W1 INVESTIGATION

Report of the Independent Investigation Team

October 2006

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This Independent Investigation was commissioned by the Birmingham and The Black Country Strategic Health Authority (now West Midlands SHA since July 2006) in keeping with the statutory requirement detailed in the Department of Health guidance titled “Independent Investigation of Adverse Events into Mental Health Services” issued in June 2005. This requires there to be an independent analysis of the care and services offered to Mental Health Service Users involved in incidents of homicide where they have had contact with the Mental Health Services in the six months prior to the incident and replaces the paragraphs in “HSG (94)27” which previously gave guidance on the conduct of such enquiries.

The Investigation Team Members were:

- Ms Maria Dineen, Director, Consequence UK Ltd
- Dr Paul Courtney, Consultant Psychiatrist, Hampshire Partnership NHS Trust
- Mr Justin O’Brien, Head of Risk Management, South West London and St George’s NHS Trust

Advice was also sought from:

- Dr Sadru Kheraj, General Practioner and GP Advisor to South East London Strategic Health Authority

Acknowledgements:
The Investigation Team thank:

- The granddaughter of the lady killed by W1 for meeting with the Investigation Team.
- All of the staff at Wolverhampton PCT and The Hatherton Centre who participated in this investigation.
- The Family Liaison Officer from West Mercia Police Force who supported this investigation.

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EXECUTIVE SUMMARY

Intention

This report sets out the Investigation Team's findings and recommendations following their analysis of the care and management of Patient W1 (W1) between August 2000 and November 2002. W1 was convicted of Manslaughter in 2003 following his attack on an elderly neighbour on the 26th November 2002.

Purpose

The purpose of the investigation was to:

- Determine whether or not the care and management of W1 between April 2000 and November 2002 was appropriate
- Identify areas for improvement in the delivery of community mental health services to adults of working age in Wolverhampton that have been identified as a result of this investigation
- Determine the effectiveness of any improvements the Mental Health Service in Wolverhampton had already implemented at the time of this investigation.

Outline of Review Process

The investigation was led by Maria Dineen and the core activities undertaken were:

- A comprehensive documentation review
- The creation of a detailed chronological timeline detailing W1's contact with mental health services
- The identification of key themes of concern regarding the care and management of W1
- The exploration of identified principal concerns to identify the most significant influencing factors
- The identification of good practice
- Making recommendations

Main Findings – Strengths in W1's care and management

- It is evident from the Investigation Team's analysis of W1's mental health records and the interviews conducted with staff, that he received a very good standard of care from his Care Coordinator between August 2000 and the end of September 2001. The professional concerned showed a degree of tenacity in her efforts to engage W1 in therapeutic activities that is to be complimented.
- The Forensic Liaison Service (FLS) provided W1's Care Coordinator with regular support in exploring W1's risk factors and in making recommendations regarding his ongoing management. The Forensic CPN for the South East Community Mental Health Team (SECMHT) was noted to be particularly supportive.

Main Findings – Issues of concern

This investigation identified a range of concerns, the most significant of which are:

- The handover of care coordination responsibility in September 2001 was ineffective
- The planned follow-up of W1 by the Forensic Liaison Service (FLS) did not occur
- The requested and required Care Programme Approach (CPA) Review did not occur
- There was a perception that W1 had been discharged from Out Patients in November 2001 and thus from the mental health service
- When W1 disengaged from Vocational Rehabilitation Services in February 2002 there was no notification to his Care Coordinator or his Consultant Psychiatrist for a period of eight months.

Main Conclusions

As a result of this investigation the main conclusions of the Investigation Team are:

- That the care and management of W1 up to and including 25th September 2001 was appropriate and reasonable
- That the care and management of W1 from the 26th September 2001 to the incident date on the 26th November 2002 fell significantly below the standards set out in the Wolverhampton Mental Health Service policy documents and also the national standards of care especially the Care Programme Approach (CPA)
- In spite of the short comings in W1's care and management, in the 14 months preceding the manslaughter of his elderly neighbour, one cannot say with any certainty that this incident was either foreseeable or preventable. Following W1's arrest and prior to his sentencing "there has always been some uncertainty (due to lack of evidence) about whether or not the abnormality of mind experienced by W1 at the time of the index offence was sufficient to substantially impair his responsibility for his actions"[1]. The evidence provided by W1 to the West Midlands Police and the manner in which he disposed of the clothing[2] he wore at the time of the index offence was not typical of someone suffering an acute episode of mania. However, had W1 received appropriate care and management from the mental health service in the 10 months leading up to the incident the Mental Health Service would have had the opportunity to identify any change in his presentation, or social circumstance, that increased the risk factors to himself or to other persons. Whilst there are no guarantees that contact with W1

[1] Extract from correspondence to the Crown Prosecution Service (1 April 2004) from a Consultant Forensic Psychiatrist (Dr SDV).

[2] W1 scattered the clothing he wore at the time of the incident in various locations in Wolverhampton. He was able to take the police back to most of these locations to retrieve the clothing found for forensic examination following his arrest.

over this period would have revealed any behaviour suggestive of an increase in his risk factors the fact that he was not seen leaves this open to question.

- With respect to the contemporary situation in Wolverhampton it is clear that considerable changes and developments have taken place that make it a remote possibility that the sequence of events that transpired to allow the mental health service in Wolverhampton to lose sight of W1 to occur again.

Recommendations

The priority recommendations arising from this investigation are:

1. Wolverhampton PCT needs to ensure that a training needs analysis is undertaken within the mental health directorate targeting risk assessment and CPA practice. Based on the findings of this a planned, sustainable programme of training needs to be developed to address the identified gaps in knowledge and skill.
2. Prior to the finalisation the Forensic Liaison Service's Revised Operational Policy (2005) Wolverhampton PCT facilitates an objective assessment of how the current model for the provision of the Forensic Liaison Service is working and its terms of reference. Such an assessment should include an assessment of the capacity of the FLS against the demands currently placed upon it.
3. The Mental Health Directorate in Wolverhampton PCT must agree a common auditable process across Adult Services so that Service Users on Enhance CPA who do not attend their out patient appointments can be identified for further review and efforts of engagement.

1.0 INTRODUCTION

Birmingham and The Black Country have commissioned this investigation following the unlawful killing of an elderly lady in Wolverhampton in November 2002, by W1 a patient of the Mental Health Services in Wolverhampton at the time.

The Investigation Team did not meet with W1 during the investigation as it was not appropriate to do so. Efforts were made to contact his family via the Family Liaison Officer (FLO) who had, had contact with them at the time of the incident. No response was received to the letter inviting W1's family to meet with the Investigation team.

Historical Overview

W1 did not have extensive contact with the Mental Health Services in Wolverhampton. His first contact was in February 1991, when he was admitted to New Cross Hospital under Section 2 of the Mental Health Act with a diagnosis of Acute Mania. He was initially treated with Chlorpromazine (up to 200mg three times a day) and subsequently discharged from hospital on the 5th April 1991 on no medication.

On the 6th April he was admitted to the local accident and emergency unit having thrown himself down stairs. Whilst in A&E he displayed violent behaviour and was arrested and subsequently remanded at Winson Green Prison. His psychiatric assessment at this time concluded that W1 was not suffering from a mental illness and that further treatment from the service was not appropriate.

On the 15th April W1 was admitted to the West Midlands Poisons Unit from Winson Green Prison with classical features of Neuroleptic Malignant Syndrome. He remained in this unit until the 23rd June 1991 when he was discharged. At this time he was not displaying any signs of mania and was noted to be 'calm'.

W1 was subsequently discharged and had no further contact with the Mental Health Service in Wolverhampton until April 2000.

Overview of W1's contact with the Mental Health Service in Wolverhampton April 2000 – November 2002

On the 9th April 2000, W1 was arrested following aggressive and violent behaviour in a grocery store within his local community. Following a mental health assessment he was detained under Section 2 of the Mental Health Act at New Cross Hospital.

On the 22nd April W1 was transferred to a forensic unit in Stafford (The Hatherton Centre). He was cared for here until the 23rd June 2000, when he was transferred back to New Cross Hospital. He was eventually discharged into the care of his Community Mental Health Team (CMHT) on the 22nd August 2000.

Between August 2000 and September 2001, W1's care and management was reasonably uneventful and he experienced no further episodes of mania.

In September 2001 his then Care Coordinator left the Mental Health Service in Wolverhampton and Care Coordination responsibility was transferred to the Day Services Team Leader.
Between September 2001 and February 2002, W1 attended Vocational Rehabilitation on a regular basis but stopped attending early in February 2002.

Between the 6th February and the 26th November 2002, W1 had no further contact with the Mental Health Service in Wolverhampton. W1 did however attend his GP Surgery on a regular basis over this time.

W1's contact with the lady he attacked and subsequently killed
It appears, from information provided by the family of victim and the police that the lady W1 attacked, and subsequently drowned, was a close friend of W1's mother's. It appears that a member of W1's family had been undertaking gardening work for the lady and that when this individual could no longer continue with this W1 took over this work. How long he had been doing this for, and the nature of W1's relationship with his victim is not clear.

Note: see Appendix 1 for a more detailed chronology of W1's contact with the mental health and primary care services in Wolverhampton

2.0 TERMS OF REFERENCE

The terms of reference for this investigation were as follows:

1. To examine the circumstances and events surrounding the treatment and healthcare of W1 by Mental Health Services within Wolverhampton and the events leading up to the killing of his neighbour.

2. To assess the extent to which W1's care and management complied with statutory obligations, relevant guidance from the Department of Health and local operational policies.

3. To assess the level and scope of the healthcare and treatment provided to W1 including the assessment and management of risk.

4. To assess the extent of inter agency input to the care and management of W1 and the effectiveness of inter agency working relationships.

5. To review the internal investigation undertaken into the care of W1 already undertaken by Wolverhampton Primary Care Trust and any action plans, or action taken as a result of such an investigation.

6. To prepare an independent report for Birmingham and the Black Country Strategic Health Authority, Wolverhampton Primary Care Trust and other relevant bodies that;
    - sets out the events surrounding the care and treatment of W1
    - identifies the key facts that contributed to the death of W1's neighbour
    - reviews the effectiveness of action taken since the death of W1's neighbour
    - makes recommendations for any necessary further action

3.0 METHODOLOGY

In this investigation Root Cause Analysis (RCA) principles were applied. The guiding investigative framework followed was that detailed in the National Patient Safety Agency's (NPSA) RCA e-learning tool kit.[3]

The specific investigation and analysis tools utilised were:

- The Consequence UK Ltd structured Timeline
- The NPSA's systems analysis framework
- Thematic Analysis
- A semi structured questionnaire exploring key areas of concern identified in the care and management of W1 with a cross section of community staff working with adults of working age in Wolverhampton's Mental Health Service.

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

- W1's clinical records
- Key policies and procedures pertinent to the care and management of W1
- Interviews with key staff engaged in the care and management of W1
- Interviews with the leaders of the Forensic Liaison Service (FLS)
- Interviews with the past and current CPA Coordinator and CPA Facilitators
- Observation of two Community Mental Health Team (CMHT) team allocation and review meetings
- The Arresting Officer following the incident and the Family Liaison Officer for the family of the victim
- A review of W1's custody records and other relevant police records
- One of the victim's granddaughters
- A review of the electronic documentation system for CPA and Risk Assessment now used in the mental health service in Wolverhampton.

Note: please see Appendix 2 for a full list of persons interviewed and documents reviewed during this investigation.

[3] NPSA e-Learning tool kit August 2004 www.npsa.nhs.uk/ipsel

4.0 FINDINGS DIRECTLY RELEVANT TO THE CARE AND MANAGEMENT OF W1

Following a detailed analysis of W1's clinical records the Investigation Team agreed that the most significant period of his contact with the mental health services in Wolverhampton was between August 2000 and November 2002. It is this period therefore that the Investigation Team focused on in its investigation.

The initial documentation analysis demonstrated that W1's care and management in 1991 was reasonable and of no significance to the events that came to pass in November 2002. The analysis of W1's initial care and management from April 2000 – August 2000 also revealed appropriate care and management including an appropriately planned discharge of W1 from in-patient services to the community service.

4.1 POSITIVE FEEDBACK

The following details the identified good practice that requires recognition within the context of this report:

- There is clear evidence within the documented records that when W1 presented to the mental health services in April 2000 due consideration was given to the most appropriate medications to best manage his mania in view of his previous experience of Neuro Malignant Syndrome in 1991
- The assessment of W1 at Bilston Street Station by the then Medical Director for Wolverhampton Healthcare NHS Trust was of a high standard and the communication of this professionals' findings to the GP, and other relevant personnel fulsome
- W1's transfer to the forensic psychiatric service in Stafford, The Hatherton Centre, was appropriate and timely
- All of the correspondence sent to W1's GP by the SHO's working for W1's Consultant Psychiatrist was reasonably comprehensive and informative, giving the receiver of the information a clear indication as to the current circumstance of W1 and any actions that were required such as the monitoring of serum lithium levels. "*I would be grateful if you would do a blood test now and then check it again every three months for any fluctuations in blood lithium levels."* [4]
- It is evident from the Investigation Team's analysis of W1's mental health records that he received a very good standard of care from his Care Coordinator between August 2000 and the end of September 2001. This individual showed a degree of tenacity in her efforts to engage W1 in therapeutic activities that is to be complimented

[4] extract from correspondence with W1's GP on the 24th August 2001 from the then SHO to W1's Consultant.

- Document analysis and interviews with staff engaged with W1 revealed detailed and appropriate discussions regarding W1's risk factors between August 2000 and the 27th September 2001 within the Forensic Liaison Service (FLS) meetings
- The quality of advice provided to W1's Consultant Psychiatrist and his Care Coordinator by the FLS appears to have been of a good standard and the correspondence reiterating this clear and concise
- It is clear from interviews with those engaged in the promotion and roll out of CPA in the mental health service in Wolverhampton between 1996 and 2001 and the documentary evidence they provided, that considerable personal effort was expended in i) delivering CPA training to staff on a formal and informal basis and ii) trying to design a documentation format that was clinically relevant as well as providing reliable audit data
- The Team Leader of SECMHT between November 2000-2002 was the first person to be appointed to this post from a social services background in the Trust. This appointment was part of a drive to foster closer working relationships between health and social services. Information shared with the Investigation Team revealed that the situation within the CMHT at the time was difficult and that the Team Leader was able to effect positive change especially with the CMHT meetings. The Investigation Team understand that these did become more orderly, productive and multi-disciplinary in nature.

4.2 PRINCIPAL CARE DELIVERY AND SERVICE DELIVERY CONCERNS

The analysis of W1's care and management between August 2000 and November 2002 revealed a range of concerns that collectively allowed W1 to fall out of contact with the mental health services in Wolverhampton. The specific issues that contributed to this were:

- The handover of care coordination responsibility in September 2001 was ineffective. The newly identified Care Coordinator (the Care Coordinator elect) was not aware that she had been assigned this responsibility until October 2002
- The planned follow-up of W1 by the Forensic Liaison Service (FLS) in October 2001 did not occur
- The requested and required Care Programme Approach (CPA) Review did not occur, in fact W1 did not have a CPA Review between August 2000 and November 2002
- On the 26th November 2001, W1's Consultant Psychiatrist wrote to W1's then GP advising that he (W1) had not attended his out patient's appointment. In the letter the Consultant advises that "I have not sent him a further appointment but

would be happy to do so should you wish me to". This was interpreted by other mental health staff engaged in the care and management of W1 as a letter discharging him from the mental health service

- When W1 disengaged from Vocational Rehabilitation Services in February 2002 there was no notification to his Care Coordinator or his Consultant Psychiatrist for a period of eight months.

4.3 THE MOST SIGNIFICANT INFLUENCING FACTORS GIVING RISE TO THE ABOVE STATED CONCERNS

Following a detailed analysis of the information gathered during the investigation process the Investigation Team agreed the following factors to be most significant in enabling the above stated concerns:

- At the time W1 was receiving care from the mental health services in Wolverhampton it was not uncommon for health and social care staff to be appointed as a Care Coordinator without being consulted about this
- With specific reference to the CMHT responsible for the care and management of W1, contrary to their Operational Policy, there was no formal discussion about who would most appropriately take over care coordination responsibility for W1
- There was no robust, or readily auditable, process within the FLS for tracking those Service Users it had accepted for review, and therefore on to their 'caseload'
- The FLS, whilst undertaking its responsibilities with the best of intentions, had evolved a mode of operation that clouded the differentiation between an advisory service and a service that carried ongoing responsibility for the care and management of any referred Mental Health Service User
- There was no effective system in place for ensuring that the FLS Coordinator was aware of all the services with which a Service User was engaged and therefore the system for communicating the advice of the FLS to involved professionals was incomplete
- The task of organising the CPA Review was allocated to an individual who was not present at W1's CMHT 'allocation and review' meeting on the 4th October. This individual was on compassionate leave
- At the time there was no systematic approach within the SECMHT team allocation and review meetings for checking that previously agreed actions had been carried out. It was generally assumed that once action points had been delegated they would be undertaken
- The content and style of the letter sent to W1's GP on the 22nd November 2001 gave no indication that W1's Consultant Psychiatrist was retaining clinical responsibility for W1.

Neither did the letter provide any information to assist the GP in the appropriate surveillance of W1 and indicators requiring notification to W1's Consultant Psychiatrist

- There was a lack of organisational systems and processes to ensure that the case management of Service Users who 'Did Not Attend' (DNA) their Out Patient appointment were reviewed and decisions regarding further action made in consultation with the wider CMHT
- The lack of an effective operational policy and practice-based procedures to guide the effective management and communication with referring CMHTs for Service Users engaging with the rehabilitation service
- There was no effective assessment of the prevailing skills and knowledge of the staff working in the Day Service, against the range of skills and competencies required to deliver the extended range and complexity of services to be offered.[5]

Note: please see Appendix 3 for the detailed analysis of the stated issues of concern at Section 4.2 (p12).

[5] Whilst the Education Coordinator visited the Day Services Team to ascertain their training needs the process in place at the time relied upon individual staff and their managers recognising that there were knowledge and skill deficits. There was no defined competency framework against which staff's perceptions could be tested.

5.0 OTHER ISSUES IDENTIFIED BY THE INVESTIGATION TEAM DURING THE COURSE OF THE INVESTIGATION

In addition to the identification of the principal concerns specifically pertaining to the care and management of W1, this investigation identified a number of secondary concerns relating to the care and management of W1 and a range of contemporary issues that are of significance to ongoing improvements in clinical quality and safety within the adult community mental health services in Wolverhampton.

Wolverhampton PCT may wish to consider a more detailed analysis of some of these issues, across the whole of its mental health services, to establish whether they are unique to adult services or indicative of more wide-reaching development work required within the services provided by the mental health directorate.

5.1 SECONDARY CONCERNS RELATING TO THE CARE AND MANAGEMENT OF W1

There were two issues relating to W1's care and management that were of concern to the Investigation Team albeit to a lesser degree than those detailed in the preceding pages of this report. The issues are:

1. The risk assessment undertaken in the 25th July 2001 paid no attention to W1's dynamic risk factors

The risk assessment undertaken at this time appropriately detailed the outline of W1's contact with mental health services and the circumstances leading to this, including his attacks on staff and members of the public. The risk assessment also notes W1's non engagement with mental health services following his initial in-patient treatment in 1991 and that he continued to resist any engagement with services offered, the exception being Vocational Rehabilitation Services for which he was referred in July 2001.

The gap in the risk assessment relates to W1's social circumstance and the potential for instability in this. W1 was a gentleman who did not think he could manage living on his own.[6] Consequently he lived with his mother, in spite of a flat having been provided for him when he was discharged from in-patient services in August 2000.

On the 10th July 2001 W1 told his Care Coordinator that "his mum had to stop working as there were some problems with her liver although he was not sure what"[7].

This information was not explored further and no attempt was made to find out what the circumstance of W1's mother was. The Investigation

[6] The clinical records show that prior to W1's discharge from in-patient services in August 2000, and after his discharge into the community that he told the mental health staff that he did not think he could live on his own

[7] extract from the CMHT records of W1

Team understand that she had cancer of the liver and her prognosis was poor. She died shortly after the incident involving her son.

The discussion with W1's Care Coordinator at the time, revealed that in 2001 she had not been aware of the relevance of this dimension of the risk assessment process. However she is now fully appreciative of the importance of a holistic approach to the risk assessment of Mental Health Service Users, including family, environmental and social influences.

Discussion with a range of contemporary staff who were working within the mental health service in 2001 revealed that at this time the training in risk assessment provided to health and social care professionals was not skills and knowledge based but more akin to awareness training. The Investigation Team was also told that in the latter half of 2001 the mental health service in Wolverhampton was actively engaged in revising the design of its risk assessment documentation and the training package to accompany this.

The Contemporary Situation

Section 5.2 of this report looks more closely at the current situation regarding the provision of skills and knowledge based training in Risk Assessment and CPA. However during interviews held with staff and the questionnaire issued to a selection of staff in the community, staffs' understanding and awareness of issues to be covered during a risk assessment, including issues that would trigger a re-assessment, were explored.

The staff interviewed by the Investigation Team displayed a good understanding of what issues they would want to include in the risk assessment process and also of triggers that would prompt a re-assessment. The following are indicative of the responses provided to the question "What factors would prompt you to reassess the presenting risk in a Service User?"

"*Information provided by a source that indicated a change, or decline, in the User's coping skills/mental health. This would be additional to what are the factors for CPA risk criteria"*

and

"1. Change in circumstances i.e. starting or stopping living with another person
2. Change in behaviour, i.e. someone becoming more (or less) hostile/aggressive/doing something they hadn't done before.
3. Change in physical health, i.e. if they have had a stroke or other ill health event.
4. Change in symptoms, e.g. Paranoia"[8]

[8] Extracts from two questionnaires returned by CMHT staff

2. Lithium Monitoring

At the start of this investigation concern was expressed by the victim's granddaughter regarding the monitoring of W1's lithium levels. The trigger for this concern was the apparent diagnosis of Lithium Toxicity in W1 on the 6th November 2002, some three weeks preceding the incident.

The initial analysis of W1's clinical records did suggest that there were gaps in the monitoring of his Lithium Levels in the months leading to the incident. However, clarification of his biochemistry results was sought from the Biochemistry Department at Royal Wolverhampton Hospitals NHS Trust (New Cross Hospital). This department was able to confirm that W1 had had his Lithium Levels monitored on a regular basis between the 17th September 2001 and the 6th November 2002. The results of this monitoring are detailed below:

Date of Request	Time in Laboratory	Location of Request	Serum Lithium (mmol/L)
17 Sept 2001	15.08hrs	Church Street Surgery	0.64
6 March 2002	17.30hrs		0.82
17 July 2002	14.22hrs		0.77
8 Oct 2002	14.48hrs		0.73
6 Nov 2002	14.28hrs		1.72
6 Nov 2002	19.11hrs	A&E New Cross Hospital	1.14

The biochemistry opinion regarding the high levels of Lithium identified on the first sample received on the 6th November is:

"The apparently high serum lithium of 1.72mmol/L received from the GP on the 6th November 2002, is suggestive of the blood sample being collected too early, since a repeat serum lithium collected in A&E at least five hours later was within the target range at 1.14 mmol/L. There is therefore no biochemical evidence to corroborate 'Lithium Toxicity' or taking double the prescribed dose."[9]

The target range for serum lithium in Wolverhampton in 2001 and 2002 was 0.80 mmol/L to 1.40 mmol/L.

[9] Extract from correspondence from the Consultant Chemical Pathologist (Prof. RG) at The Royal Wolverhampton Hospitals NHS Trust.

In May 2004, in consultation with one of the Professor's of Psychiatry at Penn Hospital, these were adjusted to:
0.4-0.8 mmol/L in persons aged 65 years and over
0.5 – 1.2 mmol/L in persons aged below 65 years

The target range for serum lithium levels in Wolverhampton in 2001 and 2002 was out of step with what was happening more generally in psychiatry. In the 1990s the prevailing culture in Psychiatry was to move to lower levels of serum lithium. That no change in the levels of serum lithium was effected in Wolverhampton until 2004 raises the question of how ongoing advice regarding serum lithium levels is provided to the local Biochemistry Department and whose responsibility this is. The then Clinical Director for the mental health service in Wolverhampton was unable to shed any light on this issue though she did advise the Investigation Team that

"generally it is recommended that people with bi- polar disorder are maintained at higher levels than people with unipolar disorder (e.g. just depression). I would consider 0.8 to 1.2 (1.4 is in the toxic range) to be ok for manic (bipolar) patients and 0.5 to 0.8 to be OK for unipolars. I have found different labs have different ranges but most people get alarmed if the level is above 1.1."[10]

Whilst the Investigation team was not able to fully explore how Lithium Monitoring is currently managed in Wolverhampton it was able to ascertain that:

- While the Consultant Psychiatrist responsible for W1 believed that all of the Service User's for whom he was responsible had their Lithium levels monitored in the out patient's clinic this was not the case for W1. There is written communication to W1's GP from the various SHOs, working with this Consultant Psychiatrist, asking the GP to undertake this task.
- W1's Consultant Psychiatrist did not have any confidence in W1's GP at the time but nevertheless he did not arrange any follow up for him after November 2001 and gave no direction to W1's GP regarding ongoing monitoring of W1's Lithium levels, including what to do should an abnormal serum lithium result be received.
- The Locum GP to W1 in October 2002 would have been labouring under the belief that a serum lithium of .73 mmol/L was below the therapeutic range and therefore increased W1's Lithium dose from 600mg per day to 800mg per day. At this time the Locum GP asked W1 to have his serum lithium levels checked in one-month's time. When this GP saw W1 on the 5th November 2002, he noted that W1 had not had his lithium levels checked as requested and supplied him with another blood form.

[10] Extract from email correspondence dated 19 December 2005

With respect to the contemporary situation discussions with a small number of local GPs revealed that:

- For those Service Users on Lithium they check every couple of months to make sure that they have up-to-date results.
- They usually receive the results from the Mental Health Service as this is where the Service Users tend to have their serum lithium monitored.
- With respect to monitoring and managing Lithium, the GPs told the Investigation Team that whilst they are content to prescribe Lithium they prefer it if this is in accordance with the advice of the Mental Health Service. As 'General Practioners' they do not feel it is appropriate for them to alter any dosage advised by the Mental Health Service. If there was variance in the serum lithium outside of the target levels they would refer back to the responsible Consultant Psychiatrist, or CMHT for advice.
- The GP's also advised the Investigation Team that they perceive a lack of clarity as to where the usual responsibility lies for monitoring lithium levels

Discussions with staff working within the Mental Health Service revealed:

- A perception that the majority of the monitoring for lithium takes place in the treatment centre and that there is little reliance on local GPs.
- SECMHT have initiated a physical health clinic to enable the team to provide more locally accessible services including the monitoring of lithium levels.
- That there are no Trust Wide Guidelines for the Prescribing and Monitoring of Lithium Therapy
- The impression gained from talking to the current mental health staff is that they largely see it as the Mental Health Service's responsibility to monitor the serum lithium levels of their Service Users, accepting that for some Service Users attending their local GP surgery to have their bloods taken will be preferable.

5.2 ISSUES UNRELATED TO THE CARE AND MANAGEMENT OF W1 BUT PERTINENT TO THE EFFECTIVE CARE AND MANAGEMENT OF SERVICE USERS ON ENHANCED CPA

The additional 'added value' information gathered throughout the investigation was analysed using 'thematic analysis'[11] and a number of key themes emerged. These are as follows:

- CPA
- The operational management of SE CMHT
- Training and development of staff
- The Forensic Liaison Service
- The management of serious untoward incidents

CPA

The mental health service in Wolverhampton appointed a CPA Coordinator in 1996. Her task was to implement CPA comprehensively across the adult service. During the interview, and subsequent to this, the post-holder demonstrated, and evidenced, that she undertook her task with diligence and provided a planned programme of training to support the implementation of CPA. Furthermore it appears that she worked hard to engage in-patient and community staff in further developing the documentation design so that it was clinically useful whilst providing the necessary audit data required. In spite of this individuals efforts CPA was not uniformly supported by staff, in particular implementation by Consultant Psychiatrists was patchy. This situation was not particularly unique to Wolverhampton and many Mental Health Services across England were facing similar challenges.

Challenges experienced within the Mental Health Service in Wolverhampton in integrating CPA as central to the delivery of services to the communities served were:[12]

- Whilst there were a number of high calibre Consultant Psychiatrists working within the Mental Health Service in Wolverhampton recruitment and retention of skilled Consultant Psychiatrists was problematic due in part to high levels and density of deprivation within the communities served.
- Changing the behaviour of the senior clinicians with most influence was more challenging than the previous and current CPA Coordinators may have appreciated.
- The available CPA data for analysis was not robust or reliable in the early years of implementation. This had significant implications from a performance management perspective and in terms of generating CPA Reports for consideration by the then management team.

[11] Thematic Analysis: see glossary

[12] It is important that the reader appreciate that many of the challenges experienced within Wolverhampton were also being experienced by many Mental Health Service Providers across England

- There was a perception within the community services that the first CPA Coordinator did not have a deep enough understanding of the challenges facing CMHTs. The Investigation Team understand that this perception within the community did adversely impact on the level of engagement with CPA.
- The maintenance of CPA data was managed remotely from the CMHTs on a centralised database that was only accessible to the CPA office. This it seems resulted in an over emphasis on the documentation elements of CPA rather than the practice of CPA.
- The frequent, but necessary, iterations of CPA documentation did cause confusion amongst staff and again created an overt focus on the paperwork rather than the practice of CPA.
- There was inconsistent understanding amongst staff (at the time W1 was engaged with the service) as to the frequency with which CPA Reviews were required.

Positive Feedback

The contemporary situation in Wolverhampton is now markedly different. In the SE CMHT in particular, the Investigation Team observed behaviours indicative of strong clinical leadership being provided by the lead Consultant for this team and the current Team Coordinator, furthermore:

1. Since October 2002 all CMHT's have had a dedicated CPA facilitator who is based within each Sector CMHT to provide support to the team by:
    - ❑ Monitoring those Service Users on enhanced CPA who require a CPA Review and reminding staff about this
    - ❑ Providing a data entry function by entering on to Care Notes[13] all of the handwritten information contained in the CPA and Risk Assessment documents. This function is usually completed within a week of the documents being completed
    - ❑ Ensuring that letters confirming the outcome of any CPA Review are sent out to all persons on the agreed 'contact list' (including the Service User)

    The interviews with a range of CMHT staff across two sectors, and the information provided by the semi-structured questionnaire issued to a small selection of staff across all three adult services CMHT's in Wolverhampton revealed that the majority of staff believes that the CPA Facilitators provide a valuable service that has improved the overall practice of CPA. The CPA Facilitators themselves feel that being based within the CMHT they are supporting has given them a much greater appreciation of the constraints the CMHT social workers and mental health nurses work under and this insight has helped them in being more effective in their support function.

2. Another significant change identified within SE CMHT is that there is now a dedicated period timetabled for CPA Reviews on a weekly basis. This allocated time forms a distinct component of Consultant Psychiatrists planned sessions. This operational change within the CMHT has enabled staff to pre-book time with the Service User's Consultant for a CPA Review knowing that the Consultant has specific allocated time for this. The impression the Investigation Team have is that this is a much more structured approach than was previously used and more often than not does enable more timely CPA Reviews with attendance by relevant professionals.

3. On the 7th October 2002 the Mental Health Service moved from the situation of having a stand alone database for CPA to a system called 'CareNotes'. This was a networked system and staff, both

[13] CareNotes: This is the computerised mental health record used in Wolverhampton. Information from the hand written CPA documents and Risk Assessments are entered onto this system by the CPA Facilitator and can be accessed by all professionals at the point of care delivery where this is at a hospital or CMHT base.

clinical and administration, now have the ability to access the data held on it from their CMHT bases. The system also links to the social services system so Social Workers working with the Mental Health Service, but employed by the County Council, also have access enabling appropriate and timely sharing of information relevant to the care and management of a Service User. The benefit of this system is that the health or social care professional has up-to-date information on Care Plans, Risk Assessments, Letters, general assessments, Mental Health Act Status, the Section 117 register and other relevant documentation. Staff use CareNotes on a day to day basis re review dates etc. One of the Investigation Team was shown and interrogated the system and found it easy to navigate and concurred that it did deliver the information as advised by the CPA Coordinator. All of the staff the Investigation Team spoke with reinforced the benefits this system has brought to their ability to access essential information about the Service Users they are supporting.

4. The Manager for the Mental Health Directorate now receives monthly reports on CPA and the service has now achieved its target of 100% Service Users on Enhanced CPA having copies of their care plans. (This is evidenced within the monthly reports). In 2003-2004 only 53% of Service Users on Enhanced CPA had a copy of their care plans.

Areas for Further Development

Whilst there is no doubt that the Mental Health Service in Wolverhampton has made considerable investments in the continual evolution of their structures to support effective CPA practice there are a number of areas where the Investigation Team identified scope for further development. These are detailed below:

1. The Investigation Team are concerned that there is a lack of awareness regarding the potential risk associated with third party data entry. At this time there is no audit mechanism to enable CMHTs to test out the accuracy of the data taken from the handwritten CPA and risk assessment documents and entered onto the Care Notes system. There is a tacit acceptance that the data entry is accurate as only a few problems have occurred to date. This issue has been raised with the current CPA Coordinator and she has agreed to explore what opportunities the current mechanisms in place for auditing CPA practice and CPA documentation provide where such audit work could be accommodated.
2. The current CPA Policy requires some revision to enable it to meet good practice and the recommendations of the Safer Services Report (1999) in particular the 12 points that form the basis of the

National Suicide Prevention Strategy[14] and the Laming Report requirement 12[15]. This recommendation states that:

"Front-line staff in each of the agencies which regularly come into contact with families with children must ensure that in each new contact, basic information about the child is recorded. This must include the child's name, address, age, the name of the child's primary carer, the child's GP, and the name of the child's school if the child is of school age. Gaps in this information should be passed on to the relevant authority in accordance with local arrangements. (paragraph 17.97)"

The current CPA policy document provided to the Investigation Team:

- Does not identify the Executive Director with Lead responsible for the implementation of the CPA policy.[16]
- Makes no reference to Multi Agency Public Protection Panel (MAPPA) or its equivalent.
- There is no reference to the transfer of patients on CPA outside of the Trust boundaries (i.e. if a patient moves to the next 'shire' or another part of the country) and the procedure that should be followed in such instances. The Investigation Team were provided with a 'Sector Transfer Protocol' for Adult CMHTs though this is an undated and unreferenced document with no date for revision or review.[17]
- There is no reference to training for staff and specifically no reference to the provision of risk assessment training for clinical staff at least every three years.
- The above cited Requirement 12 of the Laming Report has not been incorporated into the policy document.
- There is no reference to transfer arrangements between Child and Adolescent and Adult Mental Health Services; Addiction Services and Adult Services; Learning Disabilities and Adult Services within the CPA Policy. Whilst a transition protocol appears to be available for the transition of Service Users between Adult and Older Peoples Services and there is a draft protocol for the transition of Service Users between Child and

[14] Safer Services – National Confidential Inquiry 1999 http://www.national-confidential-inquiry.ac.uk/nci/find_information/index.cfm?content_id=01F0A5BB-44E9-4DE6-A2BFA399D3A50620

[15] The Laming Report is the report following the Public Inquiry of the death of Victoria Climbie. http://www.victoria-climbie-inquiry.org.uk/finreport/titlepages.htm

[16] While the job description for the Clinical Director of Mental Health and Learning Disabilities does state that one of the post holders responsibilities is "to lead on CPA" the CPA policy needs to make clear the expectation of the post holder in this leadership role.

[17] The Investigation Team understands that in line with recently implemented Trust Policy the Mental Health Service will be reviewing this protocol and the revised document will comply with good practice in policy/protocol development and document control.

Adolescent Services and Adult Services these need to be cross referenced within the CPA Policy. Furthermore both documents need to be revised to meet good practice standards in policy/protocol development and document control.

Forensic Liaison Service

The Forensic Liaison Service in Wolverhampton was introduced in 1997 and represented a partnership between Wolverhampton Health Care NHS Trust Mental Health Directorate and the Foundation NHS Trust Forensic Mental Health Services based at the Hatherton Centre, St George's Hospital. The scheme was initially funded by a grant from the Mentally Disordered Offenders Strategic Fund and subsequently (2003) from Wolverhampton PCT.

The purpose of this service was:

- To promote well informed, effective and rewarding working relationships between the two services.
- To ensure that the limited available resources are utilised to the maximum potential to provide an effective service for people with mental health problems who come within the remit of Forensic Psychiatry.
- To ensure effective clinical consultation and liaison over patients receiving care in either service, patients being transferred from one service to the other, and patients jointly receiving care from a partnership of both services.
- To ensure dissemination of clinical information according to the principles and practices of the Care Programme Approach.
- To promote education and training in the principles and practices of forensic mental health care.

The FLS was awarded beacon status in the late 1990s for being a "model of good practice". It was subsequently offered extended beacon status to continue to disseminate the model across the UK. As a result the team members were engaged in a range of presentations, conferences and workshops to various audiences. These presentations were reputedly well received.

The scheme was evaluated after 18 months of operation, the main focus of which was its activity. This evaluation showed:

- That between June 1997 and December 1998, 61 Service Users were referred to the scheme of which 59 (97%) were reviewed (42 (69%) of referrals originated from the CMHTs)
- An assessment was carried out by at least one member of the forensic team on 53 (87%) of Service Users.

The Investigation Team were not provided with any evaluation data assessing the success of the FLS in its 'softer' objectives although the questionnaires issued to and returned by staff currently working within Adult Services CMHTs in Wolverhampton suggest that:

- The majority of staff agree with the statement " The Forensic Liaison Service provides a valuable service to the CMHT in the management of Service Users with a forensic history."

The Investigation Team's own observation of a FLS meeting revealed:

- A 'healthy' team that displayed good multi-disciplinary working with animated and open debate regarding the ongoing management of the 'Service User' being discussed.
- The quality of the discussion and debate was of an excellent standard and there was balanced participation from all disciplines.
- The style of the Forensic Consultant Psychiatrist facilitates an atmosphere in which open discussion can take place.

Areas for reflection

The Investigation Team recognise that the provision of a Forensic Liaison Service within Wolverhampton is a valuable resource although the lack of a reliable process for the tracking of Service Users they continue to review coupled with concerns raised by some health and social care staff working with Mental Health Service Users in the community, and the observations of the Investigation Team, does call for a period of reflection by the FLS regarding its current and future role and its boundaries of work and current mode of operation.

The issues that the Investigation has concerns about are detailed below:

- The lack of a robust Operational Policy against which it can audit its operation and provide performance management reports to the directorate governance group and/or the Governance Committee of the Trust.
- The lack of clearly defined boundaries regarding the role and remit for the FLS. These, as far as the Investigation is aware, or has been provided data on, have not been formally evaluated against its current activity levels since the activity audit in 1998. Even this audit did not incorporate an objective evaluation of the model of service design and delivery the FLS had embarked upon.
- The Forensic CPNs employed by Wolverhampton PCT hold a defined caseload although the Investigation Team were told that the FLS never discharges patients from 'their caseload'. [18]
- The Forensic CPNs employed by Wolverhampton PCT hold personal caseloads of approximately 35 Service Users.[19] In addition to this they provide day to day advice to their general mental health colleagues regarding the management of their forensic clients. It seems to the Investigation Team that as a result of the Forensic CPNs local advisory and support responsibilities they are often the professionals presenting cases

[18] It is the understanding of the Investigation Team that when a Service User is referred to the FLS this individual is then entered onto the FLS 'caseload'. The FLS analysis of data collected via the team's Quality Scorecard (approximately every four months) shows a current active caseload of between 56-74 Service Users.

[19] This caseload meets the recommendation contained in the DH document – Mental Health Policy Implementation Guide, Community Mental Health Teams (2003)

at the FLS on behalf of their colleagues. One can empathize with the range of reasons why this may be occurring but there is a risk that;

- critical information is not made available to the FLS because incomplete information has been provided to the Forensic CPN
- the responsible professionals perceive a degree of shared clinical responsibility which is not grounded in reality
- the Forensic CPN's themselves become vulnerable because of the unrealistic demands being placed upon them.

- It is noted that the Coordinator for the FLS has a Masters Degree in Forensic Psychiatry but the other two post holders have no substantive forensic experience. Whilst this in itself is not a particular concern providing that the development of these individuals is managed within a defined knowledge and skills framework the Investigation Team understands that there is no formal arrangement between the Mental Health Service in Wolverhampton and the Forensic Team at The Hatherton Centre that supervision is provided to all Wolverhampton employed Forensic CPN's by the Consultant Forensic Nurse providing input to the FLS. The supervision provided to the previous FLS Coordinator was on an informal basis only. The current FLS Coordinator has made separate arrangements for his clinical supervision and does not receive this from Hatherton Centre staff.

  The Investigation Team also understands that while the current FLS Coordinator provides his less experienced colleagues with clinical supervision we are not aware that there is any structured professional development programme in place for the post holders to support their acquisition of the range of skills and knowledge they require to operate effectively in this specialist nurse role. Furthermore there is no knowledge and skills framework against which the ongoing personal and professional development needs of newly appointed Forensic CPNs employed by Wolverhampton PCT can be assessed

- During its observation of a FLS meeting the Investigation Team saw opportunity for more effective management of the meetings. For example;
  - in the chairing of the meeting against the time limits allocated to each 'case discussion'
  - in the introduction of a prioritisation process where the number of 'cases referred' exceeds the time available for meaningful discussion and advice
  - in the management of refreshments

Risk Assessment and CPA Training

One of the recurring themes throughout this investigation was the number of contemporary staff the Investigation Team spoke with who said that they had not received any Risk Assessment Training, this presented a distinct difference of opinion to the messages the Investigation Team picked up from some of the management team within the mental health directorate who believed that a comprehensive range of training opportunities were available to staff.

This was of some concern to the Investigation Team given the central importance of the skills and competency in this area of a mental health professional's practice to:

- Enable appropriate risk taking to support the effective care of mental health service users in the community.
- Ensure that the safety of the service user is maximised.
- Ensure the safety of the general public and the families of service users are protected.

The constraints of this investigation did not allow for as full an exploration of the training opportunities made available to staff in Risk Assessment as the Investigation Team would have liked however we did ascertain the following:

- That considerable effort has been invested by the previous and current CPA Coordinator in the delivery of formal training covering aspects of CPA such as care planning and documentation as well a locally delivered training within individual CMHTs. The CPA Coordinator up until 2002 incorporated Risk Assessment awareness integral to her CPA workshops and also facilitated independently-run workshops on Risk Assessment, though these too were more akin to awareness raising then skills development.
- The Training Coordinator for the Mental Health Directorate prior to July 2005[20] was able to produce firm evidence of a range of training opportunities, including aspects relevant to a clinically focused risk assessment that are delivered either within the mental health directorate or jointly with Social Services. The Investigation Team understands that prior to July 2005 the training leads for mental health and social services worked in partnership and had a reciprocal approach making all training workshops available to both health and social services staff. The Trust is keen to successfully recruit into the Training Coordinator post for mental health to ensure that there is no compromise to the joint planning between Health and Social Care regarding the training and education agenda.

[20] The post of Training Coordinator is currently vacant. The Trust is currently trying to fill this vacancy following previous unsuccessful attempts to do so

- Wolverhampton PCT currently has no implemented and planned programme of skills development in the Risk Assessment of Mental Health Service Users and there is no stipulated requirement for its staff to attend identified training workshops currently provided by Social Care.
- The questionnaire issued to a small selection of staff across all three adult service CMHTs revealed;
    - that the majority of staff did not believe that they are currently provided with appropriate training to undertake a sufficiently detailed risk assessment with a Service User.
    - that between 55 and 66% of the staff who completed the questionnaire had received some training in:

        Assessment of risk in vulnerable adults
        Assessment of risk of self harm
        Carer's assessment
        Substance misuse
        Physical health issues

    An equal percentage said that they had received no training at all in:

        Child Protection
        Care and management of vulnerable adults
        Assessment of risk of harm to others
        Assessment of vulnerability in adults (including changes in social circumstances, family dynamics etc)

The training opportunities the Investigation Team were made aware of are as follows:

- 2001 four one-day Care Programme Approach Workshops targeting Health, Social Services Voluntary Agencies, Carer's and Service Users (attendance 66 persons).
- 2001 – 2002 Risk Assessment and Risk Management in Mental Health (708) (40 attendees).
- 2002-2003 three two-day workshops "Suicide Awareness Training" (714) (157 attendees).
- 2003 two, two-day workshops on CPA and Care Management.
- 2003- "Mental Health and Parenting Skills" (44 attendees).
- 2003 – 2004 "Risk Assessment in Mental Health" (717) (135 attendees).
- 2004 – 2005 Awareness raising presentation for all staff regarding the Seven-Day Contact Guideline (at time of investigation about 50 staff had attended).

- 2005 (February) Two day workshop “Working to engage” (15 attendees - to be redelivered in 2005/6).
- 2005 (April) two one-day workshops “Improving Risk Assessment and Crisis Management in MH Practice”.
- 2005 (June) “Assessing and Managing Risk”.
- 2005 (June) two-day workshop “Race and Culture in Mental Health Practice” (27 attendees).
- 2005 (July) two-day workshop “Personality disorder” (726) (11 attendees).
- 2005 (September) Working with mentally disordered offenders.
- 2005 (September) “Disassociation Workshop” (target audience = staff working with survivors of adult abuse).
- From June 2005 the mandatory induction training for all staff working in the mental health directorate included a 20-30 minute session on CPA.

The Investigation Team believes that part of the reason why there is a dislocation in the perception of grass roots staff and some management staff within the Mental Health Directorate is:

- The Mental Health Directorate has not stated what skills and knowledge development workshops identified staff groups must attend, nor the frequency with which staff must attend ‘update’ or refresher’ workshops. This has contributed to a situation where ‘interested’ staff only will attend workshops.
- There is a lack of appreciation of the limitation of the current training provided by the current CPA Coordinator given her administrative and non-clinical background (the training provided is appropriate from an administrative perspective but does not and cannot address clinical practice issues).
- Formal developmental risk assessment training was not initiated in the mental health service within Wolverhampton until 2002. (It is acknowledged that the training provided prior to this was more akin to awareness raising).
- Historically the annual training plan within the mental health directorate, whilst taking account of national requirements, was largely informed by the stated needs expressed by team and ward managers. At the time W1 was engaged with the mental health service in Wolverhampton it was not common practice generally for a formal training needs assessment that tested staffs knowledge and skills against a defined competency (or knowledge and skills) framework, to inform the content of training programmes.

The Management of Serious Untoward Incidents in the Directorate of Mental Health Services

Whilst it was not within the terms of reference for this Investigation Team to explore how serious untoward incidents (SUIs) are currently managed within the Directorate of Mental Health Services (Wolverhampton PCT) the following aspects of SUI management were of relevance to this investigation:

- The systems in place within the then mental health service for communicating with families of Service Users involved in a SUI.
- The systems in place within the then Mental Health Trust for communicating with the families of victims affected by incidents perpetrated by Mental Health Service Users.
- Wolverhampton PCT's systems and processes for communicating with the families of Service Users involved in a serious incident.
- Wolverhampton PCTs current systems and processes for communicating with the family of any victim as a result of an incident involving a Mental Health Service User.
- How lessons learnt are acted upon and shared across the Directorate of Mental Health.

At the time of the incident involving W1 information shared with the Investigation Team revealed that Senior Managers and the Critical Incident Analysis Group[21] (CIAG) membership did not perceive that there was any responsibility on the service to communicate with either the family of W1 or the family of the victim. This was due to a belief that W1 had not been under the care and management of the Mental Health service since November 2001. This appeared to be the case when the incident was first communicated to the Mental Health Service on the 5th December 2001 but it was clear to Senior Management by the 13th December 2001 that there had been a series of care and service failures that indicated that W1 should have remained under the care and surveillance of the mental health service.

The reasons why this knowledge did not culminate in the commissioning of a full investigation into W1s care and management are unclear, particularly as this service did have experience of initiating a full internal investigation following a previous SUI.

Information provided to the Investigation Team by the then Professional Head of Nursing, the Chair of the CIAG, the then Clinical Director for Adult Mental Health and the Acting Chief Executive suggests that there may have been a breakdown in communication between the CIAG and

[21] CIAG see glossary

the senior clinicians responsible for raising the profile of this incident with the Acting Chief Executive and the Chief Executive of the PCT.[22]

Other factors that appear to have affected decision making at this time were:

- The staged merger of the Mental Health Service with the PCT. This had meant that the Mental Health Service had not evolved mental health specific systems and processes in the 12 months it remained as a stand alone organisation having previously been part of the Community Trust, and prior to this a directorate within the local Acute Services NHS Trust. It appears that as a consequence of the organisational instability the Mental Health Service continued to utilise the previous policies and procedures used by the previous Community Trust which were not specifically targeted to its needs
- The fact this was the first homicide incident experienced by the Mental Health Services in Wolverhampton meant that the Senior Managers were unclear as to the processes and procedures to follow. This inexperience also contributed to the lack of appreciation, by the leaders of the Mental Health Service, of their responsibilities to the family of the victim

The Contemporary Situation

The mental health directorate now manages its incidents in line with the Wolverhampton PCT Policy for the Reporting and Investigation of Adverse Events (2004). This policy document makes clear the responsibility of the directorate management to notify the Director of Nursing of any incident scoring 15(code red) and above. The policy document also makes explicit the post-holders responsibility to ensure that such incidents are investigated using root cause analysis.

Discussions with the Directorate Risk Manager and the Chair of the Clinical Incident Action Group (CIAG)[23] gave the Investigation Team a sense that the mental health service is committed to managing and learning from its adverse events effectively and appropriately. Clear evidence was provided to the Investigation Team that the directorate engages in root cause analysis and the outputs of this are presented at the Directorate Risk Management Group (DRMG) where further actions are agreed, and/or supported.

A review of the DRMG minutes demonstrated that not only were its own significant incidents tabled but that the directorate is cognisant of

[22] at the time of this incident the process for merging the mental health service with Wolverhampton PCT had already commenced. This merger represented the fourth significant organisational change for the mental health services in Wolverhampton and it is well recognised that organisational instability does create vacuums in expected systems and processes and weaknesses in the robustness of systems and processes developed.

[23] CIAG – see glossary

significant Public Inquiries such as the ‘David Bennett Inquiry’ and the ‘Rowan Report’ and are assessing their own systems and processes against the recommendations made within these.

For Reflection

It is clear that the systems and processes for managing and escalating significant adverse events is now much more robust but there are one or two areas that the Trust and the Mental Health Directorate may wish to reflect on. These are:

- During the course of this Investigation ‘grass roots staff’ expressed a lack of confidence in the feedback mechanisms relating to adverse incidents and actions taken as a result. Not one member of staff was aware of any positive action taken by the CIAG or of receiving any feedback from it.
- The current Trust Policy does not adequately address the issue of communicating with patients, and their Carers and relatives.
- The current Trust Policy does not address how victims of incidents involving a patient/Service User of the Trust are to be communicated with, and supported.
- The current Trust Policy does not address how the relatives of victims of incidents involving a patient/Service User of the Trust are to be supported where the victim is gravely ill or has died as a result of the incident.
- The policy document whilst containing most of the technical content one would expect is not particularly user friendly.
- Section 16 of the policy document (Root Cause Analysis Investigation Protocol) whilst presenting an outline investigation framework in its current format is unlikely to enable, or support, the undertaking of root cause (or systems) analysis as described in the NPSA’s RCA e-learning tool kit.

6.0 ACTIONS TAKEN TO DATE BY THE MENTAL HEALTH SERVICE IN WOLVERHAMPTON

Following the mental health service's own internal investigation
Following its own internal investigation Wolverhampton PCT identified a range of actions that it needed to undertake. These are detailed below:

1. All Care Coordinators to sign to agree care coordination status.
2. No transfer of care should occur without a formal CPA.
3. Section 117 Service Users should not be discharged unless the team concludes/agrees.
4. When Service Users disengage from services the team should attempt to re-engage at all times
5. It is the Care Coordinators role to find a suitable Care Coordinator (N.B. this is at odds with the CMHT Operational Policy which advocates that this should be discussed at the CMHT Team Allocation and Review Meeting)
6. All information sent to the CPA Office, and Consultant Secretaries should be recorded with the Care Coordinator.
7. All internal services requested to engage with Service Users should have copies of current risk assessment paperwork and Section 117 status should be highlighted.
8. The distribution of FLS letters of advice/recommendation must be reviewed to ensure that the information is being received by the relevant groups (i.e. all those services engaged with the Service User).
9. CMHT Coordinators/ Team Leaders to supply action plan minutes for distribution.
10. CPA Coordinators only to be instructed to organise a CPA Review.
11. No client open to CPN should be kept 'open' and not seen.
12. CPA department to identify all clients and check the care coordinator of clients on Enhanced CPA (and Section 117).
13. All 'Section 117 clients or 'complex' cases should be discussed in CMHT meetings.
14. Referral to I.S.L for difficult-to-engage clients should occur as a matter or course.

During this investigation the Investigation Team were not able to ascertain how many of these actions had been completed or whether there had been any subsequent audit work to test out the effectiveness of any actions undertaken.

Additional developments that have a bearing on the robustness of the systems and processes designed to ensure that Service Users on enhanced CPA receive appropriate and timely care and management

CPA

The 'Effective Service' Meetings (weekly) now include a verbal report from the CPA Coordinator that enables current challenges/issues/problems to be raised in a timely manner. As a result of these continual updates the intention is that the Effective Services Group identifies and plans actions to address the concerns and the group determines actions.

In addition, between June 2005 and November 2005, the CPA Coordinator provided monthly reports to the General Manager/Head of Service. From November 2005 quarterly reports were to be made to the DCGG.

The Mental health Directorate has also recently commenced the piloting of electronic patient care pathways.

Risk Assessment

The Mental Health Directorate is currently working with the PCTs Head of Learning and Development to devise an internal programme of risk assessment training.

Communicating with Families following Serious Incidents

The Mental Health Directorate is currently designing an addendum to the Trust Policy for the Reporting and Investigation of Adverse Events to specifically address the management of cases of homicide and how communications with the families of all parties affected are to be effected.

Operational Management Developments

During this investigation the Mental Health Directorate confirmed the appointment of Locality Managers to further strengthen the operational management of community and in-patient services. The Investigation Team understands that the appointed individuals will have as their core responsibilities the performance management of CPA and Risk Assessment practice as well as ensuring that there is effective dissemination of lessons learnt and actions to be taken following local, corporate, and national adverse incident investigations.

7.0 RECOMMENDATIONS

In addition to the works already undertaken by the Mental Health Service in Wolverhampton the Investigation Team requests that due consideration is given to the recommendations arising from this investigation.

To support the development of robust action implementation plans and the audit of the effectiveness of actions taken, each priority recommendation is presented as a 'work stream' encompassing a number of inter-related issues.

Priority Recommendations
These represent the most important, and pressing, pieces of work the Investigation Team believes Wolverhampton PCT and its Mental Health Directorate need to consider and address to ensure and assure the robustness of the systems and processes designed to deliver a safe and effective mental health service to the population of Wolverhampton.

Secondary Recommendations
These represent additional works that the Investigation Team believes is also required by Wolverhampton PCT and its Mental Health Directorate to strengthen existing systems and processes. Whilst these recommendations are relatively easy to implement they should not take precedence over the priority recommendations.

Priority Recommendation 1:
Wolverhampton PCT needs to undertake a training needs analysis within its Mental Health Directorate targeting CPA and Risk Assessment Practice and develop a planned programme of training to address any skill and/or knowledge deficits identified

During this investigation it was highlighted to the Investigation Team that there is no current provision of practice skills development training in the areas of CPA and Risk Assessment by Wolverhampton PCT. The skills development training made available to mental health staff is via the Social Services Training Programme whose priority audience is the independent sector, the voluntary sector and Social Services. The initial Mental Health Grant that supported a shared and reciprocal approach to the delivery of Risk Assessment and CPA training across 'health' and 'social care' has come to a natural end and staff from the mental health directorate are currently invited to the workshop programmes run by social services as a goodwill gesture. The Investigation Team are aware that the Mental Health Directorate has recently begun work to devise its own internal programme of training but it is essential that the following factors are an integral component of this work if the programmes are to deliver the standard of practice required.

The Directorate Management Team for mental health in conjunction with the Trust's Training Department should:

- ❑ Devise a clearly defined knowledge and skills framework that makes clear the minimum levels of skills and knowledge required within the range of staff working within mental health. Whilst it is appreciated that there will be some generic skills and competencies that transcend the boundaries of individual specialisms a generic framework on its own will be insufficient to appropriately define a competency based framework for mental health.
- ❑ Undertake a baseline assessment of existing skills and knowledge across a percentage of its staff across all professional disciplines and care groups that it manages.
- ❑ Create a map of all the training programmes currently provided by The Trust/directorate that are intended to deliver the knowledge and skills required.
- ❑ Using the training map identify the gaps in current training and education provision.
- ❑ Determine which training workshops are a mandatory requirement for defined groups of staff within the mental health service and the frequency with which attendance at refresher workshops is required (cognisance of national expectations will be required).
- ❑ Review the workshops currently provided through social services. Where these are already providing the opportunity

for the Trust's staff to achieve the required skills and competencies consider exploring the options for sustaining the availability of these programmes for Trust staff.

The above points are believed by the Investigation Team to be the minimum requirements for action.

To enable a manageable programme of training that allows for appropriate time to be provided for the acquisition of knowledge and skills, along with appropriate discussion and debate, ie active learning, the Mental Health Directorate may wish to consider a modular style programme that would enable a package of interlinked workshops to be delivered and targeted appropriately. This approach, the Investigation Team believes, may complement the existing philosophy in the directorate regarding how training workshops are designed. Module topics might be:

- Introduction to CPA (history, what it sets out to achieve etc).
- Undertaking a full initial assessment and subsequent reviews (to include documentation issues, care planning and Service User Involvement).
- Working with Carers and the Carers' Assessment.
- Risk assessment and risk management (to include issues such as risk posed social change, risk containment plans, cultural issues, the 'difficult to engage Service User in addition to the standard aspects of 'harm to self and others').
- Legal Aspects of CPA.
- Child Protection.

In addition to the work required to devise a robust training programme the management team for the Directorate of Mental Health is encouraged to:

- Ensure that there are mechanisms in place to enable the mental health's Directorate Clinical Governance Group to receive performance reports on the numbers of staff attending core/mandatory workshops by locality as well as 'across the board'.
- Incorporate attendance at mental health specific training workshops in the performance management of the newly appointed Locality Managers.
- Consider the re-establishment of a dedicated Training Facilitator/Coordinator post.

For consideration: The current design of risk assessment tool is reasonable if the Trust moves to a more formalised and structured approach to its CPA and Risk Assessment Training although it may be worthwhile assessing how helpful the current form design is:

- To staff in guiding them through the assessment of key evidence based risk factors
- In providing good quality risk assessment information that is of value to other health and social care professionals engaged with the Service User (and his/her Carers).

Target Audience:

- Executive Director Responsible for Mental Health Services
- Chair of Wolverhampton PCTs Education and Training Board
- Chair of the Effective Services Group – Directorate of Mental Health
- Chair of the Clinical Governance Board – Wolverhampton PCT

Priority Recommendation 2:
Prior to the finalisation the Forensic Liaison Service's Revised Operational Policy (2005) Wolverhampton PCT facilitates an objective assessment of how the current model for the provision of the Forensic Liaison Service is working and its terms of reference. Such an assessment should include an assessment of the capacity of the FLS against the demands currently placed upon it.

While it is quite clear to the Investigation Team that the provision of a Forensic Liaison Service is greatly valued by staff working within general adult mental health services the incident involving W1, and the observations of the Investigation Team, highlight the need for an objective evaluation of how this service currently functions and how it can be best provided in the future to maximise accessibility and to preserve the boundaries of its advisory function. As this service currently operates there is a real risk that another Service User, such as W1, could fall by the wayside within this service. This is a situation that cannot continue.

The Investigation Team strongly suggest that the following issues are incorporated into any objective analysis of the current provision of this service:

- ❑ The appropriateness of discussing Service Users, and their ongoing management, who have not either
  - been actively been referred on a 'meeting by meeting' basis by the Care Coordinator for the Service User or the Service Users Consultant Psychiatrist;
  - or where there is the absence of a clearly recorded decision between the FLS and the /Responsible Consultant that there is merit in re-presenting the Service User's case on a pre-agreed date.

  The overriding principle here is that the FLS holds no clinical accountability or responsibility for the case management of Service Users they discuss and are not in full possession of the Service User's history or current circumstance.
- ❑ The appropriateness of accepting a referral 'for advice' without any formalised process for receiving pre-meeting information that provides core background information about the Service User including;
  - diagnosis
  - outline history of contact with the mental health services
  - key forensic history
  - current concerns
  - other services with which the Service User is engaged and their full contact details.

  The availability of core information may significantly enhance the efficiency of the FLS meetings and enable maximum benefit to be realised from the restricted time available for their advisory function. The original policy documents setting out

how referrals were to be made set out its expectations quite clearly and then negated this by stating that circumvention of the formal process was acceptable.

- ❑ The appropriateness of discussing the management of Service Users without their Care Coordinator or Consultant Psychiatrist being present at the meeting. At the very least one would expect a set of auditable ground rules detailing the circumstances in which the FLS can consider and give advice on Service User management if those who are most knowledgeable about the Service User are not present at the meeting.
- ❑ The appropriateness of effectively creating a pseudo caseload out of Service Users for whom the Forensic Liaison Service carries no clinical accountability or responsibility.
- ❑ Whether the concept of 'non-discharge' of Service Users from the FLS is commensurate with a liaison service.
- ❑ Patient W1 did not represent the usual type of patient that required forensic liaison in-put. In light of the reported high 'caseload' of this service (approximately 56-74) the FLS might consider developing a screening tool to assist systematic assessment of the appropriateness of referrals to the FLS, and their subsequent prioritisation.

In addition to the above there would be merit in reassessing the current roles, responsibilities, and supervision, of the Forensic CPNs attached to each sector CMHT. These staff are seen as specialists in the eyes of their general mental health colleagues however whilst the current FLS Coordinator is very experienced, and has a higher degree in Forensic Psychiatry, none of the other current post holders have substantive experience of working in forensic psychiatry or relevant qualifications for the post.

The Investigation Team therefore recommends that the following suggestions are given appropriate consideration:

- ❑ The provision of management supervision for the Wolverhampton Forensic CPN's is revisited. In undertaking this consideration needs to be given to
  - how the Forensic CPNs for the South West and North CMHTs are currently receiving Management Supervision and whether this is being provided by someone who can appropriately assess and analyse on the appropriateness of their case load management;
  - the frequency with which all Forensic CPNs are receiving clinical supervision;
  - whether there should be individual timetabled reviews by the Consultant Forensic Nurse and the Forensic Consultant Psychiatrist from The Hatherton Centre where

each of the Forensic CPNs go through their caseload and management plans with the specialists in this field;

- whether the current FLS Coordinator has the capacity to hold a full caseload, provide additional specialist advice and support to his allocated CMHT, coordinate the FLS (including the post meeting correspondence) and provide the necessary supervision and educational opportunities to the Forensic CPNs who report to him.

- ❑ That there is a clearly defined skills and knowledge competency based framework developed for the Forensic CPNs in consultation with the forensic service in Staffordshire.
- ❑ That clear provision is made for the professional development of the Wolverhampton Forensic CPNs within the training budget for the mental health directorate. These nurses are acting in a specialist capacity and it is therefore necessary that they are appropriately facilitated in developing their specialist skills.
- ❑ consideration is given to supporting the Forensic CPNs working on periodic 'time limited' secondments within the forensic service in Stafford as a means of enhancing their forensic experience.

Target Audience:

- ❑ Chief Executive Wolverhampton PCT
- ❑ Executive Director responsible for Mental Health Services
- ❑ Chair of the Directorate of Mental Health Clinical Governance Board
- ❑ Lead Forensic CPN and FLS Coordinator
- ❑ Lead Consultant and Consultant Nurse FLS

Priority Recommendation 3:
Review and Management of Service Users on Enhanced CPA who do not attend for their Out Patient Appointment

The management team for the mental health directorate believes that this issue has been addressed following its own internal investigation in 2002, but this investigation has highlighted a lack of systematic approach to addressing instances where Service Users on Enhanced CPA do not attend for their out patient appointment. Whilst the Investigation Team appreciates that the implementation of a foolproof system may not be achievable the implementation of a common and auditable approach across the Adult Service CMHTs is.

The Investigation Team therefore recommends that:

- The accountability and responsibility for identifying those 'DNA' Service Users for discussion at the next team allocation and review meeting is clarified and made explicit within the respective operational policies.
- That the notes for those Service Users brought for discussion are available where possible at the team allocation and review meeting so that decisions made can be recorded directly into the case notes.
- That there is a designated agenda item for the discussion of DNA's that is either separate to, or a distinctly identifiable component of, discussions around 'cases of concern'.

The Investigation Team would also encourage the mental health directorate to consider an audit, or analysis, as a defined governance project, of how DNA episodes at Out Patients are currently managed across all of its services.

Target Audience:

- Directorate of Mental Health Service Effective Services Group and Clinical Governance Board
- Directorate of Mental Health Service Locality Managers

7.1 SECONDARY RECOMMENDATIONS:

In addition to its principal recommendations the InvestigationTeam encourages the management team for Adult Mental Health Services in Wolverhampton to reflect on and consider the following as measures that may enhance the robustness of existing clinical quality and safety systems.

1. That the audit of CPA practice incorporates periodic audits of the data entered into Care Notes by the CPA Facilitators for accuracy. This will probably be best accommodated as a component of peer review audit and of necessity will need to involve the Care Coordinators who made the original documentation of the electronic records included in such an audit.

2. Clear guidelines need to be developed to guide written communications with a Service Users General Practioner by Medical Staff in particular. In discussing such guidelines consideration might be given to the following:
    - Clarity of diagnosis, and if this is not certain that this is openly communicated with the 'working diagnosis'.
    - Instructions regarding the monitoring of medication.
    - Criteria for re-referral if a patient is either being discharged or there is to a significant reduction in the Out Patient follow up by the mental health service.
    - If a Service User is being discharged an outline of why this is considered appropriate.
    - Any specific expectation of Primary Care.

3. That the omissions in the Trust's current CPA Policy document are remedied. The current CPA policy document provided to the Investigation Team:
    - Does not make clear the role and responsibility of the Executive Director with Lead responsible for the implementation of the CPA policy.
    - Makes no reference to Multi Agency Public Protection Panel (MAPPA) or its equivalent.
    - There is no reference to the transfer of patients on CPA outside of the Trust boundaries (i.e. If a patient moves to the next 'shire' or another part of the country) and the procedure that should be in place (the Investigation Team were provided with a Sector Transfer Protocol for Adult CMHTs though this is an undated and unreferenced document with no date for revision or review).
    - There is no reference to training for staff and specifically no reference to the provision of risk assessment training for clinical staff at least every three years.

- ❑ Requirement 12 of the Laming Report has not been incorporated into the policy document.
- ❑ There is no cross reference to transfer arrangements between Child and Adolescent Services and Adult Mental Health Services or Addiction Services and Adult Services. All such transfers represent periods when Mental Health Service Users can 'become lost' to the service.[24]

4. The Operational Policy for CMHTs is revised to include:
   - ❑ Clear guidance on the optimal caseload size for the individual disciplines, and specialist post-holders within each CMHT.[25]
   - ❑ Clarity about the expectations of CMHT Team Leaders.
   - ❑ The requirement of active case file audit as an integral component of management supervision.
   - ❑ A greater level of detail about transfer of care arrangements. At the very least appropriate cross referencing to the CPA Policy where this detail may be better placed as it follows the care pathway of the Service User.
   - ❑ Greater clarity in what is expected with regard to the training and development CMHT staff are expected to avail themselves. For example Clinically Focused Risk Assessment Training at least once every three years (note: once the directorate has agreed what its core training requirements are of its staff this will be easy to address).
   - ❑ The effective management of a CMHT should rely on a collaborative working partnership between the CMHT Manager and the Consultant Psychiatrists.[26] At present the operational policy does not make explicit the role and responsibility of the Consultant Psychiatrist. For example their role in
     - the clinical leadership of the CMHT;

[24] The Mental Health Directorate has not finalised its guidance to staff on the transfer of Service Users between Learning Disabilities and Adult Mental Health Services. The Senior Management for Adult Mental Health assured the Investigation Team that this was currently being addressed.

[25] Although the Mental Health Directorate has a Caseload Activity Policy (Community And Specialist Teams) that refers to the national guidance on individual case load size in CMHT's (page 13) it does not address the issue in the depth one would expect within a CMHT Operational policy.

[26] Whilst an effective CMHT is reliant on the working relationships and communications of all team members the Consultant Psychiatrist as a senior clinician has leadership responsibilities that should be clearly defined. In looking at this issue the Mental Health Directorate is encouraged to think more broadly about how clearly the roles and responsibility of other key team members is defined, for example the lead CPN or 'G' grade.

- active involvement in prioritising the clinical resources deployed by team;
- jointly ensuring, with the team coordinator/leader effective assessment, planning, delivery of care and clinical governance within the team.

5. That the CIAG and Directorate Risk Management Group consider developing a quarterly risk management bulletin where anonymised summaries of incidents, pertinent reflection and learning points and actions taken can be shared with all staff.

6. That the DCGG undertakes an audit of the action points recommended by CIAG to the DRMG following the services internal investigation into the incident involving W1 to determine any that are outstanding, and any that should be incorporated into existing rolling audit programmes.

7. That any revision of the Trust for the Policy for the Reporting and Investigation of Adverse Incidents is cognisant of the NPSA's Safer Practice Notice 10[27] and the NPSA's Patient Briefing – Being Open Saying Sorry When Things Go Wrong. In addition to these documents it is essential that the Trust develop a clear communication strategy so that the families of victims as well as the families of Service Users are appropriately communicated with. It is recommended that consideration is given to developing this on a multi-agency basis working in partnership with
   - ❑ the local police force;
   - ❑ the local coroner and the coroner's officers;
   - ❑ local statutory and non-statutory victim and mental health support groups.

8. The development of guidelines for the prescribing of and monitoring of Lithium. Consideration should be given to
   - ❑ setting out plainly where the principal responsibility lies for the monitoring of Service User's on Lithium;
   - ❑ making it explicit that Consultant Psychiatrists must retain responsibility for determining what action is to be taken if there is a serum lithium level outside of the agreed target range with the local biochemistry service.

[27] Being Open When Patient's are Harmed, NPSA 15 September 2005

8. CONCLUSION

The analysis of W1's care and management during this investigation revealed that W1's care and management fell short of the standards one would have expected between the end of September 2001 and 27 November 2002.

With respect to the specific terms of reference for this investigation:

- W1's care and management did not comply with the then statutory obligations with regards to the Care Programme Approach or local operational policy guidance in place at the time.
- Up until July 2001 there was a reasonable assessment of W1's risk factors undertaken between his then Care Coordinator and the Forensic Liaison Service. After this date factors that might indicate an increase in W1's risk status were identified in FLS documents but were not communicated to all relevant personnel.
- The quality of communication by W1's Consultant Psychiatrist with W1's GP surgery in November 2001 was insufficient to enable these professionals to have a clear picture of triggers for re-referral or for the appropriate monitoring of medications and what actions to take if problems were identified. Furthermore the correspondence did not make explicit that W1's Consultant Psychiatrist was retaining clinical responsibility for W1.
- The system for identifying and discussing those Service Users who had failed to attend for an Out-Patient appointment was overly reliant on individuals, most notably nursing staff, to gather the DNA records at the end of a clinic and bring them to the next CMHT meeting. In November 2001 it was not standardised practice for the medical staff to proactively table these Service Users for team discussion. Nevertheless W1 was on Enhanced CPA and at the very least his Consultant should have copied his correspondence of the 26th November to his Care Coordinator at the time. Such action may have enabled the Team Leader of the Day Service to identify at a much earlier stage that she had been nominated as his new Care Coordinator and for the appropriateness of this to have been reconsidered prior to W1's disengagement from Horizon House in February 2002.
- The system for identifying and discussing, at the next CMHT meeting, those Service Users who had failed to attend for an Out-Patient appointment was overly reliant on individuals, most notably nursing staff, to check the clinic records, or to gather DNA records at the end of a clinic. It was not standardised practice for the medical staff to proactively raise these Service Users for team discussion.

- The monitoring of W1's Lithium levels was undertaken at appropriate intervals between 2001 and 2002.
- Whilst the local investigation undertaken by the CIAG on the 13th December 2002 identified a good number of issues that this investigation has re-highlighted the subsequent escalation of concern did not result in the level of internal investigation one would expect following an incident of such severity.

In spite of the short comings in W1's care and management, in the 14 months preceding the manslaughter of his elderly neighbour, one cannot say with any certainty that this incident was either foreseeable or preventable. Following W1's arrest and prior to his sentencing "there has always been some uncertainty (due to lack of evidence) about whether or not the abnormality of mind experienced by W1 at the time of the index offence was sufficient to substantially impair his responsibility for his actions"[28]. The evidence provided by W1 to the West Midlands Police and the manner in which he disposed of the clothing[29] he wore at the time of the index offence was not typical of someone suffering an acute episode of mania. However, had W1 received appropriate care and management from the mental health service in the 10 months leading up to the incident the mental health service would have had the opportunity to identify any change in his presentation, or social circumstance, that increased the risk factors to himself or to other persons. Whilst there are no guarantees that contact with W1 over this period would have revealed any behaviour suggestive of an increase in his risk factors the fact that he was not seen leaves this open to question.

With respect to the contemporary situation in Wolverhampton it is clear that considerable changes and developments have taken place that make it a remote possibility that the sequence of events that transpired to allow the mental health service in Wolverhampton to lose sight of W1 to occur again. Nevertheless this report clearly identifies that additional measures are required to further improve the systems and processes aimed at providing a safe and effective mental health service.

The Wolverhampton PCT Trust Board and the Management Team for the Directorate of Mental Health Services are therefore asked to give the recommendations in this report their most careful consideration.

[28] Extract from correspondence to the Crown Prosecution Service (1 April 2004) from a Consultant Forensic Psychiatrist (Dr SDV).

[29] W1 scattered the clothing he wore at the time of the incident in various locations in Wolverhampton. He was able to take the police back to most of these locations to retrieve the clothing for forensic examination following his arrest.

APPENDIX 1

OUTLINE CHRONOLOGY OF W1'S CONTACTS WITH THE MENTAL HEALTH SERVICES PROVIDED BY WOLVERHAMPTON PCT

Historical Background

Date	Event
Feb 1991	W1 first came into contact with the psychiatric services following disorderly and inappropriate behaviour. His behaviour at this time was elated and disinhibited. An initial diagnosis of acute psychotic state was made and there was no evidence of drug or alcohol misuse. His actions resulted in an admission to an acute mental health unit. Two days after his admission to hospital W1 took his own discharge but was subsequently arrested when he was found creating a disturbance in a local shopping centre. At this time he was re-admitted under Section 2 of the Mental Health Act. The range of medications used to control W1's manic and aggressive outbursts were Chlorpromazine 200mg three times a day and Haloperidol 20mg six hourly, Procyclidine 10mg three times per day, Sulpiride 200mg twice a day, Zuclopenthixol Decamoate 200mg once a day. The old style medication charts make it difficult to ascertain when the range of medications were commenced and/or changed. However what is apparent from the historical records is that these medications were noted to be ineffective during this period. Prior to these incidents W1 was considered to have a 'good and quiet nature'.
Apr 1991	W1 was remanded in Winson Green Prison for wrecking a local A&E department. Soon after being taken into custody (on the 15th April 1991) W1 was admitted to the West Midlands Poisons Unit at Dudley Road Hospital with Malignant Neuroleptic Syndrome. His most likely diagnosis at this time was Acute Mania. This was confirmed by the then Consultant Neuro-Psychiatrist. Following a slow recovery W1 was discharged from the poisons unit on the 23rd June 2001. He was not on any medication at this time. Arrangements were apparently made for psychiatric follow-up in Wolverhampton. Subsequent correspondence with W1 from the psychiatric services indicated that W1 did not engage with the psychiatric service at any time following his discharge from the poisons unit until April 2000.

July 1991 – May 1992	W1 attends his GP surgery with “anxiety state” and continues to attend his GP surgery on a weekly basis between through out this period

Summary of W1’s contact with Mental Health Services April 2000 – November 2002

Date	Event
9 Apr 2000	W1 was arrested following an aggressive and violent outburst at a local grocery shop. On this occasion W1 assaulted the shopkeeper, and threw shop merchandise around the shop when the shopkeeper would not give him the money he demanded. Following his arrest W1 head butted a police officer while enroute to the police station. Following assessment by a Consultant Psychiatrist and Approved Social Worker W1 was detained under Section 2 of the Mental Health Act and admitted to the Psychiatric Intensive Care Unit at Wolverhampton Health Care NHS Trust on the 10th April 2000 under Section 2 of the Mental Health Act.

Date	Event
10 – 22 Apr 2000	While initially appearing calm, W1's behaviour escalated. This manifested itself in the throwing about of furniture and singling out persons he seemed to believe were particularly vulnerable. At this time W1 exhibited his focus on litigation claims he was pursuing against the health authority (this was in spite of having a successful claim regarding his NMS). *This fixation was to be a perpetual feature for W1 and remains so today.* **Treatment:** There was no medication chart in W1's records for April 2000 although it appears from medical correspondence that W1 was initially commenced on Clonazepam and Diazepam. On the 13th April he was started on 800mg of Lithium which was subsequently increased to 1000mg on the 19th April in view of his difficult to manage behaviours. On the 13th April, W1 was assessed by the forensic team from Hatherton House in Staffordshire for his suitability for transfer for care there. Initially the Forensic Service believed that W1 could be managed within the ICU environment, however in view of his unpredictable and violent behaviours he was subsequently accepted for admission to The Hatherton Centre and was transferred into their care on the 22nd April.

22 April – 23 June 2000 W1 was resident at The Hatherton Centre, Staffordshire.

23 June – 22 August 2000 In-Patient Management ICU and B8 New Cross Hospital

Date	Event
23 Jun 2000	W1 was transferred back to the Psychiatric Intensive Care Unit at Wolverhampton Health Care NHS Trust. Shortly after his transfer back to ICU, W1 was moved onto Ward B7 an acute in-patient ward in view of his more settled behaviours. He was generally noted to be more sociable, having improved sleep, and more settled in mood.
24 Jun 2000	W1 commenced on his first episode of Section 117 escorted leave.
25 Jun 2000	W1 is provided with six hours unescorted leave.

Date	Event
26 Jun – 15 Aug 2000	During this period W1's Section 117 leave periods are gradually increased culminating with a week's leave being supported on the 15 August. Over this seven week period W1's behaviour is appropriate; he uses his Section 117 leave appropriately. The only issue of concern, expressed by W1 himself, is whether he could cope living alone. His mother is reported as agreeing that he can stay with her.
22 Aug 2000	W1 returns from his leave for his pre-discharge CPA. At this meeting a decision is made for W1 to be discharged from his Section 3 of the Mental Health Act. The risk assessment undertaken highlights that he will require regular monitoring to minimise the risk of his non-participation with services a 'major factor' in his risk. His appointed 'Care Coordinator' is present at the meeting and the Forensic CPN for SE-CMHT agrees to provide support to this individual regarding any forensic issues that may arise. At the time of discharge the plan is for W1 to move in with his mother for a period of three weeks until his flat is ready.

23 August 2000 – 27 November 2002 Community Care Management

Date	Event
1 Sept 2000	Attempted visit to W1's residence by Care Coordinator.
5 Sept 2000	Home visit to meet with W1 by Care Coordinator and a Social Worker. On this occasion W1 is at home with his daughter. He informs his Care Coordinator that he has stopped taking his medication. He also advises that he is tense because of his ongoing allegations against the health authority. W1 informs his Care Coordinator that he does not want to go to his flat but to stay with his mother instead. **Action:** W1's Care Coordinator arranges an out patient appointment for W1 with his Consultant for the 8th September where it is agreed that W1 can stop his medication.
20 Sept 2000	Home visit to W1 by Care Coordinator and Social Worker. No response. Note left advising that the Care Coordinator and a colleague would visit the following week.

23 August 2000 – 27 November 2002 Community Care Management

Date	Event
27 Sept 2000	Home visit again attempted. W1 is not in, but a family relative advised that he is well and agrees to give W1's mother the Care Coordinator's contact details. **Action:** The Care Coordinator plans to discuss W1's on going management in the CMHT Team Allocation and Review Meeting the following day. This results in formal correspondence with W1's mother and a plan to monitor whether he attends 'an appointment' on the 4 October.
16 Oct 2000	W1 attends for an out patient appointment. It is noted that W1 was arrested the previous week on the 10th October for assaulting his previous partner. The SHO correspondence to W1's GP clearly indicates a return of his symptoms of anxiety, lack of motivation, nightmares, broken sleep, talking to himself. A plan is made to reassess him in three months time in the out patient clinic and to continue with contact. On this same day W1 is visited by his Care Coordinator and a Social Worker.
19 Oct 2000	W1's Care Coordinator seeks the support and advice of the Forensic Liaison Service. It is noted that W1 appeared in court on the 13th October and is to re-attend on the 7th November. A decision is made that W1 will be followed up by the Court Liaison Nurse with respect to this.
20 Oct 2000	A home visit is made to W1 by his Care Coordinator and Social Worker. W1's presentation is similar to that on the 16th October. The plan at this time is to continue to monitor W1 and to discuss his case management with the Forensic Liaison Service (FLS) Coordinator.
23 Oct 2000	W1's management discussed with FLS Coordinator. The plan is to continue with regular monitoring by the CMHT.
26 Oct 2000	Home visit cancelled because there were no team members available to accompany the Care Coordinator. The clinical records note that a conversation with W1 on the phone revealed that he was relatively stable.

Date	Event
30 Oct 2000	W1's Care Coordinator visits him at home accompanied by a colleague. W1's mother is present and advises that she is happy for W1 to live with her. W1 is asked to attend for his Lithium Monitoring (it is approximately two months since his levels were last monitored). W1 is noted to remain preoccupied with past events rather than focusing on the present.
7 Nov 2000	W1's Care Coordinator is advised by the Probation Office that W1 has been given until April 2001 to make improvements in managing himself. There is to be no probation followup and no treatment order is made.
15 Nov 2000	Home visit by Care Coordinator and Colleague. W1 is noted in the records to be tense and agitated. The content of his discussion with the mental health professionals remains focused on his allegations against the health authority. W1 is attributing his current problems to his episode of neuro-malignant syndrome. For the remainder of November, through to mid-December W1's situation remains constant with regular home visits.
19 Dec 2000	Home visit by Care Coordinator and colleague. It transpires that W1 has not been attending at the Day Centre. He continues to remain fixated with the topic of his complaint. The plan at this stage is to discuss W1 with his Consultant Psychiatrist and again with the Forensic Liaison Service.
22 Dec 2000	W1 is discussed with his Consultant Psychiatrist and an urgent out patient appointment is offered for the 4 January 2001.
5 January 2001	The clinical records show that W1 was discussed at the Forensic Liaison Scheme on the 4th January and again at the CMHT Team Meeting on the 5th January. W1 did not attend his out patient's appointment on the 4th January and his Care Coordinator is concerned that he is planning to go the Philippines (*this is where his mother's family is from)*. The FLS advise communication with the Probation Office to establish exactly whether there is a probation order in existence and the nature of this. (This occurs on the 8th January). It is agreed that the position with W1 will be reviewed at the next FLS meeting on the 11th January.

Date	Event
9 Jan 2001	Home Visit: W1 told his Care Coordinator that he was 'OK'. His speech was normal and he appeared to be satisfied with his case against the health authority. However he did advise that he was going back to court with a case against his solicitor regarding a 'loss of earnings claim'. W1 confirmed that he still intended to go to the Philippines on the 2nd February.
22 Jan 2001	Home Visit: W1 reports spending much more time with his children and partner and that when he returns from the Philippines he may live with them. W1 also talks about working, and feels that this is the only way forward. His Care Coordinator suggests that this may not be an opportune time to commence work in view of his stress levels. W1 accepts the caution but doesn't see that 'coping strategies' will alleviate this. His Care Coordinator therefore suggests a referral to Vocational Rehabilitation at Horizon House.
20 Feb 2001	W1 is sent an appointment letter for vocational rehabilitation.
26 Feb 2001	Home Visit: Thoughts of compensation continue to dominate. W1 tells his Care Coordinator that the only help he wants is to progress his litigation case. His Care Coordinator and the CPN accompanying her tell W1 that the mental health professionals can only assist with his mental health needs and not his litigation case. He is encouraged to engage with services.
27 Feb 2001	W1's partner contacts the CMHT to inform them that W1 had come close to losing his temper two days earlier over a phone call. The Forensic CPN is advised and the CPN informed that an out patients appointment has been made for W1 to be seen on 1st March.
1 Mar 2001	W1 attends his out patient's appointment. At this time he is noted to be symptomatically better though agitation about past events remains an issue. W1 remains on Lithium 1000g and Clonazepam 0.5mg at night. The medical records note: "mood agitated, appropriate affect, low confidence, low self esteem". The plan is to continue on the same medication with the GP checking on W1's Lithium Levels.

Date	Event
22 Mar2001	W1 is again reviewed within a Forensic Liaison Scheme meeting, the records note: ❑ If W1 will not engage at Wrekin House then the FLS will continue to monitor him. ❑ W1 remains obsessed with court cases and litigation. ❑ W1's mood is stable. ❑ W1 assaulted his girlfriend since he was discharged from hospital. ❑ W1 is noted to be good with his children and his interactions are appropriate. ❑ The risk of W1 re-assaulting his girlfriend remains. ❑ To be reviewed again on the 7th June. A few days later (26 March) the Consultant Psychiatrist for the Forensic Liaison Service advises close monitoring of W1's mood, as signs of mood lifting would be an indicator of mental health deterioration.
26 Mar – 24 May 2001	The situation remains constant with W1. He continues to receive regular follow-up by the CMHT, there is nothing remarkable to note.
24 May 2001	W1 presents at his out patient appointment with atypical and inconsistent facial tingling. W1 attributes this to medication he was given in 1991. The SHO finds W1 to be quite well, notes that W1 is off all his medications and that his sleep pattern is reportedly normal. W1 reports an 'agitated problem at the Post Office', but no details of this are recorded. The SHO notes that W1 is to be reviewed in a further three months time.
30 May 2001	Home Visit: Care Coordinator and colleague (social worker) – nothing of note is recorded in the clinical records.
6 June 2001	W1 sends an abusive letter to one of the CPNs at SE-CMHT. W1 wants to bring a complaint against this individual, and also his Care Coordinator. W1's correspondence is responded to appropriately.

Date	Event
28 Jun 2001	FLS Meeting: The plan after this meeting is to continue with monthly monitoring of W1. The main focus of observation is for any change in his mood. It is noted that W1 will not engage in any therapy and continues to focus on his belief that he was unfairly treated by the NHS in the past. Both W1's Care Coordinator and her colleagues report W1 to be stable at this time. It is also noted that W1 living with his mother is a good thing as it is felt that the risk of him attacking others is reduced if he is not living in a volatile relationship with his partner. The next FLS review meeting re W1 is agreed for 27 September.
10 July 2001	Home Visit: W1 advises his Care Coordinator and her colleague that his mother has stopped working owing to liver problems though he does not fully understand what is wrong with her. The plan at this time is for W1 to visit Horizon House to explore vocational rehabilitation opportunities.
25 July 2001	W1 attends at Horizon House. It is noted that he has taken good care over his appearance. He agrees to attend Horizon House twice a week, though he does not think it will help.
23 Aug 2001	W1 attends his out patient appointment. W1 reports feeling calmer but remains restless at times. His sleep and diet is reported as OK. W1 does complain of numbness in his lower limbs, and he is concerned about his Disability Allowance Living Form, and that he has not received any forms to have his Lithium Monitored since August 2000. The SHO re-requests these from W1's GP. W1's Care Coordinator informs him that she will be leaving the Trust and that they will need to have a CPA Review.
4 Sept 2001	There is a note in W1's records showing that he had a telephone conversation with his Care Coordinator over his housing arrears (this particular record did not seem to follow in sequence with W1's records and the Investigation Team did question whether they belonged to another Service User), There is nothing in the Care Coordinators' contact sheet' to suggest that she had any dealings with W1 on this day.

Date	Event
17 Sept 2001	W1 attends his GP surgery to have his blood taken for Lithium Monitoring.
28 Sept 2001	FLS meeting: The FLS Team was informed by W1's Care Coordinator that he continues attending Vocational Rehabilitation at Horizon House. She also advised that she was leaving the Trust and would be handing over responsibility to a colleague at Horizon House. The Care Coordinator told the FLS Team that she had concerns regarding Horizon House as to whether they fully recognised the risk and difficulties with W1. The plan at this time was recorded as: ❑ If W1 stops attending Horizon House the CMHT must be informed. ❑ To monitor for signs of relapse. ❑ To clarify the date for the next CPA. ❑ For FLS review 4 October.

Between 28 September 2001 and the 21 November 2001 there are no records regarding W1 made by the FLS or the CMHT

Date	Event
22 Nov 2001	W1 does not attend at his out patient's appointment. His Consultant Psychiatrist does not offer a further appointment but writes to W1's GP advising that he is happy to see W1 at any time in the future if the GP is concerned. The correspondence to the GP constitutes approximately four lines of text and is woefully insufficient.
6 Feb 2002	W1 has been attending his vocational rehabilitation programme at Horizon House on a regular basis since the 8th August 2001.
13 Feb – 16 Aug 2002	W1 does not attend vocational rehabilitation at all during this period. The records show a limited number of attempts were made to contact him by phone and the Team Leader for Horizon House writes to W1 in June 2002 requesting that he get in contact if he wishes to continue with the programme.

Date	Event
About the 13 Oct 2002	The Team Leader at Horizon House receives a CPA reminder form advising that W1 is overdue a CPA review. This is also followed up by a telephone call from the CPA Coordinator. The Team Leader for Horizon House advises the CPA Coordinator on the 17th October that she was not aware of being asked to act as W1's Care Coordinator and in view of his non-attendance at Horizon House since February she feels unable to do so. On the 17th October the Team Leader also writes to W1's Consultant Psychiatrist to advise him that W1 was being discharged from vocational rehabilitation due to his persistent non-attendance.
6 Nov 2002	W1 attends the A&E department at New Cross Hospital. His Lithium Levels have been reported at toxic levels at 1.72 following the taking of bloods at his GP surgery. W1 attends A&E at New Cross Hospital to have these levels reassessed. The A&E bloods show a reduction in his Lithium Levels to 1.14. The clinical impression is that W1's initial Lithium Level was a false high reading as a result of the bloods being taken too soon after the ingestion of Lithium. W1 is advised to stop his Lithium for one day, to increase his fluids and to contact his GP.
26 Nov 2002	W1 is seen at his GP surgery when he comes to collect his MED3 certificate. (The MED3 form has to be signed by a doctor and the Service User has to have been seen by the doctor).
27 Nov 2002	W1 attacks and kills his elderly neighbour.

Note 1: While there was no contact between W1 and the specialist mental health services between 6 February 2002 and the date of the incident, W1 was seen regularly at his GP surgery on at least a monthly basis, excepting the months of April, May and June. There is nothing in the GP records to suggest any instability in W1's mental health state. The GP record on the 7th October states that W1 is 'calm and reasonable' and that he was taking his medication. Other than this there is nothing of particular note about the state of W1's mental health until the request for specialist mental health services to again take over the monitoring of him.

Note 2: In the period of W1's non-attendance at Horizon House (vocational rehabilitation) he was seen 'in town' by a number of staff working in this service. They have reported that he appeared well and that he came to say hello to them. They saw nothing in his behaviour to suggest that he was relapsing.

APPENDIX 2

SOURCES OF INFORMATION ACCESSED

To underpin the findings and recommendations of this investigation there were five main sources of information:

- The information shared by people at interview.
- Attendance at two CMHT Team Allocation and Review Meetings.
- Attendance at a Forensic Liaison Service Review Meeting.
- Information gathered via questionnaire.
- Information gleaned from a broad and detailed document review.

The initial review of clinical, police and court records was undertaken prior to the interviews and group meetings so that the Investigation Team could be quite clear regarding the range of issues to be explored on an individual or group basis at interview.

The following tables detail the full range of personnel interviewed and documents accessed and utilised during the course of the investigation:

Table 1: Staff currently employed by Wolverhampton PCT

Designation	Interviewed By	Date Interviewed (all in 2005)
Team Leader SW CMHT	Maria Dineen and Justin O'Brien	12 Sept
Team Leader SE CMHT 2001 and 2002		14 Sept
Team Leader Day Services Horizon House 2001 and 2002		
Acting Team Leader Brooklands Day Centre 2004		
Forensic CPN SE CMHT		
Professional Head of Nursing (Mental Health Directorate)		
Chair CIAG and Consultant Psychiatrist Older Peoples Services		19 Sept
Team Leader SE CMHT		
Occupational Therapist SE CMHT 2001 and W1's Care Coordinator		
Chief Executive		20 Sept
Customer Services Manager		
Social Services SE CMHT		
Risk Manager Mental Health Directorate (also Training Coordinator in 2001 and 2002)		
(Joint) Head of Health and Social Care Mental Health Services		
Consultant Psychiatrist SE CMHT and Clinical Director Adult Services		27 Sept
Consultant Psychiatrist to W1 up to August 2002		
Risk Manager Mental Health Directorate (also Training Coordinator in 2001 and 2002)	Maria Dineen and Justin O'Brien	5 Oct
Directorate Manager – Mental Health Services		
CPA Coordinator 1996 – 2002		
CPA Coordinator 2002 – date		
CPA Facilitator's (x4)		

Table 2 Staff either not, or no longer, employed by Wolverhampton PCT

Designation	Interviewed By	Date Interviewed (all in 2005)
Consultant Psychiatrist Forensic Services, Staffordshire Mental Health Services	Maria Dineen and Justin O'Brien	15 Sept
Nurse Consultant Forensic Services Staffordshire Mental Health Services		
CPN SE CMHT (retired)		20 Sept
Clinical Director Adult Mental Health Services 2001 and 2002	Maria Dineen and Dr Paul Courtney	26 Sept
Consultant Psychiatrist to W1 up to August 2002		27 Sept

Table 3 Telephone Interviews, Meetings, and Email

Designation	Interviewed By	Date of conversations (all in 2005)
General Manager and then Acting Chief Executive, Wolverhampton Mental Health Services 2001 and 2002	Maria Dineen	25 Sept
CPN SE CMHT Wolverhampton PCT		4 Nov
Risk Manager, Wolverhampton PCT		19 Nov
Clinical Governance Manager, Wolverhampton PCT		20 Nov
Consultant Nurse, South Staffordshire Mental Health Services (The Hatherton Centre)		29 Nov 6 Dec
Staff Development Officer, Social Services Wolverhampton		1 Dec
Head of Learning and Development, Wolverhampton PCT		6 Dec
(Joint) Head of Health and Social Care, Mental Health Services		Throughout November and December

Table 4 Team Meetings

Meeting	Attended By	Date (all in 2005)
SW Team Allocation and Review Meeting	Maria Dineen and Justin O'Brien	12 Sept
Forensic Liaison Scheme		15 Sept
SE Team Allocation and Review Meeting		19 Sept

PAPER RECORDS:
The following documents were reviewed and/or referred to:
Clinical Records:

- All medical and nursing records created by Wolverhampton Healthcare NHS Trust, 1991 – November 2002.
- GP records relating to W1.
- Forensic Records, April 2000 through to January 2005, relating to W1 held by The Foundation NHS Trust.
- Forensic Liaison Service Correspondence, April 2000 – September 2001.

Policies and Procedures:

- Operational Policy for Community Mental Health teams Review date June 2005.
- Wolverhampton Mental Health Services (Health & Social Services) Effective Care Coordination Policy
  Two documents were reviewed:
  [1] Initiated: May 2004 Review date: January 2004
  and
  [2] Initiated: January 2005 Review date: January 2006
- Effective care coordination policy Towards integrated CPA/CM May 2002, (noted for review Jan 2004).
- Sector Transfer Protocol for Adult CMHT's – 28 July 2003
- Wolverhampton Forensic Mental Health Service Liaison Scheme Procedures – 22 October 1998.
- Policy for Joint Working Practices between Wolverhampton Healthcare Mental Health Directorate and The Hatherton Centre Foundation NHS Trust – February 1997.
- Wolverhampton Forensic Mental Health Service Liaison Scheme Operational Policy (Draft) September 2005.
- Wolverhampton PCT's Policy for the Reporting and Investigation of Adverse Events – 2004.
- Learning from Experience Committee Terms of Reference (Draft) – November 2005
- Caseload Activity Policy (Community And Specialist Teams) Wolverhampton City Primary Care Trust Mental Health Directorate – 1 September 2004

Other Documents:

- West Midlands Police Custody Record, 9 April 2000.
- West Midlands Police Custody Record, 10 October 2000.
- West Midlands Police Custody Record, 26 February 2002.
- West Midlands Police Custody Records, 24 July 2002.
- West Midlands Police Incident Log, 28 November 2002.
- Wolverhampton Forensic Mental Health Services Liaison Scheme Briefing Paper – 5 October 2000.
- Evaluation of Wolverhampton Forensic Services Mental Health Scheme – 23 September 2005.

- Wolverhampton Mental Health Services Critical Incident Analysis Group File (including action plan). Incident number: 094.
- Occupational Therapy Location Codes and Contact Sheets, August 2001 – September 2001.
- Selection of 2005 Wolverhampton PCT's Directorate of Mental Health's Risk Management Group minutes and agendas.
- Selection of Wolverhampton PCT's Directorate of Mental Health's Clinical Governance Meeting minutes and agendas.
- Performance Improvement Plan (patient survey 2005) – Mental Health Directorate, Wolverhampton PCT.
- Two sets of additional patient records (anonymised) created by W1's Care Coordinator (August 2000 – October 2001).
- Correspondence received from the Biochemistry Department at New Cross Hospital, The Royal Wolverhampton Hospital NHS Trust.

APPENDIX 3

SYSTEMS ANALYSIS OF THE SPECIFIC CARE DELIVERY AND SERVICE DELIVERY CONCERNS IDENTIFIED DURING THE ANALYSIS OF W1'S CARE AND MANAGEMENT

In keeping with the principles espoused by the NPSA in its national RCA training programme, the key concerns identified by this review have been analysed using its systems analysis framework.

The following pages set out the Review Team's understanding of the contributory factors to the stated concerns and issues detailed in Section 4.2 page ten of this report.

1. The Care Coordinator Elect was unaware that this responsibility had been passed to her when W1's Care Coordinator left the employment of the Mental Health Service in October 2001

Prior to W1's Care Coordinator leaving the Mental Health Service on 3 October 2001, his care and management had been well managed by this individual. Unfortunately when this individual left the service the Care Coordinator elect was unaware that this responsibility had been passed to her. Furthermore a number of staff engaged with W1 in 2001 have suggested that with the benefit of hindsight care coordination responsibility should have remained with one of the CPNs who already knew W1 within the CMHT.

The most significant influencing factors identified as contributing to the above stated concern were as follows:

- At the time W1 was receiving care from the mental health services in Wolverhampton it was not uncommon for health and social care staff to be appointed as a Care Coordinator without being consulted about this.
- With specific reference to the CMHT responsible for the care and management of W1, contrary to their Operational Policy there was no formal discussion about who would most appropriately take over care coordination responsibility for W1.
- The CPA meeting where the formal transfer of Care Coordinator should have occurred did not happen.

The additional range of factors that influenced the above stated concern were as follows:

Task Factors:

- Contrary to the Operational Policy for Adult Services the discussion about who would be a suitable Care Coordinator for W1 did not take place at the SE CMHT Team Allocation and Review Meeting.
- There appears to have been a dislocation in the communication between the Forensic CPN and the CMHT. On the 4th October there is reference in the Team Allocation and Review Meeting of the concern raised by the Forensic CPN of W1's potential discharge from the community. This is at variance with the advisory correspondence issued by the FLS seven days earlier. This emphasised the need for a CPA Review and that the process for securing a new Care Coordinator for W1 was in motion.
- The CPA review documentation in 2001 did not lead the clinician through a structured decision making process. Neither did it require the documentation of all persons present at a meeting or the counter signature of the Care Coordinator Elect.
- A range of staff informed the Investigation Team that at the time W1's Care Coordinator left the Service, it was not uncommon for

Community Staff to be given Care Coordination status without their being aware of this.

- The Investigation Team were told that in 2001 it was not uncommon for the Team Leader for a service to take Care Coordination responsibility until an more suitable team member has been identified – it has been hypothesized by the staff we spoke with that an assumption had been made regarding this when W1's Care Coordinator left the Trust.
- Whilst W1 was sent a letter informing him of the change in his Care Coordinator the letters that should have been issued to W1's Consultant Psychiatrist and his new Care Coordinator were not issued.[30]
- Within the Forensic Liaison Service there was no reliable system in place that ensured that the FLS Team Members were aware of the range of services engaged in supporting a Mental Health Service User. Consequently this disabled the effective communication of the FLS's advice to all relevant personnel. Had the FLS communication been sent to the Vocational Rehabilitation Service at Horizon House the Team Leader would have been made aware that consideration was being given to her taking on Care Coordination responsibility for W1. Furthermore this individual would have been more aware of increasing risk if W1 disengaged from the service.

Leadership Factors

- The then Team Leader for SE CMHT had a high degree of confidence in the outgoing Care Coordinator and did not exert her leadership responsibility in ensuring that due process was followed in the identification of, and communication with, the identified service who were to take lead responsibility for W1. This individual made a tacit assumption that because this Care Coordinator told her that all necessary arrangements were in place then all appropriate actions had been taken.

Working Conditions

- It is the Investigation Teams impression that while the Team Leader in 2001 was clearly capable she was working at, and possibly beyond her capacity, increasing her reliance on those members of her team who were recognised for their diligence and performance.

[30] The CPA system operational at the time should have automatically generated a letter to all persons on W1's contact list. Interrogation of this system showed the 'last entry update' relating to W1 was made on the 27th September 2001. The 'check boxes' that show a tick if letters have been sent to individuals on the contact list were all unchecked except for W1's. Whilst the 'check boxes' are highlighted automatically the generation of the letters was essentially a manual operation.

The Contemporary Situation

In order to gain an insight into the understanding of mental health professionals when there is to be a transfer of Care Coordinator within or across services all interviewees were asked to describe the process they usually followed. The data collected via the interviews was supplemented by the questionnaires issued to, and returned by a small range of staff across all three CMHTs.

As a result of these enquiries the Investigation Team is satisfied that the staff it spoke with have an appropriate understanding and expectation that meets with accepted good practice when transferring care coordination responsibility.

2. The Planned Follow up of W1 by the Forensic Liaison Service on the 4th October 2001 did not occur

The Forensic Liaison Service correspondence of the 27th September 2001 made clear its intention, and agreement with the outgoing Care Coordinator, that it would table the continuing management of W1 for discussion on the 3rd October 2001. A review of the clinical records and diaries maintained by the FLS showed that this did not happen.

The most significant influencing factors identified as contributing to the above stated concern were as follows:

- ❑ There was no robust or readily auditable process within the FLS for tracking those Service Users it had accepted for review, and therefore on to their 'caseload'.
- ❑ The FLS, while undertaking it's responsibilities with the best of intentions has evolved a mode of operation that clouds the differentiation between a liaison service and a service that carried quantifiable responsibility for the care and management of any referred mental health service user.
- ❑ There was no system in place for ensuring that the FLS Coordinator was aware of all the services with which a Service User was engaged and therefore the system for communicating the advice of the FLS to all involved professionals was inadequate.

The additional range of factors that influenced the above stated concern were as follows:

Organisational/ Management Factors

- ❑ When the FLS was initiated in 1997 it was a new innovative service and there was no service template for Wolverhampton or The Hatherton Centre to follow.
- ❑ The staff involved in the development of the FLS were unfamiliar with working within a liaison/advisory framework and their predominant experience was with caseload holding and caseload management.
- ❑ The procedural document (agreed and amended 22 October 1998) reflects the caseload holding and caseload management model of work with which the FLS team members were familiar.
- ❑ Nowhere is it explicitly stated within the "Policy For Joint Working Practices between Wolverhampton Health Care Mental Health Directorate and The Hatherton Centre Foundation Trust" (1997) that the FLS carries no clinical responsibility or accountability for the care and management of Service Users referred to it for advice.
- ❑ No detailed operational policy was developed for the FLS at its inception that set out;
    - the role and purpose of the FLS,
    - the boundaries of responsibility for the FLS,
    - the types of referrals that it was appropriate for the FLS to accept,

- the rules of engagement with the scheme, and exception management (e.g. that cases referred must be presented by the Care Coordinator etc),
- how referrals were to be made and then subsequently prioritised,
- the limitation to the number of cases that could be discussed within the context of the FLS meeting,
- what process was to be followed if a Service User was tabled for discussion and time constraints prevented this,
- how FLS meetings were to be managed (ie run and organised),
- the process for determining whether subsequent, or ongoing, review of Service User management by the FLS was appropriate (e.g. direct advice to the to responsible Consultant Psychiatrist, or following re-referral of the clients case management to the scheme).

Working Conditions

The Investigation Team are advised that the way in which the FLS meetings operate now does reflect how they operated in 2001. Observation of a FLS meeting revealed:

- ❑ That their meeting takes place in cramped conditions which makes the efficient chairing of the meeting challenging.
- ❑ There is no easily accessible refreshment facility which has resulted in a very informal meeting process where team members are welcome to take refreshments as they require. This the Investigation Team observed does disrupt the flow of the meeting and results in the inefficient management of the limited time available for case management discussion.
- ❑ Because the FLS meetings are held in the staff room for the Psychiatric Intensive Care Unit the meeting is vulnerable to interruptions, a number of which were observed.
- ❑ The volume of Service User's referred for review and advice sometimes exceeded the capacity of the FLS team to discuss all cases.

Task Factors

- ❑ In 2001 it was the practice of the FLS to notate those Service Users for discussion in their meetings diary. If a Service User listed for discussion did not occur then the Mental Health Service User would be listed under an alternative date as agreed by the team. A review of the FLS diary showed that on the 4th October W1 was not discussed and that he was re-listed for discussion on the 11th October. On the 11th October there were 12 cases tabled of which eight were discussed. W1 was not one of cases discussed. Thereafter his name did not appear in the FLS diary.

- At the time of the incident involving W1, if the Forensic CPN for the CMHT responsible for the referred Service User was absent from the FLS meeting, then any case from that sector would not have been discussed. It does appear from a review of the FLS diary for 2001 that this may have been a contributor to W1 not being 'brought forward' to subsequent meetings.
- W1's history and presentation would not have represented a particularly high profile forensic Service User for the FLS. It is possible therefore that the emphasis on the need for FLS followup and review was reduced.

Team Relationship Factors

- It seems that W1's outgoing Care Coordinator was a key influence in engaging the FLS in advisory services regarding W1. Her leaving the service left a vacuum that was not filled.

3. The requested and required CPA Review did not occur

On the 28th September 2001, the SE CMHT Minutes clearly state that a CPA Review meeting was to be organised regarding W1. However this meeting never occurred. Why?

The most significant influencing factors to this were:

- ❑ The task of organising the CPA Review was given to an individual who was not present at the team meeting on the 4th October. This individual was on compassionate leave.
- ❑ At the time there was no systematic approach within the SE CMHT team allocation and review meetings for checking that previously agreed actions had been carried out. It was generally assumed that once action points had been delegated they would be undertaken.

Other factors that may have contributed to the non organisation of W1's CPA Review were:

Task Factors:

- ❑ The Forensic CPN who was aware that a CPA Review needed to be organised for W1 was frequently absent from the SE CMHT team allocation and review meetings as the forensic liaison scheme meetings were held at the same time as the team allocation and review meetings.
- ❑ Following the discussion on the 28th September, a review of the team allocation and review minutes between October and the end of December 2001 showed that W1 was never again discussed by the SE CMHT. It seems clear that the general consensus was that;
  - W1 had been handed over to a Care Coordinator outside of the team and
  - that W1 was effectively discharged from the mental health service in November 2001 following his non-attendance at his outpatient appointment.
- ❑ A number of mental health and social care professionals told the Investigation Team that in 2001, and even now occasionally, tasks would be allocated to a team member not present at a meeting.
- ❑ There was an assumption that staff not present at the team allocation and review meeting would read the Minutes in advance of the next meeting so that they could pick up or at least be aware of actions assigned to them.
- ❑ While there is a belief that if a team member who is absent from a meeting is allocated a task, a colleague will be tasked with ensuring the action is appropriately communicated, there is no evidence to suggest that this occurred on the 28th September 2001.

Individual Personnel Factors

- The CPN to whom the responsibility of organising the CPA Review advised the Investigation Team that it was his usual practice to read the minutes of team allocation and review meetings as soon as they were available. He could not say why this did not occur in September/October 2001, however, he had suffered a significant bereavement and acknowledges that he was not as focused as he might otherwise have been.

Cultural and Working Condition Factors

- At this time it was generally recognised that the SE CMHT team allocation and review meetings could be challenging with difficulties experienced between a range of personalities.
- Commitment to CPA was variable in the mental health service at the time. It was largely seen as a 'paper chasing exercise' with little bearing on the practise of caring for persons with mental health needs.
- There was no-one in the CMHT at the time who believed that they held any clinical responsibility for W1.

Contemporary Situation

The Investigation Team were consistently told that the team allocation and review meetings within SE CMHT were much better structured than they were in 2001. It was also apparent during the staff interviews that the morale across the team is much better than it was in 2001. This is attributed to

- key staff changes
- a respected and valued Team Leader
- Consultant Psychiatrists who are actively engaged with the team and attend as active participants the team allocation and review meetings.

Two members of the Investigation Team also 'sat in' on a team allocation and review meeting in SE CMHT and SW CMHT. Both CMHTs had a similar agenda and running order in their meetings however there appeared to be no formalised processes for ascertaining whether actions previously agreed had been undertaken. Whilst this may not be common practice across CMHTs in other mental health services, these CMHTs take detailed formal minutes of their team allocation and review meetings where actions/tasks allocated are clearly documented.

The Investigation Team members present at the meetings did observe previous meeting Minutes being circulated in both meetings and some staff placing a tick by actions that had been identified as their responsibility.

A review of the layout of the Minutes circulated revealed a lack of consistency in the presentation of the Minutes of these meetings and a layout that did not facilitate the easy identification of actions planned nor of any facility for staff to be able to notate that the actions had been completed.

Finally, as has been previously mentioned, there is a general acknowledgement that the implementation of CPA Facilitator posts in each CMHT has made a significant difference in supporting the overall improvement of CPA Practice across adult services. All staff the Investigation Team spoke with, could confidently say that it would be a complete aberration if a required CPA Review did not happen today.

4. On the 26th November 2001, W1's Consultant Psychiatrist wrote to W1's then GP advising that he (W1) had not attended his out patient's appointment. In the letter the Consultant advised that "I him a further appointment but would be happy to do so should you wish me to". This was interpreted by other mental health staff engaged in the care and management of W1 as a letter discharging him from the mental health service

The correspondence from W1's Consultant Psychiatrist to his GP on the 26th November 2001 was seen to constitute a letter of discharge from the service by the SE CMHT. The Consultant Psychiatrist at the time did not intend it to be seen in this light and strongly contests that he arbitrarily discharged W1. With the passage of time it is difficult to be entirely certain what communications passed between SE CMHT and W1's Consultant. What is certain is that whatever the intention of W1's Consultant Psychiatrist, W1 was considered discharged and not entitled to Community Psychiatric Nurse in-put.

The following appear to have been of most significance in enabling this perception to prevail:

- The content and style of the letter sent to W1's GP gave no indication that W1's Consultant Psychiatrist was retaining clinical responsibility for W1. Neither did the letter provide any information at all to assist the GP in the appropriate surveillance of W1 and indicators requiring notification to W1's Consultant Psychiatrist. Essentially the style of letters provided to GP's where responsibility was being retained was not distinctly different to those where the Service User was being discharged back to the GP for primary care management.
- There was a lack of organisational systems and processes to ensure that the case management of Service Users who 'Did Not Attend' (DNA) were reviewed and decisions regarding further action made in consultation with the wider CMHT.

In addition to the above the following range of issues, the Investigation Team believes, influenced the practice and culture of DNA management at the time:

Task Factors:

- When W1's Consultant Psychiatrist referred him back to his GP he did not believe that he was discharging him from the service. This Consultant told the Investigation Team that he believed he continued to carry clinical responsibility for W1, he had merely made a decision that W1 could be followed up by his GP until such time that the GP requested further specialist input.
- The Investigation Team were told by the CPA Coordinator in 2001, and the current CPA coordinator, that a number of secretaries to Consultant Psychiatrists refused to file CPA paperwork as there was a perception that it was not part of their role. These

documents would be filed in a separate lever arch file away from the records. During the course of this investigation one such file was discovered by the current CPA coordinator in the administrative office providing support to W1's Consultant Psychiatrist in 2001. This practice would have reduced the opportunity for a Consultant Psychiatrist to be reminded that a patient was on Enhanced CPA and therefore of the need to communicate with a patient's Care Coordinator regarding significant decisions affecting the ongoing care and management of the patient.

Communication Factors

- The content of the letter sent to W1's GP was shown to a range of staff. The CMHT CPNs and Social Work staff, and the current GP's at W1's GP Practice, quite clearly read the letter as a discharge letter. Conversely the Clinical Director of Adult Services in the Mental Health Directorate, at the time of this investigation, did not see it as a discharge letter and supported the interpretation offered by W1's Consultant Psychiatrist in 2001.
- Discussions with W1's then Consultant Psychiatrist and the Clinical Director for Adult Services at the time of this investigation, revealed that there is little material difference in a letter of discharge and a letter advising the GP that no further out patient appointments are going to be offered to a Service User unless a request to do so is received.
- In 2001 a Consultant working in Out Patient's would not necessarily have had sight of CPA documents that would have emphasised that W1 was on enhanced CPA, and therefore any decisions regarding changes in his management plan needed to be a team descision and not a uniprofessional one.
- The attitude to the appropriate filing of CPA documents in 2001 (see Organisational and management factors) would have meant that W1's Consultant would have not had easy access to documents that would have highlighted W1's Enhanced CPA status.

Team Relationship Factors

- W1's Consultant in 2001 firmly believed that the GPs he worked most closely with would have recognised that his correspondence of November 2001 did not constitute a discharge letter.
- W1's Consultant Psychiatrist was recognised as an individual who arbitrarily discharged Service Users from clinic without any discussion with other team members.

Organisational and Management Factors

- Except for the Professional Head of Nursing, there is no evidence that the management team for the mental health service positively addressed the issue of how DNA's were managed across the multi-professional team nor the relatively common practice of Consultant Psychiatrists of discharging Service Users without any reference to the CMHT.
- The information shared across a range of mental health staff leads the Investigation Team to believe that the system for managing DNA's at Out Patient's was chaotic.
- There seems to be a general acknowledgement that in 2001 whilst the nursing and social care staff were trying to work as a team the Consultants were not necessarily engaged in, or interested in working as a team.
- At this time the Consultant Psychiatrists working in the mental health service in Wolverhampton were known to discharge Service Users directly from out patient's without any discussion with other professionals engaged in the Service User's care. It is the understanding of the Investigation Team that no formal decisive action was taken by the then management team to address this.
- At the time, as there was no agreed process for how DNA's should be assessed and managed, one of the CPNs in SE CMHT had taken it upon herself to go through the 'DNA Box' in out patients. There would be no fixed time or day for this activity, it would occur when she 'had a gap in the day'. If there were cases she felt required further discussion she would place a sticky label on them so that i) this might trigger further action ii) anyone else looking at the file would know she had a concern. For those files where she did not have any particular concern she would try and make contact with the Service User by phone and agree a new appointment date with them. If contact via telephone was unsuccessful this individual told the Investigation Team that she would contact the GP and if there was any cause for concern then either she or a colleague would make a home visit, generally referred to as a 'door step challenge'.
- The Investigation Team were told by the CPA Coordinator in 2001 and the current CPA Coordinator that a number of secretaries to Consultant Psychiatrists refused to file the CPA paperwork as there was a perception that it was not part of their role. These documents would commonly be filed in a lever arch file separate to the clinical records. During the course of this investigation once such file was discovered by the current CPA Coordinator in the administrative office previously providing support to W1's Consultant Psychiatrist in 2001.

With respect to W1, this CPN told the Investigation Team that W1's Consultant Psychiatrist was extremely efficient at clearing his 'DNA Box', unlike other Consultants where the notes could be waiting months

to be sorted out. Consequently if she was unable to go through this Consultants 'DNA Box' on the day of the clinic she would not be aware of which Service Users had not attended clinic.

The Contemporary Situation

Within the SE CMHT changes were occurring as to how DNA's are managed during the course of this investigation. The Investigation Team understands that:

- All DNAs now come to the reception of SE CMHT.
- The staff member responsible for medical records ensures that the notes of all DNAs are retained and that she requests that each Consultant 'sort through' their DNAs so that an appropriate decision can be made.
- Relevant cases are then taken to the next team allocation and review meeting and discussed under 'Clients of Concern'.

The Investigation Team also understands that the above listed measures are:

- Informal in nature
- Not systematic across all CMHT's

Observation of the SE CMHT and SW CMHT team allocation and review meetings revealed that one team discusses DNAs as a specific agenda item whereas the other did not. Discussions with one Consultant Psychiatrist revealed an appropriately diligent approach to the follow up of Service Users who DNA out patient appointments. This individual advised that whatever the circumstance if a Service User is on Enhanced CPA then he will not discharge this type of Service User and will try to maintain 'some type' of contact with the Service User via the CPN's if active engagement cannot be effected. This Consultant was however unaware of the practice of other Consultant Psychiatrists within the service.

The questionnaire responses received by the Investigation Team indicate that whilst the majority of responses stated that DNAs are always discussed at the team allocation and review meeting approximately a third of responses said that there were often occasions when DNAs were not discussed, or where the quality of discussions was lacking.

Finally all mental health service personnel the Investigation Team spoke with found it inconceivable that a Service User such as W1 could be 'discharged from the service' in the same way as occurred on 2001.

5. When W1 disengaged from his Vocational Rehabilitation programme there was no notification of this to his Care Coordinator or his Consultant Psychiatrist for a period of eight months

The interviews with staff revealed a range of factors that influenced this non-communication the most significant of which appear to have been:

- The non-communication of the recommendations of the FLS following their review of W1 on the 27th September 2001, that stated that if W1 disengaged from Horizon House then he must be referred back to SE CMHT.
- The lack of an effective operational policy and practice based procedures to guide the effective management and communication with referring CMHTs for Service Users engaging with the rehabilitation service.
- The lack of assessment of the prevailing skills and knowledge of the staff working in the Day Service prior to extending the range and complexity of services offered.

In addition to the above there were a range of other factors that also influenced the delay in communicating W1's disengagement from the rehabilitation service. These are:

Organisational Factors

- At the time W1 initially engaged with the Vocational Rehabilitation Service this was provided from a building called 'Horizon House'. Horizon House had historically provided day centre recreational services to persons with chronic mental health conditions and was seen as a bit of a 'backwater' in terms of service development and modernisation.
- The Horizon House staff were not integrated with Adult Services as a whole and the Team Leader was not therefore included in Team Leader Meetings.
- The Team Leader for Horizon House had recently 'taken on' the responsibility for the Horizon House Day Service which had historically been ineffectively managed.
- The service provided from Horizon House was isolated both geographically and organisationally.

Skill, Knowledge and Rule Based Performance

- When W1 was first referred and accepted for engagement with the Vocational Rehabilitation Service there was a lack of understanding regarding his profile and his risk status. The Investigation Team have not been able to completely reveal why this was, as the service was provided with a copy of W1's risk assessment and the Horizon House admission records clearly note key episodes in W1's risk history.

- It would seem that when W1 was referred, the staff working in Horizon House were trying to evolve the profile of their service from one that provided purely recreational facilities to 'Chronic Service Users' to a rehabilitation service. The staff working in Horizon House, whilst experienced with their historical work, were not particularly familiar with the client group they were trying to attract and there had, as far as we could ascertain, been no scoping of the knowledge and skills they needed to refresh, or gain, to enable them to function effectively and safely.
- The Team Leader at Horizon House in 2001 does believe that it is possible that she assigned a more contemporary spectrum of skills and knowledge to her staff than they actually possessed by virtue of the fact that they were Registered Mental Health Nurses.
- The Team Leader for Horizon House was not cognisant of the extent of the denuding of skills and competencies in her workforce, effected by the previous model of work.

Task Factors

- The breakdown in the CPA process that should have governed the change in Care Coordinator for W1 meant that there was no opportunity for a formal handover of W1 which would have included a detailed discussion regarding his ongoing management and risk/relapse indicators.
- Whilst there is evidence that the staff at Horizon House did try and make some contact with W1 by telephone and by written correspondence when he systematically did not attend for vocational rehabilitation from February 2002, this appeared to have been sporadic. There is no evidence that there was any attempt to visit W1 at home.
- The expected process in 2001, if a Service User does not attend, would be to contact the original Care Coordinator, or Consultant Psychiatrist, after a period of attempted re-engagement. The Investigation Team were advised that this would usually be after a period of three to four weeks. In the case of W1 this usual activity did not happen.

Communication Factors

- The formal correspondence that should have been generated by the CPA Office informing the Team Leader at Horizon House that she was the new Care Coordinator for W1 in September/October 2001 was not generated and therefore not issued.
- Correspondence sent from Horizon House to W1 asking him i) if he wanted to continue with his Vocational Rehabilitation and ii) to contact Horizon House was not copied to his Consultant Psychiatrist or to either of the CPNs noted as involved in his care and management on the Horizon House records.

- No correspondence was received from the CPA Office, by the Team Leader for Horizon House, chasing up W1's outstanding CPA Reviews until approximately the 13th October 2002. This was more than a year after W1's last recorded CPA Review.

Across Team Relationships

- The Team Leader for Horizon House told the Investigation Team that she had tried to initiate attendance at the Community Mental Health Team meetings across adult services. She advised that whilst she had some success at initiating this the suggestion was not positively received by the SE CMHT at the time and attendance of her team members was considered to be unnecessary.

The Contemporary Situation

This incident and the contribution the Horizon House Team had in W1 being lost to the mental health service in Wolverhampton has been a salutary experience for the Horizon House Team. Since this incident:

- The service is now housed in Brooklands Day Centre along with the main CPA Office thus effecting easy communications between the services
- The service has been brought under the umbrella of Adult Services and the Team Leader attends all Team Coordinator meetings hosted by the Professional Head of Services
- The Team Leader has instigated a system where Service Users who DNA their planned appointments are regularly reviewed in their team meetings and decisions made collectively regarding the measures required to effect re-engagement if possible. (This takes place at least on a weekly basis and sometimes daily)

APPENDIX 4

MINI BIOGRAPHIES FOR THE REVIEW TEAM

Maria Dineen – Director, Consequence UK Ltd
(RGN, RM, Bsc Hons, Capsticks Risk Management Diploma)

Maria is a Director of Consequence UK Ltd; she has an NHS background having worked as a nurse and a midwife between 1987 and 2004. In 2004 she took a career change within the NHS and moved into clinical risk management. She is recognised nationally for her work in the field and worked closely with the NPSA in their development of the NPSA's RCA e-learning tool kit.

Maria leads training workshops for health and social care staff in the application of root cause analysis in adverse incident investigations. She also leads statutory and non-statutory independent investigations on behalf of Strategic Health Authorities in England, and independent health organisations.

Justin O'Brien - Head of Risk Management, South West London and St Georges NHS Trust (SWLSG's NHS Trust)
(RMN, RGN, Bsc Hons HSM, Dip Counselling)

Justin has worked in healthcare services for the last 26 years working in the NHS and the voluntary and private sectors. He has accumulated extensive knowledge and experience in Adult Mental Health Services over this time. In 2004 he became the Head of Risk Management at SWLSG's NHS Trust. In this capacity, and in previous clinical management positions, he has undertaken a number of reviews into serious untoward incidents.
In addition to his commitment to SWLSG's NHS Trust, Justin is also a reviewer for the Health and Social Care Advisory Service (HASCAS)

Dr Paul Courtney – Consultant Psychiatrist Hampshire Partnership NHS Trust

Dr Courtney accepted his first consultant position Adult Psychiatry for West Hampshire NHS Trust in 1991. His current position is as Consultant Psychiatrist to the Southampton Home Treatment Service, Hampshire Partnership NHS Trust

He has held the following significant positions:

- 1994 to 2001: Director of Mental Health and Learning Disabilities Division, Winchester and Eastleigh Healthcare NHS Trust
- 2001 to 2004: Chairman of Senior Medical Staff Committee, Hampshire Partnership NHS Trust
- 2003 to date: Clinical Assessor to the National Clinical Assessment Authority
- 2005 to date: Regional Representative in Adult Psychiatry for the Royal College of Psychiatry

Dr Courtney's current research interests include decision making regarding hospitalisation in adult psychiatry and changing patterns of psychiatric admissions subsequent to the introduction of home treatment services.

APPENDIX 5

GLOSSARY OF TERMS

Approved Social Worker:

The ASW role is a discrete one within a multidisciplinary context. The ASW service has built up considerable expertise in the correct implementation of the Act with local investment in developing and maintaining good working relationships with other agencies such as the police. The additional training and experience required to become an ASW acknowledges the responsibility of making assessments and reaching decisions in often stressful circumstances and of being a guardian of good practice in assessment (such as providing the least restrictive alternative for someone in acute mental distress).

An ASW has overall responsibility for co-ordinating an assessment under the Mental Health Act (1983). This service is available 24 hours a day, seven days a week and 365 days a year. Although warranted and appointed by an LA the ASW is personally liable for their actions. Following an assessment and in consultation with other professionals, families and carers, they make an independent decision ensuring that any intervention is the least restrictive necessary in the circumstances. The ASW provides a third party perspective, independent of the medical opinion, which is an essential part of maintaining the balance between liberty and safety required by past and current mental health legislation.

Care Delivery Concerns:

Where there are identified weaknesses, or failures, in the actual care and treatment that has been provided to a patient/Service User, either of commission or omission, these are termed Care Delivery Concerns.

Care Programme Approach:

The Care Programme Approach (CPA) was introduced in 1991 to provide a framework for effective mental health care. Its four main elements are:

- systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- the formation of a care plan which identifies the health and social care required from a variety of providers;
- the appointment of a Care Coordinator to keep in close touch with the service user and to monitor and co-ordinate care; and
- regular review and, where necessary, agreed changes to the care plan.

Critical Incident Analysis Group (CIAG):

The CIAG is a sub group of the Directorate Risk Management Group (DRMG). It reports to the Directorate Risk Action Group and up to Directorate Clinical Governance Group. The DRMG allocates referrals from incident reports above a certain score to the CIAG. The main function of the CIAG is to review these significant incidents, to identify relevant learnings, facilitate 'Multi-Disciplinary Root Cause Analysis' and make recommendations.

Clinical Governance:

Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

Community Mental Health Team:

When the Mental Health Implementation Guide was launched in March 2001, it declared:

"Community Mental Health Teams, in some places known as Primary Care Liaison Teams, will continue to be the mainstay of the system. CMHTs have an important, indeed integral role to play in supporting service users and families in community settings."

Contributory Factors Framework:

This is a framework that enables one to explore and identify a broad range of influencing factors to any given problem. It is usually applied to complex problems and requires one to look at issues associated with:

- Team and social relationships such as team leadership and role congruence.
- Equipment design, maintenance, functionality and usage.
- Communication factors such as the delivery of verbal commands in terms of tone and the actual words used, and the clarity and legibility of written communications.
- Task design such as the detail contained within organisational policies and task guidance and the availability of decision making aids.
- Organisational culture and management, such as clarity regarding lines of accountability, the style of management, the presence of an open and fair culture or blame culture.
- Individual personal influences, such as ill health.
- Specific patient/Service User influences, such as their clinical presentation, long term illness, lack of compliance with treatment
- Training and education issues, such as the design, delivery and attendance at appropriate training events.
- Working environment issues such as heat, temperature, ratio of staff to patient and the skill mix of the staff.

HSG(94)27:

This is Department of Health Guidance on the discharge of mentally disordered people and their continuing care in the community. It contains specific guidance regarding the need for an investigation that is independent of the affected NHS health care provider when a person who is a patient of the mental health service commits or is involved in a violent incident, especially where another person is harmed.

Multi Agency Public Protection Arrangements (MAPPA):

This is a requirement of the Criminal and Court Services Act 2000 (amended in 2003) where Police, Probation, Local Authority and Health bodies have a statutory responsibility to supply and share information between agencies for the assessment and management of risks posed by violent and sexual offenders and other offenders who may cause serious harm to the public.

National Patient Safety Agency:

The NPSA is a Special Health Authority created in July 2001 to co-ordinate the efforts of the entire country to report, and more importantly to learn from mistakes and problems that affect patient safety.

Primary Care Trust:

A Health Service Trust that is responsible for the provision of primary healthcare services and the commissioning of secondary and specialist services within a geographical area.

Root Cause Analysis:

This is a structured and analytical approach to understanding the underlying features of significant care delivery, and service delivery problems identified in the analysis of a patient's/Service User's care and treatment. A range of tools and techniques are available to help with this including the NPSA's contributory factors framework, which was the tool used in this review.

Section 17 Leave:

Section 17 leave is a prescribed intervention under the 1983 MHA, whereby a detained individual's Consultant Psychiatrist allocates leave as a fixed period of time, or on an indefinite basis up to the expiry date of the detention period, as part of an individual's treatment plan. The leave prescribed is only valid if the nurse in charge of the ward assesses the individual to be fit to use it when they want to leave the ward.

Section 17 Leave can be revoked in writing at any time by the patient's consultant in the interests of the person's health or safety or for the protection of others.

Senior House Officer:

The Senior House Officer grade is the initial training grade for all doctors after full registration. It forms part of the continuum of medical postgraduate training, building on the experience and learning of the pre-registration year and preparing trainees for their next stage of training.

Service Delivery Concerns:

Where there are identified weaknesses or failures in the systems that should support, or underpin safe and effective care delivery, these are termed Service Delivery Concerns. Examples of Service Delivery Concerns are: A failure in management supervision, the design of a training programme which did not enable the core competencies expected of the staff to be achieved, the 'new' policy document was inappropriately implemented, and its impact on practice not assessed.

Timeline:

A timeline is a graphical, usually horizontal, map of the steps and stages in the patient's/Service User's care pathway, including significant events in a patient's/Service User's home or social circumstances. It enables the whole story to be reviewed in an easily digestible format, and triggers a broader range of questions about the care and management of the patient/ Service Users.

W1 INVESTIGATION