furthermore the role of the Associate Nurse was inadequately defined. There was also a systems failure in achieving access to the MHSU's past clinical records.

- In addition:
    - All of the care team held a narrow perspective of the MHSU's needs and minimised the risk implications of his contemporary history which was known about by all involved professionals. These risks were the risk of medication non-compliance and moderate to severe self-neglect.
    - There was a complete failure in the Care Programme Approach process. Although the MHSU was treated as though he was on Enhanced CPA, he was actually placed on Standard CPA. This meant that in January 2004 it was possible for him to be discharged by one clinician, without there being a wider discussion regarding the appropriateness of this with the Community Mental Health Team and in particular the professionals who has also been involved in his care.
    - There was no exploration of a change in the MHSU's social circumstances when it was reported that his stepfather was drinking excessively and that things were 'fragile at home.'
    - There were inadequate communications with the family of the MHSU and in particular his stepfather with whom he was living

The overall conclusion of the Investigation Team following the analysis of the MHSU's care and management is that the incident that occurred on 26 February was not predictable by the mental health services at the time. There was nothing known by the mental health service that could have alerted staff to the possibility that the MHSU was capable of such a display of violence. There was however information available that would have alerted staff to potential vulnerability of the MHSU's stepfather from the MHSU if he became unwell. Therefore, the question of whether the homicide was preventable is more difficult. Had the family been more involved with the mental health services and had there been a risk management and relapse prevention plan for the

MHSU that involved the family, then there may have been a greater likelihood that they might have made proactive contact with the mental health service in the days leading up to the incident if they were concerned about his behaviour.

Also had the MHSU's unsubstantiated allegation about the sudden large alcohol intake of his stepfather and the increased fragility in their relationship been explored, as it should have been, then it is possible that early signs of deterioration in the MHSU's mental state may have been identified.

Had either or both of the above occurred it is possible that the MHSU would have received an assessment by a member of the psychiatric team, and/or an increase in the frequency in his assessments by his Care Coordinator and in outpatients.

Whether or not such assessments would have identified the extent of deterioration to the MHSU's mental health or his medication non-compliance is impossible to say.

Furthermore it is not possible to give any assurance that the MHSU would have been detained under the Mental Health Act prior to the incident, or would have required hospital admission.

Consequently we cannot say with any confidence that this incident would have definitely been prevented on the day on which it occurred by virtue of a change in the actions and non-actions of any member of the community mental health team in the then Doncaster and South Humber NHS Trust. However, the preventability of the incident remains a possibility.

Recommendations

The Investigation Team has three recommendations for the mental health service in North East Lincolnshire Partnership Care Trust.

The current service is so far removed from the situation that prevailed in 2003 and 2004 that many of the issues that needed to be addressed at the time this incident occurred have now been addressed. The improvements that have occurred within the mental health service in Grimsby have been endorsed and confirmed by service users and other local non-statutory organisations.

The Investigation Team's recommendations are:

1. To reconsider the practice of employing inexperienced social workers in positions that carry care coordination responsibility for service users with complex mental health needs. If the Trust feels that such appointments are appropriate, then it must ensure that such individuals receive effective supervision both professionally and from a case management perspective.
2. To make amendments to the design of the current medical records tracer card in use,

3. To ensure that all qualified mental health workers, including medical staff, understand the process set out by and their obligations with regards to Section 117 aftercare as set out in the Mental Health Act. (see glossary p75)

1.0 BACKGROUND

On 26 February 2004 a mental health service user (MHSU) of the then Doncaster and South Humber NHS Trust attacked his stepfather on his doorstep. The attacked resulted in the death of the MHSU's stepfather. On 8 November 2004 the MHSU was convicted of the manslaughter of his father on the grounds of diminished responsibility and was sentenced under Section 37 (41) of the Mental Health Act.

The MHSU was first referred to mental health services in 1987 by his general practitioner (GP). He had a history of being nervous and introspective since 1970 and had been treated with antidepressants by his GP. At the time of this first referral his symptoms had become worse.

The MHSU's initial assessment by the psychiatric services confirmed that the MHSU did have paranoid beliefs that centred around others believing him to be a homosexual, including his wife. He was given an injection of the antipsychotic flupentixol (Depixol) 20mg at this first appointment. A subsequent visit to see the consultant psychiatrist revealed that he had been much calmer since receiving the injection and less aggressive towards his wife. Depixol 20mg was therefore prescribed to be administered once a fortnight.

The clinical records between 1988 and 2002 show that by and large the MHSU was successfully managed in the community with community psychiatric nurse (CPN) support and out patient follow up. He did have two admissions to hospital during this time, as follows:

- ❒ once in 1988 for observation and assessment of his medication regime; and
- ❒ once in September 1989. Following this admission he was commenced on weekly zuclopenthixol (Clopixol) 200mg injections intra-muscularly. (Note: This had previously been stopped in February 1989 in favour of lithium carbonate 400mg twice a day. in June 1989 his mother advised his CPN that he had stopped all his medications two months previously but appeared well.)

In November 1989 the MHSU was discharged back to the care of his GP having not attended his outpatient appointments on three occasions.

The MHSU was re-referred to mental health services in November 1990 under Section 2 of the Mental Health Act. The antecedents to this were:

- ❒ ordering his wife to leave the house; and
- ❒ not allowing the GP admission to the house.

Once entry to the house was achieved the psychiatric assessment revealed that the MHSU was again experiencing paranoid beliefs. The MHSU refused to take any medication except on a compulsory basis.

He was subsequently discharged from hospital on 5 December 1990. This was followed by an informal admission on 17 December 1990 with a further detention under Section 5(2) of the Mental Health Act on 19 December 1990 because of the MHSU's repeated attempts to leave the ward. He remained firmly convinced that everyone was against him. The antecedent to his deterioration following his discharge on 5 December was non-compliance with his medication.

The MHSU remained an inpatient between December 1990 and June 1991. On discharge he was on a range of oral medication and also monthly injections of haloperidol decanoate 100mg to be administered by his CPN.

His next admission to hospital was in May 1992 following a self-harm attempt where he threw himself down the stairs at home. He was at this time missing his wife and children. His wife had divorced him in 1991.

Following this admission the MHSU remained very well with no further in-patient episodes. It seems that between 1994 and 1999 he was followed up via the depot clinic and via his GP.

In April 1999, seven years following his last in-patient episode, the MHSU was assessed by a consultant psychiatrist covering the Depot Clinic. At this visit the MHSU requested to be 'weaned off' his medication. It was agreed that his medication could be reduced by half, taking his haloperidol to 40mg monthly. In the event he was maintained on a monthly injection of 50mg. This dosage continued until April 2001 when it was reduced further to 25mg per month. Over the previous two years the MHSU had remained symptom free. Between April 2001 and October 2001 the MHSU continued to remain symptom free on the 25mg monthly dose. Because of the proven period of his stability and because the MHSU wished to cease his depot injections, these were ceased completely on 16 October 2001.

The MHSU was assessed again in out patients in April 2002 and presented as well and symptom free. He was therefore discharged from mental health services into the care of his GP.

There MHSU had not further contact with mental health services until 21 May 2003 when he was found to be acting bizarrely in the local public baths and taken to a place of safety under section 136 of the Mental Health Act.

At this time the MHSU had no insight to his mental ill health and, bar the fine detail of his beliefs, his presentation was very similar to those of November and December 1992.

As previously he settled relatively quickly once re-medicated, and was discharged from hospital into the care of his Care Coordinator with outpatient follow up on 19 June 2003.

The MHSU's subsequent course in the community was unremarkable. He appeared:

- ❒ well;
- ❒ medication compliant;
- ❒ to have positive contact with his grown up sons; and
- ❒ to have settled comfortably into living with his stepfather again

On the 26th January he was discharged from the Community Mental Health Team by his Care Coordinator but was to continue with outpatient follow up on a three to four monthly basis.

One month after his discharge from his Care Coordinator's caseload he attacked his stepfather.

PLEASE SEE APPENDIX 1 (page 64 FOR A MORE DETAILED CHRONOLOGY OF THE MHSU's CONTACTS WITH THE MENTAL HEALTH SERVCIES

2.0 TERMS OF REFERENCE

The terms of reference for the investigation are:

To examine:

The circumstances surrounding the treatment and care of the service user involved in the homicide and in particular:

1. To examine:
    - The care and treatment provided and its appropriateness.
    - The extent with which the care and treatment reflected the expected standards at the time in relation to local policies and guidelines and also national expected standards. In this case of particular relevance are:
        - risk Assessment including relapse prevention;
        - care Programme Approach;
        - carers Assessment ; and
        - records Management
    - The exercise of professional judgment and clinical decision making of all staff.
    - The interface, communication and joint working between all those involved in providing care to the MHSU.
    - The quality of care plans and record keeping in general.
2. To examine the appropriateness of the professional and in-service training provided to staff in Adult Services in relation to
    - risk assessment;
    - the Care Programme Approach;
    - conducting Carers Assessments; and
    - vulnerable Adults.

    Note: If possible a contemporary perspective will be elicited.
3. To examine the adequacy of the working arrangements, collaboration and engagement with housing services and general practice where appropriate.
4. To provide comment on the quality of the Trust's internal investigation close to the time of the incident and implementation of recommendations made.

To identify:

- Learning points for improving systems and services; and
- developments in services since the user's engagement with mental health services and action taken since the incident.

To make:

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

To report:-

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

3.0 METHODOLOGY

This was a targeted investigation of the care and management of the MHSU concentrating on the period between 21 May 2003 and 26 February 2004. However, the principles espoused in the National Patient Safety Agency's root cause analysis e-learning tool kit[1] were applied.

The specific investigation and analysis tools utilised were:

- The Consequence UK Ltd Structured Timeline.
- Investigative interviewing
- Structured content analysis
- Affinity mapping

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

- The MHSU's clinical records held by North East Lincolnshire Partnership Care Trust.
- Interviews with staff engaged in the care and management of the MHSU.
- Liaison with Humberside Police Force.
- Liaison with the consultant psychiatrist initially responsible for the MHSU's management at the Humber Centre Medium Secure Unit.
- Liaison with the MHSU's sister.

[1] NPSA e-Learning tool kit August 2004
http://www.npsa.nhs.uk/patientsafety/improvingpatientsafety/rootcauseanalysis

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

In this case the family of the victim and the family of the MHSU were one and the same. At the outset of the investigation positive communication was had with the MHSU's sister. At this time she expressed a wish to meet with the Investigation Team and to have some involvement with the investigation. This situation subsequently changed but further written correspondence did take place between the investigation lead and the MHSU's sister.

The Humber centre was also contacted to try and locate the whereabouts of the MHSU's sons. The contact details for one son was provided, including the address of his mother. A letter was sent to the address of 'the mother'[2], i.e. the MHSU's former wife, for the attention of the MHSU's son. No response to this was received.

A further letter was sent to the daughter of the deceased advising her of the completion of the report, and offering the opportunity for her, and her nephews, to meet with the Investigation Team leader to have a supervised reading of this. A meeting was subsequently arranged for 4 November.

The MHSU himself declined the offer of a meeting but did express a wish to be sent a copy of the final investigation report. He also agreed to let his son know that we were trying to contact him.

The perspective of the daughter of the deceased and her husband
The Investigation Team met with the daughter of the deceased and her husband on 4 November (Mr and Mrs Y). At this meeting it was very evident that Mr and Mrs Y continue to have very strong feelings about the shortcomings in the service offered to the MHSU and also to the deceased Mr H.

Mr and Mrs Y told the Investigation Team that until 2002 the MHSU had been very much cared for by his family and that while he was on his depot injections he had always been very stable and life was manageable.

They have some difficulty in accepting the appropriateness of the change from depot to oral anti-psychotic medication in 2002 but do understand that this was reasonable thing to do.

[2] The reason why the letter was sent to the MHSU's former wife's address was that on a postcode search the address provided for the son was not recognised by the Royal Mail search system and his mother's was.

However what they find difficult to accept is the lack of longer term monitoring of his medication compliance after his admission in May 2003 when it was plainly evident that unmedicated he became very ill.

The lack of effort, as they see it, by the local mental health service to engage with them as a family also continues to be a source of anger.

Mr and Mrs Y were able to recall in some detail the efforts they made to let the police and health services know about their concerns regarding the MHSU's violent behaviour in the weeks preceding admission. This included Mr Y sustaining two punches to the head he received from the MHSU that were intended for Mr H (Mrs Y's father and the MHSU's step-father).

Mr Y also recalled going to ward D2 with clothes for the MHSU and being told that he had been moved to hostel type accommodation and they could not tell him, his wife or the MHSU's step-father where he had gone for data protection reasons. Consequently the family visited a number of hostels to locate the MHSU.

Mr and Mrs Y also told the Investigation Team that, in the weeks leading up to the MHSU's admission to hospital, he had been evicted from Mr H's home because of his increasingly unreasonable behaviour which included throwing all of Mr H's belongings out of his home.

It remains the firm opinion of Mr and Mrs Y that Mr H should not have been asked by the MHSU's care coordinator if the MHSU could again live with him. To this day Mrs Y believes that the care coordinator should have spoken with her in the first instance especially as her father was in his mid 70's at the time. Although Mr and Mrs Y accept that the MHSU's behaviour could not have suggested that he was capable of murder they do believe that the information they had was sufficient to identify that the MHSU posed a serious risk of violence to an elderly man. Their anger stems from their belief that no one wanted to listen to them or sought their input at any time.

Mr and Mrs Y told the Investigation Team that they did remonstrate with Mr H over his decision to again provide accommodation for the MHSU as they were concerned for his safety especially if the MHSU stopped taking his medication. Mr H however told his daughter that he was fine and quite able to look after himself. Clearly he did not see himself as at risk.

We did talk about what might have been different had the mental health service in Grimsby offered Mr H a carers assessment. Mr and Mrs Y thought that if had been impressed upon Mr H that he must tell the mental health service about any concerns he had about the MHSU's behaviours then he probably would have done this as he was a person who followed rules and wanted to do 'the right thing'. With family

however he saw his daughter's concern as interference and she and her husband were asked not to interfere.

Mrs Y did tell the Investigation Team that she had contact with her father most days and saw him a few days prior to his death. He did not say anything that suggested that he was concerned about the MHSU's behaviour. However this is not information he would have shared with her.

5.0 CONTEXTUAL INFORMATION ABOUT MENTAL HEALTH SERVICES IN GRIMSBY 2002 - 2004

At the time this incident occurred the mental health services in Grimsby were in the early stages of a complete overhaul. The context of the situation in Grimsby is relevant to some of the factors identified as contributing to some of the identified weaknesses in the delivery of care and treatment to the MHSU involved in the homicide incident. Consequently an overview of the situation is presented in this section of the report.

Overview

The management of mental health services in North East Lincolnshire transferred to Doncaster and South Humber Healthcare NHS Trust in late 1999. The Director of Mental Health Services had taken the post in Grimsby in summer 2001 following examination of the service with the express purpose of implementing a complete redesign of how mental health services were structured and delivered. To develop plans, develop the service and give the service a stronger local basis were key parts of the director's job description. Because of long term underfunding in the area and the need for extensive consultation the changes required took longer to implement than might have been anticipated. It was not until 2003 that NE Lincolnshire began in earnest its modernisation programme. The two years 2002 – 2004 were focused on addressing priority quality and safety issues for the service. In 2005 the mental health service in Grimsby was transferred to the North East Lincolnshire Primary Care Trust. This has made a material difference to the development of the service as supporting infrastructures immediately became more accessible than they had been when the service was run by Doncaster and South Humber Healthcare NHS Trust. A significant investment of about £2m was committed to the development of mental health services in Grimsby over this time.

2002 - 2004

It was the vision of the newly appointed Director to change the perception of Grimsby that was widely held within the field of mental health. In the early 2000's Grimsby was not seen as a place to work, it was definitely not perceived as a career development opportunity and generally the perception was of an undernourished and under developed service. Indeed a comment made to the newly appointed Director of Mental Health Services for Grimsby was: "*If you look at NE Lincs the only way is up".*

The area had one of the lowest spends per head in the country in relation to mental health. There was a lack of staffing both in relation to nursing staff and also consultant psychiatrists, significant difficulties in recruitment, isolated staff, and low morale. Bed occupancy was 138%. It was almost as though it was a forgotten area.

Up until 2002, the perception of many Doncaster and South Humber Healthcare NHS Trust staff working in Grimsby, was that the Trust had overlooked the service in Grimsby in favour of the service in Doncaster, and subsequently in later years Rotherham.

Virtually all of the supporting structures were based in Doncaster. This meant that all significant meetings were held on this site which further denuded Grimsby of its management and leadership resource, as significant amounts of time were spent travelling to and from meetings.

However, there was, the Investigation Team believes, a genuine intent in the Doncaster and South Humber Healthcare Trust for the development and delivery of good mental health services across all of the main geographical areas that it covered. This is evidenced by the stated philosophy of linking the delivery of mental health services to the relevant council so that mental health services could deliver to local needs.

When the new Director of Mental Health Services commenced in Grimsby management staff recall that there was a sense of positive joining with the council, and a local board with six users and carers on it was set up.

In 2002 the mental health services in Grimsby consisted of a 29 bedded all acute unit. Qualified staffing was at 49% of the agreed establishment number and there was therefore high usage of agency staffing which was less than ideal. Violence levels were very high and both the environment and a lack of development in staff skills were worrisome and in need of urgent remediation.

There were a number of key clinical leadership positions that were vacant at this time and measures were taken to resolve this with the advertising of posts. There were difficulties in appointing as no one wanted to work in NE Lincs.

Key services were absent: there was no homeless team, little in the way of long term facilities (such as supported accommodation), a mixed dementia and functional care older people's area, no early intervention, no focussed employment and training schemes, no intensive home treatment, no psychiatric intensive care unit or easy access to such facility, a limited crisis service and no crisis facility.

Service redesign

The plan therefore was to totally redesign the whole service with the aid of service users, carers and staff as this was needed.

Acute wards were a source of very early concern and therefore a priority issue. After a full option appraisal it was decided that the inpatient unit should be divided to make two 10-bed units with staff working flexibly working in the unit and in the community. This would have the added benefit of improving continuity of staff for the service

users. From an organisational perspective such an initiative would increase the overall skill base of staff and make positions in Grimsby more professionally attractive. A separate enhanced care area should also be provided.

The first step in this process was to create two areas of 12 and 15 beds, the best the environment would allow. This was later reduced to 12 and 12 when home treatment, flexible outreach from staff and consultant agreements reduced bed usage. An outline business case (OBC) was developed in tandem to request capital to build new appropriate facilities and take the unit off site. All staff were trained very quickly in a non - invasive management of aggression package (SCIP® UK) after having sought the permission of the user/carer forum to change the approach to this issue. The independent user forum was also asked to provide members to teach on the course, giving their views on what it was like to receive staff care for these issues and where these things sometimes went wrong. The user forum also helped redesign the course within objectives to ensure the content addressed the issues as they saw them.

Note: All management of aggression courses in NE Lincolnshire now have Service User teaching input. The incidence of violence and aggression incidents went down markedly and recruitment following the advertisement of the new model and changes improved dramatically over a period of two years to the present day. There is now a small waiting list of staff waiting for work opportunities to arise in Grimsby. This represents a remarkable change in how mental health services are perceived in Grimsby. In addition to changes in perception bed occupancy figures are markedly different to those of 2002. Occupancy now stands at 90-92% occupancy even with the reduced bed numbers.

Other developments implemented 2002 - 2003

A single line management structure for all staff was designed (with the appropriate person in charge of each team regardless of discipline), interviewed and appointed to this. Social care staff were seconded into the teams. This was considered to have been successful in the main, but it also meant that the service was operationally split into two, with two heads of mental health. This reflected the need politically to have a senior health and senior social care post, as a means to facilitating the transition to a seamless management structure, regardless of the professional background of the senior post holder. The final system is now in place with one operational Assistant Director and one Assistant Director who deals with commissioning and performance. This has resulted in clearer definition of roles, responsibilities and accountabilities for all.

Medical staffing 2002 - 2008

Between 2002 and 2005 there were three substantive consultants and one long term locum. Now there are eight consultants. The Trust has also implemented new ways of working with one senior member of the medical team being allocated time for homelessness, asylum seekers,

people without adequate GP cover and other socially excluded groups. Historically the caseloads in Grimsby were very large, more than would have been expected elsewhere. Royal College of Psychiatry Guidelines regarding an ideal caseload size were and are challenging for most to achieve, but even taking this into consideration the caseload sizes in NE Lincolnshire were excessive. This issue began to be addressed in earnest on transfer to the then PCT in 2005 with Polish recruitment and further UK recruitment.

The contemporary situation

The way in which mental health services are now delivered in NE Lincolnshire bears no resemblance to the services as they were in 2002 – 2004. This situation is wholly down to the efforts of the management team, the staff employed by the service and the support and input of numerous service users and carers who have worked alongside the mental health staff in Grimsby to develop a service that offers them evidence based treatments and respects them as individuals. There is now for instance a homelessness team and highly developed employment and training schemes that would be open to service users such as the gentleman involved in the incident leading to this investigation.

6.0 FINDINGS OF THE INVESTIGATION

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

- The care and treatment provided to the MHSU and its appropriateness.
- The extent with which the care and treatment reflected the expected standards at the time in relation to local policies and guidelines and also national expected standards. In this case of particular relevance are
    - risk assessment including relapse prevention;
    - Care Programme Approach;
    - carers' assessment; and
    - records management.
- The exercise of professional judgment and clinical decision making of all staff.
- The interface, communication and joint working between all those involved in providing care to the MHSU.
- The quality of care plans and record keeping in general.

This section of the report therefore sets out the Investigations Team's findings in relation to these issues.

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

Up to and including 2002 the care and management of the MHSU was reasonable in relation to the following:.

- Care in the late 1980s and 1990s was very good. The clinician's were attentive to the needs of their patient and help was provided with housing, regaining employment and so on. There was also evidence in the records of positive engagement with the MHSU's family and also his GP.
- Follow up in outpatients was regular and appropriate.
- The MHSU was supported in coming off depot medication. This was managed over a reasonable length of time and was appropriate.
- There was appropriate monitoring of the MHSU's adjustment to medication changes.
- The discharge of the MHSU back to the primary care team in April 2002 was appropriate once it had been ascertained that he was stable on oral medication.
- Following admission in May 2003 the MHSU was discharged from in-patient services in the June with a seemingly appropriate care package from inpatient services. He had a

- Care Coordinator
- An Associate Nurse
- Follow up in outpatients

- Support with housing and financial issues. There is good evidence in the records that the MHSU's Care Coordinator in 2003 and 2004 did maintain good communications with various housing agencies to find and secure accommodation for him.

- The MHSU received regular home visits from his Care Coordinator and Associate Nurse. These visits were on a fortnightly basis until the end of December 2003.

6.2 The appropriateness of the MHSU's care and treatment – care management and service delivery concerns

Although there were aspects of the MHSU's care and management that were satisfactory from 1987 to January 2004, there were a number of significant concerns regarding the service provided to the MHSU and his family between May 2003 and February 2004 that are relevant to the terms of reference of this investigation.

The Investigation Team's analysis of the MHSU's clinical records identified a number of key questions that needed to be explored within the context of the investigation. These questions were:

- Why was the MHSU placed on standard and not enhanced CPA?
- Why was there no access to the MHSU's past medical records?
- Whether or not the surveillance of the MHSU's medication compliance was acceptable?
- Whether or not it was reasonable to facilitate the MHSU residing with his elderly stepfather?
- How effectively the MHSU's Care Coordinator communicated with the family of the MHSU, most notably his stepfather and his sister?
- Whether or not the risk assessments undertaken were appropriate?
- Why, when the MHSU reported a change in his stepfather's behaviour around alcohol, and a change in their relationship, was this not further explored by his Care Coordinator?
- Why was there a uni-professional discharge of the MHSU from mental health services in January 2004?

During the interviews with staff a further key concern arose which was:

- Whether or not the choice of Care Coordinator was appropriate, and whether or not the individual's supervision was satisfactory.

In the subsequent sections of this chapter each question will be taken in turn, with the Investigation Team's findings and (where appropriate) opinion presented.

6.2.1 Why was the MHSU placed on standard and not enhanced CPA?

The CPA documentation (undated) showed that the MHSU had been placed on Standard CPA at, or around the time of his discharge from Ward D2. However the range of professionals engaged in his care package suggests that he received an enhanced package of care. Certainly the analysis undertaken by the Investigation Team suggested that he should have been on Enhanced CPA.
The reasons for this were:

- He was a gentleman who had a history of medication non-compliance resulting in acute psychotic episodes.
- He was a gentleman who had a range of needs requiring the input of a number of professionals and agencies. These were:
  - support with medication compliance;
  - support with finding and sustaining accommodation;
  - support with financial matters; and
  - he had previously been sectioned under the Mental Health Act in 1990 and as far as the Investigation Team could ascertain from the clinical records had never been formally discharged from Section 117 aftercare.

Discussions with staff working in the Trust at the time revealed:

- That the first dedicated CPA Coordinator's post for CPA was created at the end of 2001 or early in 2002. This was a period of significant change in the organisation. Responsibility for CPA had previously been 'tagged on' to another individual's role.
- The Green team (the MHSU's Community Mental Health Team) were a new team and not an established team.
- The perceptions of some staff new to East Lincolnshire regarding CPA are presented by the following;
  - "*At the time there was no robust system in place to ensure that the Mental Health Act process was followed or the CPA process was followed"*
  - "*There was a policy on CPA but no one to administer it. The Care Coordinators were left to do it themselves. That is haphazard stuff*"
  - *[When we joined the Trust] "There were a lot of clients who were on Standard rather than Enhanced CPA. They should have been on enhanced"*
  - *"There was a poor view of what constituted enhanced CPA"*

However not all staff agreed with this. One experienced member of staff, but a new employee of the Trust, said "*Yes CPA worked OK. The reviews were sometimes a bit late but not desperately so"* "*The line manager audited the process and chased people up".*

- The CPA Coordinator (2002 – early 2003) told the Investigation Team that an audit of CPA documentation in 2002 did show that the Trust was a long way from where it needed to be in terms of CPA. It was clear that a common process and training on CPA was required. Consequently a range of CPA training was devised which all CPA coordinators were expected to attend.
- The time period 2002 to 2003 was very developmental for the Trust in terms of pulling systems together for supporting CPA practice.

With specific reference to the MHSU, who is the subject of this report, the Investigation Team were told by his then consultant psychiatrist that he "*was on enhanced CPA whatever the paperwork says, and the care package afforded him evidences this."* The MHSU had "*a consultant psychiatrist, a care coordinator, a community psychiatric nurse for medications monitoring and a general practitioner (GP). There was also housing input even though this was not overly successful. "*

The Care Coordinator however told the Investigation Team that there was no joint decision making via a CPA discharge meeting at the point of the MHSU's discharge from the inpatient ward D2 to the community She made the decision regarding the MHSU's CPA level on her own.

In determining that the MHSU was on standard CPA, and not enhanced CPA, the Care Coordinator told the Investigation Team that she referred to the CPA handbook and assigned the MHSU's CPA level based on the guidance it contained.

Section 3.6 of the "Care Programme Approach Policy and Procedures" in use in Doncaster and South Humber NHS Healthcare Trust in October 2003[3] states:

"*The characteristics of people on standard CPA will include some of the following:*

People without Dementia	People with Dementia
They require the support or intervention of one agency, or discipline, or require only low key support from more than one agency or discipline	Are usually accepting of care from as many agencies and workers as is appropriate to maintain them safely in their environment
They are more able to self manage their mental health problems	Risks are minimised by their acceptance of appropriate care.
They have an active informal support network	
They pose little danger to themselves or others	
They are more than likely to maintain appropriate contact with services	

The CPA Handbook issued by the CPA Association in February 2001 provides the same guidance. It was the handbook that the MHSU's Care Coordinator referred to, as her decision regarding the CPA level for the MHSU preceded the implementation of a coordinated trust policy.

In the opinion of the MHSU's Care Coordinator, the MHSU:

- Did not have a significant mental health problem.
- Required no formal housing input – he was not referred to housing.
- The only reason a CPN was involved was to support her in the monitoring of the MHSU's medication compliance. She (the Care Coordinator) was at this time a newly qualified social worker with minimal mental health experience. She did not therefore have the required experience or competencies to undertaken the monitoring of medication compliance. There was nothing perceived in the presentation of the MHSU by the CMHT that required the input of a CPN other than this.

Based on her understanding of the MHSU's needs and presentation when benchmarked against the CPA guidance available, the MHSU's Care Coordinator did not perceive him as a client with complex needs, and therefore did not appreciate that the usual approach was to always place an individual on Enhanced CPA if there was more than one mental health or other professional, or any other agency, involved in delivery of the care package.

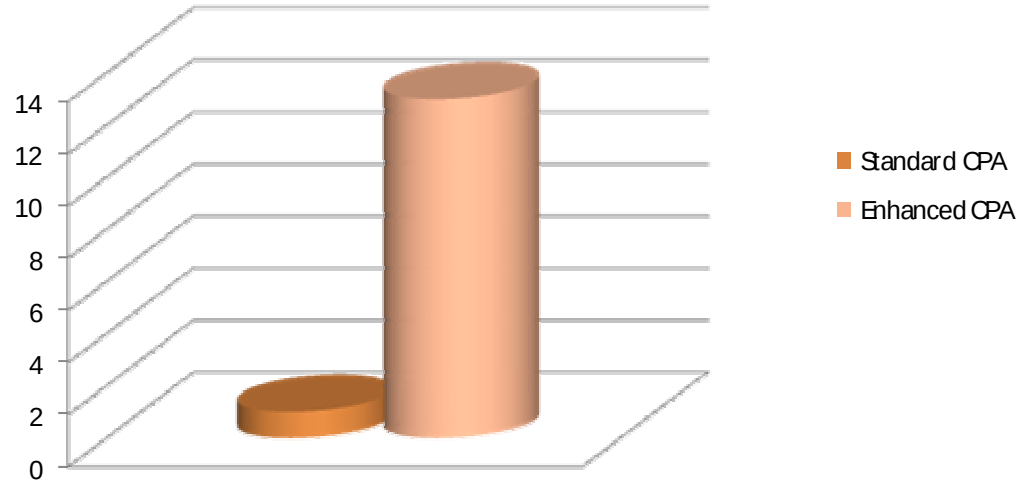
All but one member of professionally qualified staff the Investigation Team interviewed said that they believed that the MHSU should have been on Enhanced CPA. The member of staff who dissented said that "*the number of workers involved is not an indicator of complexity regarding the assigning of the CPA level". "It is complexity of need that*

should govern the CPA level. One must look at why one needs the range of professionals involved not just the number of professionals."

To further test out what a range of appropriately qualified practitioners believed to be the appropriate level of CPA for an individual such as this MHSU a semi-structured questionnaire was issued to a sample of staff working in the community and in the inpatient setting.

Staff were presented with a scenario (see appendix 2 page 73 and asked to say what level of CPA such a patient would be on. The response are depicted in graph one overleaf.

Graph One:
Respondents: 14
Standard CPA 1
Enhanced CPA 13



The views of her professional colleagues were presented to the Care Coordinator who made a number of valid points. These were:

- Prior to this independent investigation no-one had challenged the level of CPA she had placed this MHSU on.
- Throughout her role as Care Coordinator for the MHSU she had sought the advice of more experienced professionals who at no time had suggested that this CPA tier was inappropriate. What is not clear is whether anyone had properly appreciated that the MHSU had been placed on Standard and not Enhanced CPA.

She also told the Investigation Team that now she would automatically place someone like this MHSU on Enhanced CPA. She has five years more experience in the field and is more aware of how levels of CPA are assigned. Furthermore now all service users who are admitted to inpatient services are discharged on Enhanced CPA, and the process

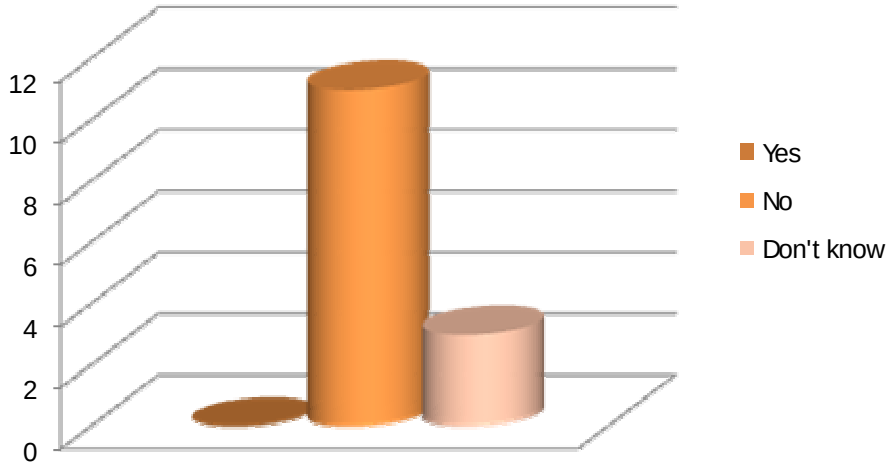
of CPA commences on the ward which was not the situation, locally or nationally, in 2003.

The Investigation Team were interested to know what impact level of experience has in determining the correct level of CPA for a service user. Therefore following question was also posed in the questionnaire issued to staff:
"Would you expect a newly qualified RMN to be able to correctly determine the level of CPA for the 'above scenario' without support or supervision?"

The response of the 14 persons who responded to this question is detailed in Graph 2 below:

Graph Two:

Yes: 0 No: 11 (79%) Don't know: 3 (21%)



If the Care Coordinator's perception of the MHSU was based on full and complete information about the MHSU we as an Investigation Team would have been satisfied:

- That the MHSU had received input from an appropriate range of individuals; and that
- his placement on Standard CPA was not unreasonable.

However the Care Coordinator's perception of her client was not based on full and complete information.

At the time she was appointed as the MHSU's Care Coordinator there had been no access to his past medical history in the late 1980s and early 1990s by inpatient services. However it was known to the Care Coordinator, his Consultant Psychiatrist and the inpatient staff that the MHSU did had a past history with the mental health services.

6.2.2 Why was there no access to the MHSU's past clinical records?

At the time when the MHSU was a patient of Grimsby Health Authority and then Doncaster and South Humber Healthcare NHS Trust, patients had

- One set of hospital records; and
- One set of community records.

On discharge from inpatient services the hospital records would be stored onsite behind reception, in a room designated for notes where there had been hospital contact within the last eighteen months.

Once the last contact time exceeded eighteen months the notes were moved to an archive room, also behind reception , where they were kept for a further five years before being moved to an offsite storage facility.

The community records would be stored at the CMHT base to which the service user was linked.

It was not, and continues not to be, the practice for all records to be brought together and stored at a single location once discharge from all secondary mental health services has occurred. This is not uncommon practice nationally.

When the MHSU was admitted to Ward D2 in May 2003 the medical and nursing records show that there was no access to his past records. This was confirmed by the individual appointed as his Care Coordinator and also by his Consultant Psychiatrist. That the MHSU's notes were missing is also noted in two sets of CMHT team meeting minutes on 22 May 2003 and on 5 June 2003. The tracer card for the MHSU's first set of temporary records commenced in May 2003 also says:

"Tracer for temporary notes. Others missing. (Not found on ADM)"

The last noted entry on the original tracer card says:
Date : 9 4 02
"*SY OP Kate"*

What the Investigation Team has not been able to elicit is what actions and/or efforts were made to locate the old notes by the medical records team, given that there was a last known location of them as the secretary to the MHSU's Consultant Psychiatrist. The design of tracer card did not allow for the recording of actions taken to try and find notes. Clearly the records were found at some point but when we do not know, or by whom.

Discussion with the Care Coordinator revealed that although she had not had sight of the MHSU's previous hospital based records, she had been able to locate his old community records. She faxed information from these records to the MHSU's Consultant Psychiatrist at the

Princess of Wales Hospital, Grimsby on 5 June 2003. The MHSU was an inpatient on Ward D2 at this time. When asked what other measures were taken to locate the MHSU's previous hospital notes, the Care Coordinator told the Investigation Team that she did not personally pursue the matter further as she was aware that the inpatient staff had requested the notes. It was her belief that they were being actively pursued.

In trying to work out how this MHSU's notes were not retrieved in a timely manner, one of the managers working in the mental health unit in 2003 advised the Investigation Team that the period of the MHSU's admission may have coincided with the temporary move of Ward D2 whilst renovation and refurbishing works were carried out. The temporary location of D2 did not provide adequate administrative space with the ward clerk being based in what had previously been a cupboard. The manager suggested that a note could have been left for the ward clerk to obtain the records that then got lost. However this seems not to have been the case as the MHSU's Care Coordinator remembers him being on a ward in the usual location for D2.

Although all of the staff the Investigation Team spoke with appeared to appreciate the central importance of accessing past records in the contemporary assessment and care planning of an individual service user, it became clear that not all staff were aware of whom to contact about different types of records.

For example the historic community records showed quite clearly that the MHSU had a previous detention under the Mental Health Act, however the Mental Health Act Manager was not contacted by the MHSU's Care Coordinator, his Consultant Psychiatrist or the nominated associate worker to find out the detail of this. The Care Coordinator told the Investigation Team:

"As discussed there was some reference in the old community notes regarding him being on a S3 which I forwarded to the Consultant Psychiatrist whilst the MHSU was still an inpatient. I have some recollection of having a conversation regarding this with ward staff but I suppose I assumed that he had been taken off S117. I did not know how to check this out though – I suppose I assumed this information would have been in his missing notes. I also assume that someone would have checked his past history as he had already been involved with an ASW, ward staff, and he was known to the Consultant Psychiatrist from out patients. However, I did not pursue this further."

It would be easy to say that the Care Coordinator should have assumed nothing. However her assumptions were not unreasonable. The MHSU had come through the inpatient system and had been in contact with a number of individuals and been an inpatient for some 29 days before he was discharged. Furthermore his current Consultant Psychiatrist was the same one who had been seeing the MHSU in outpatients between 1999 and 2002. One has to question why this

individual was not more cognisant of the MHSU's past history and why he did not provide more detailed contextual information to the MHSU's Care Coordinator. With the passage of time between the incident date and the independent investigation, staff were not able to recall the depth of information required to gain a full understanding of what was happening or staff's thinking on these issues at the time. This was not surprising to the Investigation Team. The Investigation Team can understand how an inexperienced practitioner might assume that the Consultant Psychiatrist for a service user would have highlighted to her all necessary information, including historical information, especially as this individual did have prior knowledge and contact with him.

With regards to accessing further information regarding the MHSU's previous detention under the Mental Health Act, the Care Coordinator was asked:

Question: *"Also at this time did you know how to find out more information about a patient's MHA status even if the notes were not available?"*

Response: *"No not really apart from checking the database system and old community notes, but our database system did not go back very far."*

We asked other members of the CMHT whether they knew how to access such information. All individuals advised that they would have contacted the Mental Health Act Manager. The issue for the Care Coordinator therefore was a lack of knowledge about the system. [4]. (The appropriateness of appointing this individual as a Care Coordinator and the effectiveness of the supervision provided is addressed in Section 6.2.8 page 51).

The nominated Associate Nurse also told the Investigation Team that she would have contacted the Mental Health Act Manager but as she did not read the notes herself there was no trigger for her to do this or advise her colleague to do this.

The current ward manager on one of the inpatient wards (there are two, Diamond and Sapphire) kindly described the current system for accessing records and advised that the process had not changed in any material way since 2003. It was her opinion that she could not think of any reason why the MHSU's records were not made available during his inpatient stay especially as they were so quickly and easily located following the incident. This individual told the Investigation Team leader that she could not recall an occasion where the notes for a patient were not found. The administration staff were known to be tenacious in their efforts to locate notes. At least four of the community staff interviewed endorsed this statement.

[4] At the time the MHSU was admitted to hospital and discharged into the community his Care Coordinator had been an employee of the Trust for less than one year.

The bottom line in the case of this MHSU is that the Investigation Team have not been able to identify any reason whatsoever for why his notes were not made available to the staff on Ward D2 and/or the MHSU's Care Coordinator. Clearly they could be located as they were in the medical records store behind the mental health service reception on 16 March 2004 when a senior manager of the Trust accessed them.

Staff experience of the ease of access to past patient records in North East Lincolnshire Partnership Care Trust

The lack of access to the MHSU's records in this case was significant as the past records did reveal aspects of his behaviour that if known by the mental health professionals in 2003 and 2004 would have altered their perspectives of him, and in particular the risk he posed to himself. Whilst there was nothing in his past records that suggested in any way that he was capable of the degree of violence he displayed towards his stepfather on 26 February 2004, the MHSU's records did indicate factors that would have aided the avoidance of relapse.

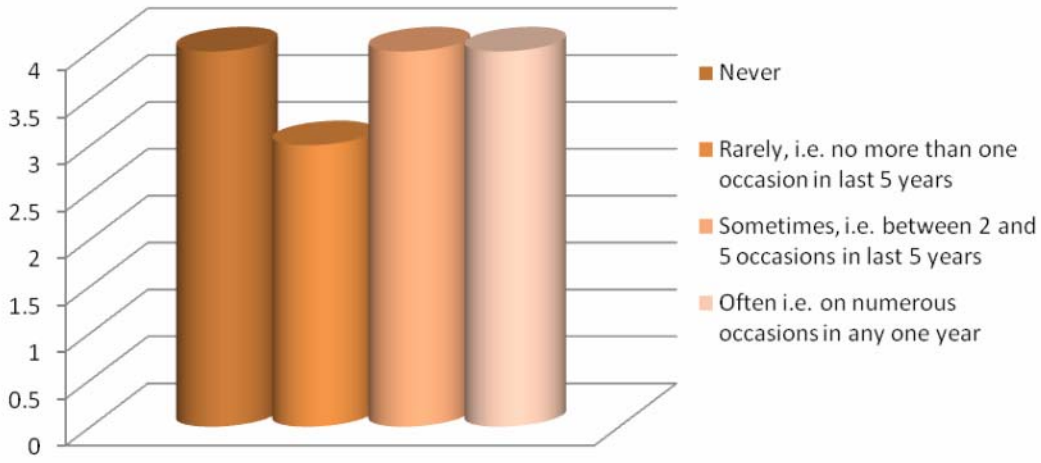
Although it is accepted that clinical records do go missing from time to time, the Investigation Team felt it important to test out with a wider group of staff than those interviewed as to the frequency with which past notes could not be accessed. A small selection of staff were asked the following question in the survey questionnaire:

"In your experience have there ever been occasions where you have not been able to access a service user's past medical records?"

Graph 3

Respondents: 15

Never	4
Rarely, i.e. no more than one occasion in last 5 years	3
Sometimes, i.e. between 2 and 5 occasions in last 5 years	4
Often i.e. on numerous occasions in any one year	4



Although no statistical significance can be attributed to these responses the fact that just over 50% of respondents have experienced problems with accessing historical records suggests that the monitoring of this issue over a twelve month period might be prudent.

6.2.3 Whether or not the surveillance of the MHSU's medication compliance was acceptable.

When the MHSU was assessed by his Consultant Psychiatrist following his attack on his stepfather it was clearly apparent that he had been non-compliant with his medication.

A retrospective analysis of the MHSU's past medical records quickly revealed that the MHSU had a history of poor compliance with his medication. (for example in December 1990 – see Appendix 1 p64).

However, the Investigation Team did not get any sense of foresight or planning for any such eventuality from the records made by any of the mental health professionals involved with the MHSU between May 2003 and the date of the incident in February 2004. For example, there is no evidence that any history of the MHSU's compliance with medication was sought from his family.

The team therefore decided to:

1. Explore the appropriateness of staff's assessment of the MHSU's compliance with his medication regime following discharge from Ward D2 in June 2003; and
2. Assess staff understanding regarding the MHSU's risk of non-compliance with his medication

Context:

In 2003 when the MHSU was admitted to one of the inpatient wards in the mental health unit, he had been living independently in the community without any input from secondary mental health services for approximately 13 months.

Prior to this time he had been seen by a senior member of the medical team at out-patients on a six monthly basis while he was weaned off his depot medication haloperidol

The MHSU had been on depot medication since 1992 following previous episodes of non-compliance with oral medication.

It is the opinion of the independent Investigation Team that:

- It was reasonable and in keeping with NICE guidance to explore newer anti-psychotic medications for the MHSU and to accommodate his wishes by weaning him off depot medication.
- The time taken to wean the MHSU off his medication was reasonable.

- The decision to discharge him from mental health services back to primary care services in April 2002 was reasonable. The MHSU had been stable on no medication since October 2001 at the time of discharge.

The MHSU had been out of contact with secondary mental health services for a total period of 13 months when he again became unwell and required the care of secondary mental health services. It is presumed that in the period leading up to his admission to hospital that he had not been taking his medication.

The way in which medication compliance was assessed at the time the MHSU was a patient of Doncaster and Humber Mental Health Trust between June 2003 and February 2004:
The staff interviewed during this investigation revealed the following routine activities that were undertaken as part of their assessment of medication compliance:

- Observing for signs of relapse
- Speaking with the service user
- The service user attending or not attending for appointments
- Signs of ambivalence in the service user towards their medication
- Medication scripts not being collected from the relevant GP surgery or pharmacy
- Asking relevant family members.

Other less routine measures included:

- Attending at a service user's home and watching them take their medications

None of the staff were aware of any occasion where a blood test had been obtained from a service user to test the serum level of the medicine's active ingredient. However all were aware that this was an option that could be used. A number of staff also believed such a measure to be invasive and of potential threat to the therapeutic relationship between mental health professionals and service users[5]. It is important to note that measuring serum levels of olanzapine would not constitute normal practice within a Community Mental Health Team.

Discussions with the staff also revealed that the length of time one would want to maintain specific observation of a service user's medication compliance was something that required consideration. One member of staff suggested that one would want a substantial period of stability before discharging a client from the service. Although

[5] Although such concerns are understandable, where there is significant concern over the level of medicines compliance, and where relapse carries significant risk for the safety and well being of the service user and the public, ascertaining serum levels of medicines such as olanzapine can be helpful in gaining quantifiable evidence that the medicines are being taken. Clearly any service user would need to consent to this.

a specific time frame couldn't be provided, seven months was thought to be too short a period of time.

What happened with this MHSU?
Overall the measures initially instituted to monitor this MHSU's compliance with medication were reasonable.

- A qualified and experienced Registered Mental Health Nurse was identified to work as an associate' with his Care Coordinator. The specific remit of the 'associate worker' was to monitor the MHSU's medicines compliance and also to provide support to the Care Coordinator who was very inexperienced and had no real knowledge of mental health medications.
- The Care Coordinator did undertake to check with the MHSU's GP that the medicines scripts were being collected.
- The MHSU was seen regularly in out-patients by a senior house officer (SHO).

The Investigation Team are also satisfied that the Associate Nurse did carry out reasonable assessments of the MHSU on the four occasions she assessed him.

Unfortunately:

- The MHSU was not seen or assessed by a more experienced member of the medical team at any point following discharge.
- The Associate Nurse did not make sure that she was as informed as she could be about the past history of the MHSU.

Assessment by a senior member of the medical team
At the time this MHSU was a patient there were severe staffing difficulties in Grimsby. These issues are set out in Chapter 5, pages 14-15 of this report.

The MHSU's Consultant Psychiatrist told the Investigation team that he would have preferred to have seen the MHSU at outpatients himself. However the MHSU preferred to attend at the Princess of Wales Hospital for his outpatient appointments and not the Eleanor Centre where he himself held his clinic. The situation was, in the opinion of the MHSU's Consultant Psychiatrist, far from satisfactory. However he was satisfied with the frequency of outpatient appointments and the level of attendance by the MHSU and also by the quality of the SHO's records. The Consultant Psychiatrist is confident that the SHO was very aware that he could call him at any time and that he (the Consultant Psychiatrist) would attend at the Princess of Wales Hospital at the end of his clinic if there were any issues of concern that the SHO felt unable to effectively manage. In the case of this MHSU there were no such issues and the way he presented himself at outpatient clinics was not suggestive of someone with worsening mental health state or

medication non-compliance. For example the letter from the SHO to the MHSU's GP on 7 January 2004 says:

"*He reported feeling very well and said that he enjoyed his Christmas and New Year very much. He spent it with his step-dad and his 2 sons came to visit him and they had a lovely time together.*

The MHSU's appetite and sleep are very good as is his energy. He has no thoughts of self harm and is very happy with his medication. On mental state examination I found him to be well kempt, pleasant with good eye contact and rapport. His speech was normal in rate, rhythm and volume and his mood euthymic[6]*, both objectively and subjectively. He expressed no suicidal ideation and there was no evidence of psychopathology and he displayed good insight".*

His Care Coordinator also told the Investigation Team that his mood was stable and that he was engaging in positive activities such as fishing with his sons.

The involvement of the Associate Nurse

This individual does not recall:

- having read the past records that were available; or
- being aware that the MHSU had previously been on depot injections for a long period of time.

Neither was she aware that historically the MHSU had a history of non-compliance with oral medication. However she was aware that the reason for his most recent relapse was because of medication non-compliance.

The Associate Nurse saw her role as one of:

- monitoring for medication side effects; and
- providing support to the Care Coordinator if she needed it.

She did not see her role as that of a clinical supervisor or mentor. Indeed it appears that the role of associate worker was an informal arrangement that lacked clear lines of accountability in 2003.

The Associate Nurse expected the Care Coordinator to:

- advise her of all relevant information; and
- to inform her if she needed her assistance or support with any aspect of the MHSU's care.

The MHSU's Care Coordinator is adamant that she did provide the Associate Nurse with as much information as she herself had.

With specific regard to the MHSU's medication the associate nurse told the Investigation Team that there was nothing peculiar about this service user. The only reason for assigning an associate worker was to monitor medications compliance and nothing more.

[6] Euthymic means that the MHSU's mood is moderated and he is not manic or depressed.

Our discussions with this individual suggest that even had she known that the MHSU had previously been noncompliant her approach to monitoring his medication compliance would have been the same. The only thing that might have changed was her decision on 30 September 2003 to not arrange any further meetings with the MHSU unless it was felt necessary by his Care Coordinator.

The Associate Nurse also told the Investigation Team that with the benefit of hindsight she does feel that the scope of her role as the Associate Nurse should have been more clearly defined and she should have undertaken more of a supervisory role. Had this been the case she would have ensured that she was fully conversant with the content of the MHSU's records and she would have maintain a closer surveillance of the actions and decisions of the Care Coordinator. Although this would not have impacted on how the MHSU's medicines compliance was monitored it would have influenced:

- The length of time she continued to specifically monitor medicines compliance
- The decision of the Care Coordinator to discharge the MHSU in January 2004
- The fact that although she and her colleagues believed the MHSU to be on Enhanced CPA the Care Coordinator had placed him on Standard CPA.

Opinion of the Investigation Team

In light of the above, although following the interview with the MHSU's Consultant Psychiatrist the Investigation Team's initial impression was that the medicines surveillance for this MHSU was reasonable; it transpires that the surveillance was not as robust as it should have been in terms of:

- Staff's insight as to the MHSU's risk of medicines non-compliance: The Associate Nurse should have read the records that were available. As a senior member of the Community Mental Health Team to rely on an inexperienced worker to inform her of all necessary and relevant information showed poor judgement. Furthermore although some effort was expended in trying to locate the MHSU's past records, greater effort should have been expended. It is clear from their ease of availability following the incident that they had not been irretrievably lost.
- The lack of senior medical assessment at any point after the MHSU's discharge from the inpatient unit in June 2003. The Investigation Team do appreciate, and accept, the difficult conditions the medical staff were working under at this time. This would have made regular senior follow up challenging. However the Investigation team are not satisfied that any mechanism, other than reliance on SHOs to identify the need for a senior assessment had been thought about. For example, the location of the Consultant led and SHO clinics could have been alternated. Service Users could also have asked to attend to see

the consultant on alternate assessments. In this case the MHSU met with his Care Coordinator at the Eleanor Centre so there was no reason why he could not have been asked to attend here to see his Consultant Psychiatrist.

- The length of time a specific focus on the MHSU's medicines compliance was maintained. He should not have been discharged from the Community Mental Health Team in January 2004. The Investigation Team appreciate that that the MHSU was going to continue with Out Patient appointments but this was not considered a satisfactory plan to ameliorate the possibility of relapse, indeed his next appointment after the one in January 2004 was not required until May 2004. The Consultant Psychiatrist for the MHSU is in agreement with this. Had there been a more robust system in place he would have suggested earlier Outpatient follow up. However it is extremely unlikely that the MHSU would have been seen again in Outpatients prior to the incident that occurred.

With specific regards to the methods chosen for monitoring the MHSU's medicines compliance, that is:

- home visits;
- assessment at the Eleanor Centre[7];
- direct questioning/
- checking with the GP surgery that medicines were being collected; and
- assessment of the MHSU's mental state

The Investigation Team considers these methods to have been reasonable and par for the course within a community setting.

6.2.4 Whether or not it was reasonable to encourage the MHSU to live with his elderly stepfather?

Up until the 4 November the Investigation Team had not been able to elicit much information relating to the relationship between the MHSU and his stepfather. The MHSU's past records allude to the close involvement of his stepfather in his care and treatment when he first came to the attention of mental health services. It is also known that the MHSU had lived with his stepfather for significant periods of time in the past. The MHSU's stepsister and her husband told the Investigation Team on the 4 November that they had all supported the MHSU until spring 2003. It was at this time that they began to have concerns about his risk of violence and the risk to his stepfather.

[7] The Eleanor Centre is the Health Centre that was the base of the MHSU's CMHT – "The Green Team"

The MHSU's stepsister tod the Investigation Team:

- That the MHSU's stepfather was advancing in years at the time the MHSU moved in to his home in 2003. He was in his mid 70's.
- That there had been a previous incident where the MHSU had been asked to leave his step-father's residence in the period prior to his most recent admission to hospital. In the days leading up to this the MHSU had tried to punch his stepfather. His brother in-law stepped in to protect the stepfather and sustained two punches to the head.

The Investigation Team also know on 23 June 2003 the MHSU was agitated and said he was leaving the Salvation Army where he was residing because it was "*dirty and horrible"* and that "*he couldn't stay a minute longer*." His plan was to go to a B&B in Cleethorpes. His Care Coordinator asked him if he would consider moving back to his stepfather's house for a short time whilst suitable accommodation was sought. The MHSU agreed providing the Care Coordinator telephoned his stepfather.

The record made by the Care Coordinator says:

"I telephoned his father who stated that the MHSU was welcome to stay with him. The MHSU agreed to continue with his medication and that he would get a taxi straight away to his father's."

We also know that at no time was the MHSU's stepfather offered a Carer's Assessment, and that no in-depth conversation took place between the Care Coordinator and the stepfather to enable a more informed opinion regarding the appropriateness of the MHSU residing with his stepfather for any length of time. It must be highlighted that the initial intention was that the MHSU stayed with his Step-father while more suitable accommodation was found for him.

The question of the appropriateness of the MHSU residing with his stepfather cannot be addressed without looking at the overall quality of communication with the MHSU's family.

This issue is therefore what this section will focus on.

Communication with the MHSU's Family

The clinical records show that the MHSU's Care Coordinator informed his sister about:

- his admission to hospital;
- his discharge from hospital; and
- his discharge from the CMHT.

The notes also show that there were two episodes of communication between the Care Coordinator and the MHSU's stepfather. Only one of these predated the MHSU's residing with him.

However, it does not appear as though any in-depth conversation was had with either the MHSU's sister or his stepfather in relation to:

- the MHSU's past history;
- concerns the family may have;
- support for the MHSU when he was discharged;
- the frequency of contact between the MHSU and his family; and
- any support needs of the family in relation to their caring / support role to the MHSU

There is some suggestion by the Consultant Psychiatrist to the MHSU that his family did not want to be involved during his in-patient episode. The family strongly refute any such suggestion and were able to recall and recount in some detail their efforts to support and help the MHSU.

There is no documentation to suggest that the MHSU's did not want the mental health services to communicate with his family. In 2003 the Community Mental Health Team at the Eleanor Centre were using a consent and confidentiality statement with their service users which set out the need for sharing information and the purposes of this. This MHSU signed his consent form allowing staff to seek and share relevant information with other agencies on 20 June 2003. Although the form does not specifically mention family members and carers the fact that this MHSU signed this consent suggests that he was open to his mental health care team seeking information to enable him to receive the most appropriate care.

Discussions with the MHSU's Care Coordinator revealed that at the time *"It was not really the norm to proactively seek the views of the family or to do a Carer's Assessment – yes if they were doing the 'Caring Role' – but at this time she had a narrow perspective of the role of a carer."* Essentially at the time, *"it would not have crossed her mind to speak with the MHSU about seeking information from his family".*

The Care Coordinator also revealed that those individuals responsible for her supervision did not highlight to her the family role and the need to proactively engage with them. The MHSU was able to articulate for himself, there was nothing to suggest to her at the time that he needed a carer as such. Indeed she did not see the MHSU's sister or stepfather as carers.

Discussions with other staff working in Grimsby at the time revealed:

- One member of staff would have expected a substantial discussion with the stepfather so that a clear understanding of his perspective and any risk issues could be determined and contingency plans put in place. This of course presumes that the stepfather would have been forthcoming with information.

- At this time in Grimsby support and engagement with carers was a bit '*hit and miss"*. The process for assessing and supporting carers was embryonic and not fully bedded down.

- Another individual said "*there was no emphasis on carers at the time". They did have Rethink and a Carer's Assessment process but there was not much to follow on from this"*

- Another said: *" At the time the Carer's Assessment was not undertaken consistently".*

- Another said: there were "*no Carer's Assessments in 2002, but they did start. They also had carers' education programmes run by Rethink. Specific 13 week programmes for carers of those with Schizophrenia, bipolar disorders etc."*

It is openly acknowledged that at this time communication with and involvement of carers and families was not a strength of the mental health service in Grimsby at the time. Whether or not more assertive attempts to engage with the MHSU's family would have resulted in alternative accommodation being sought on 23 June 2003 is difficult to say. The records suggest that the MHSU's stepfather readily acquiesced to having him back home.

Opinion of the Investigation Team

On balance the Investigation Team do not believe it was unreasonable for the MHSU's Care Coordinator to suggest that the MHSU consider moving back home with his stepfather for a short period of time. The MHSU's stepfather had previously been involved in supporting the MHSU for many years.

However, what was unsatisfactory was the lack of positive communication with the stepfather and the MHSU's sister in relation to:

- The family's previous experiences of the MHSU when he was living at home.
- Any issues of concern they had.
- Contingency planning if the arrangement did not work out for either the MHSU or his stepfather. There was no risk contingency plan at all.
- The lack of risk assessment undertaken especially in relation to the risks associated with the MHSU residing with his stepfather if he stopped taking his medication.

Furthermore it was also unsatisfactory that the stepfather was not offered a Carer's Assessment. The Investigation Team accept that the Care Coordinator although fully qualified did not have the depth and breadth of knowledge, that comes with time served experience, to be carrying Care Coordination responsibility. However, the team leader for

the ‘Green Team’ was her supervisor and he should have guided the care coordinator in this area of her work.

In addition a review of the minutes of the Green Community Mental Health Team’s weekly meetings between May 2003 and January 2004 reveals that specific Carer’s Assessments were discussed at this meeting on a regular basis. The minutes of these meetings conflict with what staff said regarding attitudes towards carers as clearly members of this team were undertaking Carer’s Assessments and sharing this with their colleagues. Indeed the fact that ‘Carer’s Assessments’ was a dedicated feature in the minutes constitutes good practice. As the Care Coordinator for this MHSU was present at over 90% of the meetings it is not reasonable to suggest that she was not aware of the importance of this type of assessment. Rather her self-stated perspective of the MHSU’s stepfather as not being a carer as such was, the Investigation Team believes, the determining factor in him not being offered one. Her perspective of what constituted a carer at this time was constrained and did not include the circumstances of many unpaid carers that provide a range of support to family members with mental illness.

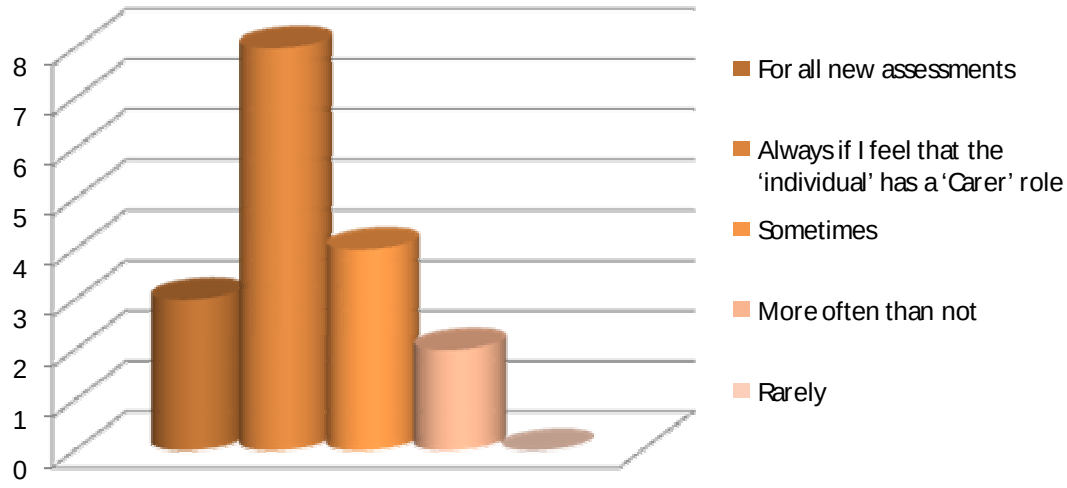
The Contemporary Situation

The interviews and meetings with staff suggest that the trust’s approach to, and consideration of carers has much improved. This fact was endorsed at a meeting the Investigation Team attended with a range of service users and carers from the ‘Service Users and Carers Independent Forum’. A discussion with a worker at the Carers Support Unit in Grimsby also confirmed that the recognition by mental health workers of the needs of carers is much improved. This individual told the Investigation Team that in the early 2000s it was difficult to get recognition and Care Coordinators were not proactive in recommending carers to them. Care Coordinators are now much more proactive and General Practitioners also.

The questionnaire data in response to the question, “How often do you offer the carer, or significant other, in a service user’s life a ‘Carer’s Assessment’?” also revealed that most staff either always, or more often than not, offer a Carer’s Assessment.

Graph 4

Resp: 16 (1 person ticked 2 boxes!)	
For all new assessments	3
Always if I feel that the individual has a ‘carer’ role	8
Sometimes	4
More often than not	2
Rarely	0

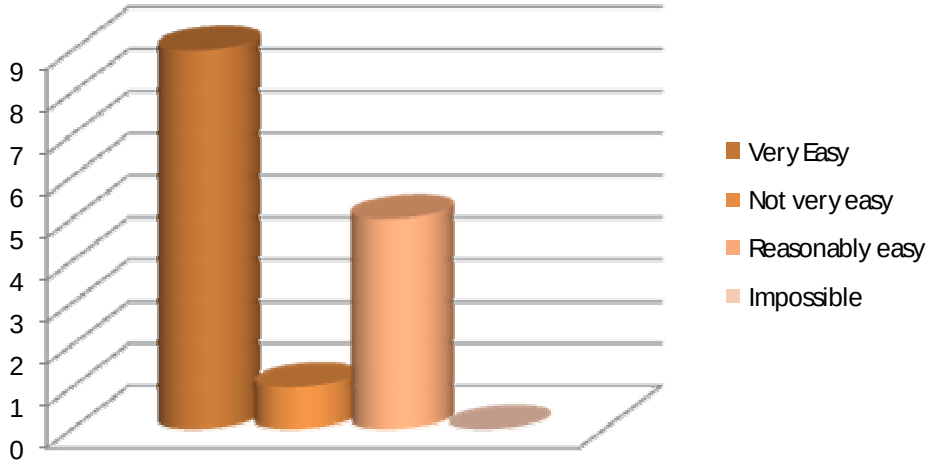


With regards to the ease with which families and/or carers could access support and advice the following information was gathered:

Graph 5

Resp: 15

Very easy	9
Not very easy	1
Reasonably easy	5
Impossible	0



Again the staff's perceptions were endorsed by the Service Users and Carers Independent Forum in Grimsby.

6.2.5 Why, when the MHSU reported a change in his stepfather's behaviour around alcohol, and a change in their relationship, was this not further explored by his Care Coordinator?

On the 24th November 2003 the MHSU told his Care Coordinator that he was concerned about his step-father. The MHSU said that his step-father had started drinking two bottles of whisky a day. The notes also said that *"he stated that their relationship was fragile at present".* And that "*he spent most of his time out of the flat".* The notes also indicate that the MHSU had heard nothing from the housing association.

There is no evidence that the reported change in living conditions of the MHSU were explored by his Care Coordinator and the MHSU was given another appointment for 19 December 2003.

At interview the Care Coordinator told the Investigation Team that she was not curious about the stepfather's drinking. She simply did not ask about it further. To her mind the MHSU was near the top of the housing list and it was her anticipation that he would not be living with his stepfather for very long. Consequently the information the MHSU shared was not passed on to any other member of the mental health team.

The Associate Nurse told the Investigation Team that she had been to the MHSU's home on one occasion in the July. She advised that she probably spent about 30 minutes at his home. She recalled that the MHSU did not wish to talk with his stepfather in the room and that there was a tone of irritation towards his stepfather. However she did not sense anything sinister in this, in her experience it was more the tone of irritation one can have when one shares the same living space and is wanting some privacy.

Note: The MHSU's stepsister and brother in-law told the Investigation Team that their father was not a heavy drinker, and they did not believe that he was consuming the amounts of alcohol suggested by the MHSU.

Opinion of the independent Investigation Team

The Investigation Team is very mindful of the lack of experience of the MHSU's Care Coordinator and the inadequate supervision afforded this professional. However, none the less it is concerning that this professional did not consider the need to further explore the MHSU's allegations about his stepfather further. The MHSU had been evicted from his stepfather's home before in the period preceding his most recent admission to hospital and this was known to his Care Coordinator. The Investigation Team is not convinced that one needed to have substantive post-qualification experience to recognise the need to explore any reported changes in social circumstance for a Service User especially where fragility in the home environment has been highlighted.

At the very least we would have expected the following to occur:

- A planned home visit so that the home situation could be assessed
- Contact with the MHSU's sister to find out if she was aware of any increased tension or fragility in the relationship between 'father and son'
- Contact with the stepfather himself to find out how 'things were at home'.
- The information regarding the change in social circumstance to be communicated to the medical staff at the next outpatients appointment.

It is tempting to suggest that had the allegation about the MHSU's step-father's drinking been explored then his deteriorating mental health state may have been identified. However:

- He was seen on two separate occasions on 19 December and 5 January where his mental health state appeared good.
- The MHSU is reported to have said he was well on 12 January 2004.
- On 26 January 2004 the Care Coordinator progress notes state that the MHSU's sister felt that he was mentally very well at present. It is important to note that she also raised her concern about his continuing wellness if he stopped his medication.

There is therefore nothing to suggest that at the time of discharge that the MHSU was anything other than well.

6.2.6 Whether or not the risk assessments undertaken were acceptable?

The simple answer to this question is no. The risk assessments undertaken in relation to this MHSU were not acceptable.

There was only one risk assessment carried out with the MHSU between the time of his admission to the mental health unit at the Princess of Wales Hospital in May 2003 and the time of his discharge from the community team in January 2004. His circumstances did change over this period which should have triggered a revision of his risk assessment. A risk assessment should also have occurred before his discharge from the CMHT.

Furthermore in the historical CMHT notes there was clear evidence that the MHSU had previously been subject to Section 117 aftercare. There was no evidence that he had ever been discharged from Section 117

aftercare.[8] The implications of his not being discharged from Section 117 Aftercare were not appreciated by the MHSU's Care Coordinator or any other member of the team, it would seem. The Associate Nurse did not recall having been aware of his Section 117 status. Had she been aware she told the Investigation Team that she would have contacted the Mental Health Act Manager to ascertain:

- The circumstances of the MHSU detention under the Mental Health Act.
- Whether or not he had been formally discharged from Section 117 Aftercare.

As a professional having involvement in the MHSU's management in the community the Associate Nurse should have been aware of his Section 117 status. Accessing the MHSU's old community records, which were available, would have given her this awareness. The Care Coordinator believes that she did ask the Associate Nurse about the MHSU's Section 117 Aftercare status but the Associate Nurse has no recollection of this.

At the time the following risk assessment process was utilised in Grimsby mental health services:

- An initial risk screening tool was completed that then guided the professional if further more in-depth risk assessment was required.

  The screening tool was accompanied by a set of straightforward guidance notes that in the Investigation Team's opinion are easy to use and interpret.

- A detailed risk assessment tool that meets current good practice standards in that it made provision for the narrative description of the 'risk behaviour', its known antecedents, and its known consequences to date. This document also included a section for the risk management plan. Note: The detailed risk assessment paperwork was only required if a service user scored a medium or high risk on the risk screening tool.

The risk screening tool asked a range of reasonable questions about the MHSU's past history. These included the requirement to note whether the past history was available for, or whether there was a history of:

- Aggression
- Self-harm
- Self-neglect
- Absconding
- Arson
- Sexual vulnerability
- Road safety awareness
- Care package non-compliance

[8] See Glossary page 75 of this report for an explanation of Section 117 Aftercare

- Criminal history

The completed document in the MHSU's records shows that he was rated as low risk on all of the above with a previous history of self neglect only being noted. It is written that:

"*Due to deterioration in mental health state after gradual withdrawal of medication, the MHSU was homeless and neglected to eat and attend to his basic needs"*

That the MHSU had been noted as low risk meant that a more fulsome risk assessment and risk management plan or relapse prevention plan was not required.

The Investigation Team noted with interest that the guidance notes for professionals, that should have been on the back of the screening form, were not detailed on the back of the form the MHSU's Care Coordinator used. The Investigation Team were not able to establish how this error occurred.

In relation to self neglect the guidance notes said:

- "High Risk: Life threatening self neglect. E.g. failing to eat/drink adequately – poor care of physical needs / environment
- Medium risk: Potential to suffer serious harm through self neglect if not monitored – lack of adequate care for basic needs.
- Low risk: Shows sufficient care, needs minimal support to look after self. "

Prior to his being taken to a place of safety under Section 136 of the Mental Health Act in May 2003 this MHSU had become homeless, was neglecting to eat and drink, was unclothed and in a public place acting bizarrely. Even without knowing any of his pre-2001 history this gentleman was at least at medium risk of self neglect when unwell if not a high risk of self neglect when unwell.

In relation to compliance with medication/care package the guidance notes said:

- "High Risk: Persistently refuses to accept medication – tablets/injections – consistently does not attend out-patients department appointments, appointments with key worker – reduced contact with family and friends and carers.
- Low Risk: Happy to take medication – aware of benefits of care package – actively seeks out support networks when distressed."

The risk screen form has a "NA" recorded by this assessment prompt. The precursor to the MHSU's admission to hospital in May 2003 was not being on any medication and a concomitant deterioration in his mental health state which reduced his ability to recognise he was

unwell and needed help. Even without any knowledge of the MHSU pre-dating his current episode of care one could not reasonably say that the issue of 'care package non-compliance' was not applicable to this MHSU.

In light of the above the MHSU had at least:

- a medium risk of neglect to self when un-medicated; and
- a medium risk of medication non-compliance on the basis that it was this that had triggered his current relapse and admission to hospital.

This risk level is without having access to any of his previous clinical history.

Taking into account his previous history (1987 – 2002) one might suggest that he would also have been considered:

- A low risk of harm to others
- A low risk of harm to himself.

There is nothing in the MHSU's past history to suggest that he was a medium or high risk of harm to others or self.

Opinion of Investigation Team

It is accepted that the mental health professionals responsible for the care and management of this MHSU did not, for whatever reason, have access to his past medical records relating to the late 1980s and early 1990s.

Nevertheless in spite of the lack of access to past history for this MHSU there was sufficient contemporary information available to enable a more realistic and grounded risk assessment than that actually performed.

This MHSU should have scored a medium risk against two markers on the risk screening form. There, therefore should have been a more detailed risk assessment undertaken and a risk management plan devised.

What impact a more robust risk management plan would have made is difficult to say especially as:

- There was, as stated above, a poor culture of family involvement in the Trust at the time.
- The Care Coordinator had a very narrow perspective of the MHSU's mental health needs.
- The Associate Nurse was inadequately informed about the MHSU and could not therefore form her own judgment as to the appropriateness of the Care Coordinator's risk assessment, or the complexity of the MHSU.

One might reasonably have expected that at least the MHSU would have been placed on Enhanced CPA by his Care Coordinator. This

would have materially affected the way in which he was subsequently discharged from the Community Mental Health Team.

Had the lack of clarity regarding the MHSU's Section 117 status been recognised by any of the professionals involved and exploration with the Mental Health Act Manager occurred, this would have revealed that the MHSU had never been discharged from aftercare. **Note:** The MHSU's Consultant Psychiatrist was aware of the MHSU's previous detention and Section 117 status and assumed that because of passage of time, since detention, that he had previously been discharged. Although not a wholly unreasonable assumption, it was an incorrect assumption. Furthermore establishing precisely what the situation was would have materially affected the MHSU's CPA status.

The above two issues raise again the appropriateness of appointing a novice practitioner without any specialist mental health training, or any substantial exposure to the care and management of mental health service users in the community as a Care Coordinator. It also raises concern about her clinical and management supervision. (see section 6.2.8 page 51)

The contemporary situation with regard to risk assessment
The situation in North East Lincolnshire Partnership Care Trust is vastly different to how things were in 2003 and 2004. The Trust now has a formal risk assessment training programme whereas previously there was none. It has also invested in a risk assessment process called DICES. In purchasing this approach to risk assessment all qualified staff were provided with a three-day training programme in risk assessment.

The survey questionnaire issued to staff revealed that all those who responded had received training in the last three years.

With regards to the usefulness of the training most staff said that it was helpful. Only two members of staff said that it was of little value

The staff the Investigation Team met with at interview also said that the introduction of the DICES ^{TM} risk assessment system and paperwork had made the risk assessment process more robust and streamlined.

With regards to Section 117 Aftercare, at interview the Investigation Team were not convinced that staff were aware of their legal obligations or how to properly cease the aftercare arrangement, nor the fact that this responsibility was not the gift of health or social care staff to enact but rather requires a formal joint meeting to approve.

With the survey questionnaire staff were therefore asked the following question – "Is it possible to discharge a service user from Section 117 aftercare?". To which 100% responded positively, i.e. yes.

Staff were also asked how they would go about discharging an individual from Section 117 aftercare.

The responses provided by staff did not give the Investigation Team confidence that:

- ❒ Staff appreciate that the decision to cease section 117 aftercare must be agreed to by both the Trust and the local authority, and that it is a legal requirement that both organisations jointly agree the cessation of aftercare.
- ❒ If a service user continues to require service input then he/she cannot be considered to no longer require aftercare

Only one respondent mentioned the role of the local authority the majority of responses contained generalisms such as

- ❒ "*CPA review involving all disciplines"; or*
- ❒ *"A meeting with all involved parties".*

The following extract from the MIND website[9] articulates the process succinctly:

"The duty to provide aftercare services under section 117 ends when the Primary Care Trust or Health Authority and local social services authority are satisfied that the person concerned is no longer in need of such services. The authorities can only be satisfied that the person concerned is no longer in need of aftercare services if they have monitored that person's progress in the community since discharge.

The duty to provide services continues until both authorities have come to a decision that the person no longer requires any services. Therefore, if any part of the care plan is continuing, such as regular outpatient appointments, it is not possible to say that the person no longer has aftercare needs.

It would seem from these responses that the Trust needs to ensure that this area of practice is addressed in its training workshops on the Mental Health Act, and that all medical staff also need to be included in this. "

6.2.7 Why was there a uni-professional discharge of the MHSU from mental health services in January 2004?

The answer to this question is quite simply because he was on Standard CPA, whatever else his Consultant Psychiatrist believed, and a uni-professional discharge was therefore technically acceptable.

The reasons why the MHSU should have been on Enhanced CPA are fully covered in the preceding sections of this chapter.

[9] http://www.mind.org.uk/Information/Legal/s117.htm

Had he been on Enhanced CPA it is very unlikely that he would have been discharged. However, had such a decision been taken a multi-disciplinary meeting would have occurred between the Consultant Psychiatrist, the SHO who most frequently saw the MHSU at outpatients, the Care Coordinator and the Associate Nurse.

The sequence of events regarding his discharge from the Community Mental Health Team is as follows:

- On 19 December 2003 the MHSU's Care Coordinator told him that she would next meet with him on 5 January 2004 with a view to discharging him. The Care Coordinator's records show that the MHSU agreed with this plan saying that "*he no longer felt that he needed to be involved with the CMHT and would contact his GP or his Consultant Psychiatrist if he needed help in the future."*
- The Care Coordinator was unable to attend the OPA with the MHSU on 5 January as planned owing to ill health. She therefore spoke with him on the phone on 12 January. The notes show that discharge was again discussed and the MHSU was effectively discharged at this point. No further visits or contacts were planned and the MHSU was advised that she (his Care Coordinator) would write to him confirming his discharge.
- On 26 January 2004 the notes show that the Care Coordinator and the sister of the MHSU had a telephone conversation where the MHSU's sister was informed of her brother's discharge. The records say

  "Telephone call to the MHSU's sister, and explained that I was discharging her brother from the CMHT on our "Fast Track" system and if she had any concerns about his mental health to contact the Eleanor Centre. The MHSU's sister stated that the she felt the MHSU was mentally very well at present but if he ceased taking his medication he would deteriorate. I reassured her that if that happens to contact the Eleanor Centre."
- On the 27th January 2004 the Care Coordinator received a letter from North East Lincolnshire Council Housing Department regarding an offer of accommodation for the MHSU at Derry Way. The Care Coordinator advised the housing department that the MHSU had been discharged from the CMHT. She also suggested that she contact the MHSU to advise him of the offer. Her records say

  "*Telephone call to MHSU and explained about the offer of accommodation – he sounded pleased and stated that this news was a good start to 2004. I wished him well for his future."*

This was the last contact the Care Coordinator or anyone from the mental health service had with the MHSU prior to the incident four weeks later on 26 February 2004.

Opinion of the Investigation Team
Setting aside the fact that this MHSU should have been on Enhanced CPA making a uniprofessional discharge not possible, the timing of the discharge of this MHSU was (whatever his CPA status) ill-advised.

Up until 24 November he had been seen fortnightly by his Care Coordinator. There had only been one face-to-face meeting on a monthly timed interval after this date before discharge took place. This was not a sufficient time period to determine whether with less Care Coordination contact the MHSU would remain medication compliant.

The preceding sections of this chapter set out plainly that the MHSU's Care Coordinator did not have the experience or the insight into mental health to consider these factors. Her perspective of this MHSU was simply that of a gentleman with housing and social needs that to her mind had almost fully resolved themselves. The preceding sections of this chapter have also highlighted that the Associate Nurse was ill informed about the MHSU's contemporary history and did not read any of the available records about him. This it seems perpetuated that lack of insight into his needs and potential risks.

The MHSU was, as far as the Care Coordinator concerned:

- Living successfully with his step-father
- Enjoying regular self reported contact with his sons
- At the top end of the housing list
- Relatively well. She saw nothing in the behaviours reported, and displayed, that suggested that he was anything other than well. The SHO's outpatient records also confirm that the overall impression of the MHSU was of an individual who was well. The plan with regards to further outpatient follow up was to see him again in May 2004[10].

The Consultant Psychiatrist to the MHSU has told the Investigation Team, at interview, that had he been aware of the alteration in the MHSU's living relationship[11] with his step-father some eight weeks prior to discharge he would have suggested that discharge from the CMHT did not occur when it did. However, before becoming aware of the

[10] Note – The Consultant Psychiatrist for the MHSU believed that the timescale of four months was too long and that a two – three month period for follow up would have been preferable. This would still have meant that the earliest date for follow up would have been in March 2004 after the incident date.

[11] The Consultant Psychiatrist told the Investigation Team that the first time he became aware of the alleged increase in alcohol intake by the MHSU's stepfather was in 2008.

accusation made by the MHSU about his father's drinking the MHSU's Consultant Psychiatrist did not have any strength of feeling about the MHSU's discharge from the CMHT because he was being followed up in outpatients.

6.2.8 Whether or not the choice of Care Coordinator was appropriate, and whether or not the individual's supervision was satisfactory.
Before looking at whether or not the MHSU's Care Coordinator was an appropriate person to be his Care Coordinator it is important that the role and remit of the Care Coordinator in Grimsby in 2003 – 2004 is properly defined.

The Care Programme Approach Association Handbook 2001 says:
The Care Coordinator has responsibility for:

- co-ordinating care
- keeping in touch with the Service User
- ensuring that the care plan is delivered and ensuring that the plan is reviewed as required.

The handbook also says that Care Coordinators must be;

- clear about where their role starts and ends;
- clear about the role of others involved in the care; and
- communicate concerns, risk factors and changes to everyone involved.

With regards to who can be a Care Coordinator the handbook says that "both health and social care managers should ensure that the Care Coordinator can combine the CPA care coordinator and care manager roles by having:

- Competence in delivering mental health care (including an understanding of mental illness);
- Knowledge of the service user/family;
- Knowledge of community services and the role of other agencies;
- Coordination skills; and
- Access to resources

The Handbook also sets out a minimum data set for the competencies required of an individual who is to undertake care coordination responsibility.

The Doncaster and South Humber Healthcare NHS Trust `Care Programme Approach Policy and Procedures' October 2003 states that:
"The Care Coordinator will be a qualified worker who is trained and experienced in mental health".

Similarly it is important to set out the Trust's expectations around supervision.

The ASW who assessed the MHSU in May 2003 implemented the supervision structure for the Trust. The supervision policy as he recalls

was written in 2002 and then implemented. He advised that "*everyone would have had it, i.e. a proper monthly meeting with their line manager. It would be minuted. The supervision would cover staff care and support, workload allocation and monitoring, HR issues, annual performance reviews and for clinical/practitioner staff – support and evaluation of service user work. "* Built in to the supervision was the option for staff to seek specific clinical supervision from another person of their choice. In fact it was the expectation that they would do this and be able to evidence it.

In 2003 / 2004 there was an audit of supervision. The ASW (Training Manager in 20003/2004) recalls that in the 12 months following the implementation of the policy some areas had not implemented it as well as others.

Did the MHSU's Care Coordinator meet the Care Coordinator requirements?

It is the opinion of the Investigation Team that an individual who has minimal mental health experience or knowledge cannot safely fulfil the basic role and function of a Care Coordinator. It is interesting to note that none of the staff the Investigation Team spoke with, who were appointed to jobs in Grimsby but came from other parts of the country, had ever come across a situation where such inexperienced social workers were appointed to work within a community mental health setting before. The following extract encapsulates what the Investigation Team heard:

"He had only known experienced SW's and more commonly ASW's being appointed to CMHT's. In Grimsby newly qualified SW's were given relatively complex case loads to manage with a limited experience base."

In this particular case the Care Coordinator for the MHSU qualified as a social worker in 2002. She did both of her placements during training in child care. Prior to qualifying as a social worker she also worked with the elderly and with family support both in the community and in a residential setting. She also had some experience of working with The Samaritans and as an advocate for people with mental health needs. Upon qualification she applied for a position in child care but somehow her application form was sent to the Eleanor Centre by the Human Resources department[12]. She was offered an interview the outcome of which was she was offered a job on the 'Green Team'[13].

When she started at the Eleanor Centre she did participate in an induction programme that covered both corporate and local issues. Locally her new manager introduced her to her colleagues, and

[12] Note: It is not at all uncommon for newly qualified Social Workers to take employment in mental health services on qualification without and mental health experience.

[13] At this time each of the CMHT's was differentiated by a different colour.

showed her around the building. She remembers her desk having a welcome note on it. She was taken to a number of different departments by her manager and introduced to key staff in each. She was also given a copy of the CPA handbook and shown all of the CPA paperwork.

This Care Coordinator also received training in the Trust's electronic recording system Maracis and received SCIP (Strategies for Crisis Intervention and Planning) training. For the first few weeks of her employment this Care Coordinator recalls going out with others on visits in an observational capacity. There was no pressure as far as she can recall to have a full case load when her induction period finished. The Care Coordinator recalls gradually being given more work to do and then taking on the Care Coordination role. She also recalls being encouraged to spend time with other teams and wards which she did.

The Investigation Team asked the current Assistant Director of Operations (Mental Health)[14] what he would have expected in terms of the supervision for a newly qualified social worker taking Care Coordination responsibility in a community mental health team. This individual advised that all newly qualified social workers should be supervised by another social worker until they have completed their Post Qualification Award, commonly referred to as PQ1. In 2004/2005 as the then training manager he arranged a meeting with all staff who had failed to meet the deadline for achieving PQ1. As a result of these meetings he came to the conclusion that there was a need for increased support to newly qualified social workers. He consequently implemented a process whereby all such staff would have an element of social work supervision up until the completion of the PQ1 process.

With regards to the MHSU's Care Coordinator the Assistant Director of Operations (Mental Health) told the Investigation Team that when he reviewed her supervision and support structure he was shocked at how poor it had been. He told the Investigation Team that by the time he worked with her it was a case of encouraging her to just get on with it. At that point she had all the skill and knowledge. The issue was that for years she had failed to complete the PQ1. In the beginning he believes that this was due to a lack of knowledge and skills, or more correctly, a lack of support to develop those skills and knowledge. His support amounted to going through the requirements, advising on standards of work and setting time scales for tasks to be completed.

The current team leader at the Eleanor Centre also told us that this Care Coordinator needed significant support and development when he took over the team leader's position. He believed that she herself was aware of this and that she was out of her depth at times and did not always feel confident in making the decisions required of her for some of her clients. There had, he advised, been an expectation in the Trust

[14] Note: In 2003 this individual was the Approved Social Worker who assessed the MHSU under Section 136 of the Mental health Act.

that a newly qualified social worker could deliver the same skills and competencies as an experienced mental health nurse. However, this individual had a predominantly child care background. Quite simply the expectations of the service and the reality of the situation were at odds with each other. The impression of the current Eleanor Centre Team Leader was endorsed by the Director of Operations (Mental Health) who advised that in an effort to support integration of health and social care within mental health services there was a tendency to allow 'everyone to do everything'. The Investigation Team also picked up a sense amongst the mental health nurses interviewed that if social workers were going to be appointed to Care Coordination posts then they should have the requisite experience and competencies to fulfil the post's demands. Whilst this may relate to professional allegiances, comment was passed about the level of 'seniority' that a mental health nurse must attain before they are able to take on community carer coordination roles vs the levels of experience required for social workers as highlighted in this case. The Investigation Team can understand why mental health nurses feel that it is the level of knowledge and practice based experience that an individual practitioner holds that should be paramount in decisions regarding staff appointments to posts carrying care coordination responsibilities.

It is important to note that the MHSU's Care Coordinator, with the benefit of hindsight, was and remains able to reflect on her experience between 2002 and 2004 and recognises that she was too inexperienced for the job for which she was employed. This however is not her fault. She underwent a competitive interview process and was assessed as suitable for the position. Those who appointed her were fully aware of her lack of experience and thus had the responsibility to ensure that she was properly supervised and not asked to practise beyond her competencies – competencies that she had little insight into.

The supervision provided for the MHSU's Care Coordinator

The MHSU's Care Coordinator told the Investigation Team that she received supervision because she asked for it. Her social work and local authority background had made her very aware of its importance. During supervision she would go through her case management with her manager, this would not always be with the records of the individual service user but she recalls that she did take some service user records with her. At five years after her involvement with the MHSU she cannot remember whether or not his records are ones she took to supervision with her.

The Care Coordinator also told the Investigation Team that a lot of joint working occurred within the team between the newly qualified and less experienced staff and those with more experience. There was one particular member of staff (the Associate Nurse) who joint worked with her in the case management of the MHSU. The main reason for this was to monitor for signs of medication side effects and also to give her 'a hand' if she needed it. The Care Coordinator recalls that they did

discuss the MHSU but in how much depth she cannot remember. She remains firm in her belief that the MHSU's issues appeared to be predominantly of a social origin rather than a serious mental health illness.

What seems clear from the Investigation Team's discussions with the Care Coordinator, the Associate Nurse and other members of the Green Team at the time was that there were no clear structure to the role and responsibility of an Associate Nurse. In this particular case the Care Coordinator herself asked one of her colleagues to associate work with her. This followed a Community Mental Health Team meeting on 22 May 2003 where the this individual agreed to be the Care Coordinator for the MHSU but that the 'identified' Associate Worker was not present at. It was not something that was requested by the Team Manager to enhance the Care Coordinator's practice supervision.

The Care Coordinator told the Investigation Team that her supervisor was her manager, with a nursing background. He had been very supportive but had frequent periods of sick leave and then did not return to work. On reflection she feels that her supervisor may have assumed that she had more experience than she did. This has been confirmed by the Service Manager at the time who recalls

"At the time the MHSU's Care Coordinator (CC) worked closely with the Associate Worker (AW) on several cases, with the AW leading on some and the CC on others. She also had good working relationships with other colleagues and overall the Green Team were considered to be a close working group. The CC also came across as a confident and hardworking social worker which possibly belied her limited experience at that time."

The CC herself said:
"*I was concerned at times that I did not know what I was doing and felt my supervision was more a paper exercise than being constructive and beneficial to my practice and learning*"

The personal experience of this individual was validated by other members of the Green Team at the time. It would seem that supervision did not occur on a monthly basis as it should and for all staff we spoke with it did not meet their professional needs or the needs of the team.

The Service Manager, who was appointed after the Green Team was formed, recalls that the team manager was not undertaking supervision sessions as he should and that the more experienced nurses on the team tried to provide extra support to colleagues where they could. The Investigation Team did ask this individual why more assertive action was not taken to ensure that at least the inexperienced staff were appropriately supervised. We were told that:

The team manager "*did not raise difficulties in being able to allocate cases safely and appropriately. We often discussed challenging cases and there were several of them within that particular sector, however this particular case in question was not one of them and the first I knew of the case in detail was after the incident had occurred.*
Generally the team gave the impression that in the absence of the team manager, they felt adequately supervised through the more senior health and local authority personnel, their peers and the weekly multi-disciplinary team meeting. They also frequently brought issues to the attention of the other sector manager or myself for guidance and support." Given the circumstances in Grimsby at the time, in terms of service development and recruitment, the perspective of this individual and their acceptance of how the Green Team was addressing supervision and support needs does not seem wholly unreasonable.

The contemporary situation
The current manager for the Eleanor Centre advises that he has a highly structured approach to management supervision. He uses a weighted model which allows him to attach numerical values to issues such as:

- patient contact levels;
- CPA levels of clients;
- levels of risk associated with clients; and
- caseload size

This coupled with other variables such as:

- levels of experience of individual practitioners; and
- knowledge and skill base

enables him to manage performance with better insight and responsiveness. This manager also uses a numerical scoring system to

help him and his staff identify those cases that require individual attention within management supervision.

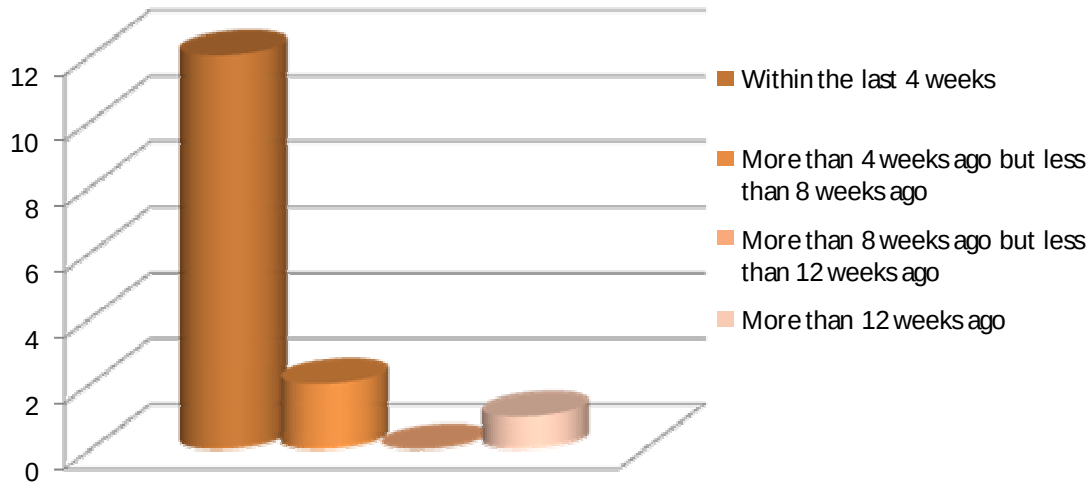
The current Assistant Director (Operations) Mental Health also emphasised that supervision was now much more robust and audited on a regular basis.

In the questionnaire issued to a small number of staff a question was asked about the frequency of management and clinical supervision.

The responses were:

Graph 6

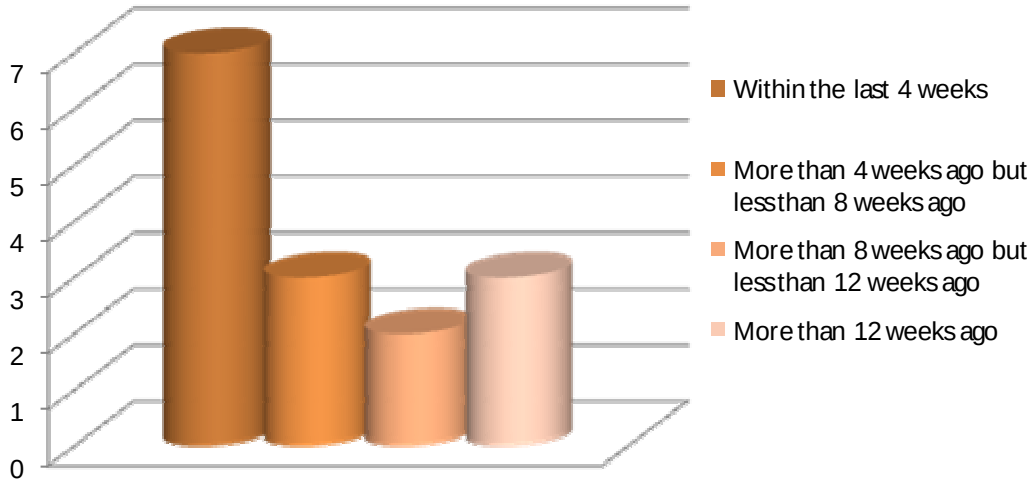
Management supervision:	
Within the last 4 weeks	12
More than 4 weeks ago but less than 8 weeks ago	2
More than 8 weeks ago but less than 12 weeks ago	0
More than 12 weeks ago	1



Graph 7

Clinical supervision:

Within the last 4 weeks	7
More than 4 weeks ago but less than 8 weeks ago	3
More than 8 weeks ago but less than 12 weeks ago	2
More than 12 weeks ago	3



In terms of value 75% (12/16) of respondents said that they found management supervision to be “reasonably to very” valuable and 87% of respondents (14/16) said that they found their clinical supervision to be very valuable or of reasonable value.

The issues currently covered in management supervision were stated as:

MANAGEMENT SUPERVISION

Case load management	10
Case load weighting	4
Clinical concerns about specific clients	7
Review of the quality of my documentation	7
An assessment of the quality of my risk assessments	3
An assessment of the quality of my care plans	3
An assessment of the quality of my risk management and/or relapse prevention plans	2
The appropriateness of the level of CPA for my client	3
Work based issues that I want to talk about	7
Personal issues that I want to talk about	9

The issues covered in clinical supervision were stated as:

CLINICAL SUPERVISION

Case load management	9
Case load weighting	2
Clinical concerns about specific clients	8
Review of the quality of my documentation	3
An assessment of the quality of my risk assessments	2
An assessment of the quality of my care plans	3
An assessment of the quality of my risk management and/or relapse prevention plans	3
The appropriateness of the level of CPA for my client	2
Work based issues that I want to talk about	6
Personal issues that I want to talk about	6

In the context of this case it is perhaps a point of reflection that in neither management nor clinical supervision do the activities of looking specifically at the quality of care plans, risk assessments and risk management and relapse prevention plans feature highly.

Finally in the most recent Healthcare Commission assessment North East Lincolnshire Partnership Care Trust achieved seven out of the eight assessment criteria. One of the seven criteria was clinical supervision.

7.0 OTHER ISSUES ARISING FROM THE INVESTIGATION

The overriding impression of the Investigation Team as a result of the analysis of the MHSU's care and treatment between 2003 and 2004 is that the mental health service in Grimsby today bears no resemblance to the service as it was then. Developments in the rust since 2002 are a testimony to all of the staff working in mental health services in Grimsby and also to the non-statutory agencies and the service users and carers that have helped make the changes possible.

It was not within the scope of the investigation to undertake a detailed assessment of the contemporary systems and processes in place but initiatives such as Tukes Cafe, which started in 2004, and the positive efforts the rust has made to initiate employment schemes for its service users, do deserve specific reference within this report.

The Director of Mental Health in North East Lincolnshire reports that the employment schemes developed have had about 450 persons through them and many service users have now gained NVQs. A substantial number gained work with the Trust or with external employers. For example all cleaning and catering on the older persons' unit is delivered by the Trust's employment scheme. This work is done to a much better standard than the previous external contractors did. The service used to get 34% cleanliness ratings but now it is 90%+. This in itself validates the success of the scheme.

At time the MHSU was a user of the Trust services there were no opportunities like this.

Tukes Cafe
The Grimsby Telegraph of 7 July 2008 says:

"A pioneering mental health project has gained yet another prestigious award for its work in the community. Tukes Cafe, on Grimsby's Brighowgate, was set up in 2003 as a day centre providing work experience for people with mental health issues.

Nearly five years on, the project has expanded to include a cafe at Grimsby's Diana, Princess Of Wales Hospital, another at the Weelsby View Medical Centre on Ladysmith Road, Grimsby, a cleaning team, and even an onsite hairdressers and conference facility at the former Baker Street site.

Now, the project, run by North East Lincolnshire Care Trust Plus (CTP), has received a prestigious National Health And Social Care Award for its services to mental health and wellbeing.

The scheme's win follows its success at the regional awards, held in Sheffield in April, where it was chosen as a finalist for the national honour."

The Investigation Team are satisfied that the management team for the mental health services in Grimsby remain committed to ongoing improvements in their service and in particular to ensuring that their community services improves from a fair to a good rating in the 2007/2008 assessment by the Healthcare Commission.

8.0 CONCLUSION OF THE INVESTIGATION TEAM

The conclusion of the Investigation Team following the analysis of the MHSU's care and management is that the incident that occurred on 26 February was not predictable by the mental health services at the time. There was nothing known by the mental health service that could have alerted staff to the possibility that the MHSU was capable of such a display of violence. There was however information available that would have alerted staff to potential vulnerability of the MHSU's stepfather from the MHSU if he became unwell.

The issue with regards to preventability is less clear cut. We know that

- The risk assessment of the MHSU with regards to his risks to self and in particular his risk of medication non-compliance was underestimated to the extent that no in depth risk assessment occurred.
- That in November 2003 the MHSU made reference to a change in his stepfather's behaviour that was not explored or validated in any way by his Care Coordinator. This meant that its significance in relation to early signs of relapse could not be excluded.
- There is no evidence that the MHSU was ever discharged from section 117 aftercare
- The MHSU was formally discharged from the Care Coordinator's caseload on 26January 2004 but was maintained as an outpatient with follow up planned for May 2004.
- The CMHT records show that the Care Coordinator did speak with the MHSU's sister on 26 January and advised her to contact the Eleanor Centre if she was concerned about her brother's medication compliance.
- That the Care Coordinator records note that the MHSU's sister informed her that the MHSU was mentally 'very well'. (January 2004)
- We also know that no one from the mental health services had a detailed conversation with the MHSU's stepfather at any stage prior to his discharge. The fast track referral system was certainly not explained to him.
- That the MHSU's sister cannot recall having any conversation with her brother's Care Coordinator at the time of discharge, or being told about the fast track referral system.
- On 25 February 2004, the day preceding the incident, that the MHSU was asked to leave his step-father's house and that the police were in attendance.
- We also know, from one of the MHSU's recent Consultant Psychiatrists, that it took protracted exploration and therefore time for the forensic service to unravel the depth of the

MHSU's mental illness, time that an average mental health worker in the community would not have had. Furthermore we also know that it is the opinion of this forensic psychiatrist that the MHSU was competent in masking his symptoms of ill health.

Had the family been more involved with the mental health services and had there been a risk management and relapse prevention plan for the MHSU that involved the family, then the family may have been more likely to make proactive contact with the mental health service if they were concerned about the MHSU's behaviours in the period leading up to the incident.

Also, had the MHSU's allegation about the sudden large alcohol intake of his stepfather and the increased fragility in their relationship, which he reported to his Care Coordinator in November 2003, been explored as it should have been with the MHSU and with the family of the MHSU, then there would have been a greater opportunity to detect early signs of deterioration in the MHSU's mental state[15]. It must be noted that this MHSU was adept at masking his symptoms and even following the incident the unraveling of these took prolonged and careful exploration. To have identified inaccuracies in his allegations would have required the involvement of the family by the MHSU's Care Coordinator.

Had either or both of the above occurred and had there been any issues of deeper concerned identified, then it is possible that the MHSU would have received an assessment by a member of the psychiatric team, and/or an increase in the frequency in his assessments.

Given the extent of the MHSU's hallucinations and paranoid beliefs at the time of the incident, it is unlikely that the MHSU's deteriorating mental health would have enabled him to mask all of these symptoms during a comprehensive psychiatric examination. Furthermore had he been behaving bizarrely at home it is inconceivable that if directly asked that the family would not have been forthcoming.

Whether or not such assessments would have identified the MHSU's medication non-compliance is impossible to say.

Furthermore it is not possible to give any assurance that the MHSU would have been considered sufficiently unwell to have required detention under the Mental Health Act prior to the incident, or would have required hospital admission on a voluntary basis.

Therefore the independent Investigation Team cannot say with any confidence that this incident would have definitely been prevented on

[15] **Note:** The daughter of the victim advised the Investigation Team leader that she was not aware of any increase in her father's drinking at all. She advised that to the best of her knowledge he did not drink large quantities of alcohol at all.

the day on which it occurred by virtue of a change in the actions and non-actions of any member of the community mental health team in the then Doncaster and South Humber NHS Trust. However, the preventability of the incident on 26 February 2004 remains a possibility.

9.0 RECOMMENDATIONS

Because of the many changes that have occurred within the Mental Health Services of the North East Lincolnshire Partnership Care Trust we do not have any substantial recommendations to make.

There are however three areas that the Investigation Team wish the current management team for the mental health service to address.

These are:

1. **The employment of inexperienced social workers with community mental health teams**
   It is not the place of this Investigation Team to tell the mental health service who it can and cannot employ. However the Investigation Team does urge the Trust to consider very carefully the wisdom of placing inexperienced social workers in roles which would not be open to a registered mental health nurse of similar experience. The role of the Care Coordinator carries significant levels of responsibility and complexity in Service Users can be subtle. It requires grounded time served experience in addition to a proven knowledge and skill base for a mental health practitioner to effectively care for complex individuals such as the MHSU in this case.

   We do recommend that for Community Mental Health Teams:
   - The length of post registration experience expected of mental health nurses who are applying for CMHT positions also applies to social workers.
   - That a social worker must be able to demonstrate a grounded understanding of mental health illness and the systems and processes under pinning the delivery of community based mental health care before being appointed as a Care Coordinator for a Service User on Enhanced CPA.

   We also recommend that the Trust undertakes an audit of all CMHT appointments in the last 18 months and assures itself, and the SHA, that where inexperienced staff (nursing or social work) have been appointed to positions where they are expected to act as Care Coordinator that:
   - They have possessed at the time of appointment the necessary skills and experience to fulfil the job specification and expectations.
   - Where staff have not had sufficient experience that the manner in which they are or were supervised, including the scrutiny of their individual Service User case management is robust enough that the risk of the errors of

judgement that occurred in the case management of this MHSU are reduced to as low a risk as is possible.

2. **The tracer card for medical records.**
   As part of this Investigation we reviewed the current design of tracer card used by the mental health services. Whilst the design is much improved on that which pre-dated 2003 we noted that it is not consistently completed and that there is nowhere for anyone to record the actions taken to locate a set of records where they are not immediately found.

   We suggest that lost/ misplaced records do pose a threat to the delivery of safe, effective and well informed care as this case highlights. It would seem prudent therefore that when notes cannot be located that a full record is kept attached to the tracer card of what actions were taken, by whom and when to try and find the records.

3. **The North East Lincolnshire Partnership Care Trust ensure that all qualified mental health workers, including medical staff, understand the process and their obligations with regards to Section 117 Aftercare**
   The information gathered during this investigation does not suggest that qualified mental health workers have a clear understanding about the process of discharging a Service User from Section 117 Aftercare or their statutory obligations around Section 117.

   It is suggested that the Trust check to ensure that this aspect of the Mental health Act is covered in the Mental Health Act training it provides to its staff and that the documentation tools to be completed following discharge from Aftercare support the correct following of procedure and are clearly signed by both the responsible health and local authority representatives. As a failsafe it is further recommended that all CPA discharges are signed by the respective CMHT manager.

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

This chronology gives a comprehensive picture of the MHSU's contacts with Mental Health Services between 1987 and 2004 It does not however list every single episode of care.

Date	Contact
28/05/87	Following a referral from his GP on 29April the MHSU had his first psychiatric assessment. The MHSU was noted to have a history of being 'nervous and introspective'. He had, since the 1970s, been prescribed anti-depressants on a number of occasions. The trigger for this referral was his belief that others thought him to be a homosexual. Following his psychiatric assessment the MHSU was prescribed Depixol 20mg IM every fortnight. He was also given a stat (immediate) dose in outpatients. No diagnosis is recorded at this time. ?Psychotic. Low, depressed, aggressive towards wife.
04/06/87	Attended outpatients with his wife. She reported that his mood was better and that he was less aggressive towards her. The MHSU also reported that he was better in mood and that he had not experienced any further voices.
07/09/88	The MHSU is admitted to hospital under Section 2 of the Mental Health Act. His thoughts regarding others believeing him to be homosexual continue. His wife was concerned for her own safety. The MHSU believes that his wife and father (stepfather) hate him. The clinical impression at this time is paranoid delusions with auditory hallucinations. The MHSU refused voluntary admission. Prior to assessment the Police removed the MHSU's wife to place of safety
07/09- 09/09/88	Because of aggressive behaviours and attempts to leave the ward the MHSU is nursed in seclusion. On 9 September he is more settled and accepting oral medication. He is now out of seclusion.
14/09- 16/09/88	It is noted that the MHSU continues to improve. A discussion with his wife reveals that she is happy to have him back at home. It is noted that he is 'lovely with the kids – couldn't wish for a better father'. Also noted that his normal persona is 'happy go lucky'. The records note that the wife feels some of his behaviours are linked to troubles where they live. Their windows have been broken by children and there is no peace from them.

Date	Contact
30/09/88	The MHSU is experiencing side effects from his medication. Difficulty in putting sentences together and tremor. His zuclopenthixol is reduced to 200mg monthly and his trifluoperazine is stopped. Procyclidine continues at 5mg three times a day (TDS). A subsequent outpatients appointment on 13 October revealed that he was much better with less shaking.
18/10/88	The MHSU is very depressed – waking early, poor sleep. Has a death wish. He is admitted to hospital on a voluntary basis. Assessment reveals that he continues to have beliefs about others calling him 'a poofter' – he can hear them saying it. He has no further auditory hallucinations. He does have fleeting thoughts regarding suicide. Informal Admission. His medications are changed to: Flupentixol 40mg stat and then monthly Procyclidine 5mg four times a day Prothiaden 75mg at night On the 20th October the plan is to speak with his consultant psychiatrist regarding the need to resection the MHSU. Consultant assessment that he is commenced on droperidol 10mg 4hrly overnight and chlorpromazine as the MHSU requires it.
27/10/88	The MHSU left the ward. He was known to be at home but refused to speak with staff. On 31 October his wife accompanied him back to hospital. On readmission he was tense, shaky and preoccupied. He said he was frightened of everyone on the ward. The MHSU agreed to remain informally after he was warned that they would use the Mental Health Act if necessary.
23/11/88	Following a continual improvement in his mental state the MHSU is discharged with community support and the support of his wife.
03/01/89	The MHSU attends outpatients. It is noted that he has returned to work. It is also noted that: ❑ He is tired. He doesn't sleep at night ❑ The accusations regarding his sexuality have stopped ❑ He denies being depressed. ❑ His wife is noted to be pleased. ❑ He is experiencing erectile dysfunction since commencing on his tablets. His trifluoperazine is reduced to 5mg twice a day.

Date	Contact
10/01/89	Outpatients' appointment (OPA): - The MHSU's medications are changed due to side effects (complete impotence).
25/01 – 21/03/89	Problems with medication side effects continue. There is a complete overhaul of the MHSU's medications. The zuclopenthixol is stopped and he is started on lithium 400mg twice a day. He is to be followed up in outpatients every three weeks. It is also planned that he should be referred for cognitive behavioural therapy. (26th May '89 – The MHSU was offered an OPA with a psychologist for 30 June '89.) By 7 March the MHSU reports that he is 'not bad now'. He reports some continuing problems but that he is more relaxed and less depressed. Stelazine is reduced to 5mg at night. On 21 March his procyclidine is stopped but the MHSU is told he can take 5mg if he needs it.
2/05 – 19/09/89	The MHSU fails to attend his outpatient appointments. He is therefore discharged back to the care of his GP.
09/11/90	The MHSU's wife raises the alarm regarding her husband's behaviour. The MHSU's GP also contacts the MHSU's Consultant Psychiatrist on 11 November. The MHSU's wife has left the family home (8November) and the MHSU will not let anyone into the home. Once entry is achieved the MHSU is persuaded to go into hospital – after the Mental Health Act Section 2 papers were signed. They are to be held and applied if the MHSU refuses medication or tries to leave the ward. The MHSU leaves the ward on 12 November and goes home. **Note:** In the lead up to this admission the MHSU had thrown all his wife's possessions out of the home. He believed that she was being promiscuous. He believed that his wife had told her work colleagues that she was gang raped with him as the ring leader. He also believed that his workmates know what has been going on and have been loosening the nuts and bolts on his bicycle. Prior to this relapse it appears that the MHSU had stopped his medication. **Working diagnosis:** If beliefs about his wife and community are not true then the MHSU has a schizophrenic illness.
05/12/90	The MHSU was discharged from the Mental Health Act detention. He is also discharged from hospital this day with CPN support.

Date	Contact
14/12/90	The CPN records note that the MHSU has thrown his medications away and is threatening to kill his wife after she says she wants to divorce him.
17/12/90 - March 1991	Informally admitted via CPN due to re-occurrence of symptoms. He is not taking his medications, despite his seeming acceptance at last discharge that he should. His beliefs about his wife have resurfaced and his beliefs regarding others thinking him a homosexual persist especially in relation to his wife. **Note:** The MHSU had no insight whatsoever regarding his relapse and believed himself to be alright. Also in a report for the hospital managers dated 2 January 1991, it is noted that two days prior to this the MHSU is reported to have been uttering murderous threats towards his wife. He did abscond from the hospital around the same time but was returned to the hospital by the police without incident. The notes also show that until 24 December the MHSU was challenging to care for and required seclusion on numerous occasions because of aggressive out bursts. A number of appeals were made by the MHSU against his compulsory detention during this admission. **Clinical impression**: At this juncture the MHSU's Consultant Psychiatrist is clear that the MHSU will require prolonged treatment to gain control of his symptoms, but if this is achieved then his prognosis is excellent.
27/03/91	Planning for discharge has commenced under careful supervision. The first Section 117 Aftercare meeting is held on 2 April.
20/05/91	The MHSU residing at Worrall House, on leave. He is also working full time. This is Section 117 enabled leave leading towards the end of his detention under Section Three in June.
04/06/91	Attempted to leave Worrall House and move back with his wife. Unfortunately the MHSU still believes that she had an affair and this it is understood is the motive for moving back home. He did return to Worrall House and was advised that his section remained in place and that a condition of his leave was that he remained at Worrall House, maintained his work and did not visit his wife. **Note:** At this time the MHSU's wife has instituted divorce proceedings against the MHSU.
11/06/91	The clinical records show an overall improvement with the MHSU, and better insight in to the situation between him and his wife. The Consultant Psychiatrist notes "allow section to expire".

Date	Contact
29/08/91	Records note:- Worrall House placement going well. CPN to visit MHSU at least monthly between August 1991 - February 1992. Then to have a two week and a three week gap reverting to monthly between July 1992 and October 1993. Content of the CPN records were unremarkable.
30/08/91 – 13/05/92	Nothing of note. The MHSU is successfully supported in the community.
11/05/92 - 26/06/92	The MHSU is again depressed. Admission to Grimsby District Hospital. Upon discharge, to be followed up by Dr Chauhan in OPA. Droperiodol 10mg qds Procyclidine 5mg bd Fluoxetine 20mg od Haloperidol deconate 100mg monthly IM.
30/05/92	Admission- informally. Low mood. ?Para-suicide attempt.
25/06/92	Discharged.
26/06/92	Aftercare plan completed.
16/07/92	OPA:- did not attend (DNA)
20/08/92	OPA:- DNA
26/08/92	OPA:- Wants to stop Depot because of extra-pyramidal side effects (EPSE) etc. This is not agreed.
7/10/92- 14/10/92	DNA x 2 OPAs.
01/03/93	OPA:- Remains concerned re side effects. Mental state - stable.
07/10/93	OPA - Dr Chauhan:- Medication revised. Revised plan: Haloperidol Deconate 50mg IM 4 weekly Lustral 50mg and procyclidine (Kemadrin) 5mg to be taken daily (for GP to write script and MHSU to collect).

Date	Contact
21/10/93- 10/04 01	Remains well on consistent treatment regime.
29/06/00	Day Hospital Report states not subject to CPA.
10/04/01	Letter (12 April). Depot reduced by half.
16/10/01	Depot stopped at client's request who has been stable for 10 years now. To be reviewed in six months' time. MHSU aware to go to GP if experiences relapse for re-medicating.
24/10/01	Discharged from Day Hospital Depot Clinic.
29/04/02	Discharged back to GP. Mental state examined. No abnormalities identified. Without medication since October 2001. The Consultant Psychiatrist feels discharge is now appropriate, but is happy to see him again should the need arise.
21/05/03	Admitted following section 136 assessment. Assessor – Consultant Psychiatrist..
22/05/03	Commenced sodium valproate/ olanzapine. New Care Coordinator appointed..
26/05/03	Verbally aggressive to peer on ward.
28/05/03	Possible evidence of psychotic symptoms. Now homeless.
05/06/03	Old records reviewed back to 1988. Noted diagnosis of schizophrenia.
11/06/03	Clinically stable. "Happy to continue with meds".
13/06/03	Letter to housing department advising of "depressive illness".
19/06/03	Discharged to Salvation Army Hostel. Aim is to try and find him more long term accommodation. To take out (TTO) prescriptions for one week OPA:- in six weeks 7 day follow up by Care Coordinator.
23/06/03	Unhappy with Salvation Army accommodation. Social worker suggested he move back in with step-father.
30/06/03	Risk assessment
08/07/03	Home Visit:- Patient reported relationship with stepfather was fine at present.

Date	Contact
17/07/03	Care Coordinator records say MHSU "not sure of the use of it", referring to his meds. MHSU could not tell Care Coordinator what his psychiatric drugs were and he seemed to be using his mouth a lot. Happy to chat.
11/08/03	MHSU phoned to say he may not be able to make appt. Care Coordinator visited him at home at later time. MHSU in, but would not let her in. MHSU reported that he was feeling fine. Care Coordinator said she would check that hospital was sending OPA appointments to right address, as MHSU says did not receive the last one.
08/09/03	Care Coordinator spoke with MHSU's stepfather. No detail as to content of conversation.
28/08/03	Care Coordinator agrees to reduce level of contact with MHSU while he is feeling so well.
15/09/03	Care Coordinator spoke with MHSU 's step-father and left a message asking MHSU to make another appt. Care Coordinator cancelled MHSU 's appt on the 9th Sept (Training Day).
19/09/03	MHSU sees Care Coordinator at Eleanor Centre. All noted to be well. MHSU advised that plan is to reduce his contacts with Care Coordinator and Associate Nurse. LR suggested attending OPA with MHSU to review care plan.
30/09/03	Offered a flat, but turned it down.
11/10/03	OPA:- Self-reporting compliance with medication. Stable.
03/11/03	OPA:- Remains with stepfather. Has turned down further offer of own flat. Agreed at this OPA that Care Coordinator would see MHSU once a month - next appt - 24th Nov 2003. The OPA assessment (SHO) reveals good sleep, appetite and concentration. Energy levels 'satisfactory'. MHSU says 'not excessively energetic or spending lots of money'. Compliant with medication. CPN visiting monthly and reporting no concerns. Olanzapine 20mg Semi sodium valproate 750mg BD Voltarol 75mg BD (no side effects)
24/11/03	MHSU attended the Eleanor Centre with LR as arranged. Patient raised concerns re step-father's drinking. Relationship was "fragile". DL said at OPA that his step-father was drinking 2 bottles of whisky a day and that the relationship was fragile at present. DL said he spent most of the time out of the flat.

Date	Contact
19/12/03	Remains concerned re stepfather's drinking.
05/01/04	OPA:- seen by Locum SHO (? same SHO saw him in Nov 03). MHSU reports being very well. Enjoyed Christmas - spent it with his step-dad and 2 sons. Denies any hyperactivity, no thoughts of self-harm and no evidence of psychopathology. Good insight also displayed. To continue with medication.
12/01/04	MHSU says that he feels he can manage without CMHT input. LR agrees to discharge him.
26/01/04	Sister advised by Care Coordinator that the MHSU was discharged and that if she was concerned at all they should have the option to use the fast track referral system if needed.
27/01/04	Patient received further offer of accommodation.
02/02/04	Discharged from CMHT caseload under fast track' programme. Outpatient care to continue. MHSU awaiting suitable accommodation with North East Lincolnshire Council. Currently living with stepfather. Care Coordinator feels that MHSU no longer requires support of CMHT - MHSU agrees. MHSU advised that he can re-access via fast track system.
25/02/04	Police called by step-father, who asked for MHSU to be removed. MHSU went to stay at a B&B.
26/02/04	Assessed in police station, having been arrested for the murder of Father. Stopped medication. MHSU admitting killing. Denies alcohol or drugs. "Paranoid ++" mood. Elevated for two weeks2 - not taken medication since discharge in June. Psychotic relapse.

APPENDIX 2- THE QUESTIONNAIRE SCENARIO

You have been appointed as the Care Coordinator for a Service User. You know that the Service User has a past history but you currently have no access to the detail of this. You also know that the patient has previously been treated under Section 3 of the mental health act. The patient's diagnosis is schizophrenia. The Service User had been discharged back to primary care services approximately 12-18 months ago but has recently been admitted with an acute psychotic episode – wandering in the street partially clothed, acting bizarrely. The precipitating factor seems to be medication non-compliance. (This Service User had been on depot medication for many years and had been weaned off this over a two year period, and when considered stable discharged back to primary care.)

The Service User has settled quickly on medication, and was an inpatient on an informal basis for approximately 6 weeks. The Service User's main problems seem to be social – predominantly housing related.

The discharge plan is to:

1. For the Service User to attend three monthly outpatient appointments
2. For a CPN to visit on alternate weeks in the initial post discharge period to assess medication compliance
3. For a Social Worker to be the Service User's Care Coordinator who will also take a lead with the service user's current housing difficulties.

What level of CPA would you put this Service User on? (please tick relevant box)

STANDARD CPA ☐ **ENHANCED CPA ☐**

APPENDIX 3- Sources of Information Used to Inform the Investigation's Findings

Persons Interviewed:
Director of Mental Health Services NE Lincolnshire
Assistant Director (Operations) Mental Health
Associate Nurse
Care Coordinator to MHSU
Consultant Psychiatrist
Current CMHT Leader at the Eleanor Centre
A CPN at the Eleanor Centre
Consultant Psychiatrist at The Humber Medium Secure Unit
CPA Coordinator 2002/2003 and 2004-2007
Manager of the Crisis and Home Treatment Team
Previous Ward Manager for Ward D2
Service Manager Adult Services

Meetings Attended
Two members of the Investigation Team attended a meeting with the Independent Service Users and Carer's Forum at the Tukes Cafe in Grimsby

Telephone Discussion and written correspondence
With and from the daughter of the deceased

Documents Reviewed
All of the MHSU's clinical records
Best Practice in Managing Risk July 2007 Department of Health
The CPA Policy for Doncaster and South Humber NHS Trust 2003
The CPA Policy for Doncaster and South Humber NHS Trust 2004
Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach – A Policy Booklet January 1999
Doncaster and South Humber NHS Trust Prototype clinical records which set out what each documentation tool template was for
Department of Health Information Leaflet – Making The CPA Work for You March 2008

Information Websites accessed
Department of Health
Rethink (http://www.rethink.org/about_mental_illness/index.html)
MIND
The Association for Psychological Therapies regarding DICES risk assessment (http://www.apt.ac/dicesld.html)
Facecode.com regarding the FACE risk assessment tool and process (http://www.facecode.com/papermh.html)
The CPA Association (http://www.cpaa.co.uk/thecareprogrammeapproach)

GLOSSARY

Care Programme Approach

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

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

The Cornerstone of the CPA

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

Modernising the CPA

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

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

Key Changes

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

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

- Levels of the CPA — two levels of the CPA must be introduced — Standard and Enhanced.
- Abolition of the Supervision Register — from April 2001, Supervision Registers can be abolished providing the Strategic Health Authority is satisfied that robust CPA arrangements are in place.
- Change of name — Key worker to be referred to as Care Co–ordinator.
- Reviews of Care Plans — the requirement to review care plans 6 monthly is removed. Review and evaluation should be ongoing. At each review the date of the next meeting must be set.
- Audit — regular audit will be required to take place looking at qualitative implementation of the CPA.
- Risk assessment/risk management — risk assessment is an ongoing part of the CPA. Care plans for people on enhanced CPA are required to have a crisis plan and contingency plan.

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

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

Place of Safety
Both Section 135 and Section 136 of the Mental Health Act make arrangements for people to be taken to a "Place of Safety".

The Act (in Section 135) defines a Place of Safety, in general terms as:

- a hospital;
- a police station;
- a specialist residential or nursing home for people with mental health needs;
- residential accommodation provided by a local social services authority; or

- "any other suitable place, the occupier of which is willing temporarily to receive the patient"

There is widespread agreement that a police station - which in practice may mean a cell or a rather stark interview room - is not an ideal place to conduct a mental health assessment. Both the Home Office and the Mental Health Act Commission have indicated that the best Place of Safety is usually a hospital. Some people have felt that a hospital is inappropriate as the process may label someone as mentally ill, when in fact they are found, on assessment, not to have a mental health problem. However, a hospital can have facilities (e.g. a special room set aside for the purpose) to act as the Place of Safety without the person necessarily entering a ward or being admitted as a patient.

If the Place of Safety is a hospital, the police may leave once the person has been "delivered" there. Sometimes local agreements will exist to ensure the police stay for a limited period and to ensure that, for example, the person is searched by the police for weapons if this appears appropriate. Again, local agreements may provide for the police to be notified if the person concerned is assessed as not having a mental disorder and/or not needing admission. The police may nevertheless have grounds for questioning the person about the behaviour which led to a Section 136, or about other matters.

Section 117 Aftercare

Section 117 of the Mental Health Act (MHA) puts a joint duty on health and social services to arrange aftercare for certain people when they leave hospital. It applies to anyone who has been detained ('sectioned') in hospital under the treatment sections of the MHA (sections 3 and 37, including 37/41), or who has been transferred for treatment from prison to hospital (under sections 47 and 48).

The purpose of section 117 aftercare is to stabilise the person back in the community, to prevent him or her from having to be readmitted to hospital. Section 117 aftercare does not have to include any specific services. It's up to health and social services to decide what they think the person needs. It's free of charge to the person concerned. The process is similar to the assessment for community care services, but a section 117 needs assessment should take place in hospital, before discharge.

Section 117 will still apply if a service user comes off section 3 but stays in hospital voluntarily. The aftercare will start when the service user leaves hospital, even if this is not immediately after your detention ends. It also applies to those who are still on section 3 who are on extended leave from hospital, and to patients on conditional discharge. People detained for assessment under section 2 of the MHA are not entitled to section 117 aftercare.