Independent Investigation into the Care and Management of Mental Health Service User 2004/680

13 November 2008

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

The Investigation Team members were:

- Ms Maria Dineen, Director, Consequence UK Ltd
- Dr Michael Clarke ,Consultant Psychiatrist, Assertive Out Reach

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EXECUTIVE SUMMARY

Intention

This report sets out the findings of the independent Investigation Team following its analysis of the care and treatment of a mental health service user (MHSU) who was convicted of the murder of his friend on 12 March 2004. He was subsequently convicted on 18 November 2004 and sentenced to life imprisonment.

Purpose

The purpose of the work commissioned was:

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

- To critically analyse the documented care and to identify any areas that appeared weak or unsatisfactory, and then to analyse the Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust's (RdaSH's) own internal investigation report in order to identify any significant omissions in the Trust's own investigative process.

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

Outline of the investigation process

The analysis of the MHSU's clinical records and the Trust's own internal investigation report revealed:

- An internal report that was not at all analytical and did not evidence the degree of critical appraisal expected in this level of investigation.
- That following the prescribing of carbamazepine in October 2003 there was no appropriate follow up or monitoring of this medication.
- Following a request by the MHSU's then consultant psychiatrist in August 2002 for CPN follow up he was not offered an appointment until June 2003.

The subsequent activities were:

- Advising NHS Yorkshire and the Humber of the Investigation Team's findings
- Obtaining the pre-sentencing psychiatric report from the MHSU's defence solicitors
- Seeking further information from the Trust in relation to the three areas of concern about the MHSU's care and treatment.

Main conclusions

It is the opinion of the Investigation Team that the MHSU was challenging to offer an effective service to. His contacts with the service were punctuated by periods of engagement, most notably with his first community psychiatric nurse and consultant (CPN 1 and Cons P1), and by significant periods where he appeared to show no willingness to engage in a therapeutic regime that might have improved his social situation and therefore have been of benefit to his mental health. There is clear documentary evidence that he was offered regular follow up at outpatients and that his CPNs up to and including 2002 made numerous attempts to visit him at home. He also received the support of the Richmond Fellowship (see glossary page 38). The MHSU was discharged from both the Richmond Fellowship and the community mental health team by community psychiatric nurse 2 (CPN2), and assessed as not suitable for CPN follow up in 2003 because of his ambivalence about engaging in a structured therapeutic programme.

In addition to the MHSU's lack of sustained engagement with mental health services, both statutory and voluntary, he had a long standing problem with alcohol. It was this problem that appeared to precipitate his attack on his friend on 12 March 2004.

The Investigation Team do not believe that the mental health services could have done anything to have prevented the incident that occurred. Furthermore for as long as the MHSU did not recognise that he had a serious problem with alcohol, there was little anyone could have done to assist him in living a more orderly life.

Recommendations

The internal investigation report had no recommendations. We have five.

- The Trust is very aware that it has some work to do, to ensure that clinical records evidence a robust approach to the clinical risk assessment of its service users. Consequence UK has recommended in a previous report that a full documentation audit should be undertaken to assess the quality of documentation (not merely whether specific "boxes" have been "ticked"). We reiterate this recommendation here (see Independent Investigation Report 2006/1787 published 13 November 2008, Yorkshire and Humber SHA Board Meeting).

- The Trust must develop a detailed and auditable action plan for submission to the SHA that shows the specific activities it is engaging in to achieve:
    - a uniform approach to risk assessment across all of its services;
    - clarity in understanding in its staff regarding their roles and responsibilities in the risk assessment process, for example in undertaking a full risk assessment where it has been clearly noted that this is required; and

- a robust audit approach to risk assessment that employs a qualitative as well as quantitative approach, so that the Trust can be assured that the quality of practice is as it should be, or if such audit shows quality to be lacking then action can be taken in a timely manner to address this.

(See also the recommendations in Independent Investigation Report 2006/1787 published 13 November 2008 Yorkshire and Humber SHA Board Meeting).

- The governance committee for adult services (inpatient and community) needs to consider the current medication safety audits it conducts and whether or not these are sufficient. In particular this group needs to determine whether:
  - there are medications in addition to lithium where detailed audit would also be beneficial to the checking and enhancement of clinical practice, and
  - any of these medicines could be appended to the existing process for auditing practice around Lithium thereby utilising an existing audit mechanism. This Investigation Team expects that carbamazepine, although infrequently prescribed, could be one such medication.

- The alcohol treatment service needs to reflect on its own documentation to determine whether by-and-large it is satisfied with its own standards of documentation, and that the documented contacts with its client group adequately reflect the 'in the moment' position for the service user in relation to their consumption of alcohol and their attitudes to it, along with the subjective impression of the key worker or other assessing professional.

- The Trust must provide much more comprehensive and useful guidance to its staff on how to conduct a good investigation. The Trust is encouraged to take note of the information provided on pages 19 -21 of this report in addressing this issue. It may also benefit the Trust to invest in some skills based training for a targeted group of staff who could form a dedicated group of investigation facilitators. We are aware that some Trust staff have already attended investigator training but feel that the benefits of this are not reflected in the internal investigation reports we have read.

1.0 BACKGROUND

On 12 March 2004 the MHSU had spent much of the day in the pub. When he went home, he reports, he could not get into his house. The gentleman staying with him (a drinking acquaintance) at the time had locked him out. The MHSU could not rouse him for about an hour. His 'friend' then let him into the house. An argument broke out followed by a violent physical altercation the result of which was the death of the MHSU's 'friend'.

Outline chronology

The MHSU first came into contact with mental health services in June 1990. This first referral followed the ingestion of rat poison. The antecedents to this were:

- financial difficulties;
- personal relationship difficulties; and
- problems relating to driving whilst disqualified, failure to stop following an accident and failing to provide the police with a breath specimen.

In addition to the above the MHSU was drinking dangerous quantities of alcohol and required detoxification on admission to hospital.
The MHSU was subsequently discharged from hospital on 3 July 1990. Follow up was arranged with the alcohol team.

The MHSU had a second admission for detoxification in August 1990.

There was a third inpatient admission in December 1990 following his experiencing suicidal thoughts as his wife had left him. It is noted that he continued to drink heavily at this time.

Following discharge from inpatient services in January 1991 the MHSU is followed up in outpatients. He is discharged in April 1991 for non-attendance at his appointments.

The MHSU is next referred to mental health services in November 1992. At this time there appears to have been a breakdown in the service delivery as the MHSU was not seen again in outpatients until January 1994.

From this date to the date of the incident the MHSU did have reasonably regular contact with the mental health services. However there was a distinct change in his documented levels of engagement following a change in his initial care team in 2001. The MHSU reports not being able to 'get on with' his new care coordinator. He was subsequently discharged from the CPN case load in August 2001.

In October 2001 the MHSU was re-referred by his GP for CPN input and Consultant Psychiatrist input was sought in the assessment of

need for this. The MHSU did not attend for his CPN assessment appointment.

Following a consultant psychiatrist appointment in February 2002 it is noted that the MHSU made a request for further CPN input, but not CPN 2. (*Having spoken with the MHSU it is clear that he wanted a CPN of similar personality to CPN1 with whom he felt he had a rapport, and who he believed 'looked out for him'.)*

In August 2002 a following the MHSU's repeated request for CPN input he was assessed as being of 'low level risk and need' and was put on the CPN waiting list. He is eventually provided with a face to face assessment in July 2003 where is assessed as being not suitable for the continuing care service.

In the intervening period the MHSU has been referred to and attends at the Well Centre (an alcohol treatment service).

The MHSU is assessed in September 2003 by a consultant psychiatrist specialising in alcohol abuse. The outcome of this was detailed in a fulsome letter to the MHSU's GP. At this time it is noted that the MHSU sees no link between his drinking and his social problems. He did however accept that there was a link between his drinking and drink driving offences. His solution was to get rid of his car so that this would no longer be a problem.

The MHSU is noted to want no further contact with the consultant.

On 5 September 2003 the MHSU is discharged from the Well Centre as he does not see his alcohol consumption as problematic.

In October 2003 the MHSU is seen by consultant psychiatrist 4. He is commenced on carbamazepine 200mg and offered a follow up appointment in four months time. (February 2004). This appointment was cancelled by the mental health service and a later appointment was offered for May 2004, two months after the month of the incident.

PLEASE SEE APPENDIX 1 (page 25) FOR A MORE DETAILED CHRONOLOGY OF THE MHSU's CONTACTS WITH THE MENTAL HEALTH SERVICE

2.0 TERMS OF REFERENCE

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

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

Following this Consequence UK was required to advise the SHA of any further investigatory work required.

In addition the terms of reference were to:

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

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

- Provide the SHA with a report of the Investigation Team's findings and recommendations.

3.0 METHODOLOGY

There has always been a reservation regarding the need for case 2004/680 to be investigation under the auspices of the statutory guidance HSG(94)27.

Consequence UK Ltd shared the reservation of NHS Yorkshire and Humber.

Consequently a conservative approach was agreed.

Following an assessment of the MHSU's mental health records, Consequence UK set out what it believed to be a reasonable and proportionate approach to the investigation.
This did not involve interviewing staff on a face-face-basis but did involve seeking written information from the Trust about the contemporary situation, relating to areas where there was a lack of clarity in their own investigation and/or the records.

The reasons why it was decided that conducting a full investigation was neither appropriate nor necessary in this case were:

- The length of time between the incident and the investigation being commissioned. This case constituted a legacy case.
- The clear non-preventability of the incident.
- The clear documentary evidence that staff made many attempts to encourage the MHSU to engage with therapeutic activities and his non-engagement with these.
- The MHSU's inability to stop drinking or to accept that his drinking was uncontrolled.

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

The Investigation team wrote to the MHSU in Dovegate Prison. He was agreeable to the Investigation Team having access to his health records.

The MHSU has no close family members and did not advise the Investigation Team of anyone he would want notified of the investigation.

Members of the Investigation Team met with the MHSU at HMP Dovegate on the 3 November 2008.

With regards to the family of the victim, South Yorkshire Police kindly agreed to deliver a letter from the Investigation Team, to the address at which they were living at the time of the incident, advising them of the investigation and inviting them to meet with the Investigation Team. The police however, did advise the Investigation Team that if the family had moved they would not be able help further.

At the time this report was published the Investigation Team had received no contact from the victim's family.

5.0 FINDINGS OF THE INVESTIGATION

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

- comment on the Trust's own internal investigation; and
- identify any key questions that needed to be asked of the Trust.

5.1 Positive feedback

Before addressing the above the Investigation Team's analysis of the MHSU's clinical records showed that the staff appeared to do their best for this MHSU. For example:

- In 1997 his consultant psychiatrist (Cons P 1)
  - made a referral to the physiotherapist in relation to his mobility needs;
  - wrote to the benefits office in Blackpool supporting the MHSU's ongoing claim for disability allowance, setting out clearly his mental health and physical health problems; and
  - wrote to the Director of Housing to ask if the MHSU's current housing could be reviewed on medical grounds. His hope was that the MHSU could be placed in accommodation that would enable greater social contact.
- The alcohol service in Rotherham, recognising that they could not meet all of the MHSU's varied needs, also referred him to a range of services to try and meet these needs.
- In 1998 the MHSU's CPN (CPN 1) wrote to the relevant authority to ask if the MHSU could be exempt from paying for his community support, as without input from these services she was concerned that his mental health would deteriorate rapidly.
- In October 2000 CPN 1 supported his application for rehousing as he could no longer manage in his residence.
- In March 2001 the MHSU's second CPN (CPN 2) completed Jury Service forms on his behalf requesting that he be excused from service on health grounds.

In addition to the above although it is not possible to isolate any specific instance, the impression gleaned from our analysis of the clinical records is that consultant psychiatrist 1 took a very holistic approach to the care and management of his patients and one gets a real sense that there was a genuine interest in the well being of the MHSU. This impression was validated by the MHSU himself who spoke warmly about the clinicians he had initial contact with. He told the Investigation Team that he felt he could engage with and open

up to CPN 1 in particular. He did not experience this with any of other CPN's he had contact with.

In addition to the above throughout this MHSU's contacts with the mental health services, all of the discharge letters and other correspondence between the service and the MHSU's GP were of informative and of good quality.

5.2 The Trust's investigation report

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

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

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

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

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

  been adequately explored?

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

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

- Did the internal investigation report show that a systems based approach to the investigation was taken, or was the overriding impression one of an investigation predominantly focused on the

care and management of the service user with little evidence of a deeper/wider systems analysis?

The following information presents the Investigation Team's reflections on the Trust's internal investigation report.

Title page, index and date: The report does have a title page, but it is undated and has no page referenced index. The author of the report was the then assistant director of mental health services.

The main sections of the report were:

- introduction;
- 'the MHSU's' history;
- the MHSU's mental health contacts in Rotherham; and
- the homicide.

The terms of reference

There are no stated terms of reference as such in the report document. However there was a statement setting out the remit of the 'panel'. This was to:

"Examine the care and treatment of the MHSU and to identify if the service provision to him was appropriate".

Have all facts been identified?

The Trust's internal investigation report does provide a full summary of the MHSU's contacts with the mental health services between 1990 and the date of the incident in March 2004.

Diagnosis and adequacy of the MHSU's care

There is no section of the report that presents the investigation team's reflective analysis of the MHSU's care and treatment. The only place where this is alluded to is in the conclusion to the report. The Trust's report does not comment on:

- The non-response to the MHSU's GP's referral for further psychiatric assessment in November 1992, and that subsequent to this the MHSU was not again assessed until December 1993.
- The significant delay in the MHSU being assigned a CPN following a request for CPN involvement made by the MHSU's then consultant psychiatrist in August 2002. The MHSU was not offered an appointment until June 2003.
- The fact that the MHSU was commenced on carbamazepine but that the follow up offered to the MHSU was not in keeping with the Maudsley Prescribing Guidelines 2003.

The report does note, in the conclusion, the panel's reservation regarding a possible diagnosis of a bipolar disorder which they could find no information in the MHSU's records to support.

Whether other issues had been explored

With regard to whether issues such as

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

had been adequately explored, there is no evidence that any of the above had been explored as part of the Trust's investigation. However this Investigation Team does not consider the non-examination of these issues to have been inappropriate. Any analysis of this MHSU's healthcare records would support a targeted assessment of his care and management rather than one that took a whole systems approach. The nature of the incident and the overall quality of the MHSU's care and management would not justify such a far reaching investigation.

Conclusions

The conclusions of the Trust's report are clearly stated.

Evidence of a systems analysis

There was no systems analysis undertaken as part of the Trust's internal investigation. Although we do not believe that a full systems analysis was merited in this case we would have expected the Trust's investigation panel to have explored the three issues we have highlighted above. Namely:

- The delay in providing the MHSU with any consultant follow up, following referral from his GP.
- The long delay in providing the MHSU with a CPN assessment following a consultant psychiatrist referral.
- The non-compliance with the Maudsley Prescribing Guidelines.

5.3 The Trust's current position in relation to the above three stated issues.

Because of the passage of time between the incident on 12 May 2004, the commissioning of this report in November 2007, and the lack of connection between events in 1992 and 2004, the Investigation Team decided in the interests of proportionality that it was not appropriate to explore the sequence of events surrounding the non-response to the GP referral in August 1992. Systems and processes have changed so much since this time that it is highly unlikely that there would be anything of value to be gained for contemporary clinical practice, systems or processes.

Consequence UK therefore agreed with NHS Yorkshire and the Humber SHA that it would explore only the issues relating to the monitoring of carbamazepine and the way in which non-urgent referrals for CPN input are managed.

5.3.1 Trust guidance regarding follow-up when medicines such as carbamazepine are prescribed.

The treatment of this MHSU's bipolar disorder was not best practice. In October 2003 he was commenced on carbamazepine by consultant psychiatrist 4 and not offered another appointment with this, or any doctor, for four-and-a-half months. This gap increased to seven months when the appointment with this consultant was cancelled.

In psychiatry textbooks dating from the 1990s there was guidance available which states "it is prudent to monitor the *blood* count in the first 3 months".

The 2003 (7th) edition of the Maudsley Prescribing Guidelines states that individuals put on carbamazepine:

- should be followed up every 2-4 weeks until stable;
- should be followed up every 3-6 months when stable; and
- should have a full blood count done pre-prescribing and then two weeks after prescribing. Subsequent blood monitoring should be conducted every 3-6 months.

There is no evidence in the case notes that this MHSU's care and treatment complied with this guidance.

The consultant psychiatrist responsible for the MHSU's care and management no longer works at RDaSH. However in response to the question of what its guidance had been at the time, the Trust advised the Investigation Team that medical staff were expected to work within the licensing terms for the drug in the UK. There were and are no specific standards around the drug's usage and each doctor is individually responsible for ensuring that its usage is appropriate and is monitored in line with nationally available guidance.

The Trust also advised that in 2006 the National Institute for Clinical Excellence suggested six monthly monitoring for carbamazepine.

What is clear from the Trust's response is that with only two clinical pharmacists it is not possible for them to undertake the monitoring of all medicines prescribed within the Trust in terms of full compliance with NICE and other nationally recognised guidance.

The director of nursing advised the Investigation Team that carbamazepine was an infrequently prescribed medication, and was in the MHSU's case prescribed because he specifically asked not to be prescribed lithium carbonate. The infrequent usage may have

contributed to the lack of proactive monitoring of the MHSU's blood post prescribing.

The Investigation Team is not confident that there is a robust approach to the monitoring of the prescribing of, and compliance with established rules, around certain types of drugs such as carbamazepine. It should be quite possible via the Adult Services Governance Group to plan a programme of medicines audits that looks at groups of drugs e.g. lithium and carbamazepine rather than one or the other. Indeed one would expect all medicines where serum levels are expected to be monitored to be subject to some type of periodic governance audit.

The Investigation Team did make enquires in two other mental health trusts about the provision of clinical protocols for carbamazepine and both had clear clinical protocols for this medication. RDaSH therefore needs to consider its current position in relation to the non-provision of such guidelines, especially in view of the non-compliance with expected standards for this MHSU in 2003.

5.3.2 The long delay in offering the MHSU a CPN assessment following the initiating referral in August 2002.

On 18 July 2002 the MHSU was seen in outpatients by his then consultant psychiatrist. One of the outcomes of this assessment was the MHSU's re-referral for community psychiatric nurse (CPN) support. This was detailed in a letter to the MHSU's GP on 1 August 2002 and copied to the team leader for the Community Mental Health Team (CMHT)-North.

On 22 August the team manager wrote to the MHSU advising him that he had been placed on the waiting list for a CPN when one became available. This letter was copied to the MHSU's consultant psychiatrist and also his GP.

On 3 October 2002 a further letter was sent to the MHSU advising him that "due to increased demands on the service" the CMHT was still unable to allocate him a worker. The MHSU was asked to complete the reply slip at the foot of the letter advising the CMHT whether or not he still required CPN support. A stamped addressed envelope was provided for this purpose. The letter to the MHSU at this time clearly stated that if no reply was received by 11 November 2002 then an assumption would be made that he no longer required the service. The MHSU was also advised to attend at his GP surgery if he felt that his situation had deteriorated.

On 22 November the MHSU was again seen by his consultant psychiatrist. The content of this correspondence clearly indicates that he continued to await the allocation of a CPN. What however is completely unclear is whether or not the MHSU returned the rely slip attached to the previous letter sent by the team manager of the CMHT.

In any event the consultant psychiatrist's letter of 22 November was copied to the team leader, so he would have been aware of the consultant's continuing expectation that he would be allocated a worker and also the MHSU's continuing need for a CPN.

A further letter from the same consultant to the MHSU's GP in February 2003 again noted that the MHSU continued to await the allocation of a CPN. This letter was again copied to the team leader for the CMHT.

On 16 June 2003 a letter was sent to the MHSU from a CPN working in community continuing care, offering him an appointment for 7 July. The appointment was with two CPNs.

The assessment did take place as planned at Swinton Health Centre. Following this a detailed letter was sent by the CPNs to the MHSU's new consultant psychiatrist (Cons P 5). The outcome of the CPN assessment was not to offer the MHSU support from the continuing care CPNs. The main reason for this was because of the MHSU's "expressed ambiguous intentions in engaging long term commitment around purposeful activity". It is also noted that the MHSU would continue to attend the Well Centre and have outpatient appointments for the periodic review of his medication regime.

The decision of the CPNs is not altogether surprising. The MHSU had been engaged with the Richmond Fellowship in 1997 and 1998 but was discharged from its service because of his unwillingness to engage properly with his key worker. The report undertaken for the magistrates court in May 2003 also highlights the MHSU's sporadic engagement with services, and his tendency to disengage once life appears to be running more smoothly.

The observation of this Investigation Team is that the MHSU appeared to engage well in the late 1990s when his consultant psychiatrist and CPN were supporting him clinically and socially, but as soon as he was expected to take some responsibility for his recovery and engage in a structured therapeutic programme, this caused problems.

In response to our question about how allocations of CPNs are made the Trust advised that in 2002 a grading process was used to categorise a MHSU's referral status on the basis of risk and need. Cases referred were assessed by the team and placed in one of three categories:

- Level 1 (A) – Risk and need considered very high and would be seen within 7-14 days;
- Level 2 (B) – Risk and need moderate, would be seen within the month; and
- Level 3 (C) Risk and need low, would be put on the waiting list.

Cases placed on the waiting list would be reviewed every two to three weeks by the team manager.

In the case of this MHSU his referral for counselling support was assessed as low risk, and it was not inappropriate for him to have been placed on the waiting list.

Comment by Investigation Team
It is accepted that there are limitations on the resources of the secondary mental health services and especially community mental health teams. However this MHSU did not present with an enduring mental health disorder and many of his documented problems seemed to be of a social and physical origin. It does not therefore seem unreasonable that following assessment he was not taken onto the CMHT caseload.

The Investigation Team were concerned that there were no timescales at all linked to the referrals graded as 'level three' (C). In determining the level of resource for a contemporary service it would seem sensible if time frames were set for level three referrals. Clearly as in the case of this MHSU an eleven month delay from the date of first referral to the CPN assessment does not seem at all satisfactory, regardless of any screening methods utilised.

Subsequent discussions with the Trust have revealed that it does now monitor the time period between a CMHT referral being made and the first face-to-face assessment for all persons regardless of their assessed risk and need levels. It advises the Investigation Team that the length of time that elapsed in this case is highly unusual.

6.0 OTHER ISSUES ARISING FROM THE INVESTIGATION

Although this investigation was predominantly conducted via documentation review there are a small number of issues the Trust may wish to reflect on.

Documentation:
In assessing the clinical records for this MHSU, the Investigation Team observed good quality documentation in relation to:

- GP correspondence; and
- progress notes made by in-patient services

However:

- The in-patient medical records were not always easy to read.
- In the progress notes made by alcohol services in 2002/2003, there is no mention of the MHSU's alcohol intake or attitude to alcohol, except for two occasions. Once, when the MHSU was drunk when his key worker attended at his house and once at the time he was discharged from the service. The progress notes mainly detailed the MHSU's mood and social circumstances only. For a specialist alcohol service this does not seem to be entirely satisfactory. One would expect for each meeting or assessment some record of how a service user is managing their alcohol habit, or not managing it. One might also expect some reflection by the key worker in relation to the presentation of the service user and whether or not there appeared to be any signs of intoxication.

Risk assessment
Although this case is some five years old, there is an issue in relation to the lack of formally documented risk assessments, and also of there being clear evidence within the clinical records that clinicians were mindful of the increased risks that this MHSU presented. The main reason we highlight this is that in both other cases associated with RDaSH, there were weaknesses in both risk assessment practice and in the documentation of risk. The Trust is very mindful that there are issues within its services in relation to risk assessment and in 2006 there was an action plan linked to case 2006/1787 that committed to reviewing the risk assessment documentation. Although the Trust did implement the Sainsbury's Risk Assessment paperwork expectations about the quality of documentation around risk assessment have increased and it is imperative that RDaSH puts the whole issue of risk assessment practice, and the revision of its documentation tools to support this, at the top of its healthcare governance agenda. It is also important that a clear auditable action plan is provided to NHS Yorkshire and the Humber.

To this end the Trust is referred to the recommendation made on pages 28 – 30 of the 2006/1787 report presented to the Yorkshire and Humber SHA Board on the same date as this (13 November 2008).

Serious untoward incident reports

This case was one of three cases investigated involving service users of RDaSH between 2004 and 2006. In all cases the investigation reports did not evidence the degree of analysis one would expect of a retrospective analysis of care and treatment post-homicide.
Because of the Investigation Team's collective reflections on the quality of internal investigation, we explored the content of the Trust's current policy on untoward and serious untoward incidents.

It is our opinion that this policy document could be more robust and provide better guidance for staff in how to conduct good quality investigations.

Specifically:

- If not addressed within a supporting risk management or incident reporting policy, RDaSH needs to provide clearer guidance regarding those incidents that require a high level investigation and those that can be investigated locally, or within a discrete service. It is the common standard in the UK that a 5X5 risk assessment matrix is used to grade all untoward incidents and the grade of incident should be used to determine the level of investigation required. In our experience a colour based coding system is easy for clinical staff and managers to use. For healthcare governance committees, and for the purposes of appropriately populating service based and corporate risk registers, there will need to be a more sophisticated approach to further prioritising any identified high risk issues.
- The responsibilities of local and senior managers need to be more clearly defined. At present the guidance leaves a lot open to individual interpretation and this is not ideal. One needs to achieve complete consistency in approach in how adverse incidents are managed and investigated across the whole organisation. We are doubtful that the current guidance achieves this.
- At point 5.3 "Stage Two" Investigations the RDaSH guidance about not automatically ceasing an investigation because of police interest is appropriate. However any such investigation should be steered at the highest level of the organisation and the involvement of the police sought in setting out the terms of reference for the Trust lead investigation. This is in keeping with the "Memorandum of understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm: A protocol for liaison and effective communications between the NHS, Association of Chief

Police Officers and Health and Safety Executive. ” Department of Health February 2006.

- Section 6 of the RDaSH policy is the section that needs most work. The current content does not follow the logical order of the investigation process. To provide good quality guidance for its staff, the Trust needs to consider a separate appended and cross referenced document that only provides guidance on the investigation process. If this is too onerous the Trust could directly refer its employees to the National Patient Safety Agency’s root cause analysis (RCA) e-learning tool kit http://www.msnpsa.nhs.uk/rcatoolkit/course/iindex.htm

- The Trust must provide much better guidance on the collection of information from staff involved in an incident. Currently to suggest that “appropriate notes of such information to be recorded” are made is insufficient. Whether staff are met with on a formal or informal basis, a full record of what was discussed should be recorded. Shorthand notes are not acceptable and of little use to an investigator or team. As a matter of good practice for formal interviews there should always be a note taker (preferably a member of the investigation team). The record of all meetings and interviews must be shared with the staff member so that they can validate the accuracy of the record, i.e. that it does reflect what was discussed and what the interviewee intended to convey. The whole issue of the digital recording of interviews also needs to be highlighted and the issues that need to be considered if this is thought necessary, including the interviewee’s right to a copy of the recording.

- Under section 6.2 the Trust alludes to the potential scenario where the actions of an individual may need investigation via the disciplinary policy or professional performance and monitoring polices. However nowhere does it require staff to utilise the NPSA’s Incident Decision Tree in formulating a decision about this. This good practice guidance can be found at http://www.msnpsa.nhs.uk/idt2/(jg0xno55baejor55uh1fvi25)/index.aspx

- The current policy document does not give any guidance on how records might be interrogated. It merely says that a ‘root cause analysis’ approach will be taken. This suggests a lack of understanding about the term root cause analysis. Root cause analysis means taking a systems based approach to the analysis of the incident. This means that issues such as culture, systems and processes of work, team leadership, supervision, task design (including the adequacy of clinical guidance tools), and the content and delivery of training workshops will be explored as an integral part of the investigation process. The Trust should provide its staff with a

clear statement relating to the investigation tools it expects them to utilise when undertaking assessment of a service user's records, for example the construction of a tabular timeline, or the construction of a 'process and control map'.

- Nowhere in the current guidance document does the Trust say that it expects clear identification of the main care delivery and service delivery concerns that directly impacted on the antecedents to the incident, and the incident itself. Neither does it require staff to discuss any other significant learning identified by virtue of doing the investigation.

- With regards to Appendix II of the policy there are a number of omissions in the report format template provided to staff. Specifically these are:
  - Under the cover page there is no requirement to put the date of the report
  - Under Part B there is no section where the findings of the investigation are expected to be presented, nor any requirement to state:
    - what positive feedback there is for staff;
    - what the main care delivery and service delivery concerns were and their impact or not on the subsequent incident; or
    - what the most important influencing factors were to each care delivery and service delivery concern identified.
- Although the report format does require a conclusion it would be useful to provide staff with an overview of what a conclusion is for. It is not for stating the investigation team's findings in full. It should however at least set out the investigation team's perspective regarding the preventability of the incident.
- Section 9 – Appendices. It would be helpful to staff to provide an overview of what information should be detailed within the appendices. For example:
  - The full chronology of the service user's contacts with the service;
  - The sources of information that informed the investigation team's findings. (Note: No individual's name should be used. All persons should have a coded reference or be referred to by their job title);
  - The detailed analysis of each main care delivery concern if the analysis is lengthy and complex; and
  - A glossary.

7.0 CONCLUSION OF THE INVESTIGATION TEAM

It is the opinion of the Investigation Team that the MHSU was challenging to offer an effective service to. His contacts with the service were punctuated by periods of engagement, most notably with CPN 1, Consultant Psychiatrist 1, and Consultant Psychiatrist 2, and by significant periods where he appeared to show no willingness to engage in a therapeutic regime that might have improved his social situation and therefore have been of benefit to his mental health.

There is clear documentary evidence that he was offered regular follow up at outpatients and that his CPNs up to and including 2002 made numerous attempts to visit him at home.

Between August 2002 and June 2003, there was a ten month delay in providing the MHSU with a CPN assessment, and when this did occur the outcome was that the MHSU was not a suitable candidate for the continuing care team. The primary reason for this was the MHSU's own stated ambivalence towards engaging in a structured programme with the team. Reflecting on his history of contact with the mental health service, the Investigation Team does not believe that a more timely CPN assessment would have changed this ambivalence.

In addition to the MHSU's lack of sustainable engagement with mental health services, both statutory and voluntary, he had a long standing problem with alcohol. Although he did accept that his pattern of drinking caused some problems in his life, most notably in relation to drink driving offences, he never accepted that it may have been a significant contributing factor to his continuing depression and social isolation. It is well recognised within statutory alcohol services, non-statutory services and Alcoholics Anonymous that until an individual accepts for themselves that their drinking is damaging their lives, and has an inner desire to stop drinking, then there is little anyone else can do to enable this.

In summary the Investigation Team does not believe that the mental health services in Rotherham could have done anything to have prevented the incident that occurred.

8.0 RECOMMENDATIONS

The recommendations the Investigation Team have for RDaSH are not numerous and none of them would have prevented the incident that occurred. The impetus behind each of these recommendations is to support the Trust's own commitment to improving its governance systems and processes and have come directly from this Investigation Team's reflections on the 2004/680 case.

- The Trust is very aware that it has some work to do, to ensure that clinical records evidence a robust approach to the clinical risk assessment of its service users. Consequence UK has recommended in a previous report that a full documentation audit is undertaken to assess the quality of documentation (and not merely whether specific "boxes" have been "ticked") is undertaken. We reiterate this recommendation here (see Independent Investigation Report 2006/1787 published 13 November 2008 Yorkshire and Humber SHA Board Meeting).

- The Trust must develop a detailed and auditable action plan for submission to the SHA, that shows the specific activities it is engaging in to achieve:
  - a uniform approach to risk assessment across all of its services;
  - clarity in understanding in its staff regarding their roles and responsibilities in the risk assessment process, for example in undertaking a full risk assessment where it has been clearly noted that this is required; and
  - a robust audit approach to risk assessment that employs a qualitative as well as quantitative approach, so that the Trust can be assured that the quality of practice is as it should be, or if such audit shows quality to be lacking then action can be taken in a timely manner to address this.

  (See also the recommendations in Independent Investigation Report 2006/1787 published 13 November 2008 Yorkshire and Humber SHA Board Meeting).

- The governance committee for adult services (inpatient and community) need to consider the current medication safety audits it conducts and whether or not these are sufficient. In particular this group needs to determine
  - whether or not there are medications in addition to lithium where detailed audit would also be beneficial to the checking and enhancement of clinical practice, and
  - whether any of these could be appended to the existing process for auditing practice around lithium thereby utilising an existing audit mechanism. This Investigation

Team expects that carbamazepine, although infrequently prescribed, could be one such medication.
    - whether there should be specific clinical guidelines for the use and monitoring of carbamazepine in the Trust.

- The alcohol treatment service needs to reflect on its own documentation to determine whether by-and-large it is satisfied with its own standards of documentation, and that the documented contacts with its client group adequately reflect the 'in the moment' position for the service user in relation to their consumption of alcohol and their attitudes to it, along with the subjective impression of the key worker or other assessing professional.

- The Trust must provide much more comprehensive and useful guidance to its staff on how to conduct a good investigation. The Trust is encouraged to take note of the information provided on pages 19 -21 of this report in addressing this issue. It may also benefit the Trust to invest in some skills based training for a targeted group of staff who could form a dedicated group of investigation facilitators. We are aware that some Trust staff have already attended investigator training but the benefits of this are not reflected in the internal investigation reports we have read.

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

This chronology gives a comprehensive picture of the MHSU's contacts with mental health services between June 1990 and 21 October 2004.

Date	Contact
3 June 1990	It is noted by the alcohol service that the MHSU "does not think he is an alcoholic"" but would accept that he has problems related to excessive drinking.
16 June 1990	The MHSU is admitted to hospital having taken some rat poison the night before. The precipitating factors were that: ❑ His wife was mentally unwell. ❑ He and his wife had opened a guest house in Rotherham, however his wife frequently went to Hartlepool to visit another gentleman and her mother. ❑ His wife was not settled in Rotherham. ❑ He had begun to drink heavily because he could not cope with his life stressors. ❑ He was on a charge of grievous bodily harm (GBH) towards his wife, and he also had a drink driving offence pending. On admission the MHSU is commenced on a medical detoxification regime and reviewed by the clinical nurse specialist in alcohol. The MHSU remained an inpatient for 17 days and was discharged on 3 July 1990. The plan was for him to receive follow up by the clinical nurse specialist in alcohol.
8 August 1990	A note in the records says that the MHSU recommenced a heavy alcohol intake following discharge from inpatient services. He has made contact with his GP but does not want hospital admission. The MHSU was subsequently seen at home by his consultant psychiatrist (Cons P 1). The MHSU and his wife requested that he be given another chance to 'dry out' in hospital. In view of the physical presentation of the MHSU (i.e. clear signs of physical withdrawal) Cons P 1 felt that his request should be supported. A bed was booked for him for 16 August. The MHSU was discharged on Vitamin B compound strong on the 22 August with outpatient follow up by the clinical nurse specialist.

Date	Contact
30 August 1990	The discharge letter relating to the previous admission revealed that the MHSU had been drinking since the age of 15, though he only admitted to it being a problem for the last two years. His wife also is noted to have an alcohol dependency problem with the MHSU supporting her.
16 October 1990	The MHSU is seen in outpatients. He is noted to be low in mood and feeling that he has no future. He has financial worries and social pressures with impending court cases. The guest house he and his wife were running has also gone into voluntary receivership. The letter to the MHSU's GP says that he will be followed up again in two weeks time and if there is no improvement in his low mood the psychiatric team will consider commencing him on anti-depressants. **Comment:** There is no mention of his alcohol dependency syndrome.
29 October 1990	A psychiatric report is prepared at the request of the MHSU's solicitors. This report says: "The psychiatric assessment revealed significant alcohol dependency syndrome". At the time of the psychiatric report the MHSU is noted to be drinking again but in a more controlled way at present. However it is also noted that his prognosis "has to be guarded, since he relapsed very quickly following his previous admission". The psychiatrist notes that he is "not particularly optimistic about his complete co-operation with treatment in the future". He also indicates that he would be prepared to continue to treat the MHSU as a condition of probation.

Date	Contact
15 December 1990	The MHSU is again admitted to hospital and is seen by a second consultant, Cons P 2. The reason for admission was suicidal thoughts as his wife had left him. He was also drinking heavily. On admission he was depressed, irritable, uncooperative and aggressive. The discharge summary of 14 January 1991 says “it has always been difficult to treat the MHSU as he doesn’t consider his drinking to be a problem”. In fact on this admission he continued to drink, and was therefore discharged from the ward.
25 April 1991	The MHSU is discharged from Cons P2’s caseload as he failed to attend his out patients appointments. He consultant indicates to see him again should the need arise.
3 November 1992	The MHSU is re-referred. The reason for referral is stated as depression and anxiety and that he has taken to his bed and will not leave it. His family are very concerned. It is noted in the record that Cons P 2 did not want to go and assess the patient as they did not get on. However no arrangement was made for another consultant to assess the MHSU at home. The MHSU’s GP therefore re-referred the MHSU in January 1993, again with little response from the psychiatric services. They are aware of his long standing alcohol dependency problems. They also note that anti-depressants have little to no effect. The response to this re-referral was to send an urgent outpatient appointment to the MHSU.

Date	Contact
3 December 1993	The MHSU's GP makes a substantial complaint about the psychiatric services' lack of response to the director of operations at the Priority Health Services Trust, which is passed to the then medical director of the Trust. There is no evidence that the complaint is ever investigated, it seems because the GP did not provide the name of the clinicians concerned or the patient. Without at least the patient's name, investigating the GP's concerns would have been very difficult. **Comment:** What is interesting is that the letter was filed in the MHSU's notes so someone did deduce which patient and therefore which clinicians the GP was unhappy about.
4 January 1994	The MHSU (now 57 years old yrs) is seen in outpatients. At this time he is complaining of feeling depressed. He is having difficulty in sleeping; his appetite and weight are poor. He is tearful and ruminates over morbid thoughts. His previous alcohol dependency is noted although the MHSU says that for the previous two years he has drunk very little and now drinks only occasionally. The SHO's letter to the GP notes that he has managed to remain abstinent without any Antabuse therapy. Medication at this time is omeprazole for a 'stomach complaint'. He is also noted to have been on a range of anti-depressants that he could not recall the names of. The community alcohol services are also noted to be continuing in their support of the MHSU. Further out patient follow up has been arranged for two weeks time. Medication prescribed was Prozac (fluoxetine) 20mg once a day (od)
24 August 1994	The MHSU is discharged from the psychiatric services for not turning up to his appointments.

Date	Contact
08 March 1995	The MHSU is discharged from inpatient services having been admitted on 22 February. He was admitted via alcohol services. His alcohol consumption was noted to be well controlled but his depression continued along with poor motivation. He was also noted to be neglecting his basic needs. He was also not wanting to go out and meet people and if anyone came to the door he would not answer.
6 December 1995	The MHSU is seen in outpatients. It is noted that he has been 'up and down' since his admission in February. He has a support worker who visits him once a week. His medication is increased to Prozac 20mg and 40mg on alternate days.
17 February 1997	The MHSU is discharged from mental health services as he did not attend four consecutive appointments.
22 July 1997	The Rotherham alcohol services write to the MHSU's GP advising that they are referring the MHSU to a range of additional services which they believed are better placed to meet some of his needs which are outside the scope of a specialist alcohol service.
10 September 1997	The MHSU is assessed in outpatients by the consultant psychiatrist (Cons P 1) who first saw him in 1990. The letter to the GP following his assessment is very informative and notes that although the MHSU's drinking is now much more controlled with him being able to go some weeks without a drink, when he does drink there is a tendency for his consumption to be excessive. On examination the consultant can find no psychotic features and says that persistent depression is his dominant problem along with social isolation. The MHSU's fluoxetine is increased to 40mg a day, and the consultant commits to liaising with social services in relation to his disability living allowance and also the alcohol team regarding the social support he is receiving. A referral is also made to the physiotherapy department.

Date	Contact
10 September 1997 continued	On the 19 September the consultant wrote to the Disability Living Allowance service in Blackpool supporting the MHSU's application for continuing financial support. The records also evidence referrals to the physiotherapist and also a letter to the director of housing asking if perhaps the MHSU could receive a visit from the housing department, so his housing needs could be reassessed with a view to supported housing accommodation where someone makes a check on his well being.
18 November 1997	The MHSU is reviewed in outpatients by Cons P 1. He is accompanied by his community support worker. It is not clear whether or not his increased medication has helped but there appear to be no detrimental effects so it is to be continued.
14 January 1998	The MHSU has a home appointment booked for 29 January with the community psychiatric nurse (CPN 1). His community support worker is to attend.
16 March 1998	The MHSU is referred to a cognitive and behavioural therapy nurse. CPN 1 is concerned about his social phobia. Many community support workers record negative house calls because the MHSU cannot face opening the door, not because he is not there. The MHSU is aware that the CPN is making a referral as he is keen to try anything that might help him progress socially.
24 March 1998	CPN 1 takes the MHSU onto her caseload as his alcohol abuse is no longer considered to be his primary problem. She advises the MHSU's GP of this.
22 April 1998	Follow up in outpatients by Cons P 1. The situation of the MHSU is much the same. His fluoxetine is increased to 60mg, with an instruction to the MHSU to reduce it if the increased dose doesn't suit him. This consultant psychiatrist is also to write to the Benefits Agency as the MHSU is due a 'benefits medical' which he may not be able to attend owing to his ill health. The consultant requests that he have his assessment at home.
30 April 1998	The MHSU is discharged from the alcohol support service. His drinking is stable and within normal limits.

Date	Contact
9 June 1998	The MHSU's support worker from the Richmond Fellowship liaises with CPN 1 as it is looking increasingly as though he will have to cease his attempts to provide support owing to the MHSU's elusiveness. The main reason for him being discharged is that the fellowship can only work with clients on a structured basis, they do not provide a crisis intervention service. A letter is sent by the Richmond Fellowship on 23 June to the MHSU explaining why they are having to discharge him and offering him further support should he wish to engage with them in a structured programme.
2 July 1998	The MHSU stops taking his fluoxetine due to tremors. His consultant psychiatrist therefore commences him on Lustral (sertraline) 50mgs bd. The plan is to review him in three months' time.
11 November 1998	CPN 1 supports the MHSU's request that he be exempt from paying for his community support as she feels that without input from their service his mental health state will deteriorate rapidly.
19 November 1998	The MHSU is seen in outpatients by the assistant to Cons P 1. The letter notes that the assistant counselled the MHSU at length, that his depression had relapsed over the last few weeks and that his Lustral was increased to 150mg in divided doses.
April 1999	There is an undated letter from the cognitive and behavioural therapy nurse advising that she is leaving the employ of the Trust and therefore will not be able to offer the MHSU an appointment. Note. The MHSU was referred in March 1998.
28 June 1999	The MHSU is seen in outpatients by his Cons P 1. The letter to the MHSU's GP notes that 'he is drinking a little bit' but is trying to ease off this. It is also noted the MHSU has not increased his lustral but Cons P 1 asks the GP to prescribe him 50mg three times a day.
22 November 1999	Seen in outpatients. Nothing new noted.

Date	Contact
24 February 2000	The MHSU is seen by Cons P1. It is at this appointment that the possibility of bi-polar disorder is tabled. The MHSU's CPN, CPN 1, has alerted the consultant to some behaviours in the MHSU that are suggestive of this disorder. Further questioning and reflection on the MHSU's past does bear this out. It is therefore mooted that the MHSU may be a 'lithium candidate'. Baseline bloods are therefore performed and Cons P1 advised the GP that he will see the MHSU again in March and discuss lithium therapy further with him.
16 March 2000	All of the MHSU's blood test results are normal including his liver function tests. The MHSU is advised about the side effects of lithium and also the dangers of mixing other medications with it especially non-prescription medications. The MHSU is started on 400mg nocte of lithium carbonate. The plan is to see him in eight days for a blood test (he has also been advised about these.)
11 April 2000	It is noted that the MHSU's lithium levels are just below normal i.e. 0.49mmol/l, the normal level being 0.521 mmol/l. His lithium dose is therefore increased to 600mg daily. His lithium levels are to be checked in six weeks.
6 October 2000	An application is made by CPN 1 for him to be re-housed as he can no longer cope in his current residence.
13 November 2000	Cons P1 writes to CPN 1 highlighting that the MHSU has 'missed more than a few appointments of late. The last time we saw him we were giving him a trial of lithium." The consultant advises that another appointment has been made for him and asks the CPN if she can facilitate his attendance.
22 February 2001	There is a change of CPN to CPN 2. The GP is informed.
6 March 2001	In a letter to a consultant psychologist it is highlighted by CPN 2 that when he was last seen in February, by his previous CPN, he was not taking any medication other than analgesics.
13 March 2001	CPN 2 writes to the Jury Service asking for the MHSU to be excused on health grounds.

Date	Contact
13 August 2001	There is a letter from CPN 2 to another consultant psychiatrist, Cons P 3, advising that the MHSU feels that he cannot work with her because she asks too many questions. He also feels her role is to look after him which she has advised him it is not. He is responsible for himself. The MHSU is noted as to not want any input from support services. He acknowledges that he has binge drinking sessions and during these times he doesn't see his support worker. He has been informed that if he doesn't want to work on a therapeutic level with CPN 2 then he will be discharged from her caseload.
8 October 2001	The GP surgery re-refers the MHSU for CPN input. The CMHT manager asks Cons P 3 if he would reassess the MHSU in outpatients on the 20 November and determine whether or not he needs re-referring for CPN input then.
23 November 2001	Following the MHSU's non-attendance at his outpatients' appointment CPN 2 writes to his GP explaining that she believed that alcohol services would again be a more appropriate service for him to be referred to. It is noted that he had not attended his last six outpatient appointments and that between March and August 2001 she had made several visits to his home, on three occasions he was under the influence of alcohol and due to a previous conviction of GBH to his last wife she did not wish to enter his home. On two further occasions she raised no response from his home.
21 February 2002	The MHSU is reviewed. He had last been seen by Cons P 1 on the 10 April 2000 and since then had failed to attend the out patients clinic. It is also noted that he had stopped all of his medications. With regards to his mental health the MHSU reports that his mood fluctuates for no apparent reasons and he tends to cry. He feels he doesn't have any adequate social company. He is noted to have a broken sleep pattern waking at around 1am and then two to three times after that. It is also noted that the MHSU feels that CPN input would be beneficial to him. The MHSU continues to admit to binge drinking, and this was especially so when he lived in his previous flat where his neighbour also used to drink. It is noted that the MHSU is not happy to take medication and will not engage in any social group. He was provided with a follow up appointment in three months time and advised to continue with Losec, Ventolin and Co-codamol for his physical health problems

Date	Contact
1 August 2002	At an out patients appointment the MHSU was encourage by Cons P 3 to recommence with Lustral 100mg in the morning. He advised the MHSU to obtain a prescription from his GP surgery. It is also noted that the MHSU again requested CPN input but not his previous CPN, CPN2.
22 August 2002	There is a letter from North Community Health Team advising the MHSU that he has been referred to them and as soon as a member of the team have a space on their caseload he will be allocated to a worker.
3 October 2002	The CMHT again write to the MHSU and advise that they still cannot offer him a CPN and are writing to find out if he still wants one. **Comment:** The history of this gentleman should have alerted the CMHT to the fact that such correspondence would be unlikely to elicit a response from this MHSU.
12 November 2002	The MHSU is seen by Cons P 3. It is noted that the MHSU is not taking any of the medications he has been prescribed – " he has been off lithium and sertraline for the last year or more". Cons P 3 also notes that the MHSU reports that he lives alone but that he used to get support from the Richmond Fellowship and also CPN 2 who 'has also stopped visiting him.' The MHSU's complaints about his life remain the same as previously. Cons P 3 tried to give reassurance and re-prescribed sertraline 100mg to be taken in the mornings. A 28 day supply of the medication was provided. Cons P 3 asks the GP to continue with repeat prescriptions. The letter dated the 22 November gives the impression that Cons P3 believes that the MHSU continues to await allocation of a CPN. **Note:** This time gap of waiting for allocation of a CPN is unacceptable. An outpatient appointment is offered for three months' time.

Date	Contact
10 February 2003	There is a file note from the court liaison officer advising Cons P 3 that the MHSU has been arrested in November 2002 on a charge of driving while disqualified and failing to provide a breath test for the police. The preliminary hearing was on 7 February and adjourned pending the acquisition of a psychiatric report. Cons P 3 is asked to provide a psychiatric report for the court hearing on the 21 March. On telephone discussion it is agreed that a further consultant, Cons P 4, will be asked to assess the MHSU and write the report.
14 February 2003	There is a letter from Cons P 3 to the MHSU's GP advising that the MHSU did attend outpatients on 4 February and is reporting that he is compliant with his medication of sertraline 100mgs once a day. On examination Cons P 3 notes that the MHSU is in a happy mood and free from any morbid ideations. The letter says "clinically he is free from depressive symptoms and as such he has maintained his progress since I saw him last". This letter is copied to the team manager for CPN allocation and also the court liaison officer.
26 March 2003	There is a letter from Rotherham Magistrates Court to the court liaison officer advising that although no psychiatric report was provided for the hearing on 21 March 2003, because the MHSU did not attend the appointment with the assessing clinician, one was still required by the court and therefore sentencing of the MHSU had been deferred to 16 May to enable one to be provided. The letter provides a clear outline of what areas they would like to see covered in the report. In the intervening time period the MHSU is on bail with a condition that he complies with his psychiatric treatment. An appointment is sent to the MHSU for 28 March with the consultant who will prepare the report for the court. The report is prepared and is dated the 12 May.

Date	Contact
12 May 2003	The psychiatric report for the court contains a concise summary of the MHSU's contacts with mental health services and his social and physical difficulties. It concludes that a custodial sentence would be difficult for the MHSU in relation to his physical and mental health issues. It suggests that the addition of a mood stabilising drug might assist along with continuous engagement with mental health services rather than the pattern of engagement and then non-engagement that the MHSU has had in the past. The report also highlights that alcohol misuse continues to be a significant problem for the MHSU. The report also notes that the MHSU is to have a new consultant psychiatrist as Cons P 3 is leaving the service.
5 June 2003	The MHSU has an appointment with his key worker at the Well Centre (an alcohol treatment service).
16 June 2003	The MHSU is offered a CPN appointment for 7 July 2003. Cons P 4 is copied into this correspondence as is the court liaison officer.
24 June 2003	The MHSU's first home visit from the alcohol service at the Well Centre takes place.
14 July 2003	The new CPN (CPN 3) for the MHSU writes to Cons P 4. The letter details the CPN assessment of the MHSU on the 7 July. The letter states the MHSU's history, social and physical problems. It also highlights that: ❑ The MHSU rarely goes out because he feels shaky and uncomfortable. ❑ His Sertraline is having very little effect. ❑ His sleep and appetite are poor. ❑ He presented with good eye contact, spontaneous and appropriate speech – although this was morbid in content. ❑ He established a good rapport. ❑ His mood was reactive and he, to the CPN, didn't appear low in mood of displaying any depressive symptoms. ❑ There were no reported plans of self harm. ❑ There was no evidence of abnormalities or disordered thinking and his cognitions were intact. The letter also notes that as a condition of his most recent drink driving offence he was engaged with the alcohol service from the Well Centre. The letter also notes that the MHSU continues to binge drink at his local recreational club, having previously said that he finds it difficult to leave the house. It is noted that the CPN has reminded the MHSU that he can use the drop in centre at the Richmond Fellowship if he feels socially isolated.

Date	Contact
CPN assessment cont	The conclusion of CPN 3 is that as a result of the MHSU's stated ambiguity in engaging in long term commitment around purposeful activity, the Team Leader and she feel that the provision of continuing care CPN support is not appropriate. It is noted that the MHSU will continue to attend the Well Centre and his outpatient appointments. The MHSU was advised of the outcome of his assessment on the 23 July.
3 September 2003	The MHSU is assessed by a consultant psychiatrist in alcohol abuse. The outcome of this assessment was detailed in extensive communication to the MHSU's GP on the 10 September 2003. The impression, unsurprisingly, is one of: ❑ harmful alcohol use; ❑ co-morbid affective disorder; ❑ social isolation; and ❑ arthritis and respiratory disease. It is also noted that the MHSU sees no link between his drinking and his physical mental or social problems. The only link accepted by the MHSU is in relation to his drink driving offences, but as he has sold his car this will no longer be a problem. The consultant notes that: ❑ They discussed safe ways of drinking. ❑ The MHSU wanted no further contact with the consultant but the consultant notes that he is willing to see the MHSU again at any stage. ❑ The consultant would check and see whether the MHSU has any recent blood tests including liver function and to arrange for these if not. ❑ The consultant would obtain a copy of the report prepared for the court.
5 September 2009	The MHSU is discharged from the Well Centre service as he does not see his alcohol consumption as problematic. There is therefore no value to him being seen by the alcohol service.

Date	Contact
21 October 2003	The MHSU met with Cons P 4. The key point from this assessment is that the MHSU was open to recommencing a mood stabilizer but not lithium. He was therefore commenced on carbamazepine modified release (MR) 200mg BD. The MHSU was provided with one month's supply. It is also noted that the MHSU has stopped going to the Well Centre and continues to binge drink about once a month. A follow up appointment has been offered for four months' time.
12 March 2004	The Incident occurs..

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

This investigation was confined to the analysis of the MHSU's clinical records the internal investigation report and the pre-sentencing report compiled by the consultant psychiatrist instructed by the MHSU's defence solicitor.

These activities were supplemented by telephone, email and written communications with Rotherham and Doncaster Mental Health Services and a face-to-face meeting with the MHSU.

The need to deliver a proportionate investigation, given that this MHSU was not affected by any acute mental health deterioration at the time of this incident, and the subsequent information revealed during the criminal justice proceedings meant that a more searching investigation of the care afforded this MHSU was not appropriate in this case.

GLOSSARY

Richmond Fellowship

Richmond Fellowship (RF) is one of the biggest voluntary agency providers of mental health care in the country. Every year, it works with hundreds of people who are living with the effects of serious mental health problems, often exacerbated by issues such as sexual abuse, or drugs and alcohol. RF helps people to gain a new sense of purpose and fulfilment, making a real contribution to the lives of service users.

RF offers a wide range of housing, care and community support services, and works extensively with people who might otherwise be excluded from the workplace because of mental ill health. Through training, work experience and work placements, it provides the support needed to get people back to work.

Bi Polar Disorder

The following explanation is taken from NHS Direct
http://www.nhsdirect.nhs.uk/articles/article.aspx?ArticleID=47

"Bipolar disorder, previously called manic depression, is a condition that affects your moods, which can swing from one extreme to another. If you have bipolar disorder, you will have periods, or episodes of depression and mania. The two extremes are characterised as follows:

- depression where you feel very low, and
- mania where you feel very high. If your symptoms are slightly less severe, it is known as hypomania.

Both extremes of bipolar disorder have other symptoms associated with them (see symptoms section). Unlike simple mood swings, each extreme episode can last for several weeks or longer. The high and low phases of the illness can be so extreme that they interfere with your daily life.

The exact cause of bipolar disorder is not fully understood, but the condition seems to run in families. It is a relatively common condition, with around 1 person in 100 being diagnosed as having bipolar disorder. It can occur at any age, but often develops between the ages of 18 and 24 years. Both men and women, and people from all backgrounds, can get it.

The pattern of mood swings in bipolar disorder varies widely between individuals. Some people have only a couple of bipolar episodes in their lifetime and are stable in between, while others may experience many episodes.

The depression phase often comes first. Initially, you may be diagnosed with clinical depression, and then have a manic episode some time later (sometimes years later), after which your diagnosis

might change. During a phase of depression, you may have overwhelming feelings of worthlessness which often lead to thoughts of suicide.

During a manic phase, you may feel extremely happy and have lots of ambitious plans and ideas. You may also spend large amounts of money on things that you cannot afford. Not feeling like eating or sleeping, talking quickly, and becoming annoyed easily, are also quite common. You may be very creative, and feel that mania is an extremely positive experience. However, during a manic phase, you may also have symptoms of psychosis, where you see or hear things that are not there."

Alcoholism

There are many definitions of alcoholism and most centre on the fact that an individual is dependent on alcohol. NHS Direct says:

"Alcohol misuse definition:
The problems associated with alcoholism, or alcohol dependence, are wide ranging, and can be physical, psychological, and social. For someone with a drink problem, drinking becomes a compulsion and takes precedence over all other activities.

A person with alcohol dependence:

- has a strong desire to drink alcohol,
- has difficulty controlling their use of alcohol,
- persistently uses alcohol despite being aware of the harmful effects,
- shows increased tolerance for alcohol, and
- shows signs of withdrawal when without alcohol.

Alcohol dependence can remain undetected for many years. Although some scientists think that there may a genetic link to alcohol dependence, it is very difficult to prove. The easy availability of alcohol and social patterns can influence the likelihood of a person becoming alcohol dependent.

Binge drinking

Binge drinking is defined as drinking eight or more units of alcohol in one session if you are a man, and more than six units in one session, if you are a woman. Studies are starting to reveal that drinking a large amount of alcohol over a short period of time may be significantly worse for your health than frequently drinking small quantities.

In the UK, binge drinking is becoming a big problem. Teenagers as young as 16, admit to binge-drinking, and around 40% of patients admitted to A&E are diagnosed with alcohol-related injuries or illnesses."

Perhaps the most straightforward is the general understanding detailed in the Alcoholics Anonymous website:

"Most of us agree that, for most of us, it could be described as a *physical compulsion, coupled with a mental obsession.* We mean that we had a distinct physical desire to consume alcohol beyond our capacity to control it, and in defiance of all rules of common sense. We not only had an abnormal craving for alcohol but we frequently yielded to it at the worst possible times. We did not know when (or how) to stop drinking. Often we did not seem to have sense enough to know when not to begin."

http://www.alcoholics-anonymous.org.uk/newcomer/What.shtml