Independent Investigation

into

SUI 2007/5748

Commissioned by

Yorkshire and the Humber

Strategic Health Authority

September 2011

Independent Investigation: HASCAS Health and Social Care Advisory Service

Report Author: Dr. Androulla Johnstone

Contents

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. Z, a service user with the South West Yorkshire Partnership NHS Foundation Trust, was commissioned by NHS Yorkshire and the Humber Strategic Health Authority pursuant to *HSG (94)27*[1]. This Investigation was asked to examine a set of circumstances associated with the death of Mr. W, in March 2007 who was also a service user with the Trust.

Mr. Z along with two other accomplices was convicted of the murder of Mr. W. Mr. W had been beaten to death.

Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's senior management who have granted access to facilities and individuals throughout this process. The Trust's Senior Management Teams have acted at all times in an exceptionally professional manner during the course of this Investigation and have engaged fully with the root cause analysis ethos of this Investigation.

1. Health service Guidance (94) 27

2. Condolences

The Independent Investigation Team would like to extend their condolences to the family and friends of Mr. W. Mr. W appeared to be estranged from his family and it was not possible to establish any contact with them.

3. Incident Description and Consequences

Background for Mr. Z

Mr. Z was born in 1961. It was reported that he had an unhappy childhood and home life. Mr. Z was bullied at school which he attended until the age of eighteen years. He remained unemployed from the time he left school to the time of the death of Mr. W in 2007, although he had taken part in various community training programmes.

Mr. Z lived on his own from the age of twenty years and maintained little contact with his family. He lived a chaotic and unstructured lifestyle. Mr. Z was referred to psychiatric services for the first time in December 2001 when he was suffering from low mood and panic attacks. Initially Mr. Z was assessed by a Community Psychiatric Nurse.[2]

In early 2002 Mr. Z was described as being low in mood without suicidal intent. At this time he disclosed that he had been hearing voices and this prompted a Psychiatrist-led assessment in the outpatient clinic. It became evident that Mr. Z had a significant problem with alcohol consumption. Mr. Z continued to be monitored in the outpatient clinic between May 2002 and the time of his sentencing and disposal by the Crown Court in December 2007. During the majority of this time he was diagnosed as *maybe* having either a depressive illness with psychotic features, or schizophrenia, which was accompanied by a harmful use of alcohol. Mr. Z reported auditory hallucinations on occasion. No definitive diagnosis was made prior to the incident occurring. At the time of the incident Mr. Z had failed to attend his last two outpatient appointments. At the time of the incident Mr. Z was on Standard CPA and was forty-six years of age.

Background for Mr. W

Mr. W was born in 1934 of Asian/Caribbean ancestry. At the time he received his care and treatment form the Trust he lived alone and had no relatives living in the United Kingdom. About fifteen years prior to his death Mr. W had sustained a blow to his head, which had led to him suffering considerable memory problems.

2 Internal Investigation Report

Mr. W had received care and treatment for mental health problems for a period of at least twenty-six years due to anxiety, panic and depression. Mr. W was described as 'vulnerable' and was also in the habit of consuming alcohol which served to increase his vulnerability when intoxicated. When under the influence of alcohol Mr. W would be befriended by people who took financial advantage of him, he would also become aggressive and sexually disinhibited. Prior to the incident Appointeeship had been discussed with him in order to prevent future financial exploitation. Mr. W refused this intervention.[3] At the time of his death Mr. W was on Enhanced CPA.

Incident Description and Consequences

Mr. Z and Mr. W had known each other for several years. On the day of the incident Mr. W visited Mr. Z's flat in the early evening. Another man and a woman, both friends of Mr. Z, also visited. During the evening neighbours reported hearing arguing and banging noises coming from Mr. Z's flat. Mr. W had allegedly made some offensive remarks about Mr. Z's female visitor, and these remarks led to Mr. Z and his two friends conducting a sustained attack upon him. During this attack Mr. W was punched, kicked and stamped upon. Mr. Z and his friends then left the flat after having removed Mr. W's mobile telephone and searched his pockets for money. Mr. Z and his friends went to a local off licence in order to buy alcohol. At this stage Mr. W was unconscious.

When Mr. Z and his friends returned to the flat they continued to attack him. They were interrupted by an unexpected caller to the flat whereupon an ambulance was summoned. Mr. W was dead when the paramedics arrived. He had received extensive injuries to his head, body and abdomen.[4]

Post Incident Care and Treatment

Immediately following the killing of Mr. W, Mr. Z received support from a Social Worker and Community Psychiatric Nurse from the Community Mental Health Team. On the 21 March Mr. Z was arrested on suspicion of murder and was released on bail.[5] The Social Worker acted as an Appropriate Adult on two occasions when Mr. Z was interviewed by the Police.

3 Case Notes Internal Investigation Mr. W P1
4 Court Transcription
5 Case Notes Mr. Z P142

In the days following the killing of Mr. W, Mr. Z could not return to his flat because it was a scene of crime and he was placed in Bed and Breakfast accommodation. Mr. Z continued to be seen in the outpatient clinic. Mr. Z continued to drink alcohol.

Initially Trust staff believed Mr. Z was regarded as a witness to the killing of Mr. W. However after a period of time it became apparent that Mr. Z was to be charged with murder. Trust staff attended Court with Mr. Z on the 7 June 2007 after which time Mr. Z was charged with murder and continued on bail until his trial in November 2007. During this period Mr. Z continued to receive regular support from the Community Mental Health Team.

Following the trial in November 2007, Mr. Z and his accomplices were found guilty of murder. Mr. Z was sentenced to life imprisonment with a minimum tariff of fourteen years prior to becoming eligible for consideration of release by the Parole Board. Mr. Z's place of disposal was prison.

4. Background and Context to the Investigation (Purpose of Report)

The Health and Social Care Advisory Service was commissioned by NHS Yorkshire and the Humber (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance *EL(94)27, LASSL(94) 4*, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*...in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery

of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what should have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident. The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been investigated fully by an impartial and independent Investigation Team.

5. Terms of Reference

Terms of Reference – Independent Investigation SUI 2007/5748

This case was graded a type 'C' review, which is primarily a desk top review.

The terms of reference, set by Yorkshire and the Humber Strategic Health Authority (the SHA) in consultation with South West Yorkshire Partnerships NHS Foundation Trust and NHS Kirklees, are as follows:

To examine the care and treatment of both service users (victim and perpetrator) by means of a documentary review, making recommendations for further investigation should the investigator believe this to be necessary.

In particular, to take account of and comment on:

- Application of the SUI (serious untoward incident) Policy.

- The quality of the internal investigation, including identification of good practice, root causes and learning points and the effectiveness of the recommendations made.

- The quality of the internal action plan.

- The Court's consideration of the service user's mental health status as a contributory factor to the incident.

The review of both service users' care and treatment should include assessment of:

- The suitability of that care and treatment in view of the service users' history, the extent of their vulnerability and their assessed health and social care needs;

- The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies,

including the Vulnerable Adults Policy, DNA Policy, Discharge Policy and Drug and Alcohol Strategy;

- The adequacy of risk assessment and care plans and their use in practice;

- The exercise of professional judgment and clinical decision making and the quality of clinical supervision provided;

- The interface, communication and joint working between all those involved in providing care to meet the service users' mental and physical health needs;

- In relation to the service user who committed homicide, a specific additional line of inquiry is the extent to which care and treatment was interrupted as a result of CPN staff changes.

To identify:

- Developments in services since the incident, notably local procedures to safeguard adults, and in particular progress made on implementation of the internal action plan. This should include assessment of the impact of action on frontline clinical practice.

- Points of good practice in the services users' care and treatment and the internal handling of this incident.

- Any additional learning points for improving systems and services.

To make:

- Realistic recommendations for action to address the learning points identified in order to improve services.

- If deemed necessary, realistic recommendations for any further investigation which the investigator believes is essential to complement their documentary review and to explore further potentially significant issues for learning.

To report:

- The investigation findings and recommendations to the Board of Yorkshire and the Humber Strategic Health Authority via the Independent Investigations Committee.

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of Pennine-based Mental Health Services. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation and Inquiry work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Team Leader and Chair

Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service. Chair, Nurse Member and Report Author.

Investigation Team Members

Mr. Alan Watson	National Development Consultant, Health and Social Care Advisory Service, Social Worker Member.
Dr. Len Rowland	Research and Development Director, Health and Social Care Advisory Service, Clinical Psychologist Member.

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, HASCAS Health and Social Care Advisory Service.
Mrs. Tina Coldham	National Development Consultant, Health and Social Care Advisory Service, Service User.
Dr. David Somehk	Consultant Psychiatrist.
Mrs. Louise Chenery	Stenography Services.
Mr. Ashley Irons	Capsticks Solicitors.

7. Investigation Methodology

In July 2010 NHS Yorkshire and the Humber (the Strategic Health Authority) commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in Section Six of this report.

This Independent Investigation was graded as a 'C' type review by NHS Yorkshire and the Humber. A 'C' type review is principally a documentary analysis review which utilises:

- clinical records;
- Trust policies and procedures;
- the Trust Internal Investigation report;
- the Trust Internal Investigation archive.

A 'C' type review does not seek to reinvestigate a case from the beginning if it can be ascertained that the internal review was robust. In a 'C' type review the Independent Investigation is charged with building upon any investigative work that has already taken place. After careful consideration the Independent Investigation Team found the work of the Internal Investigation to have been sound.

The Independent Investigation Team decided to interview Mr. W's Consultant Psychiatrist in order to understand better his life and vulnerabilities and to ascertain whether the care and treatment he received contributed in any way to his death. It was not possible to interview the two lead clinicians involved in the care and treatment of Mr. Z due to serious ill health and immigration.

It is usual for a 'C' type review to be conducted by a single person with the support of a peer reviewer. As the Health and Social Care Advisory Service had been asked to work on two other Investigations within the Trust at the same time, it was decided that a multidisciplinary team would be recruited to work upon all three cases simultaneously. Due to the economy of scale a multidisciplinary team was deployed to examine the care and treatment that both Mr. Z and Mr. W received.

The Investigation Methodology is set out below.

Communication with the Victim's Family

Mr. W had no family living in the United Kingdom. No contact details could be found for any family members or friends.

At the time of writing this report arrangements were being made by the Strategic Health Authority to make contact with the family of Mr. Z in order to explain the report publication arrangements with them.

Communication with Mr. Z

At the outset of the process NHS Yorkshire and the Humber, the Strategic Health Authority, wrote to Mr. Z. This was in order to explain the investigation process to him and to ask for his consent for the Independent Investigation Team to access his clinical records. Mr. Z gave his consent. At the time of writing this report arrangements were being made by the Strategic Health Authority to meet with Mr. Z to explain the findings and the report publication process to him.

Communications with the South West Yorkshire Partnership NHS Foundation Trust

In June 2010 NHS Yorkshire and the Humber wrote to the South West Yorkshire Partnership NHS Foundation Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. Z and Mr. W.

The Independent Investigation Team Chair worked with the Trust liaison person to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished.

On the 27 September 2010 a preliminary meeting was held between Senior Officers from NHS Yorkshire and the Humber, South West Yorkshire Partnership NHS Foundation Trust,

NHS Kirklees, and the Health and Social Care Advisory service. The purpose of this meeting was to discuss the Independent Investigation process and to determine key actions, roles and functions.

On the 6 December 2008 the Independent Investigation Team Chair and Social Worker Member of the Team visited the South West Yorkshire Partnership NHS Foundation Trust headquarters. This was in order to meet with the nominated Trust liaison person and to conduct a workshop for the witnesses who had been identified as requiring an interview with the Independent Investigation Team. The purpose of the meeting was to clarify the arrangements that were required for the forthcoming Investigation interviews planned to be held on the 11, 12 and 13 January 2011. The purpose of the workshop held for witnesses was to ensure that they understood the process, were supported and could contribute as effectively as possible.

Between the 11 and 13 January 2011 interviews were held at the Trust headquarters. During this period the Independent Investigation Team were afforded the opportunity to interview witnesses and meet with the Trust Corporate Team.

On the 8 February 2011 a meeting was held between the Independent Investigation Chair and the Trust Corporate Team in order to discuss the findings and to invite the Trust to contribute to the recommendation development.

At the time of writing this report a 'Learning the Lessons' workshop was being planned between the Health and Social Care Advisory Service and the Trust in order to provide witnesses to the Investigation, and other relevant members of the Trust, an opportunity to reflect upon the findings and the lessons learned as a consequence of this Investigation.

Communication with NHS Kirklees (Primary Care Trust)

The Independent Investigation Team Chair made contact with NHS Kirklees and a liaison person was identified. The PCT provided GP clinical records and performance management data to the Investigation Team.

Senior Members of the Health and Social Care Advisory Service Team met with the NHS Kirklees Director of Nursing and Associate Director of Clinical Governance on the 27

September 2010. On the 12 January 2011 another meeting was held between the Independent Investigation Team Chair and the Associate Director of Governance to discuss progress and additional process requirements.

At the time of writing this report a meeting was in the process of being arranged to discuss the Investigation findings and to ensure NHS Kirklees involvement with the recommendation development.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon processes.

Table One

Witnesses Interviewed by the Independent Investigation Team

Date	**Witnesses**	**Interviewers**
12-13 January 2011	Trust Acting Chief Executive Trust Acting Director of Nursing Trust Medical Director Service Director Consultant Psychiatrist of Mr. W	Investigation Team Chair (Nurse) Investigation Team Social Worker Investigation Team Clinical Psychologist In attendance: Stenographer

Salmon Compliant Procedures

The Independent Investigation Team adopted Salmon compliant procedures during the course of its work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign; and

(h) that they will be given the opportunity to review clinical records prior to and during the interview.

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Investigation Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual manner' and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview the general questions that they could expect to be asked. The Clinical Records were sent to the Health and Social Care Advisory Service during the first week in October 2010 and the Internal Investigation archive was sent during November 2010.

The Team Met on the Following Occasions:

22 October 2010. On this occasion the Investigation Team met to discuss the timeline and to identify issues that required further examination.

10 January 2011. On this occasion the Team met in order to plan the three-day meeting with the Trust in more detail following examination of the Internal Investigation archive.

7 February 2011. On this occasion the Team met to discuss findings and to work through a root cause analysis process.

Other Meetings and Communications

The Independent Investigation Team worked with the Trust between the 11 and 13 January 2011. During this period interviews with witnesses took place together with corporate interviews and meetings with Senior Trust and Primary Care Trust personnel. The Investigation Team were able to work on analysing Trust systems and clinical governance processes during this period.

Other communications were maintained via email and telephone in order to complete the Investigation report and to develop recommendations. A Consultant Psychiatrist was employed to objectively peer review the Investigation.

Root Cause Analysis (RCA)

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

The ethos of RCA is to provide a robust model that focuses upon underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learnt to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.
RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed.

2. **Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the Decision Tree and the Fish Bone.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team seeks to avoid generalisations and uses findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

8. Information and Evidence Gathered (Documents)

During the course of this investigation 790 pages of clinical records have been read and some 4,000 pages of other documentary evidence were gathered and considered. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. Z's South West Yorkshire Partnership NHS Foundation Trust records.
2. Mr. W's South West Yorkshire Partnership NHS Foundation Trust records.
3. The South West Yorkshire Partnership NHS Foundation Trust Internal Investigation Report and action plan.
4. The South West Yorkshire Partnership NHS Foundation Trust Internal Investigation Archive.
5. South West Yorkshire Partnership NHS Foundation Trust action plans.
6. Secondary literature review of media documentation reporting the death of Mr. W.
7. Independent Investigation Witness Transcriptions.
8. South West Yorkshire Partnership NHS Foundation Trust Clinical Risk Clinical Policies, past and present.
9. South West Yorkshire Partnership NHS Foundation Trust Incident Reporting Policies.
10. South West Yorkshire Partnership NHS Foundation Trust Being Open Policy.
11. South West Yorkshire Partnership NHS Foundation Trust Operational Policies.
12. South West Yorkshire Partnership NHS Foundation Trust Safeguarding Vulnerable Adults' Workbook.
13. Healthcare Commission/Care Quality Commission Reports for South West Yorkshire Partnership NHS Foundation Trust services.
14. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006.
15. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005.

9. Profile of the South West Yorkshire Partnership NHS Foundation Trust (Past and Present)

Profile of South West Yorkshire Partnership NHS Foundation Trust

The Trust was authorised as a NHS Foundation Trust on the 1 May 2009. The Trust is a specialist NHS Foundation Trust that currently provides mental health and learning disability services to the people of Calderdale, Kirklees and Wakefield. The Trust also provides specialist medium secure services to the whole of Yorkshire and the Humber.

The Trust strategic vision is *"enabling people with health problems and learning disabilities to live life to the full".* The Trust seeks to place service users at the centre of the service and to put people in control of their lives.[6] The Trust vision is to be:

- *the service of choice for service users;*
- *the employer of choice for staff;*
- *the provider of choice for commissioners and partners.*

The Trust values are:

6 Trust Presentation to the Independent Investigation

- *give people information to help them make choices;*
- *listen before we act;*
- *be open and honest;*
- *welcome constructive challenge;*
- *embrace diversity and treat people fairly;*
- *help people stay in control and make decisions;*
- *balance rights and responsibilities;*
- *treat people with dignity and respect;*
- *celebrate good practice;*
- *learn from experience;*
- *treat others as we would wish to be treated;*
- *do what we say we will.*

The Trust goals are:

- *develop a robust service strategy based on a sound understanding of stakeholder expectation and market opportunities;*
- *ensure that organisational systems are working to best effect to support effective service strategy;*
- *maintain and develop an organisational culture that reflects the Trust's values and promotes effective delivery of services for the diverse population served by the Trust, including challenging stigma and discrimination in mental health and learning disability services;*
- *develop a clear organisational structure which promotes accountability and responsibility at all levels;*
- *seek out opportunities to develop new services and approaches which support the Trust's strategy and its core business and help maintain a strong market position;*
- *ensure partnerships are developed which support the core business of the Trust and bring benefits for the communities served.*[7]

7 Annual Report and Accounts 1 May 2009 - 31 March 2010 PP 21-25

Table Two

Showing Staff in Post by Occupational Group

Staff in Post by Occupational Group	**2009/2010**
Professional, scientific and technical	138
Additional clinical services	576
Administration and clerical	469
Allied health professionals	117
Estates and ancillary	194
Medical	122
Nursing	908
Students	8
Total	**2532**

The Trust employs *circa.* 2,500 staff, who provide services from over 40 sites. 98 *per cent* of care is delivered in the community. During 2009/2020 the Trust had direct contact with approximately 26,000 people. During 2009/2010 the Trust had an annual turnover of £123.8m.[8]

Mental Health Service Provision: Kirklees Adult of Working Age North Kirklees Community Mental Health Team (details for Mr. Z's treating team).

At the time Mr. Z was receiving his care and treatment from the Trust an Operational Policy was in place.

Operational Policy Philosophy

"The service provides timely assessments to identify Mental Health needs for individuals in the working age (18-64) adult population of North Kirklees.

The service will provide health and social care packages for those individuals ensuring users' and carers' needs are central to the process.

8 Annual Report and Accounts 1 May 2009 - 31 March 2010 P31

The service will be delivered as close to the persons' home as is possible using the least restrictive and most empowering interventions." [9]

The service provided for adults of working age (18-64) with a full range of mental health problems.

The sector teams performed functions for two groups of people.

1) *"Most people referred to the team will have emotional (common) mental health issues and be referred back to their GP's after 3 to 6 contacts when their situation is improved (Primary Care). (Care Pathways 1-2)*

2) *A substantial minority will remain in the team for ongoing treatment, care and monitoring for longer periods possibly years. (Secondary Care) (care pathways 3-12). They will include people requiring ongoing specialist care for:*

    i. *Severe and persistent mental disorder associated with significant disability, predominately psychosis such as schizophrenia and bipolar disorders.*

    ii. *Longer term disorders of lesser severity but which are characterized by poor treatment adherence requiring proactive follow up (eg depression/anxiety).*

    iii. *Any disorder where there is significant risk of self harm or harm to others (eg acute depression) or where the level of support required exceeds that which can be offered in primary care.*

    iv. *Complex problems of management and engagement such as presented by people requiring interventions under the Mental Health Act (1983), except where these have been accepted by the Assertive Outreach Team.*

9 Operational Policy 020806j P4

v. Severe disorders of personality where these can be shown to benefit by continued contact and support except where these have been accepted by the Assertive Outreach Team (AOT).''[10]

The service sought to provide:

- assessment;
- primary/secondary care working;
- regular review;
- psychological therapy input where appropriate;
- physical health care;
- continuity of care;
- medication;
- support with activities of daily living;
- help in accessing employment and education;
- family and carer support;
- relapse prevention;
- treatment of substance misuse.

Caseload

Full time Care Coordinators had a maximum caseload significantly below 35. For enhanced CPA, care coordinators included Community Mental Health Nurses, Approved Social Workers and Social Workers from within the team, plus medical staff through outpatient clinics.

Staffing

The Community Mental Health Teams each consisted of one Team Manger, Community Mental Health Nurses, Approved Social Workers, Social Workers, Principal Community Care Officers and Community Care Officers Medical staff were integrated into the teams but had only a limited amount of dedicated time within them.

10 Operational Policy 020806j PP4-5

Hours of Operation

Monday – Thursday	8.45am – 5.15pm
Friday	8.45am – 4.45pm

No crisis provision was made available out of hours from the team. Service users and carers could access the Crisis Home Treatment team based at Dewsbury and District General Hospital (DDH) for advice and support. Alternatively they could contact local emergency services (Social Services Emergency Duty Team, Accident and Emergency Department Dewsbury District Hospital, Police).

Mental Health Service Provision: Kirklees Older Peoples' Service Community Mental Health Team (details for Mr. W's treating team).

The framework underpinning Community Mental Health Team (CMHT) practice in Kirklees is, and was at the time of the incident, based upon an interdisciplinary biopsychosical model of care. This means that mental health problems are assessed for their biological, psychological and social impacts upon an individual in a holistic manner.[11]

At the time of the incident the North Kirklees Older Peoples' Community Mental Health Team comprised:

1 whole time equivalent Band 7 Team Manager;
1 whole time equivalent Consultant Psychiatrist;
(Junior Doctor cover);
2 whole time equivalent Band 6 Nurses;
1 whole time equivalent Band 5 Nurse;
0.8 whole time equivalent Level 3 Social Worker;
0.6 whole time equivalent Band 6 Occupational Therapist;
1 whole time equivalent Band 3 Support Worker;
0.4 whole time equivalent Band 3 Support Worker/Community Assistant.[12]

At the time of the incident referrals were accepted from any health or social care professional, however the operational policy made clear the expectation that General Practitioners would be consulted with prior to a referral being made. Priority was given to those individuals with

11 CMHT Older People Kirklees Operational Policy Review 2008 PP4-5
12 CMHT Older People Kirklees Operational Policy Review 2008 P8

severe and enduring mental health problems that required ongoing contact with specialist services.

The CMHT was expected to aspire to the provision of a seven-day service. However it was recognised that a seven-day response to crisis situations was not always possible. Out of hours work was possible, for example at weekends and in the evenings, but only on a pre-planned basis.[13]

Referrals were categorised as follows:

'immediate' referrals were to be seen within 24 hours;

'urgent' referrals were to be seen within three days;

'routine' referrals were to be seen within 28 days.[14]

At the time of the incident specialist assessment depended upon the needs and presentation of the person being referred. The 2008 Operational Policy stated that *"for urgent referrals, verbal feedback will be provided within 24 hours of first contact, depending on the availability of the referrer. Written report will follow within 14 days. The results of all other assessments will be made in writing within 14 days of first contact."*[15]

13 CMHT Older People Kirklees Operational Policy Review 2008 P12
14 CMHT Older People Kirklees Operational Policy Review 2008 P13
15 CMHT Older People Kirklees Operational Policy Review 2008 P14

10. Chronology of Events

This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. Z and on his care and treatment from mental health services.

Background Information

Mr. Z is a white British man who was born in 1961. He was reported to have had an unhappy childhood and home life and to have been subject to bullying at school. Mr. Z left school at 18 years of age, and between this time and the incident in 2007 he never found permanent employment. Mr. Z left home at the age of twenty years and lived alone, he began to misuse alcohol at the age of 26. In 1998 Mr. Z was arrested for being drunk and disorderly and was detained in a Police cell for one night.[16]

Clinical History with the South West Yorkshire Partnership NHS Foundation Trust

Mental Health Chronology

11 December 2001. Mr. Z was referred by his GP to psychiatric services. He was low in mood, lethargic and suffering from panic attacks. Prior to this he had been prescribed Venlafaxine (an anti depressant) that had produced little positive effect on his mood.[17]

24 January 2002. Mr. Z was assessed by a CPN (CPN 1) who was attached to the GP surgery. An assessment and HoNOS Plus (a triage and needs assessment tool) were completed. The plan was for: breathing/relaxation techniques, anxiety management, and cognitive interventions to challenge negative thoughts.[18]

16 Case Notes Y P217
17 Case Notes Y P96
18 Case Notes Y P96

15 February 2002. During a meeting with CPN 1 Mr. Z disclosed that he was hearing voices which suggested that he kill himself. CPN 1 discussed this with the GP and on the 1 March 2002 the GP made a referral for Mr. Z to be seen urgently by a Consultant Psychiatrist for an assessment. At this time the GP stated that Mr. Z was prescribed Chlorpromazine Hydrochloride.[19]

26 April 2002. Mr. Z was seen by CPN 1 who noted that he was unkempt and was neglecting himself. It was also noted that Mr. Z was binge drinking. The CPN wrote that she would check the progress of the outpatient referral request.[20]

29 April 2002. CPN 1 discussed the case at the team meeting with medical staff.[21]

21 May 2002. Mr. Z was seen in the outpatient clinic by a Staff Grade Doctor (Staff Grade Doctor 1). At this appointment it was noted that Mr. Z was unemployed and lived on his own. Mr. Z's presenting complaints were *"anxiety, panic attacks, low mood, hearing voices and drinking heavily over the past one and a half years."* Mr. Z told the Doctor that his motivation had decreased and his mood had deteriorated. Mr. Z also told the Doctor that he was hearing voices. He had been drinking two to three pints of lager three to four times a week, more recently this had increased to six or seven pints of lager a night, or sometimes three litres of cider instead. Mr. Z expressed his concerns about being exploited financially by his acquaintances, and whilst he had no desire to harm others, he stated that he had thoughts of committing suicide.[22]

During this appointment no previous psychiatric history was noted. Mr. Z had been prescribed Olanzapine 5 mg (an anti psychotic) at night by the GP three week previously and continued with his Venlafaxine. Mr. Z did not think that the medication was having any positive effect upon his mental health. The Mental State Examination established that Mr. Z was unkempt and appeared to be neglecting himself. It was also identified that Mr. Z was feeling depressed and had a blunted affect, that he was experiencing derogatory auditory

19 Case Notes Y P218
20 Case Notes Y P96
21 Case Notes Y P96
22 Case Notes Y P216

hallucinations and that he acknowledged he might be mentally ill and was willing to take medication.[23]

The impression was that Mr. Z was suffering from depression with psychotic symptoms and that a "*differential diagnosis would be paranoid schizophrenia."* There was also evidence of a harmful use of alcohol. The plan was to conduct a series of blood tests, to increase the Olanzapine to 5 mg twice daily and commence Paroxetine 20 mg (an anti depressant) in the morning. The Doctor planned to follow up Mr. Z in the outpatient clinic in six weeks time and for CPN 1 to continue to work with him in the community.[24]

6 June 2002. The Staff Grade Doctor wrote to the GP to inform him of the outcome of the first outpatient appointment.

2 July 2002. On this day Mr. Z was seen again in the outpatient clinic. On this occasion Mr. Z was seen by a different doctor, Staff Grade Doctor 2. It was noted that he appeared to be a little better, although generally low in mood. Mr. Z was still hearing voices, which he found distressing, and thought that people were telling him what to do and trying to impose their will upon him. The Doctor increased the Paroxetine to 30 mg and planned to see Mr. Z again in the outpatient clinic in six weeks time. The Doctor wrote to the GP on the 8 July 2002 to inform him of the progress that was being made.[25]

5 July 2002. CPN 1 met with Mr. Z whereupon he was described as being more animated and alert, but still drinking excess quantities of alcohol.[26]

26 July 2002. CPN 1 held a joint interview with Mr. Z and another CPN, (CPN 2) in order to transfer the case as she was leaving the service. It was noted that Mr. Z continued to drink excessively and was agitated about having an unwanted lodger at his home. On the 29 July 2002 CPN 1 wrote to the GP to inform him about the change of CPN.[27]

13 August 2002. Staff Grade Doctor 1 saw Mr. Z at the outpatient clinic. Mr. Z attended his appointment in an intoxicated state as he had been drinking since 6.10am. On this occasion

23 Case Notes Y P217
24 Case Notes Y P217
25 Case Notes Y P215
26 Case Notes Y P97
27 Case Notes Y P97

Mr. Z stated that he had been drinking between one and two large bottles of cider every day for a year. Mr. Z told the Doctor that he had someone staying with him and that the situation was intolerable and that *"she is a witch and she is very controlling".* Mr. Z said that he still had fleeting ideas about killing himself, but that he had no plan.

The plan was:

- due to Mr. Z's intoxicated state to see him again in one week's time;
- to discuss the situation regarding the lodger with CPN 2;
- to prescribe a one week supply of Zopiclone 7.5 mg (a sleeping tablet) to help with Mr. Z's insomnia;
- to discuss Mr. Z's heavy alcohol consumption with him at the next appointment.[28]

Staff Grade Doctor 1 wrote to the GP on the 19 August 2002 and wrote under diagnosis "*?depressive illness, ?harmful use of alcohol, ?schizophrenia".*[29]

20 August 2002. CPN 2 visited Mr. Z at his home. On this occasion Mr. Z was sober, but remained stressed by his lodger's presence.[30] Later on the same day Mr. Z attended his outpatient appointment with Staff grade Doctor 1.

Mr. Z apologised for his behaviour at the previous appointment. He told the Doctor that he continued to hear voices when he was falling asleep, the voices would say *"I am Jesus, kill yourself"* these voices distressed him. He denied any thoughts of wanting to harm others or kill himself. Mr. Z told the Doctor that he continued to binge drink and that he had assaulted someone the previous week whilst he was intoxicated. The Doctor discussed the dangers of using alcohol as a coping strategy. The plan was to increase the Olanzepine to include an additional 10mg at night. CPN 2 was to continue her involvement and Mr. Z was to be seen in the outpatient clinic in eight weeks time.[31]

28 Case Notes Y PP213-214
29 Case Notes Y P213
30 Case Notes Y P98
31 Case Notes Y P212

3 September 2002. CPN 2 visited Mr. Z at his home. It was apparent that Mr. Z had been drinking prior to the visit. The plan was to refer him to the Mirfield Day Centre to provide structure to his day.[32]

13 September 2002. A letter was sent from a neighbour of Mr. Z to Social Services stating concerns that he was neglecting himself. It was felt that no immediate action needed to be taken as Mr. Z was already being seen by mental health services.[33]

1 October 2002. CPN 2 visited Mr. Z at his home. The problems regarding the lodger were discussed.[34]

10 October 2002. A letter was sent from the Mirfield day centre regarding Mr. Z's referral.[35]

22 October 2002. CPN 2 visited Mr. Z at his home.[36] On this day the appointment at the outpatient clinic with Staff grade Doctor 1 was cancelled as the Doctor was on sick leave.[37]

24 October 2002. Mr. Z attended the Mirfield Day Centre. He agreed to a referral for Social Services support ('Rendezvous' Batley Enterprises).[38]

1 November 2002. A letter was sent to Mr. Z from the Mirfield Centre to offer him a half-day-a-week placement commencing on the 11 November 2002.[39]

19 November 2002. Staff Grade Doctor 1 saw Mr. Z in the outpatient clinic. The lodger had moved out (this person was another mental health service user and her CPN had been able to find alternative accommodation) but Mr. Z was worried she would return. Mr. Z said that he was still hearing voices in the night which he thought wanted him to kill himself. Mr. Z thought that the voices may have been evil forces tuning into his mind. He admitted to drinking four to six pints once or twice a week. The plan was to continue with his medication,

32 Case Notes Y P98
33 Case Notes Y P98
34 Case Notes Y P98
35 Case Notes Y P98
36 Case Notes Y P99
37 Case Notes Y P131
38 Case Notes Y P99
39 Case Notes Y P99

to continue with CPN 2, and to be referred to MIND for counselling.[40] A letter was sent to the GP four weeks later detailing the outcome of the meeting.

26 and 28 November 2002. CPN 2 made two visits to Mr. Z's home, but he was not in. CPN 2 was about to leave the service and Mr. Z's care was to be transferred to another CPN. A letter was sent to Mr. Z advising him to contact the new CPN.[41]

2 December 2002. Mr. Z attended 'Rendezvous' Batley Enterprises. He also met with his new CPN, CPN 3, in response to the letter sent to him on the 28 November.[42]

12 December 2002. CPN 3 made a home visit. Mr. Z confirmed that he felt much better now that his lodger had moved out. Following this visit he was discharged by CPN 3. The plan was for Mr. Z to continue with his outpatient appointments. CPN 3 wrote to the GP to say that Mr. Z's main difficulties were social isolation and the excessive drinking of alcohol. Mr. Z had decided not to attend the Day Centre as it was too far away from his home, but that he was going to take up the 'Rendezvous' opportunity. Mr. Z appeared to be more stable and it was thought that he no longer required Community Mental Health Team input.[43] A copy of this letter was sent to Staff Grade Doctor 1 at the outpatient clinic.

25 March 2003. Staff Grade Doctor 1 saw Mr. Z in the outpatient clinic. Mr. Z's diagnosis was still unclear. It was evident that Mr. Z had increased his drinking as he was drinking up to three large bottles of cider a day. He did this as *"a release and to help him sleep".* Mr. Z continued to feel depressed. He had not heard from 'Rendezvous' and said he would like to attend, he also said that he planned to attend MIND. On this occasion the Doctor wrote *"pseudo hallucinations".*[44] Mr. Z was referred to 'Lifeline' in order to address his alcohol problems. Staff Grade Doctor 1 wrote to the GP following this appointment to update him as to Mr. Z's progress.

40 Case Notes Y P131
41 Case Notes Y P99
42 Case Notes Y P100
43 Case Notes Y P211
44 Case Notes Y P132

31 March 2003. Mr. Z attended 'Lifeline'. It would appear that he only attended once. At this time he was drinking at least nine litres of cider each week. He was offered two further appointments which he did not attend.[45]

10 June 2003. Mr. Z attended an outpatient appointment with Staff Grade Doctor 1. On this occasion it was noted that Mr. Z was still drinking between five to eight pints of beer each day. He still described auditory hallucinations. He was not suicidal. His medication was not altered. The Doctor gave him a 'Lifeline' leaflet and explained to him that his medication would not be as effective as it could be if he carried on drinking, and that drinking would also adversely affect his mental health. The Staff Grade Doctor planned to see Mr. Z again in two months time and wrote to the GP to this effect.[46]

12 August 2003. Mr. Z attended an outpatient appointment with Staff Grade Doctor 1. Mr. Z told the Doctor that he was staying with acquaintances, as squatters had broken into his flat and that the council had boarded it up in order to make repairs. On the 4 July Mr. Z had broken his elbow in a fall whilst he was intoxicated, as a result Mr. Z had refrained from drinking. He thought he may have been pushed.

Mr. Z expressed vague ideas of persecution. His auditory hallucinations had decreased in their intensity and frequency. Although his still complained of low mood, decreased motivation and insomnia, he was not suicidal. The Doctor increased the Paroxetine to 40 mg in the morning and advised Mr. Z to take all of his prescribed Olanzapine at night time. Mr. Z was also prescribed a seven-day supply of Zopiclone 7.5 mg to help relieve his insomnia. The plan was to review him in ten weeks time. A letter was sent to the GP in order to provide an update as to Mr. Z's progress.[47]

28 October 2003. Mr. Z attended an appointment at the outpatient clinic with Trust Grade Doctor 1 (a new Doctor had been assigned to the case). No change was noted with regard to Mr. Z's mental state. Mr. Z had started drinking again and was drinking six to eight cans of beer a day, usually commencing at midday. He told the Doctor that on the days that he drank he did not take his medication. He denied having hallucinations, his mood was stable and he was not suicidal. Mr. Z said he was motivated to stop drinking and the Doctor advised him to

45 Case Notes Y P100
46 Case Notes Y PP133 & 207
47 Case Notes Y PP133 & 205

go to 'Lifeline' for detoxification. The plan was to see him in two month's time. The GP was written to with an update regarding Mr. Z's progress.[48]

12 January 2004. Mr. Z was seen in the outpatient clinic by Trust Grade Doctor 1. On this occasion it was noted that Mr. Z was feeling better, was sleeping well and had reduced his alcohol consumption. Mr. Z had not contacted 'Lifeline' because he felt that he could stop drinking without their help. He had no ideas of self harm, or of harming others and felt happy with his condition.[49]

22 March 2004. Mr. Z attended his outpatient appointment with Trust Grade Doctor 1. There was no change noted regarding Mr. Z's mental state. Mr. Z was drinking heavily again, consuming eight pints each day. He reported hearing voices coming from inside his head. He was sleeping and eating well. No psychotic or depressive symptoms were evident. Mr. Z was advised to cut down his drinking and to take his medication. The plan was to review him again in three months time. The GP was written to with a progress update.[50]

17 May 2004. On this day Mr. Z attended for his outpatient appointment with Trust Grade Doctor 1. No changes were noted in his mental state. Mr. Z reported that he had cut down on his drinking, was sleeping well and had a good appetite. Once again Mr. Z appeared to be happy with his condition. No changes were made to his medication, and Mr. Z continued to refuse help with his drinking. A letter was sent to the GP.[51]

9 August 2004. The Trust Grade Doctor 1 saw Mr. Z in the outpatient clinic for review. It was noted that Mr. Z appeared to be doing well and that there was no change in his mental state. On this occasion Mr. Z was happy with his condition was kempt and had good eye contact. No depressive or psychotic symptoms could be detected. He was advised to continue with his medication. A blood test was offered to him but he refused this. The plan was to see him again in three to four months time. The GP was written to.[52]

15 November 2004. Mr. Z was reviewed in the outpatient clinic by Trust Grade Doctor 1. Mr. Z told the Doctor that he felt well. He was taking his medication and eating and sleeping

48 Case Notes Y P204
49 Case Notes Y PP134 & 203
50 Case Notes Y PP135 & 202
51 Case Notes Y PP135 & 201
52 Case Notes Y PP136 & 200

well. He experienced no hallucinations and was not deluded. Mr. Z was still drinking two to three pints of lager every two to three days. Mr. Z was kempt and had good eye contact. He refused the offer of some community activity. The plan was to review him in the clinic in three months time. The GP was written to with an update of his progress.[53]

21 February 2005. Mr. Z was reviewed at the outpatient clinic by Trust Grade Doctor 1. No change was noted. Mr. Z said he had not been drinking for several months, he was kempt and had good eye contact. Mr. Z was advised to continue with his medication and the plan was to review him in the clinic in four month's time.[54]

13 June 2005. Mr. Z was reviewed in the outpatient clinic by Trust Grade Doctor 1. Mr. Z reported that he was feeling better and that his mood had improved. He was taking his medication and not drinking alcohol. He was well kempt and with no depressive or psychotic symptoms. The plan was for him to continue with his medication and to be seen in the clinic in three to four months time. Once again Mr. Z refused any community-based support. The GP was written a progress report.[55]

8 September 2005. Mr. Z was reviewed at the outpatient clinic. Trust Grade Doctor 1 noted that there was no change to Mr. Z's condition and that he continued to do well. He gave him a form for a blood test for a full blood count, liver function test, cholesterol, urea and electrolyte test. The plan was to review him again in four month's time. The GP was sent a letter updating him on Mr. Z's progress.[56]

9 January 2006. Trust Grade Doctor 1 saw Mr. Z in the outpatient clinic for review. Once again Mr. Z was reported as feeling well and no changes were noted in his mental state. Mr. Z had reduced his alcohol consumption and continued to take his medication. The Doctor gave Mr. Z another form for a blood test. On this occasion the Doctor decided to reduce Mr. Z's Olanzapine down to 10 mg a day. The plan was to review him again in two to three months time. The GP was sent a letter regarding Mr. Z's progress.[57]

53 Case Notes Y PP 136 & 199
54 Case Notes Y PP137 & 198
55 Case Notes Y PP137 &197
56 Case Notes Y PP138 & 196
57 Case Notes Y PP138 & 194

6 March 2006. Mr. Z attended an outpatient clinic appointment. The Doctor noted that Mr. Z was in *"good remission"* his mood was stable and there were no psychotic or depressive symptoms present. The plan was to continue as before and to review him on four month's time. The GP was written to with an update.[58]

13 June 2006. Trust Grade Doctor 1 saw Mr. Z in the outpatient clinic for review. The diagnosis was still unclear, it was noted in a letter to the GP *"?depression, ?schizophrenia".* There was no change noted and Mr. Z continued to be well. The plan was to review him again in three months time. The GP was written to with an update.[59]

5 September 2006. Mr. Z was due to be seen in the outpatient clinic. He did not attend his appointment. A letter was sent to the GP informing him of this and stating that Mr. Z would be sent another appointment. Apparently Mr. Z was drunk and had forgotten his appointment.[60]

19 March 2007. On this occasion the outpatient service cancelled the appointment. Another appointment was sent to Mr. Z for the following day.[61]

End March 2007. Mr. Z did not attend the new outpatient clinic appointment.[62] On this day Mr. W was beaten to death in Mr. Z's flat.

Account of the Incident March 2007

Mr. Z and Mr. W had known each other for several years. On the day of the incident Mr. W visited Mr. Z's flat in the early evening. Another man and a woman, both friends of Mr. Z, also visited. During the evening neighbours reported hearing arguing and banging noises coming from Mr. Z's flat. It was reported that Mr. W made some offensive remarks about Mr. Z's female visitor, and these remarks led to Mr. Z and his two friends conducting a sustained attack upon him. During this attack Mr. W was punched, kicked and stamped upon.

58 Case Notes Y P193
59 Case Notes Y PP139 & 192
60 Case Notes Y PP 190-191
61 Case Notes Y P140
62 Case Notes Y P140

Mr. Z and his friends then left the flat after having removed Mr. W's mobile telephone and searched his pockets for money. Mr. Z and his friends went to a local off license in order to buy alcohol. At this stage Mr. W was unconscious.

When Mr. Z and his friends returned to the flat they continued to attack him. They were interrupted by an unexpected caller to the flat whereupon an ambulance was summoned. Mr. W was dead when the paramedics arrived. He had received extensive injuries to his head, body and abdomen.[63]

Post Incident Care and Treatment

21 March 2007. A request was made by the Police for an Appropriate Adult to be assigned to Mr. Z as he had been taken into Police custody. It was noted during the course of the Police interviews that he was *"appearing calm, rational and communicative."*[64]

23 March 2007. Mr. Z was released from Police custody and was reviewed by a Consultant Psychiatrist at the outpatient clinic. The appointment had been organised in order to see whether he needed support in the light of recent events. At this time Mr. Z was in Bed and Breakfast accommodation as his flat was being treated as a scene of crime by the Police Service. Mr. Z was not considered to be a murder suspect by the treating team, but a witness to the murder of Mr. W. Mr. Z had not been charged with any offence, but he had been released on bail until the 4 May 2007.

It was noted by the Consultant Psychiatrist that Mr. Z's mental state was *"not doing too badly".* He rated his mood as being *"six out of ten"* with zero being extremely low. It was evident that Mr. Z had not been taking his medication for the past two months. Mr. Z said that he heard voices inside his head and that he was drinking approximately eight cans of high strength lager and two to three bottles of 7.9% Lambrini every two to three days. The impression was that *"it is unlikely he has schizophrenia"* and that his pseudo hallucinations were probably alcoholic hallucinations. No other symptoms of mental illness were detected.

63 Court Transcription
64 Case Notes Y P174

The plan was to prescribe him his previous medication with exception of the Olanzapine as the Consultant wished to assess him without this, and to review him in one month's time. Mr. Z was to have support from a Social Worker (Social Worker 1) in the community. The GP was sent a letter detailing the Consultant's observations.[65]

30 March 2007. An outpatient appointment was arranged by Social Worker 1. Apparently Mr. Z had been discharged by Trust Grade Doctor 1 from the outpatient clinic following his non attendance. It was agreed that this Doctor would continue to support Mr. Z alongside Social Worker 1.

During this outpatient appointment Mr. Z gave his account of the events that led to the death of Mr. W. According to Mr. Z the injuries to Mr. W took place whilst he was out at the off license. On his return he noticed that Mr. W was injured and attempted to help which accounted for the fact that he had blood on his clothes.

It was noted that Mr. Z was still drinking, sometimes from the morning onwards as he had nothing else to do. He was still hearing voices *"on and off"* inside his head occasionally at night when he could not sleep.

Mr. Z's forensic history was recorded. He had been in Police cells twice during the past year, once in February and once in April. This was due to theft, his accomplice on one of these occasions was Mr. W, the man who had been murdered in March 2007.[66]

1 May 2007. Mr. Z was seen in the outpatient clinic by the Consultant Psychiatrist alongside the Social Worker, it was thought that he may have been drinking. It was noted that his mental health had not been affected by the withdrawal of Olanzapine. On examination it appeared that Mr. Z had only been taking his Paroxetine sporadically, and that he had not taken his Zopiclone. Mr. Z described his mood as variable, the Consultant Psychiatrist thought that this was primarily due to his drinking.

Mr. Z expressed concerns about his forthcoming meeting at the Police station due on the 4 May, to which the Social Worker had agreed to accompany him. There were no signs of

65 Case Notes Y PP188-189
66 Case Notes Y PP142-145

either depressive or psychotic illness. The plan was to review Mr. Z again in two months time and for the Social Worker to continue to support him in the community. The GP was written to with a progress report.[67]

22 May 2007. The Social Worker referred Mr. Z to Supporting People in order to secure more appropriate accommodation.[68] A HoNOS Plus assessment was conducted by the Social Worker. Most of Mr. Z's identified problems were associated with his alcohol consumption and vulnerability.[69]

12 June 2007. Mr. Z was seen at the outpatient clinic by the Consultant Psychiatrist alongside the Social Worker. It was noted that Mr. Z had been charged with murder and released on bail two weeks previously, he was due to attend Court again on the 15 June 2007. It was evident that the Consultant Psychiatrist was surprised that Mr. Z had been released on bail.

With regard to his mental state Mr. Z described himself as *"not being too bad".* The Social Worker who had been monitoring him in the community confirmed that there had been no change to his mental state and that he appeared to be coping well.

Mr. Z was still drinking, however he had cut down on this and only had a drink when it was offered to him by his acquaintances. There was no evidence of any depressive or psychotic thoughts. This was of particular relevance as Mr. Z had not been taking medication for some time. The Consultant Psychiatrist wrote that previously Mr. Z had been given a differential diagnosis of alcohol abuse, depression and schizophrenia. On reviewing the notes and assessing Mr. Z the Consultant Psychiatrist did not think that any major mental illness such as schizophrenia was present. It was thought that Mr. Z's previous hallucinations were pseudo hallucinations caused by excessive alcohol consumption. The diagnosis was given as *"alcohol misuse - mild to moderate depression - currently appears to be in remission."* It was thought that Mr. Z did not require secondary care services. However due to the stress of the unusual situation that Mr. Z found himself in, it was decided to review Mr. Z again in one month's time. The GP was written to with a progress update.[70]

67 Case Notes Y PP150 & 186
68 Case Notes Y PP 108 & 151
69 Case Notes Y P7
70 Case Notes Y PP151 & 184-185

27 June 2007. The Social Worker negotiated a housing support plan/tenancy support package. This package comprised repairs to Mr. Z's property, assertiveness training for Mr. Z to prevent further financial abuse from his acquaintances, and a referral to Lifeline for help with his drinking.[71]

17 July 2007. Mr. Z was reviewed at the outpatient clinic by the Consultant Psychiatrist and the Social Worker. Little change was noted. Mr. Z continued on bail and visited the Police Station two to three times a week. His mood continued to be stable and his drinking appeared to be under control. Mr. Z spent a great of time in his house doing nothing. He refused any input from Lifeline. He remained on no medication and his diagnosis remained unchanged. The plan was to arrange a forensic assessment.[72]

26 July 2007. A 'multidisciplinary risk assessment' was completed by the Social Worker. The main areas of risk identified were aggression and violence, self neglect, and exploitation. It was evident to the Social Worker that Mr. Z had been subject to exploitation from his acquaintances for many years and that his flat was frequently broken into.

At this stage, due to the issues around his bail, Mr. Z was always visited by two workers. Mr. Z remained on Standard Level CPA. Mr. Z did not have access to a telephone, but in the crisis plan it was agreed that he would go to the nearest Police Station if the need arose. The long-term management plan involved Supporting People providing tenancy support, outpatient clinical support, and bail conditions ensuring regular contact with the Police.[73] It is not clear how widely circulated the risk assessment was.

27 July 2007. The Consultant Forensic Psychiatrist interviewed Mr. Z in the presence of the Social Worker who was acting as his Care Coordinator. The purpose of the consultation was to assess Mr. Z's ongoing risk and to provide an opinion on diagnosis.

Mr. Z said at interview that he was currently drinking ten cans each day of 4.1% larger or two bottles of 7.5% Lambrini. He commenced drinking at midday and continued into the night. He described his motivation for drinking as having nothing else to do. He expressed the belief that drinking was not a problem.

71 Case Notes Y PP23-24
72 Case Notes Y PP153 & 178
73 Case Notes Y PP11-14

On examination Mr. Z was unremarkable. There were no clear indications of abnormal mood, morbid thoughts, or psychotic features. Mr. Z described ongoing low grade auditory hallucinations in his head occurring mostly at night. The impression formed was that the principle diagnosis was alcohol misuse. It was thought that it was likely that Mr. Z had an established alcohol dependency syndrome. His premorbid personality was described as being socially withdrawn and unskilled with possible schizoid traits. It was thought probable that Mr. Z had suffered from a depressive episode at some time, but that he now appeared to be stable. There was no convincing evidence that he suffered from paranoid schizophrenia or any other severe enduring psychotic illness. The Consultant Forensic Psychiatrist thought that the low grade hallucinatory experiences were probably due to alcohol.

It was noted that in ordinary circumstances Mr. Z would have been referred back to the care of the GP, however it was thought that in view of the circumstances he found himself in it would be sensible to continue with the current arrangements.[74]

2 August 2007. A tenancy assessment for housing support was completed. The assessment listed his diagnosis and medication (incorrectly) and did not state explicitly that Mr. Z had been charged with murder. His problems with alcohol consumption were also underplayed. Mr. Z's vulnerability was correctly identified. The assessment form stated that no lone female member of staff should work with him alone due to *"the risks involved",* these risk were not identified. This assessment did not carry forward the decision of the Community Mental Health Team for workers to always meet with Mr. Z in pairs regardless of sex.[75]

21 August 2007. Mr. Z was seen in the outpatient clinic by the Consultant Psychiatrist and the Social Worker. At this review no major changes were found regarding his mental state. Mr. Z continued to believe alcohol was not an issue, even though the Social Worker had visited him at his home and found him to have been in a highly intoxicated state a few weeks earlier. Mr. Z's self care was assessed as being reasonable and no obvious psychotic or depressive features were present. The plan was for the Social Worker to continue to support Mr. Z in the community and for him to be reviewed in the outpatient clinic in six week's time.[76] A letter was sent to the GP to inform him with regard to Mr. Z's progress.

74 Case Notes Y PP173-177
75 Case Notes Y PP20-22
76 Case Notes Y PP154 & 171

1 October 2007. Mr. Z was seen in the outpatient clinic by the Consultant Psychiatrist and the Social Worker. There were no changes to Mr. Z's mental state. At this stage he was attending Lifeline once a week for his alcohol problems. A letter was written to the GP to provide him with an update.[77]

12 November 2007. Mr. Z was seen in the outpatient clinic by the Consultant Psychiatrist on his own as the Social Worker could not attend. Mr. Z was due to commence his trial on the 15 November 2007 at the Crown Court. On this occasion Mr. Z was kempt and had been abstaining from alcohol.[78]

Mr. Z was found guilty of murder and was sentenced to life imprisonment with a 14 year determination. Following his sentencing and disposal the Trust continued to liaise with prison services until his mental health care was transferred to them.

77 Case Notes Y PP156 & 169
78 Case Notes Y PP157 & 167

11. Identification of the Thematic Issues

Thematic Issues

The Independent Investigation Team identified 14 thematic issues that arose directly from analysing the care and treatment that Mr. Z and Mr. W received from the South West Yorkshire Partnership NHS Foundation Trust. These thematic issues are set out below.

1. **Referral, transfer and Discharge Procedures.**
2. **Diagnosis.**
3. **Medication and Treatment.**
4. **Use of the Mental Health Act (1983).**
5. **Care Programme Approach (CPA).**
6. **Risk Assessment.**
7. **Service User Involvement in Care Planning and Treatment.**
8. **Carer Involvement and Carer Assessment.**
9. **Documentation and Professional Communication.**
10. **Overall Management of the Care and Treatment of Mr. Z.**
11. **Management of the Care and Treatment Received by Mr. W.**
12. **Adherence to Local and National Policy and Procedure, C*l*inical Guidelines.**
13. **Clinical Governance and Performance**.
14. **Internal Investigation.**

12. Further Exploration and Identification of Contributory Factors and Service Issues

In its simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the 'five whys' could look like this:

- Serious incident reported = serious injury to limb;
- Immediate cause = wrong limb operated upon (ask why?);
- Wrong limb marked (ask why?);
- Notes had an error in them (ask why?);
- Clinical notes were temporary and incomplete (ask why?);
- Original notes had been mislaid (ask why?);
- (Because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. If it was applied to the killing of Mr. W it would look like this:

- Mr. Z killed Mr. W (ask why?);
- Because he was intoxicated and (apparently) motivated by financial gain.

It was evident from the proceedings of the Crown Court and the views formulated by the Investigating Police Officers that Mr. Z's actions in March 2007 were not influenced adversely by the presence of a mental illness. Consequently no root causes to the death of Mr. W can be assigned to the Trust.

RCA Third Stage

This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. key causal, contributory and service issue factors.

In the interests of clarity each critical issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the

reader to be constantly redirected to reference material elsewhere in the report. The terms 'key causal factor', 'influencing factor' and 'service issue' are used in this section of the report. They are explained below.

Causal Factors. Causal Factors. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term 'causal factor' is used to describe an act or omission that has a direct causal bearing upon the failure to manage a patient effectively and an ensuing serious untoward incident. The Independent Investigation Team found no such causal factors when reviewing the care and treatment Mr. Z and Mr. W received from the Trust.

Contributory Factors. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown of Mr. Z's/ Mr. W's mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors of an influencing kind are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party.

Service Issue. The term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the death of Mr. W need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

12.1. South West Yorkshire Partnership NHS Foundation Trust Findings Relating to the Care and Treatment of Mr. Z

The findings in this chapter analyse the care and treatment given to Mr. Z by the South West Yorkshire Partnership NHS Foundation Trust. The Care and treatment Mr. W received is examined in subsection 12.1.11.

12.1.1. Referral, Transfer and Discharge Procedures

12.1.1.1. Context

Referral

During the seven-year interval that Mr. Z received his care and treatment from the Trust he was subject to six separate referral processes.

The first referral was made on the 17 December 2001 by the GP to the Trust due to Mr. Z feeling low in mood and suffering from anxiety.

The second referral was made on the 1 March 2002 by CPN 1 requesting a Consultant Psychiatrist assessment because Mr. Z said that he was hearing voices.

The third referral was made by CPN 2 to Mirfield Day Centre and 'Rendezvous' Batley Resource Centre in September 2002.

The fourth referral was made on 19 November 2002 to MIND for counselling services by the treating Staff Grade Doctor at the outpatient clinic.

The fifth referral was made on 22 May 2007 (following the murder of Mr. W) to Supporting People for tenancy and housing input. The assessment process for housing support was completed on the 2 August 2007.

The sixth referral was made in July 2007 by the treating Consultant Psychiatrist at the outpatient clinic for a Forensic Psychiatric assessment.

During the time that Mr. Z received his care and treatment from the Trust he was advised and supported to self-refer to Lifeline, an alcohol treatment service.

Transfer

Mr. Z was transferred between Community Psychiatric Nurses (CPNs) on two occasions. The first time occurred on the 26 July 2002 when CPN 1 left the service and transferred the case to CPN 2. The second time this occurred was on the 26 November 2002 when CPN 2 left the service, transferring the case to CPN 3.

Discharge

CPN 3 discharged Mr. Z from the CMHT on the 12 December 2002.

Prior to the death of Mr. W in March 2007 the Trust Grade Doctor at the outpatient clinic was in the process of discharging Mr. Z from the service. There is no extant clinical record to suggest that this process had been completed prior to the decision to support Mr. Z between 21 March 2007 and his trial in November 2007.

South West Yorkshire Partnership NHS Foundation Trust Operational Policy

It was not possible for the Independent Investigation Team to access the operational policy in place in 2001 when Mr. Z was first referred to the Trust.

12.1.1.2. Findings of the Internal Investigation Team

Referral

Mr. Z was initially referred to a GP-attached CPN in December 2001. On the 1 March 2002 CPN 1 referred Mr. Z for a Psychiatrist assessment. However at this time CPN's were not able to make referrals directly themselves and this request had to be routed through the GP. This process meant that the first Psychiatrist appointment took some weeks to obtain. Changes since this time by implementing *New Ways of Working* (*New Ways of Working* published in October 2007 brought about significant improvements to the ways in which mental health teams across the country function) brought about a more cohesive approach. Primary Care CPNs were integrated within Community Mental Health Teams (CMHTs). Previously referrals were made by GPs to either the CMHT or to the Consultant Psychiatrist. This has now been replaced by referrals being made solely to the CMHT. Under this new

system urgent referrals are dealt with in a timely fashion and the new system allows for closer team working.[79]

Discharge

At the time of Mr. Z's discharge from the CMHT in December 2002 there was no discussion with the treating medical team prior to the decision being taken. However the new system (outlined directly above) ensures that there is closer working between treating team members.

At all stages detailed correspondence was sent between the treating team members. The Author of the Internal Investigation Report concluded that the decision to discharge Mr. Z from the CMHT in December 2002 was appropriate given the level of morbidity, improvement in functioning and continuance of outpatient monitoring.[80]

12.1.1.3. Findings of the Independent Investigation Team

Referral

The Independent Investigation Team concurs with the findings of the Internal Investigation. In addition the following relevant findings have been identified.

The second referral for a Psychiatrist assessment in the Spring of 2002 encountered a delay of some three months between the legitimate concerns of CPN 1 being identified on the 15 February 2002 and Mr. Z being seen in the outpatient clinic on the 21 May 2002. The referral sent by the GP on the 1 March 2002 was for an urgent referral. An interval of eight weeks passed between the referral being made and Mr. Z being seen.[81]

The referral for housing and tenancy support was commenced on the 22 May 2007 and completed on the 2 August 2007. The assessment listed Mr. Z's diagnosis and medication incorrectly and did not state explicitly that Mr. Z had been charged with murder. His problems with alcohol consumption were also underplayed, however Mr. Z's vulnerability was correctly identified. The assessment form stated that no lone female member of staff should work with him alone due to *"the risks involved",* these risk were not identified. This assessment did not carry forward the decision of the Community Mental Health Team for

79 Internal Investigation Report P7
80 Internal Investigation Report P7
81 Case Notes Y P218

workers to always meet with Mr. Z in pairs regardless of sex.[82] This referral process did not adequately explore the potential risks that Mr. Z presented and omitted some important information. This lack of correct information potentially placed the people who would be coming into contact with Mr. Z as a result of this referral at risk.

Transfer

Transfer procedures were confined to CPN 1 transferring the case to CPN 2 on the 26 July 2002, and to CPN 2 transferring the case to CPN 3 on the 26 November 2002. On each occasion the transfer process was managed appropriately. Attempts were made to ensure Mr. Z was introduced to his new CPNs in face-to-face meetings. The GP and the outpatient doctors were also communicated with in an appropriate and timely manner.

Discharge

The Independent Investigation Team concurred with the findings of the Internal Review regarding the appropriateness of CPN 3's decision to discharge Mr. Z from the CMHT caseload. It would have been good practice for the CPN to have discussed this decision with the Trust Grade Psychiatrist first, however the Independent Investigation Team acknowledges that CMHT processes in 2002 did not automatically lend themselves to this way of working and that things have since changed in line with national service development requirements.

It was evident from a read through of the Internal Review archive that the Trust Grade Doctor had made the decision to discharge Mr. Z from his caseload in March 2007 following his second consecutive non attendance at the outpatient clinic. The Independent Investigation Team could find no record of this decision having been made in the clinical record. However based upon Mr. Z's presentation at that time, had the decision to discharge Mr. Z been taken, it could be seen as a reasonable thing to do.

12.1.1.4. Conclusions of the Independent Investigation Team

It was the conclusion of the Independent Investigation Team that referral, transfer and discharge processes regarding Mr. Z's care and treatment were managed well in the context of the policy expectations in place at the time. It was acknowledged that the Trust has

82 Case Notes Y PP20-22

improved its processes since the time Mr. Z received his care and treatment in line with *New Ways of Working* and other service development initiatives.

The Independent Investigation Team could not identify any clinical evidence to suggest Mr. Z required secondary mental health care services. This was of particular relevance between 2005 and March 2007 when Mr. Z did not appear to have a mental health problem that required specialist input and monitoring. Whilst it was evident to the treating team that Mr. Z had an alcohol misuse problem, it was not recognised by Mr. Z. Mr. Z had a vague set of possibly 'pseudo' psychiatric symptoms, was often non compliant with his medication, and refused help with his drinking. The problems that beset him could have been viewed as being solely social in nature, and it may not have had been appropriate for a mental health service to have kept him on their books when it was evident it had a rather vague role to play in his continued wellbeing. The North Kirklees CMHT Operational Policy in place whilst Mr. Z was receiving his care and treatment stated the following: ***"****service users are discharged promptly when they are considered improved. Discharge letters provide information about the outcome of an assessment and indicate current treatment and procedures for re-referral."* [83] Mr. Z's condition was considered to have been improved between 2005 and March 2007 and no depressive or psychiatric symptoms were detected during this period.

The Independent Investigation Team found that there was a degree of diagnostic ambiguity which may have led to keeping Mr. Z engaged with services when it was no longer necessary for him to be so. These diagnostic issues are examined in the subsection directly below.

12.1.2. Diagnosis

12.1.2.1. Context

Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs, symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information

83 North Kirklees Operational Policy 020806j P4

from carers, family, GP, interested or involved others, mental state examination and observation.

The process of reaching a diagnosis can be assisted by a manual known as ICD 10. The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. In the United Kingdom psychiatry uses the ICD 10 (10^{th} revision - published in 1992) Classification of Mental and Behavioural Disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework to conceptualise and understand their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis is only part of the process of understanding and determining the treatment and management of a service user. It is critical to see the individual in their own context, and not only understand what they want from treatment and recovery but also support them in being central in decisions made about their care including risk management issues.

Background Information

Mr. Z was originally referred to the Trust in December 2001 by his GP. Mr. Z had been treated by his GP for depression and anxiety since August 2001 with no effect. Subsequently in February 2002 Mr. Z disclosed that he was experiencing auditory hallucinations and he was referred for an urgent psychiatric assessment. Between May 2002 and March 2007 Mr. Z's psychiatric diagnosis was uncertain with *"?depression/?schizophrenia"* appearing in his clinical records.

12.1.2.2. Findings of the Internal Investigation Team

The Internal Investigation report stated that in May 2002 the Staff Grade Psychiatrist who had assessed Mr. Z in the outpatient clinic wrote to the GP to say *"[Mr. Z] would appear to*

be suffering from a depressive episode with psychotic symptoms. The other differential diagnosis would be paranoid schizophrenia. There is also evidence of harmful use of alcohol."[84]

At the last outpatient appointment Mr. Z attended in June 2006, prior to the incident occurring, the Trust Grade Psychiatrist wrote to the GP stating *"diagnosis: ?depressive illness ?schizophrenia. On examination he was kempt, well orientated to time, place and person without depressive or psychotic symptoms."*[85]

The Internal Investigation noted that during the time Mr. Z received care and treatment from the outpatient clinic his alcohol problem fluctuated and efforts to get him to reduce his consumption failed. Given the lack of a definitive diagnosis the Internal Investigation observed that there had been a missed opportunity in gaining a specialist opinion.

The Internal Investigation cited the Department of Health *Dual Diagnosis Good Practice Guidance* (2002). This guidance outlined some of the challenges faced by mental health Trusts when providing services to individuals with a dual diagnosis (alcohol or substance misuse in combination with a severe or enduring mental health condition). The guidance said: *"a fundamental problem is a lack of clear operational definitions of dual diagnosis. In many areas a significant proportion of people with severe mental health problems misuse substances, whether as 'self medication', episodically or continuously. Equally, many people who require help with substance misuse suffer from a common mental health problems such as depression or anxiety…these people together would result in a huge heterogeneous group many of whom do not require specialist support for both mental health and substance misuse issues…gate keeping by specialist services is a valid activity…and should ensure that clients are included in the right services…."*[86]

The Internal Investigation elicited that in areas of the Trust, other than North Kirklees, Mr. Z could have expected to have been referred to a specialist in the assessment of alcohol use who would have focused upon the clarification of Mr. Z's diagnosis. The report Author acknowledged that in the event Mr. Z may still have declined support from Lifeline (the

84 Internal Investigation Report P7
85 Internal Investigation Report P7
86 Internal Investigation Report PP7-8

alcohol service), however Mr. Z's case would have received a more appropriate level of assessment and review.[87]

The Author of the Internal Investigation report clarified that the Trust had developed a 'Clinical Decision Support Tool' by the time the internal review had been completed. This support tool included packages of care for individuals with dual diagnosis issues.

The Internal Investigation also provided an overview as to how the outpatient clinic worked during the time that Mr. Z received his care and treatment. The Locum Consultant Psychiatrist held regular supervisory sessions with the junior medical staff in the department. However there was a tradition of long-term attendance at outpatients, a practice which was under scrutiny at the time the Internal Investigation report was written. The Trust sought to ensure that individuals would in future be assessed in a more holistic context and the Internal Investigation report stated that *"clearly a practitioner working in a clinic setting cannot have a full awareness of the social factors in play and is reliant on information solely from the patient. Currently the Trust is undergoing a major project on the development of care pathways. These developments…will identify the skill level of the practitioner required to deliver them."*[88]

12.1.2.3. Findings of the Independent Investigation Team

The Independent Investigation Team concurred with the findings of the Internal Investigation. In addition the Independent Investigation Team identified that after the murder of Mr. W Mr. Z was seen on a regular basis in the outpatient clinic by the Consultant Psychiatrist. The Consultant very swiftly assessed Mr. Z's mental state and made a diagnosis, which was confirmed by a Forensic Consultant Psychiatrist independent of the North Kirklees Team. The conclusion was that Mr. Z was unlikely to be suffering from schizophrenia and that his pseudo hallucinations were probably caused by his alcohol consumption. His diagnosis was given as being alcohol misuse with mild to moderate depression which was currently in remission. In keeping with previous assessments made in the outpatient clinic, of several years standing, no depressive or psychotic symptoms were

87 Internal Investigation Report P8
88 Internal Investigation Report P8

evident.[89] As a result of this assessment Mr. Z's medication was discontinued with no apparent ill effects.

12.1.2.4. Conclusions of the Independent Investigation Team

There is an on-going debate in the academic literature about the reliability and utility of categorical diagnostic schemas and what is sometimes, imprecisely, referred to as the medical model. What is not in debate, however, is that if an individual is to receive effective and efficient treatment then there has to be a clear formulation of his/her difficulties, which informs a plan determining how the individual might be helped to achieve identified goals.

Mr. Z did not receive a definite diagnosis between May 2002 and March 2007. Whilst it can sometimes be difficult to reach a diagnosis there was ample evidence over this five-year interval to suggest that Mr. Z was not suffering from a severe or enduring mental illness. There are three issues of significance here.

First: it was clear from the outset that Mr. Z was presenting with a potentially complex set of symptoms. He reported hearing derogatory third person auditory hallucinations. He reported being depressed and anxious and subject to panic attacks. He reported significant alcohol consumption and was frequently observed to have been intoxicated by members of the treating team. Once the complexity of his presentation had been established Mr. Z should have been considered for a specialist assessment in order to clarify the diagnosis.

Second: had the diagnosis been established at an earlier date a more assertive attempt could have been made to provide treatment for Mr. Z's misuse of alcohol.

Third: it was evident from the assessment of several clinicians over a five-year period (both before and after the murder of Mr. W) that Mr. Z probably had no severe or enduring mental illness and that he did not require inputs from secondary care services. However Mr. Z continued to be seen at the outpatient clinic even when it became increasingly evident that he did not require this level of intervention. Whilst keeping patients 'on the books' can be seen as being a caring thing to do and a sensible precaution in the monitoring of wellbeing it is not

89 Case Notes Y PP104 & 182 & 84

prudent if it is not clinically appropriate. It presents a resource challenge to the service and fosters an unhelpful dependence between the patient and the service being provided.

It was the conclusion of the Independent Investigation Team that the failure to provide a diagnosis for Mr. Z led to a prolonged, and perhaps unhelpful, contact with a secondary care mental health service. A more sure-footed and timely diagnostic process would have prevented Mr. Z being in receipt of medication he did *not* need, and may have directed him more assertively to a range of services for his alcohol misuse which he *did* need. It was the conclusion of the Independent Investigation Team that the diagnostic ambiguity surrounding the care and treatment of Mr. Z did not in any way contribute to the death of Mr. W. However this forms a significant service issue. The Independent Investigation Team understands that this issue is something that the Trust has already identified as being an area for future clinical and service development. At the time this report was being was prepared the Trust was undertaking a piece of work that aims to provide additional guidance to all clinical teams regarding diagnostic practice.

- ***Service Issue 1. Mr. Z did not receive a definite diagnosis between May 2002 and March 2007. Whilst this did not contribute to the death of Mr. W it was evident during the course of this Investigation that the assignment of a diagnosis is not always given priority by clinicians within the Trust. The continuation of this practice may lead to compromised, inappropriate or unnecessary care and treatment being delivered to other service users in the future.***

12.1.3. Medication and Treatment

12.1.3.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers.

Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and / or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders.

In prescribing medication there are a number of factors that the doctor must bear in mind. They include consent to treatment, compliance and monitoring, and side effects.

Consent is defined as '*the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent'* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practice to seek the patient's consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time? Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly / monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and / or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

All medication prescribed and administered should be monitored for effectiveness and also side effects. The most common side effects described for antipsychotic medications are called 'extra pyramidal' side effects i.e. tremor, slurred speech, akathisia and dystonia. Other side effects include weight gain and Electrocardiography (ECG) changes. Side effects can be managed by either reducing the dose of medication, changing to a different type of antipsychotic medication or by prescribing specific medication to treat the side effects.

12.1.3.2. Findings of the Internal Investigation Team

Medication

The Internal Investigation did not examine this component of the care and treatment that Mr. Z received.

Care and Treatment

The Internal Investigation found that the care and treatment Mr. Z received would have been managed better by a referral to a specialist in alcohol misuse. Whilst it may have been probable that Mr. Z would have refused any subsequent offer of care and treatment from Lifeline, a specialist assessment and care and treatment plan would have been part of a best practice pathway already extant in most other geographical locations within the Trust. The fact that this did not take place potentially disadvantaged Mr. Z's care and treatment outcome, and also contributed to the ensuing lack of clarity surrounding his diagnosis. Mr. Z demonstrated little motivation to alter his drinking habits. It was possible that a specialist worker could have engaged with him in a more effective manner.

Another issue that was identified was the probable lack of CMHT and outpatient staff knowledge and understanding of alcohol treatment issues. Whilst the input from a specialist worker would have been best practice, mainstream mental health staff could have been trained to provide a range of assessments and interventions.

The Internal Investigation report Author found that whilst Mr. Z was willing to engage with mental health services and receive community support during stressful periods of his life, he showed little inclination to deal with his alcohol problem.[90] The conclusion of the internal review process was that the Trust provided care and treatment to Mr. Z in a manner that was compatible with local policy and national best practice expectation and that there was no evidence of either service or systems failures.

12.1.3.3. Findings of the Independent Investigation Team

Medication

The long-term appropriateness and effectiveness of the medication that Mr. Z was prescribed can only be examined in the light of the working diagnosis that he received. If a diagnosis is

90 Internal Investigation Report P12

vague or unresolved then it is difficult to know what set of problems the medication is trying to affect. In August 2001 Mr. Z was initially treated with Venalfaxine by his GP for depression. Due to the fact that this had not had a positive effect on his mental health the GP referred Mr. Z to a Community Psychiatric Nurse. Once the GP was made aware that Mr. Z was reporting auditory hallucinations he prescribed Olanzepine 5 mg prior to making a referral for a Psychiatrist-led assessment.

Following the Psychiatrist-led assessment in May 2002 secondary care outpatient services treated Mr. Z's depression with Paroxetine 20 mg and continued initially with Olanzepine 5 mg to treat his emerging psychotic symptoms. By the end of 2002 Mr. Z was prescribed Paroxetine 40 mg and Olanzepine 15 mg, he was also occasionally prescribed Zopiclone to help alleviate his insomnia. He continued on this general medication regimen with minor adjustments until the time of the incident in March 2007.

During this five-year interval it was apparent that Mr. Z often stopped taking his medication, this was particularly the case when he was drinking heavily. Whilst the medication prescribed was appropriately selected to treat the symptoms Mr. Z initially presented with, it was evident that secondary care services were never certain what the underlying causes were for his symptomology. It was obvious that Mr. Z drank heavily and had significant social difficulties which caused him a great deal of unhappiness. It is significant that there was a period of some four years, between the spring of 2003 and the incident in March 2007, when Mr. Z regularly admitted to going long periods of time with no medication and when his mental state appeared to improve and remain stable. During this period whilst the diagnosis of *"?depression ?schizophrenia"* remained unchanged Mr. Z's hallucinations began to be described as *"pseudo hallucinations"* in the clinical record. This did not lead to any significant review or reflection upon the medication that he was prescribed. It was not until after the incident when Mr. Z's diagnosis was confirmed as *"alcohol misuse and mild to moderate depression now in remission"* that his medication regimen was reviewed and then discontinued.

Care and Treatment

Alcohol Misuse

Mr. Z was given the opportunity to access treatment for his alcohol misuse at Lifeline. However Mr. Z did not think he had a significant problem with alcohol and thought that he

could stop drinking on his own without any external help. Mr. Z did attend Lifeline on one occasion on the 31 March 2003. He was offered two further appointments but declined to attend again. From this time on, although Mr. Z was frequently advised to go to Lifeline, he did not want to attend. As the years went by it was evident that although Mr. Z's mental state was stable, his drinking continued out of control.

Psychological Therapy

Psychological interventions were considered in December 2001 when Mr. Z was first referred to secondary care services. The initial plan was for Mr. Z to receive support with breathing, relaxation techniques and anxiety management. Other cognitive interventions were also considered to help him challenge *"negative thoughts"*.[91] This was a sensible plan, however it is not clear from reading through the clinical records exactly how this was actually achieved and it would appear that it was not. On the 19 November 2002 Mr. Z was referred to MIND for counselling, but there is no record of his attendance there.

Holistic Care and Treatment

Initially the CPNs involved with Mr. Z's care attempted to ensure that he received social support via the Rendezvous Social Club and Mirfield Day Hospital. It was evident that Mr. Z did not take advantage of these resources. Several times between January 2002 and March 2007 it was evident that Mr. Z had difficulties in managing his own affairs. His accommodation was frequently broken into, he had a series of abusive and unsatisfactory social interactions with people he described as *"acquaintances"*, and he lived his life in almost total isolation from the world around him. For the period of a year, between January 2002 and December 2002 the CPNs attempted to assess and monitor his mental state and provide pragmatic solutions to help alleviate his social problems.

12.1.3.4. Conclusion of the Independent Investigation Team

The Internal Investigation made a sound observation in that Mr. Z was solely managed in outpatients between late 2002 and 2006. During this period Mr. Z's needs were predominantly social in nature. As time went on it became evident that Mr. Z did not suffer from any severe or enduring mental illness and the uni-professional medical input that he was receiving was probably not the best 'fit' to address his problems.

91 Case Notes Y P96

The care and treatment that was offered to Mr. Z between January 2002 and March 2007 was evidence-based and varied, it included:

- Lifeline for his alcohol misuse;
- Mirfield Day Centre to provide structure to his day;
- Rendezvous to provide social support and interaction;
- MIND for counselling;
- Community Psychiatric Nurse assessments and support (January 2002 – December 2002);
- outpatient assessment and monitoring;
- medication for depressive and psychotic symptoms.

In order for the care and treatment to have been effective it was necessary for Mr. Z to comply with it. Mr. Z declined most of the interventions that were offered to him. The package made available to Mr. Z over time was comprehensive and generally appropriate. However it was compromised by Mr. Z's reluctance to engage with it, and to some extent, by the uni-professional input and lack of a clear diagnosis and subsequent long-term management plan. In the absence of a clear diagnosis and management plan it would appear that Mr. Z was prescribed medication (Olanzepine) that he probably did not need for a period of several years, this can never be seen as good practice.

Care and Treatment Prior to the Incident

It was the conclusion of the Independent Investigation Team that the Trust diligently attempted to provide a care and treatment package for Mr. Z, even when his lack of cooperation limited its potential effectiveness. However the effectiveness of the care and treatment offered was also seriously compromised by the lack of a coherent diagnosis and a treatment strategy. Mr. Z did not appear to have required secondary care mental health services, and whilst it may be seen as commendable that the Trust persevered in its efforts to provide support to Mr. Z, in this particular case it may not have been either appropriate or necessary. The practice of keeping cases 'on the books' when it is no longer indicated clinically is not advised as it uses scarce resources on the one hand, and fosters dependence on the part of the service user on the other.

Care and Treatment after the Incident

After the incident in March 2007 the Trust ensured that Mr. Z was assessed, monitored and supported. Mr. Z received a rapid Consultant Psychiatrist assessment and a Forensic Psychiatrist assessment followed. This was done to ensure Mr. Z's risk was understood and managed and that he received the care and treatment he required whilst he was on bail. As a result of this process Clinicians came to the conclusion that Mr. Z did not require secondary care services and that there was no evidence to support the view that he was suffering from any form of severe or enduring mental illness. The Trust however continued to provide care and support to Mr. Z for a further period of six months until his sentencing and disposal. The Social Worker who was assigned to Mr. Z following the killing of Mr. W made it clear to the Police and Prosecution Team that *"mental health services would not and could not be responsible for Mr. Z."* The Magistrate assured the Social Worker on the 31 May 2007 that there were *"no expectations that mental health services would be responsible for Mr. Z when he was bailed."*[92]

The Trust continued to provide care and support to Mr. Z because the Trust thought that the unusual circumstances he found himself in required such a response. The Social Worker found it increasingly difficult to support Mr. Z as he continued drinking and was being threatened by a relative of one his co-defendants in the killing of Mr. W. On several occasions entries in the clinical records demonstrate that Trust workers were increasing 'stepping out' of their roles in order to provide support to Mr. Z.[93] Whilst this was a compassionate act, in that no other agency appeared to come forward to offer support to Mr. Z, it may have been a misguided one. Mr. Z was charged with murder; after the killing of Mr. W he was assessed as not having any symptoms of severe or enduring mental illness, and was also thought not to require secondary care services, and chose to continue drinking heavily. It may not have been appropriate for a statutory body to take on a 'quasi supervisory and support' role for a person in this situation who was deemed not to be suffering from a mental illness.

Summary

It was the conclusion of the Independent Investigation Team that Mr. Z probably did not require input from a secondary care service for the majority of the time between 2002 and

92 Case Notes Y PP40-42
93 Case Notes Y PP60-63

March 2007. Initially the care and treatment Mr. Z was offered was generally appropriate and evidence-based regarding the symptoms he self-reported. However as time progressed a clear diagnosis would have focused both the service and Mr. Z in the pursuit of successful interventions for his alcohol problem. The aetiology of his symptoms was never explored and consequently Mr. Z received care and treatment he did no ultimately require. It was the conclusion of the Independent Investigation Team that the quality of the care and treatment provided did not in any way contribute to the events of the March 2007 and the death of Mr. W.

- ***Service Issue 2. Mr. Z was kept on the outpatient caseload even when it was evident that he did not have a mental health condition that required treatment by secondary care. There did not appear to be a process in operation at the time to review cases and to ensure that service users were transferred back to primary care when clinically indicated.***

12.1.4. Use of the Mental Health Act (1983) and the Mental Capacity Act (2005)

12.1.4.1. Context

The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007.

At any one time there are up to 15,000 people detained under the Mental Health Act. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing

medical intervention and have been assessed to be either a danger to themselves or to others.[94]

The Mental Capacity Act (2005) states that *"…everyone should be treated as able to make their own decisions until it is shown that they are not*." It also aims to enable people to make their own decisions for as long as they are capable of doing so. A person's capacity to make a decision will be established at the time that a decision needs to be made. A lack of capacity could be because of a severe learning disability, dementia, mental health problems, a brain injury, a stroke or unconsciousness due to an anaesthetic or a sudden accident. The Act also makes it a criminal offence to neglect or ill-treat a person who lacks capacity.[95]

12.1.4.2. Findings of the Internal Investigation Team

The Internal Investigation did not examine whether Mr. Z required detention under the Mental Health Act (1983), or whether he had capacity in keeping with the Mental Capacity Act (2005).

12.1.4.3. Findings of the Independent Investigation Team

The fact that the Internal Investigation did not examine whether Mr. Z required detention under the Mental Health Act (1983), or whether he had capacity in keeping with the Mental Capacity Act (2005), should not be seen as an omission. These aspects did not feature significantly throughout Mr. Z's care and treatment because his presentation did not require either Act to be considered. The Independent Investigation Team however is required, in the public interest, to consider whether at any time Mr. Z should have been assessed under either Act.

Mental Health Act (1983)

In early 2002 Mr. Z told CPN 1 and the Staff Grade Psychiatrist that he heard voices telling him to kill himself, but that he would not obey.[96] He continued to report that he had fleeting thoughts of suicide, but that he did not in fact wish to kill himself and had no plans to do so.[97] There was never any evidence presented to secondary care mental health services to suggest that Mr. Z had any depressive or psychotic symptoms that would indicate he was either a risk

94 Mental Health Act Commission 12th Biennial Report. 2005-2007
95 National Archive.gov.uk
96 Case Notes Y P124
97 Case Notes Y P217

to himself or to others. Prior to the incident occurring there was no justification or reason for the Mental Health Act (1983) to have been considered.

After the incident in March 2007 a Consultant Psychiatrist within the North Kirklees Team and a Forensic Consultant Psychiatrist independent of the North Kirklees Team assessed Mr. Z and found no evidence to suggest a severe or enduring mental illness was present. Once again there was no justification or requirement for the Mental Health Act (1983) to be considered.

Mental Capacity Act (2005)

It was evident that between January 2002 and the time of his sentencing and disposal in November 2007 Mr. Z often reported having his home broken into and of being exploited financially by people he described as acquaintances and drinking companions. It was also evident however that on occasion Mr. Z also financially exploited the very same people, Mr. W being a case in point (he had been accused of stealing from and attacking Mr. W in 2006 and in 2007).[98]

Mr. Z had a history of getting himself into difficulties whilst intoxicated. However these difficulties occurred as a direct result of Mr. Z's chosen lifestyle and did not exist due to issues regarding his mental capacity.

On the 22 March 2007 the Police made a request for an Appropriate Adult to be present while Mr. Z was interviewed in custody. This request was based upon the fact that his solicitor had ascertained Mr. Z had been contact with mental health services and had been prescribed medication for his condition. An Appropriate Adult was identified. However it was soon apparent that Mr. Z was able to understand the proceedings and give his account of the events of March 2007 with no difficulty.[99]

On the 13 August 2007 the Social Worker involved with Mr. Z's care considered the Vulnerable Adult's procedure. This was because Mr. Z was not caring for himself well and had been threatened in the community by a relative of one the other people who had killed Mr. W. The Social Worker contacted the Police in order to discuss Mr. Z's situation. It would

98 Internal investigation Report P9
99 Case Notes Y PP26-27

appear that the solution to this was for the Police to approach the relative directly and to ensure that Mr. Z had locks in place on his front door. The Trust's Safeguarding Vulnerable Adults Workbook, in keeping with national guidance, defines a Vulnerable Adult as a person who because of their age, disability, mental state or illness, is unable to take care of themselves or protect themselves against significant harm or exploitation. Mr. Z did not meet the criteria for being a Vulnerable Adult, even though his chosen lifestyle often left him vulnerable to abuse.

12. 1.4.4. Conclusions of the Independent Investigation Team

It was the conclusion of the Independent Investigation Team that neither the Mental Health Act (1983) nor the Mental Capacity Act (2005) could, or should, have been considered in the delivery of care and treatment to Mr. Z between January 2002 and November 2007, and that no act or omission in this regard contributed to the events of March 2007 that led to the killing of Mr. W.

12.1.5. The Care Programme Approach

12.1.5.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness[100]. Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach*[101].

"*The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services*[102]." (Building Bridges; DoH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

100 The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990

101 Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

102 Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH 1995

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
  - to keep in close contact with the patient
  - to monitor that the agreed programme of care remains relevant and
  - to take immediate action if it is not
- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need. Currently service users in contact with secondary care with complex needs are placed on CPA, and service users in contact with secondary care services are placed on 'Standard Care'.

South West Yorkshire Partnership NHS Foundation Trust CPA Policy

The Trust had a comprehensive CPA policy in place at the time Mr. Z was receiving his care and treatment which set out the key aims and objectives of CPA together with the roles and responsibilities of those involved in ensuring its delivery.

The CPA journey was applicable to all service users receiving secondary care. The process commenced with:

- the completion of the referral/initial screening information;
- documentation of the outcome of initial screening.

The initial screening documentation included the HoNOS Plus and the Clinical Decision Support Tool. There was also a requirement to complete the "*Assessment of the Health and Social Needs Form /Psychiatric Assessment Process must be:*

- *systematic and carried out with the individual concerned, enabling them to identify their own needs;*
- *undertaken with due regard to confidentially;*
- *thorough and comprehensive;*
- *a unified health and social care assessment, joint (between health and social services) to prevent duplication for the service user and carer and commonly agreed;*
- *a single assessment to facilitate access to both health and social services, based on one point of access;*
- *the quality of initial assessments is enhanced when multi disciplinary and undertaken in partnership between health and social care staff, and information is gathered from all those involved including the service user and carer;*
- *explained to the service user in as simple terms as necessary;*
- *carried out in the most appropriate setting."*[103]

12.1.5.2. Findings of the Internal Investigation Team

Mr. Z was identified on the CPA database as being subject to a Standard-level CPA which was appropriate given his presentation and identified level of need.

103 CPA the Journey. 2006 P6

The Internal Investigation recognised that Trust systems and processes altered greatly during the five-year interval that Mr. Z received his care and treatment. It was noted that Mr. Z's attendance at Lifeline was not communicated either to the GP or to *"other agencies"*. The Internal Investigation report said *"systems and services have changed markedly since that time and where a patient and where a patient on CPA is assessed contact is made with mental health services and GPs are notified by letter."*[104]

Another point identified by the Internal Investigation was Mr. Z's failure to attend outpatient appointments. Mr. Z had missed two outpatient appointments in the six months prior to the incident. The extant CPA policy required that there should have been a contingency plan to cover clinic non attendance. There was no plan and it would appear that the default decision was to trigger a discharge from the service.[105]

12.1.5.3. Findings of the Independent Investigation Team

Mr. Z was on Standard CPA between January 2002 and December 2007. Prior to the national changes to CPA in October 2007, when a person was on Standard CPA, and seen in an outpatient setting by a single practitioner, it was often difficult to implement all of the aspects of CPA. Service Users on Standard CPA were usually seen by a single practitioner, as was the case with Mr. Z between December 2002 and March 2007.

All service users on CPA, both before and after the national changes made in 2007, should expect to receive:

- assessment (to include a comprehensive risk assessment and management plan):
- care planning (to include contingency and crisis plans);
- regular review.

CPA Prior to Incident

Between January 2002 and December 2002 CPNs 1, 2 and 3 acted as Care Coordinators for Mr. Z. Once Mr. Z had been discharged from the CMHT, between December 2002 and March 2007 the Care Coordinators for Mr. Z by default would have been the Staff Grade Psychiatrist (between December 2002 and 12 August 2003) and the Trust Grade Psychiatrist (28 October 2003 and March 2007).

104 Internal Investigation Report P8
105 Internal Investigation P9

On careful examination of the clinical records supplied to the Independent Investigation Team no evidence could be found over time for:

- holistic assessment (to include a holistic risk assessment);
- holistic care planning;
- contingency planning;
- crisis planning;
- CPA review.

It was evident from reading through the clinical records that between December 2002 and March 2007 no formal CPA documentation was utilised. However the Psychiatrists who acted as Care Coordinators provided a consistent level of medical assessment, which included the assessment of the risk Mr. Z posed to both himself and to others. It was also evident that the Care Coordinators diligently maintained a steady and comprehensive communication with the GP.

There were two significant weaknesses with the CPA that Mr. Z received. First: the CPA process offered to Mr. Z was a Standard level of CPA. Prior to the national changes in 2007 this was usually provided by a single clinician. Whilst this was not always a problem, it was evident that Mr. Z's problems were largely of a social nature, and as has already been mentioned above, a medical Care Coordinator may not have been the 'best fit' to address the particular set of problems that Mr. Z presented with. Second: at no stage did there appear to have been a formal CPA review of Mr. Z's care and treatment. All service users should receive a CPA review at least once a year. Had a CPA review been held it was more likely that Mr. Z's diagnosis would have been clarified and a long-term care and treatment strategy developed. Had there been a regular review of Mr. Z's case it is likely that he would have been discharged from secondary services.

CPA Following the Incident

Following the incident in March 2007 a decision was made to continue supporting Mr. Z in the Community. He remained on Standard CPA and although he continued to be followed up by a Psychiatrist in the outpatient clinic he was also assigned a Social Worker who acted as his Care Coordinator. At this stage the assignment of a Social Worker to Mr. Z was probably a sensible choice.

However the question still needs to be asked, did Mr. Z meet the criteria for the receipt of secondary care services? The Trust clearly decided that he did. Whilst the Independent Investigation Team finds this decision to be open to debate, several issues emerged which need noting. At the time of his arrest, once the Trust had decided to retain Mr. Z on its books, regardless of whether he had a mental illness or not that required treating, he should have been on Enhanced CPA. This is for the following reasons:

- Mr. Z's risk could reasonably be seen as posing a high risk in that he was charged with murder and living a chaotic lifestyle which presented a significant degree of risk to himself;
- Mr. Z was consuming extremely large quantities of alcohol;
- Mr. Z was receiving multi-agency inputs which required a high degree of Care Coordination.

During this period Mr. Z received one risk assessment and a very minimal care plan, no CPA documentation was completed and no review took place. Once the Trust had decided to retain Mr. Z, the CPA policy should have been implemented in its entirety. It was obvious from reading through the clinical records that there was a high degree of ambivalence as to what the roles and responsibilities of the treating team were to Mr. Z. However the Trust had taken the decision to provide care and treatment to Mr. Z and once this decision had been taken, then regardless of the uniqueness of the case, a full CPA should have been provided.

12.1.5.4. Conclusions of the Independent Investigation Team

It is difficult to understand how CPA was implemented in the Trust on an examination of Mr. Z's clinical records. Between January 2002 and March 2007 Mr. Z was on Standard CPA. He received regular assessment and treatment during this period, however 'CPA' is not mentioned within the main body of his clinical records at all, aside from each GP letter stating that Mr. Z was assigned to a Standard level of CPA. This situation remained unchanged following the killing of Mr. W and up until Mr. Z's sentencing and disposal to prison in November 2007.

Prior to the incident had CPA been implemented appropriately then Mr. Z would have been subject to a regular review which would have led to a more coherent care and treatment package had it been deemed that he met the criteria for secondary care mental health services.

Alternatively had a review been a regular feature of Mr. Z's care and treatment then it is likely that he would have been discharged from the service.

Following the incident there appeared to have been a series of contradictory assumptions and conclusions:

- Mr. Z was assessed as not requiring secondary care services;
- Mr. Z was retained by secondary services.
- Due to the fact Mr. Z had been retained by secondary care services, even though not judged to be mentally ill, he paradoxically met the Enhanced CPA criteria.
- Mr. Z was placed on Standard CPA.

Summary

It was the conclusion of the Independent Investigation Team that the clinicians involved in the delivery of care and treatment to Mr. Z over a five-year period did not adhere to the Trust CPA policy guidance. Had the policy guidance been adhered to prior to the incident then in all probability Mr. Z would not have been retained by secondary services.

The decision to retain Mr. Z within secondary services after the incident placed the Trust in a position where they were responsible for the assessment and management Mr. Z's care, treatment and risk, regardless of the assurance of the Magistrate that Mr. Z was not the responsibility of the Trust. By retaining Mr. Z, had any further incidents occurred, the Trust placed itself in a position where it was open to criticism by not adhering to its CPA policy.

- ***Service Issue 3. Whilst the Trust non-adherence to CPA policy in the case of Mr. Z did not contribute to the death of Mr. W, it has been recognised as a service issue by this Investigation. The Independent Investigation understands that since the time of the incident significant changes have been made to Trust CPA policy and the assurance mechanisms in which it operates.***

12.1.6. Risk/Clinical Assessment

12.1.6.1. Context

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and / or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service users' past and current clinical presentation to allow an informed professional opinion about assisting the service users' recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.
Best Practice in Managing Risk (DoH June 2007) states that '*positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*

- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed'*[106].

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

South West Yorkshire Partnership NHS Foundation Trust Policy at the time of the Incident

The Trust policy stated the following:

"The Trust recognises that the organisation works within a high-risk environment. We are required to achieve a balance between providing appropriate care and treatment to those who use our services and protecting the public. To achieve this balance successfully staff will be encouraged and supported to exercise their professional responsibilities and judgment. The Trust expects and supports staff to take informed, measured and managed positive risks with service users. Even with the best risk assessment practice adverse incidents may still occur. South West Yorkshire Mental Health Trust operates a 'just culture', which seeks to avoid defensive practice and encourage learning from experience."

The Trust had approved the following tools for assessing clinical risk:

- the Sainsbury Risk Assessment (adults of working age and older people);
- HCR 20 Assessing Risk for Violence, Version 2 (historical clinical risk and management, and forensic services).

106 Best Practice in Managing Risk; DoH; 2007

The HoNOS Plus risk tool was utilised as part of the initial screening process on referral in 2002. A Multidisciplinary Risk Assessment was undertaken after the killing of Mr. W on 26 July 2007.

12.1.6.2. Findings of the Internal Investigation Team

The Internal Investigation did not examine risk assessment processes. An observation was made that *"Mr. Z was registered at standard level of the Care Programme Approach, which was appropriate given the assessed level of need and lack of previous high risk behaviour."*[107]

The Internal Investigation report stated that *"risk assessment was contained within standard psychiatric assessment in outpatients. This was standard practice but means that assessment by an isolated practitioner may fail to encompass the overall social situation. However on occasion, when there was cause for concern, appropriate use was made of referral to community services...The outpatient care plan was adequate in maintaining engagement and appropriate to the known assessed risk."*[108]

12.1.6.3. Findings of the Independent Investigation Team

Risk Assessment Prior to the Incident

At the point of referral to the Community Psychiatric Nurse a HoNOS Plus assessment was undertaken on the 24 January 2002 (conducted by CPN 1).[109] This assessment identified that Mr. Z was low in mood and subject to panic attacks. It did not specifically address any potential risk issues.

On the 15 February 2002 Mr. Z told CPN 1 that he was hearing voices that told him to kill himself. This led to an urgent referral being requested for a Psychiatrist assessment. Mr. Z was also observed to be neglecting himself.

On the 21 May 2002, after a delay of three months, Mr. Z was seen in the outpatient clinic for an appointment with the Staff Grade Psychiatrist. Mr. Z told the doctor he was:

107 Internal Investigation Report P10
108 Internal Investigation Report P10
109 Case Notes Y P96

- unemployed and lived alone;
- experiencing third party derogatory hallucinations;
- drinking heavily;
- being financially exploited by his acquaintances;
- had thoughts of committing suicide.

There was no formal mention of risk within the clinical record at this stage.

Between the 2 July and the 20 August 2002 Mr. Z was seen several times, there was no change to his condition. On the 2 August 2002 the Staff Grade Psychiatrist noted that Mr. Z had no intention of harming either himself or others and that the dangers of excessive drinking had been discussed with him. It was also noted that the previous week he had assaulted a friend whilst he had been intoxicated.[110] Once again this did not lead to any formal mention of risk, and no risk assessment appears to have been discussed with CPN 2.

This manner of assessment continued until the time of the killing of Mr. W in March 2007. Risk was not formally identified and specific Trust risk assessment tools were not utilised by either the Staff Grade or Trust Grade Psychiatrists in the outpatient clinic. Whilst it was evident that Mr. Z was monitored on a regular basis in the outpatient clinic, it was not so evident what risk management plans were developed to address the issues that were identified as a result of these monitoring sessions. It was identified on a regular basis that Mr. Z:

- was at risk from his heavy drinking;
- occasionally exploited and assaulted others whilst he was intoxicated;
- was occasionally exploited by others when intoxicated;
- often neglected himself;
- had occasional thoughts of suicide (with no plans);
- was unemployed and socially isolated.

It was evident that the individual practitioners who provided care and treatment to Mr. Z between 2002 and March 2007 made many attempts to provide appropriate interventions to support him and to improve his situation. It was also evident that the risk Mr. Z presented both to himself and to others was born of his chosen lifestyle rather than having an origin in

110 Case Notes P212

mental illness. However, regardless of the origin of Mr. Z's identified risk, as a recipient of secondary care services he should have been subject to a full and formal risk assessment. Had this been worked through it may have become evident that Mr. Z could not be supported easily within the outpatient clinic and an alternative may have been identified and sought. Had this been worked through a decision may have been made to discharge Mr. Z from secondary care services.

Risk Assessment after the Incident

Within a few weeks of the death of Mr. W Mr. Z was charged with murder and released on bail to the community where he continued to drink heavily and came into contact with his previous acquaintances with whom he had frequent altercations. Mr. Z was on the verge of discharge prior to the incident taking place. At the end of March 2007 the Trust decided to maintain care and support to Mr. Z due to the usual circumstances that he found himself in.

These circumstances, by their very nature, would indicate a situation of potential risk that would require management. There was, however, no indication of any risk assessment taking place until the 26 July 2007 when a 'multidisciplinary risk assessment' was completed by the allocated Social Worker, it is unclear who else from the multidisciplinary team was involved. A period of nearly four months had ensued between the decision to maintain care and support to Mr. Z and a formal risk assessment being conducted. This risk assessment identified: aggression and violence, self neglect and exploitation as factors that required management. The management plan consisted of the following actions:

- no lone workers should visit Mr. Z;
- in a crisis situation where he believed he was at risk from others he should go to the nearest Police station (he had no telephone and could not ring);
- Supporting People to be contacted with regard to providing tenancy support in the future;
- outpatient appointments were to continue;
- bail conditions would ensure close monitoring by the Police.[111]

The following day, on the 27 July 2007, a Forensic Consultant Psychiatrist who had been asked to assess Mr. Z regarding both his diagnosis and his risk, saw him to provide an

111 Case Notes Y PP11-14

opinion. Whilst this was an appropriate and sensible thing to do, a potentially unsafe period of time was allowed to elapse between the time of the incident and the forensic assessment taking place. The Forensic Consultant Psychiatrist was of the opinion that in ordinary circumstances Mr. Z should have been referred back to the care of the GP. However in view of the unusual circumstances he suggested that the arrangements the Trust had put into place should continue.

The final assessment to be detailed in the clinical record (which also included aspects of risk) was conducted on the 2 August 2007 as part of Mr. Z's tenancy support application. This particular assessment listed his diagnosis and medication incorrectly. It did not state explicitly that Mr. Z had been charged with murder, and underplayed his significant drinking problems. The assessment stated that lone females should not be working with Mr. Z, however on the Trust risk assessment documentation conducted a week previously, no lone workers were advised to work with Mr. Z regardless of their sex. [112]

12.1.6.4. Conclusions of the Independent Investigation Team

The Independent Investigation Team concluded that risk assessment processes, as they related to Mr. Z's care and treatment, did not contribute to the circumstances that led to Mr. W's death. Whilst Mr. Z's actions *did* contribute directly to Mr. W's death, they were *not* in any manner exacerbated by the presence of a mental illness. Because Mr. Z's actions were not a consequence of a mental illness, any act or omission on the part of the Trust in relation to the management of his risk could not be seen to be relevant to Mr. W's death.

In all probability Mr. Z should not have been in receipt of secondary care mental health services for a significant period of time, both before and after the incident. Mr. Z lived a chaotic lifestyle that contained intrinsic risks to both himself and to other people. Clinical documentation suggests he did not have a mental illness that required specialist intervention. By continuing to provide a service to Mr. Z, the Trust by default, could be seen to have taken on a degree of responsibility for the management of both his risk and social situation. Individuals with chaotic lifestyles who also drink heavily cannot always be helped and supported by mental health services, particularly when, as was the case with Mr. Z, he did not want any third party interference with his drinking habits.

112 Case Notes Y PP23-24

However, Mr. Z was receiving care and treatment from the Trust for a five-year interval. As such he should have been in receipt of formal and regular risk assessments in line with extant Trust policy guidance. This did not occur.

- ***Service Issue 4. Mr. Z did not receive risk assessments in accordance with extant Trust policy and procedure over a five-year period. Whilst this did not contribute to the death of Mr. W, it highlights a potential lack of risk assessment awareness within the treating team during the time Mr. Z was receiving his care and treatment from them.***

12.1.7. Service User Involvement in Care Planning

12.1.7.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that '*the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes*'. In particular the National Service Framework for Mental Health (DH 1999) states in its guiding principles that '*People with mental health problems can expect that services will involve service users and their carers in planning and delivery of care*'. Also that it will '*deliver continuity of care for a long as this is needed'*, '*offer choices which promote independence'* and '*be accessible so that help can be obtained when and where it is needed*'.

12.1.7.2. Findings of the Internal Investigation

This aspect was not explored by the Internal Investigation.

12.1.7.3. Findings of the Independent Investigation Team

In the absence of a formal CPA process being operated it was difficult to ascertain whether or not Mr. Z was consulted with regarding his care and treatment plan. However there was plenty of evidence within the clinical record, both before the incident and after the incident, to suggest that Mr. Z received:

- clear explanations about the care and treatment he was receiving;
- advice and education about his drinking.

Mr. Z was also provided with:

- a wide variety of care and support options that focused upon his social isolation;
- the opportunity to address his excessive drinking.

It was evident that the care and treatment offered to Mr. Z was sensitive to his needs and lifestyle preferences. It would also appear that services delivered care and treatment to Mr. Z in a manner that was both service-user centered and non-judgemental.

12.1.7.4. Conclusions of the Independent Investigation Team

It was the conclusion of the Independent Investigation Team that the care and treatment offered to Mr. Z was both service-user centered and sensitive to his needs.

12.1.8. Carer Involvement and Carer Assessment

12.1.8.1. Context

The NHS and Community Care Act 1990 stated that:

"the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes".

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *"people with mental health problems can expect that services will*

involve service users and their carers in the planning and delivery of care". It also stated that it would *"offer choices which promote independence".*

Carer involvement

The recognition that all carers, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensures that services take into account information from a carer assessment when making decisions about the cared for persons' type and level of service provision required.

Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to carers. It also gave carers the right to an assessment independent of the person they care for.

Then The Carers (Equal Opportunities) Act 2004 placed a duty on local authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. Also that it facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health stated that all individuals who provide regular and substantial care for a person on CPA should:

- Have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis.
- Have their own written care plan which is given to them and implemented in discussion with them.

12.1.8.2. Findings of the Internal Investigation

This aspect was not explored by the Internal Investigation prior to the incident having taken place. Following the incident the Social Worker who was assigned as the Care Coordinator made contact with Mr. Z's mother. This contact was made in order to ascertain whether or not she needed any help or support following the incident occurring. The contact was made

initially by telephone and was then followed up with a home visit. Mr. Z consistently refused permission for any further contact by mental health services to be made with his mother.[113]

12.1.8.3. Findings of the Independent Investigation Team

Prior to the incident taking place Mr. Z lived on his own and did not maintain any contact with members of his family. Mr. Z did not have any friends, describing his drinking companions as *"acquaintances"*. At no time did it appear that Mr. Z had anyone in his life who could be referred to as a carer.

As identified by the Internal Investigation, following the incident, the Social Worker made contact with Mr. Z's mother. Initially this contact was made on the 11 April 2007 when the Social Worker visited her. On this occasion it was evident that Mr. Z had been in contact with his mother as she reported that he was upset about his situation and that he did not want to return to his flat. Mr. Z's mother was described as being elderly and appearing to have had a stroke. She was also described as feeling very worried about her son, the Social Worker left contact details with her.[114]

The Social Worker spoke to Mr. Z about whether or not he felt his mother would need support from the Trust, he said she did not. Mr. Z made it very clear that he did not want his mother contacted or involved under any circumstances.

The Social Worker recorded on the 3 December 2007 that she was not certain what her role was in relation to making contact with Mr. Z's mother in her role as a carer. The Social Worker was also uncertain as to whether Mr. Z's mother was even aware that the incident had taken place and wondered if she had read about the verdict in the newspapers.[115] It was decided to discuss this dilemma with Mr. Z and his solicitor. It is unclear from the clinical record what the outcome of this was.

12.1.8.4. Conclusions of the Independent Investigation Team

The Independent Investigation Team found nothing remarkable about the fact that Mr. Z's mother was not identified as a carer by the Trust during the time that Mr. Z received his care

113 Internal Investigation Report P6
114 Case Notes Y P94
115 Case Notes Y P66

and treatment from them. She did not appear to be involved with her son to any degree during this time.

The death of Mr. W and Mr. Z's involvement in it was regarded by both the Trust and the Strategic Health Authority as being a Serious Untoward Incident governed by both local and national procedure. Once the death of Mr. W had been categorised in this way statutory services had a responsibility to the family of Mr. Z, independent of his desire for them not to be contacted. The *Being Open* Guidance that was published by the National Patient Safety Agency in 2005 requires NHS Trusts to offer both communication and support to those affected, either directly or indirectly, by a serious untoward incident. This includes the families of service users who perpetrate homicides.

The Independent Investigation Team concluded that the Social Worker was working well within her role to make contact with the mother of Mr. Z in order to ascertain whether or not she had been adversely affected by the incident, and to understand whether the Trust could offer any support. Once an incident has been deemed to be subject to a HSG 94 (27) investigation, the responsibility of statutory services extends beyond the time immediately after the incident and continues until the time of the publication of the Independent Investigation Report (the role for providing support at this stage transfers from the Trust to the Strategic Health Authority).

Family members of service users who commit a homicide are often subject to a high degree of stress and adverse media attention. They often require support, advice and reliable information. This input should not be 'blocked' by the service user not wishing for relatives to be involved. Inputs do not disclose confidential patient information, and family support should be organised as an issue entirely separate from the needs and desires of the service user.

It was the conclusion of the Independent Investigation Team that the mother of Mr. Z had the right to an independent assessment of her need for support after the incident. This should ideally have been identified by a senior officer of the Trust. Support from the statutory agencies involved (the Trust and the Strategic Health Authority) should continue up until the time of the Independent Investigation Report publication if required by the family.

- ***Service Issue 5. The mother of Mr. Z should have been offered ongoing support throughout both the Internal and Independent Investigation processes by the involved statutory agencies. Failure to do this leaves individuals potentially uninformed about personal family information that may be disclosed, and vulnerable during a public process that may expose them to unwanted media attention.***

12.1.9. Documentation and Professional Communication

12.1.9.1. Context

Documentation

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professional have adopted similar guidance.

The GMC states that:

'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off [116] *'*

Pullen and Loudon writing for the Royal College of Psychiatry state that:

'Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised.[117]

Professional Communication

'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion. '[118]

Jenkins *et al* (2002)

116 http://www.medicalprotection.org/uk/factsheets/records

117Pullen and Loudon, *Advances in Psychiatric Treatment,* Improving standards in clinical record keeping, 12 (4): (2006) PP. 280-286

118 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) P.121

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.
Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone[119]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively[120]. The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

12.1.9.2. Findings of the Internal Investigation

The Internal Investigation found the general standard of record keeping to be good. Detailed communication was maintained between secondary and primary care between January 2002 and December 2007. A single criticism was made in that the level of CPA and the Care Coordinator was not initially identified in early correspondence between the Trust and the GP.[121]

The fact that Lifeline did not communicate with either the GP or the referring mental health service following Mr. Z's initial assessment in 2003 was identified as being an example of poor communication practice.[122]

12.1.9.3. Findings of the Independent Investigation Team

The Independent Investigation made no additional findings.

12. 1.9.4. Conclusions of the Independent Investigation Team

The Independent Investigation Team concurs with the findings of the Internal Investigation. The record keeping and communication between agencies and professionals was of a good general standard.

119 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999). P.144.
120 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)
121 Internal Investigation Report P7
122 Internal Investigation Report P11

The absence of CPA and formal risk assessment documentation, in line with Trust policy and national practice guidelines, was not thought to be a consequence of poor communication and record keeping. Rather it was thought to be reflective of a culture that was not adhering to CPA and risk assessment practices.

12.1.10. Overall Management of the Clinical Care and Treatment of Mr. Z

This subsection serves to summarise the clinical findings set out in subsections 12.1.1. - 12.1.9. above.

12.1.10.1. Findings of the Internal Investigation

The Internal Investigation found that *"in undertaking this review of services in the context of the care provided to Mr. Z the RCA Facilitator [the report author and lead investigator] were areas in which services could be improved. However there was no evidence that these contributed to the very sad death of Mr. W. These included:*

- *The safe management of individuals with alcohol problems within mental health services requires clear joint strategies with alcohol service providers.*

- *Patients who lack motivation may require specialist input but ongoing support and encouragement may elicit motivation to change;*

- *In relation to alcohol, brief primary care interventions, such as an assessment of alcohol intake with feedback can help reduce excess consumption. Training for mental health staff and/or access to specialist services is required as part of a comprehensive strategy.*

- *Improved team working and supervision systems can enhance the process of risk assessment.*

- *The process of formulating decisions related to risk should be clearly documented.*

- *Interface with alcohol services has been a major issue in relation to the local provision and service links. It is clear that much work is ongoing to improve this situation.*

- *A recent Independent Inquiry has recommended that the PCT [Primary Care Trust] and partnership agencies should develop a mutually agreed strategy to oversee the development of dual diagnosis services including information sharing in Kirklees. This includes the appointment of a lead nurse for dual diagnosis, to lead on the implementation of the strategy."* [123]

The Internal Investigation also highlighted that communication between mental health services and the GP was clear and well documented, and that the Trust and partner agencies ensured consistent support was provided to Mr. Z following the death of Mr. W.

12.1.10.2. Findings of the Independent Investigation Team

The Independent Investigation Team concurred broadly with the findings of the Internal Review.

In addition the following findings were made:

1. There was a lack of clarity regarding Mr. Z's diagnosis over a five-year period. From 2003 it was evident that Mr. Z did not have any obvious symptoms of depression or psychosis and that his hallucinations were pseudo hallucinations which were the product of his excessive drinking. Despite this conclusion being arrived at the diagnosis was not reviewed or revised and Mr. Z's medication regimen also remained unaltered. It is a fact that directly after the incident when a Consultant Psychiatrist review took place Mr. Z was deemed not to have severe or enduring mental illness and his medication was discontinued.

2. The Clinicians who provided care and treatment to Mr. Z between January 2002 and December 2007 did not appear to adhere to the Trust CPA and risk assessment policies and procedures. The documentation ratified by the extant Trust policies was not utilised and there was no record made in the clinical notes that detailed any kind of review or professional meeting ever having taken place.

3. Mr. Z had significant alcohol problems and led a chaotic lifestyle. Whilst it was evident that this often made him feel depressed and low in mood, he demonstrated no desire to stop his drinking during the time he received his care and treatment from the

123 Internal Investigation Report PP12-13

Trust. Once it had been ascertained that Mr. Z had no symptoms of depression and/or psychosis, and that he drank alcohol to excess, for which he did not want any treatment, a decision should have been made to consider discharging him back to the care of his GP.

4. It was evident that had Mr. Z's case been subject to some kind of structured supervision or CPA review his care and treatment would have been managed more effectively. Whilst Mr. Z received ongoing support and monitoring from the outpatient clinic, Mr. Z's presenting set of problems, which were largely social in nature, were not a 'good fit' to the allocation of a psychiatrist as the key worker.

12.1.10.3. Conclusions of the Independent Investigation Team

During the time that Mr. Z received his care and treatment from the Trust a set of policies were in place that did not appear to have been adhered to by Mr. Z's treating team. The Operational Policy set out clear criteria for the discharge of patients who no longer required secondary care services. The CPA and risk policies set out clear guidelines with regard to assessment tools, monitoring and review processes. It would appear that these policies were not adhered to.

It is difficult to assess whether Mr. Z's wellbeing was impacted upon negatively by a prolonged contact with a service that he did not require, and the administration of medication that he probably did not need. It is a more straightforward task for the Independent Investigation Team to conclude that it is unlikely that any act or omission on the part of Mr. Z's treating team contributed to events that led to the death of Mr. W. In order for the Trust to be held responsible Mr. Z would have to have had a mental illness of some kind that it failed to treat and manage appropriately to the detriment of Mr. Z's mental wellbeing. Mr. Z was assessed by the treating team as having no severe or enduring mental illness. The Criminal Justice System process came to the conclusion that Mr. Z was not suffering from any abnormality of mind at the time he took part in the killing of Mr. W that would suggest he lacked capacity in any way and was acting as a result of a mental illness.

The Independent Investigation Team found no contributory or causal factors in relation to the care and treatment Mr. Z received and the death of Mr. W. However it also concluded that Mr. Z's case was not managed well over time.

12.1.11. Management of the Care and Treatment Received by Mr. W

Mr. W had a mental health history that spanned some twenty-six years. This chronology provides a basic summary for the years between 1998 and September 2006. The last six months of the care and treatment that Mr. W received is set out in detail.

The reader is asked to note, that on occasion entries in the record were not signed or were not legible. These entries have been assigned as a 'CMHT Worker'. The clinical records made available to the Independent Investigation Team commence in June 1998.

12.1.11.1. Background

Mr. W was born in 1934 in Trinidad. He was of mixed Asian and West Indian ethnicity. Mr. W came to the United Kingdom in 1962. He had been working in agriculture and emigrated in order to find a better job. He ended up working in the textile industry (although in some notes he is described as an engineer).[124] Mr. W had been married but his wife died in 1998, he had no children and no family living in the United Kingdom.[125]

The Internal Review into the care and treatment that Mr. W received stated that he had a *"long history of social, housing and behavioural difficulties leading to frequent contact with the Police and psychiatric services."* He had also been identified as being a risk *to* females in domestic situations, and of being *at* risk of financial exploitation by others, particularly *"females and 'alcoholics' whose company he often sought."*[126] Mr. W was known to misuse alcohol. He would never admit the extent of his drinking, however a blood test in 2005 found high markers suggestive of heavy drinking. Mr. W was frequently described as being vulnerable to abuse which was more likely when he was intoxicated. When intoxicated his behaviour often made him vulnerable to assault as he could become both aggressive and disinhibited. Appointeeship had been discussed with Mr. W in order to protect his finances, but he refused this. At the time of his death Mr. W was on Enhanced CPA. [127]

124 Internal Investigation Report Mr. W P1
125 Case Notes W p1
126 Internal Investigation Report W P1
127 Case Notes W P1

Criminal History

Mr. W's contacts with the criminal justice system are recorded below:

- *"1982 Wounding. Conditional Discharge for three years.*
- *1985 Driving while disqualified. Suspended sentence.*
- *1993 Assault with actual bodily harm (ABH). No conviction.*
- *1995 Breach of the Peace. No conviction.*
- *1997 Breach of the Peace. No conviction.*
- *1998 Breach of the Peace and assault, kept in cells. No conviction.*
- *2006 Assault/Breach of Injunction. No conviction.*
- *2006 Sexual Assault. Suspended sentence with a Community Order for one year, placed on Sex Offenders' Register for a period of five years."*[128]

Prior to the death of his wife, the Police had been called on several occasions to deal with domestic issues between Mr. W and his wife. Mr. W's lifestyle also led him to be exploited by other people and he was also vulnerable to assault and financial exploitation. Sometime between 1994 and 1995 Mr. W was beaten over the head by a stranger and his jaw was broken. Mr. W reported significant problems with his memory following this attack.[129]

12.1.11. 2. Chronology of Mental Health Care and Treatment

Mr. W experienced anxiety, depression and panic attacks over a period of 26 years. There was evidence to suggest that he misused alcohol on a regular basis. Mr. W's diagnosis at the time of his death was:

- depressive disorder – in remission;
- Personality Disorder;
- mild cognitive impairment.

***Circa.* 1980.** Mr. W presented with psychiatric symptoms for the first time. He was in church at the baptism of a friend's child when he suddenly felt that he was going to die. It appears that he was experiencing a panic attack. A few days later he had another attack accompanied by extreme anxiety. At this stage he was referred to a psychiatrist and admitted to St. Luke's

128 Internal Investigation Report PP1-2
129 Case Notes W P300

Hospital. After a long course of Electro Convulsive Therapy (ECT) he was discharged and learned to live with his symptoms.[130]

The extant clinical records commence on the 19 June 1998.

Adults of Working Age Services

19 – 24 June 1998. Mr. W requested some help with his finances. Social Services and his Keyworker (Care Coordinator 1) expressed their concerns regarding Mr. W and discussed them with his Psychiatrist.[131]

30 June – 3 August 1998. Mr. W was admitted to a Psychiatric Unit in Dewsbury on a Section 5/2 of the Mental Health Act (1983). It was alleged that Mr. W was verbally and physically abusing his neighbours and this led to him being arrested by the Police.[132] Mr. W quickly settled down once on the ward. The Court imposed an injunction upon him so that he could not annoy his neighbours again. Mr. W was discharged on the 3 August 1998. His medication on discharge was Imipramine 50 mg three times a day and Diazepam 5 mg twice a day.

6 August 1998 – 22 October 1999. Following discharge Mr. W was followed up in the community. It was noted that Mr. W's previous behaviour was linked to a possible Personality Disorder. Mr. W was considered to be currently depressed as the result of his wife's recent death. Directly after his discharge it was planned for Mr. W to be followed up by the CMHT and to attend day care.[133]

For a period of several months Mr. W attended day care. However on occasion he was both drunken and threatening at the hospital and on the telephone.[134] Throughout 1999 there was a degree of uncertainty as to whether Mr. W required secondary care services or not. His behaviour was increasingly seen as being the result of alcohol consumption rather than mental illness.[135]

130 Case Notes W P300
131 Case Notes W P165
132 Case Notes W P339
133 Case Notes W P168
134 Case Notes W P164
135 Case Notes W P161

However by 22 October 1999 it was decided that Mr. W's CPA status was *"high priority Section 117".* It was recommended that his case be handed over to the appropriate Key Worker and that a new Consultant should be identified as Mr. W had reached 65 years of age.[136]

Older People's Services

22 October 1999. Mr. W's care was transferred to the Older Peoples' Team. However this process was not formally completed until the 27 March 2000. It was evident that Mr. W experienced panic attacks, anxiety and depression and that he had poor coping mechanisms. At this stage *"?Alzheimer's disease"* also appeared in the clinical record.[137]

21 February 2000. Following Mr. W's transfer to Older People's services a referral was made to a Consultant Neuro Psychologist. At the ensuing consultation it was found that Mr. W's concentration was very poor. The Psychologist found Mr. W was probably at the low end of average with regards to his intelligence. The area that was of most concern was Mr. W's memory. On the Wechsler Memory Scale Mr. W scored 30% below average. The impression was that Mr. W was in the early stages of dementia.[138]

14 March 2000 – 16 October 2001. During this period Mr. W was maintained in the community. It was noted that he was still grieving for his wife who had died three years previously, that he was being financially abused by several different women, and that he was drinking alcohol. The general plan was for a Community Psychiatric Nurse (CPN) to visit him every fortnight. During this period Mr. W was reviewed at regular intervals in the outpatient clinic and received regular CPA reviews.

In June 2000 there was sufficient concern regarding Mr. W's vulnerability to make a referral to Social Services to *"look for formal and more concrete ways of safeguarding this patient against exploitation"* a case conference was arranged for this purpose.[139] It was also planned for the treating Consultant to have a discussion with the Police to seek advice about protecting Mr. W. Mr. W was also referred to the Cloverleaf Advocacy Service.

136 Case Notes W P162
137 Case Notes W P300
138 Case Notes W PP295-296
139 Case Notes W PP286-287

On the 5 September 2000 the treating Consultant expressed frustration that Mr. W's risks were a direct result of his own behaviour and that his behaviour was outside of the control of mental health services. It was unclear what happened during the case conference, however Social Services did not take the case on at this stage.

On the 12 December 2000 Mr. W's needs were reviewed. It was noted that he was:

- *"still slightly suffering from grief";*

Subject to:

- financial abuse by women;

Required:

- counsellor for alcohol misuse.

Mr. W was encouraged to attend the Salvation Army. It was decided that Mr. W's drinking, diet and depression needed to be monitored.[140] The entry was not signed. The plan was to review at a CPA meeting in two months time.

10 November 2001 – 15 April 2003. On the 10 November 2001 Mr. W was charged with being drunk and disorderly, for which he was bound over to keep the peace. For a period of nearly a year following this Mr. W was followed up by his CPN and attended his appointments at the outpatient clinic. There was no change reported to his mental state.[141]

On the 8 October 2002 Mr. W's CPN was contacted to say that he had been locked up in the Police cells for being drunk and disorderly. Once again he bound over to keep the peace.[142]

During this period Mr. W often reported feeling depressed. He was offered an inpatient admission on the 9 October 2002 which he refused. Mr. W continued on with no changes to his condition.

April 2003 – February 2005. A CPA review was held on the 15 April 2003. The plan was for Mr. W to continue with his CPN, Advocacy Worker, outpatient clinic and Priestley Day Centre.[143] On the 31 July 2003 Mr. W was seen again by the Consultant Neuro Psychologist,

140 Case Notes W P28.
141 Case Notes W P149
142 Case Notes W PP138 & 146
143 Case Notes W P219

the opinion was that was suffering from early dementia and that he should have a CT scan (computerised tomography to take images of the brain), something which Mr. W refused.[144]

As 2004 progressed Mr. W's condition did not undergo any major changes, however his behaviour was considered to present a high risk to himself on occasion. He continued to be in receipt of regular CPA and good communication was maintained throughout his care network. Mr. W's needs and care and treatment plan did not change during this period. On the 6 May 2004 an incident occurred which was reported by staff at the Day Centre. Mr. W had been attacked by one of his female friends and had scratches down his face. The Day Centre staff wrote to the treating Consultant to explore whether Mr. W could be assessed under the Vulnerable Adults procedure.[145] On the 25 May 2004 the treating team discussed Mr. W's situation, no decisions were made on this occasion about whether or not to refer him under the Vulnerable Adults procedure.[146] By the 21 September 2004 at a CPA review it was agreed that Mr. W was vulnerable to exploitation by women, he was also assessed as having an unhealthy interest in the female staff at the Day Centre. It was decided that he should stop attending the Day Centre as it was no longer therapeutic.[147]

March 2005 – February 2006. During this period Mr. W's neighbours complained that he was drinking and receiving visits from *"undesirable ladies".*[148] CPA occurred on a regular basis during this time and no changes were observed to either Mr. W's mental state or risk, subsequently no changes were made to his care plan.

3 February 2006. Mr. W's needs were reviewed on this day. The needs were identified as:

- Mr. W did not like change;
- Mr. W needed a routine and emotional support;
- Mr. W continued to be reluctant to receive community services, even though he neglected his *"cleaning duties"*.

144 Case Notes W PP215 & 208
145 Case Notes W P207
146 Case Notes W P206
147 Case Notes W PP197-198
148 Case Notes W P116

The care plan was for the link worker to assist and supervise cleaning and to encourage Mr. W to attend to his personal hygiene. Mr. W was to be reviewed on the 4 April 2006.[149] It was unclear who wrote this entry.

1 March 2006. The treating team were informed that Mr. W was in Police custody and that an Appropriate Adult was required. Mr. W was to appear at a Magistrates Court on the 10 March 2006 regarding sexual assault charges.[150]

24 April 2006. The case was adjourned in order to secure a Psychiatry report. A new date was set for the 18 May 2006.[151]

3 May 2006. Mr. W's care plan was reviewed. The identified actions were that Mr. W needed to be reminded not to give his money to exploitative people and that he needed to spend his money on food, not alcohol. Mr. W was advised not to let any strange women into his home. It was noted that Mr. W was reluctant to accept community services or attend a day centre.[152]

10 May 2006. It was reported that Mr. W was beaten up. He had been attacked by a woman when he refused to let her into his house.[153]

11 May 2006. Mr. W's Community Psychiatric Nurse contacted Social Services expressing concerns about Mr. W's possible status as a vulnerable adult. [154]

15 May 2006. Once again Mr. W's Community Psychiatric Nurse contacted Social Services. The treating team's concerns were reiterated and were described as *"urgent"*. It was agreed that the treating Consultant would write a report and send this to Social Services detailing the concerns.[155]

149 Case Notes W PP26-27
150 Case Notes W PP106-107
151 Case Notes W P105
152 Case Notes W PP25-
153 Case Notes W PP96 & 99
154 Case Notes W P113
155 Case Notes W P98

15 May 2006. Mr. W was admitted to St. Luke's Hospital after threatening to kill himself. He was then transferred to the Priestley Unit at Dewsbury as an inpatient.[156] On the 17 May Mr. W was assessed for the Court and it was decided that he was fit to plead.[157]

18 May 2006. A Social Worker was allocated to Mr. W's case.

24 May 2006. The Community Psychiatric Nurse discussed the possibility of an Appointeeship for Mr. W with Social Services. However when this was discussed with Mr. W he was adamant that he wanted to manage his own affairs and agreed to open a bank account. He deemed to have the capacity to make this decision, (although it is unclear how this was ascertained).[158]

26 June 2006. Mr. W was discharged from hospital. A comprehensive discharge CPA was undertaken with the entire treating team.[159]

27 June 2006. Mr. W was arrested for harassing his neighbour.[160]

6 July 2006. Mr. W fractured his collar bone whilst intoxicated.[161]

12 July 2006. A CPA meeting was held. It was highlighted that Mr. W was at risk of exploitation by the public. When Mr. W was intoxicated he could become aggressive. It was noted that he had a current Charge against him for touching a girl in a shop. The plan was for the Community Psychiatric Nurse, the Social Worker and the Support Worker to continue to support and monitor him.[162] Mr. W refused to have home care support.

8 August 2006. Mr. W was convicted of the 'sexual touching' of an eighteen-year old girl. He was sentenced to a Community Order for one year and was placed on the Sex offender's Register for five years.[163]

156 Case Notes W P1
157 Case Notes W P96
158 Case Notes W P91
159 Case Notes W P435
160 Case Notes W P86
161 Case Notes W P84
162 Case Notes W PP 4 & 74
163 Case Notes W PP23-25

23 August 2006. CMHT Worker 1 visited Mr. W at his home, he was not in. A Neighbour said that Mr. W had been visiting a female friend who had lost her partner two years earlier it was reported that she was *"terrified of him"*.[164]

11 September 2006. A visit was made but Mr. W was not at home. CMHT Worker 1 went back to Mr. W's home with the Probation Officer later in the day. Mr. W still was not in. The Probation Officer warned that Mr. W would end up back in Court if he failed to keep his appointments with the Probation Service. Another appointment was made for Mr. W with the Probation Service.[165]

18 September 2006. Care Coordinator 1 was present when Mr. W met with a Community Police Officer regarding his Supervision Order who had been asked to have a *"stern word"* about keeping Probation appointments in the future. The Care Coordinator also accompanied him to the Probation Officer.[166]

25 September 2006. CMHT Worker 1 visited Mr. W. The Worker took Mr. W shopping and to his Probation appointment. He appeared to be *"happy".*[167]

28 September 2006. Mr. W presented at Accident and Emergency the previous evening saying that no one cared for him. He was verbally aggressive and seen by the Duty Doctor. He was then put into a taxi and sent home. The Care Coordinator visited and asked him why he had gone to the Accident and Emergency Department. Mr. W said that he felt lonely. The Care Coordinator took Mr. W into Dewsbury and bought him a meal for his tea.[168]

29 September 2006. Care Coordinator 1 visited Mr. W twice but he was not in.[169]

2 October 2006. Care Coordinator 1 and a CMHT Worker visited Mr. W to take him for his Probation appointment. Mr. W was also taken shopping and to collect his pension.[170] Mr. W

164 Case Notes W P67
165 Case Notes W P66
166 Case Notes W P64
167 Case Notes W P65
168 Case Notes W P64
169 Case Notes W P63
170 Case Notes W P63

had been accusing the Post Master of taking his money. The Post Master was advised to call the Police if Mr. W made difficulties in the future.[171]

6 October 2006. Care Coordinator 1 visited Mr. W at his home; he was outside trying to persuade a person in a van to telephone for an ambulance as he was going mad. The Care Coordinator took Mr. W into the house and tried to calm him down. A woman had tried to get into his house the night before. The Care Coordinator took Mr. W to the bank where he withdrew some money for a new television and for some food.[172]

9 October 2006. Care Coordinator 1 visited Mr. W at his home to find his new television smashed up and in the garden. Mr. W had had a female friend staying over the weekend. Mr. W appeared to be confused and disorientated. The Probation Officer was informed.[173]

11 October 2006. Care Coordinator 1 visited but Mr. W was not in.[174]

12 October 2006. Care Coordinator 1 visited Mr. W at his home. Mr. W had forgotten about his appointment the day before.[175]

16 October 2006. The Care Coordinator was telephoned to say that Mr. W had presented himself at Accident and Emergency because he was worried he had forgotten his Probation Appointment. The Care Coordinator visited Mr. W who was worried and anxious about collecting his benefits. Mr. W was reassured that the Care Coordinator and CMHT Worker 1 always collected him to take him to the Post Office.[176]

19 October 2006. Care Coordinator 1 and CMHT Worker 1 visited Mr. W to check up on him and took him for a take away meal which he enjoyed. Mr. W was no longer feeling anxious.[177]

23 October 2006. Care Coordinator 1 took Mr. W to the Probation Office and to collect his benefits. Mr. W deposited £70 in the bank.[178]

171 Case Notes W P65
172 Case Notes W P63
173 Case Notes W P61
174 Case Notes W P61
175 Case Notes W P61
176 Case Notes W PP61-62
177 Case Notes W P62

26 October 2006. Mr. W told Care Coordinator 1 that he had reported a female friend who had been harassing him to the Police. Mr. W was reassured that he had done the right thing. Mr. W had also purchased some new clothes, which was taken as evidence of him showing some initiative. [179]

28 October 2006. Mr. W arrived onto the Priestley Unit as he was worried about women turning up at his home. He was advised not to let them in and to call the Police for help.[180]

30 October 2006. Care Coordinator 1 visited Mr. W and took him to collect his benefit money. Mr. W was advised to buy some new bed linen.[181]

3 November 2006. Mr. W was visited by Care Coordinator 1. He was described as doing well and taking his own initiative. He had bought a coat as advised and was later taken to his Probation appointment.[182]

13 November 2006. Mr. W was visited at his home by Care Coordinator 1 and CMHT Worker 1 who took him for his Probation appointment. No issues were noted.[183]

20 November 2006. Mr. W was noted as not being compliant with his care plan and meeting with the Probation Service, the CMHT worker had made four visits to Mr. W's home but he was not in. The Probation Service had notified the Community Police who planned to make a visit to Mr. W to reinforce his compliance.[184]

21 November 2006. Mr. W attended an outpatient CPA. Mr. W arrived in a *"very agitated and verbally aggressive manner."* When asked why he was not complying with his care plan Mr. W said that he was not receiving enough support from his Keyworker and Link Worker. Apparently he had visited the Probation Service the following day. Eventually Mr. W calmed down.[185] Consultant Psychiatrist 2 planned to see Mr. W again in a month's time.

178 Case Notes W P62
179 Case Notes W P42
180 Case Notes W P62
181 Case Notes W P42
182 Case Notes W P41
183 Case Notes W P41
184 Case Notes W P39
185 Case Notes W PP39-40

27 November 2006. A CMHT Worker (signature illegible) visited Mr. W and took him to the Probation Service. Mr. W had had a bad weekend as a woman had been knocking on his door demanding money. [186]

29 November 2006. Mr. W visited the Priestly Unit looking for Care Coordinator 1. Mr. W was described as being agitated and aggressive. Mr. W reported that he wanted his money as he had none for food and was unable to collect any from the Post Office as the staff there had told him that Care Coordinator 1 needed to be present. Mr. W commenced to bang his head against the wall. The unit staff were able to contact the Care Coordinator on the telephone, Mr. W then calmed down. Mr. W's Social Worker escorted him off the premises after providing him with reassurance. [187]

30 November 2006. Mr. W returned to the Priestly Unit. He threatened to self harm by banging his head against the wall until he got help with getting his money. He was told that Care Coordinator 1 would visit him the following day.[188]

7 December 2006. A friend of Mr. W visited the Social Worker to say that Mr. W had been banging on his door every two hours until 4.00am in the morning. Mr. W had been requesting a lift to the airport because he wanted to return to Trinidad. He had also been 'flashing' (exposing himself) and asking questions of a sexual nature.

It appeared that Mr. W's mental state was deteriorating. The Social Worker made a record of the meeting and telephoned the Care Coordinator.[189]

8 December 2006. Care Coordinator 1 visited Mr. W. Mr. W denied the events of the previous day. The Care Coordinator noted that Mr. W's behaviour was appropriate. [190]

11 December 2006. Care Coordinator 1 visited Mr. W with the Link Worker. He was taken to collect his money and to visit the Probation Service.[191]

186 Case Notes W P40
187 Case Notes W P43
188 Case Notes W PP43-44
189 Case Notes W PP44-45
190 Case Notes W P45
191 Case Notes W P45

12 December 2006. Mr. W visited the Priestly Unit to apologise for what he had said about Care Coordinator 1. Mr. W was calm and rational.[192]

18 December 2006. A CMHT Worker 1 and the Social Worker visited Mr. W at his home. He was taken to the Post Office and to the bank. Mr. W was then taken to the Probation Service.[193]

19 December 2006. A CPA review was held on this day. It is unclear who exactly attended, but it was evident that Consultant Psychiatrist 2, Care Coordinator 1 and Mr. W were present. The review took place at the outpatient clinic. Mr. W was told that he would be transferring to a new Care Coordinator (the allocated Social Worker) as his current one was retiring. The other agencies involved with Mr. W's care were listed as Housing, General Practice, Social Services and the Police.

Mr. W's risks were noted as; being at risk of harm *to* others and also being at risk of harm *from* others. It was noted that he remained vulnerable to exploitation form others. The contingency plan listed all of the agencies involved in Mr. W's care. The care plan focused upon:

- financial advice and support;
- social relationships and skills;
- vulnerability.

It was noted that a full risk assessment had been completed on the 19 December 2006. Mr. W declined a copy of his CPA review.[194]

22 December 2006. Care Coordinator 1 visited Mr. W at his home. A female neighbour approached the Care Coordinator to say that Mr. W had been harassing her and trying to climb over her fence. She had contacted the Police, and apparently an injunction had been taken out against Mr. W. When confronted with his behaviour Mr. W denied everything to the Care Coordinator.

192 Case Notes W P46
193 Case Notes W P50
194 Case Notes W PP7-10

Mr. W was then taken to collect his money and he deposited £100 in the bank. Mr. W was left with enough money in his wallet to last him over the Christmas period. He was advised not to give his money away to women.[195]

27 December 2006. Care Coordinator 1 visited Mr. W. He was well and no incidents had occurred over the Christmas period.[196]

29 December 2007. Care Coordinator 1 visited Mr. W and took him to collect his money. Mr. W had lost his new coat and needed to buy another one.[197]

2 January 2007. Mr. W was visited at his home by CMHT Worker 1. Mr. W smelled of alcohol and said that Mr. Z had robbed him with two female accomplices. Mr. W was warned about befriending Mr. Z. Mr. W was advised to tell his Probation Officer about the theft.[198]

3 January 2007. CMHT Worker 1 visited Mr. W at his home but he was not in. He had left a note to say that he had collected his money and that he was filling in a passport application form.[199] The Worker found Mr. W and took him for his planned Probation appointment. He reported that money had been stolen from him once again by the daughter of some friends.

5 January 2007. An incident occurred at the Post Office when Mr. W refused to leave and began to bang his head against the wall. The Police were called out to the incident, but no action was taken.[200]

15 January 2007. CMHT Worker 1 tried to visit Mr. W at his home, but he was not in. He was found on his way to "*Batley with Mr. Z who 'usually' robs Mr. W of his money."* Mr. W deposited £100 at the bank and visited the Probation Service. He was advised once again not to drink and socialise with people who exploited him.[201]

29 January 2007. A home visit was made by CMHT Worker 1 and the Social Worker. Mr. W's girlfriend (described as being of many years) was present. Mr. W wanted advice as to

195 Case Notes W PP47-48
196 Case Notes W P48
197 Case Notes W P51
198 Case Notes W P49
199 Case Notes W P49
200 Case Notes W P52
201 Case Notes W P55

whether or not to let his girlfriend stay with him for a while. He was taken to the Post Office and to his Probation appointment. The Probation Officer told Mr. W he should stay away from women. Mr. W was advised that if his girlfriend came to stay with him the Housing Office would have to be informed.[202]

1 February 2007 (listed in the clinical record as being a late entry). Mr. W had been seen in the company of a known prostitute outside of the Halifax bank, it was thought she was trying to get money from Mr. W. When questioned by the Police she told them she was taking Mr. W out for his weekly shopping. The new Care Coordinator (Social Worker) was made aware.[203]

5 February 2007. A home visit was made by CMHT Worker 1. It was noted that Mr. W had withdrawn a lot of money from his bank account. He was advised against doing this if he wished to visit his nephew in America.[204]

12 February 2007. CMHT Worker 1 visited Mr. W at his home. He took Mr. W to the Post Office and then on to the bank. It was noted that Mr. W had £1,299 in his account. It was apparent that Mr. W had visited the bank recently and withdrawn a great deal of money. Mr. W was then taken for his Probation appointment.[205]

14 February 2007. Mr. W visited the Priestley Unit. He was angry and aggressive saying that no one had come to take him to collect his pension and that he had no food in the house. Mr. W calmed down when he was reminded that CMHT Worker 1 had visited him on the Monday to collect his pension. Mr. W, however, had no money. He had given some to a female friend and had also bought a second hand television. It was apparent that some £500 had been taken out of his bank account over the last month. On this occasion Mr. W's speech was slurred. Although he initially denied drinking, he later admitted to it. It was agreed that the situation would be discussed with the Probation Officer.[206]

202 Case Notes W P56
203 Case Notes W P57
204 Case Notes W PP56-57
205 Case Notes W PP57-58
206 Case Notes W PP58-59

19 February 2007. CMHT Worker 1 and the Social Worker visited Mr. W at his home. It became evident that women were 'borrowing' money from Mr. W and not giving it back. [207]

20 February 2007. A CPA review was due on this day at the outpatient clinic. Mr. W appeared at the outpatient department in an angry state because his drains were blocked. He was reported as being *"quite vocal".* He saw Consultant Psychiatrist 2 and calmed down. Mr. W told the Consultant that his old girlfriend had moved in with him and that he was still being pestered by another woman for money. Another appointment was made for the 17 April 2007 at the outpatient clinic.[208]

21 February 2007. Mr. W reported to CMHT Worker 1 on this day that a woman, who had been living with him, together with another female, had been taking money from him. Mr. W also reported that his drains were blocked.[209]

22 February 2007. CMHT Worker 1 visited Mr. W at his home. Mr. W was reported to have been smartly dressed and ready for his appointment. Mr. W was reported to be upset as some *"lads"* had thrown eggs at his home. However he calmed down on the way to the Post Office where he collected his money. Mr. W deposited some of his cash at the bank. The plan was for CMHT Worker 1 to visit in a week's time to take Mr. W for his Probation appointment.[210]

26 February 2007. A home visit was made by CMHT Worker 1. Mr. W was taken to the Post Office to collect his benefit money.[211]

27 February 2007. A neighbour of Mr. W telephoned the CMHT. Mr. W had been banging on her door because he was worried about his money; apparently an acquaintance (Female A) had bought a mobile telephone in Mr. W's name and had left him to pay the bill. A home visit was made, but Mr. W was not in.[212]

28 February 2007. A home visit was made by CMHT Worker 1 an acquaintance (Female B) was present. She had apparently taken money from Mr. W in the past. Mr. W was reminded

207 Case Notes W P38
208 Case Notes W P37
209 Case Notes W P36
210 Case Notes W P56
211 Case Notes W P36
212 Case Notes W P35

about what his Probation Officer had told him about allowing women into his home and Female B was asked to leave. Mr. W expressed fears about what would happen to him when he was too old to look after himself. A visit to the Probation Officer was made and Mr. W was once again reminded not to give money to female acquaintances. [213]

5 March 2007. A home visit was made by CMHT Worker 1. Mr. W's benefit money was collected and deposited in the bank. He was advised to look after it as he wanted to make a trip to America.[214]

8? March 2007. A home visit was made by CMHT Worker 1. Mr. W said that his house keys had been stolen. Mr. W reported that an acquaintance (Female C) had taken them. The CMHT worker called the Council for a replacement lock and key to be provided. [215]

12 March 2007. A home visit was made by CMHT Worker 1 but Mr. W was not in.[216]

19 March 2007. A home visit was made by CMHT Worker 1 and Mr. W's Social Worker. Mr. W was taken to collect his benefit money and then to deposit it in the bank (a total sum of £80). It was noted that a sum of £280 had been withdrawn throughout the week. Mr. W did not know where this money had gone. Mr. W was taken to visit his Probation Officer. No concerns were identified and it was planned that both workers would make another visit to Mr. W on the 26 March 2007.[217]

End March 2007. A friend of Mr. W telephoned the CMHT to say that Mr. W had been killed. [218]

12.1.11.3. Findings of the Internal Investigation into the care and Treatment of Mr. W

The terms of reference for the Internal Review are set out below.

213 Case Notes W PP35-36
214 Case Notes W P33
215 Case Notes W P33
216 Case Notes W P32
217 Case Notes W P32
218 Case Notes W P32

- Confirm the findings of the initial investigation (that for Mr. Z) that the care provided by the Trust was appropriate and no omission of action contributed to the circumstances leading to the death of Mr. W.
- Explore whether any lessons can be learned to inform improved care delivery.[219]

The Internal Review found the following issues for consideration:

- *"There is clear evidence from case records that the CMHT made every effort to communicate with all agencies involved regarding the risks associated with Mr. W.*
- *The level of care provided to Mr. W remained significant despite his depression being described as 'in remission'.*
- *There was no evidence of a change in care provided to Mr. W following transfer of Care Coordinator.*
- *CMHT records were not always kept in chronological order.*
- *No action was agreed during CPA if care planning failed.*
- *Although frequent reference is made to Vulnerable Adults Strategy there was no evidence of someone being identified as coordinating this nor any record of a multi-agency strategy meeting.*
- *Interventions were complicated for this individual by his reported cognitive impairment the focus of the CMHT staff appears to have been on providing practical assistance. However Mr. W remained compliant with medication independently. Though indicated in care planning there was little evidence of interventions directed at Mr. W improving his life skill, staff appeared to focus on advice giving and warnings about behaviour. Though it is extremely doubtful that this approach contributed to the circumstances leading to the murder of Mr. W, it does indicate a lack of confidence in skills for CMHT dealing with challenging clients."*

12.1.11.4. Findings of the Independent Investigation Team

Referral, Transfer, and Discharge Procedures

Mr. W was referred to, transferred between, and discharged from services on several occasions. The most significant of these was the transfer from Adult Services to Older Peoples' Services sometime early in 2000, and the multiple attempts to refer Mr. W to Social

219 Internal Investigation Report P1

Services for assessment under the Vulnerable Adult procedures between June 2000 and the summer of 2006.

The transfer between Adult Services and Older People's Services appeared to be protracted over a period of some six months. However it was evident that Mr. W's care and treatment was effectively held by the Older Peoples' Team during this period and Mr. W's care, treatment and supervision suffered no ill effects.

The multiple attempts to refer Mr. W to Social Services regarding Vulnerable Adult issues between 2000 and 2006 did not result in either appropriate or timely responses. It was evident that Mr. W was a person who was vulnerable and required a detailed assessment and action plan. Trust staff are to be commended for considering such a referral from such an early point in time, as in the year 2000 Vulnerable Adult awareness across the country was embryonic. At the present time a reported incident of exploitation or abuse would result in a strategy meeting and a case conference. By 2006 when the last referral was made by Trust staff to Social Services a formal response should also have been instantly forthcoming. Whilst Mr. W was allocated a Social Worker in the summer of 2006 it was evident that Vulnerable Adults issues were not addressed in a formal manner.

Diagnosis

Mr. W had a diagnosis of anxiety, panic attacks and depression. He also exhibited high risk behaviours which were thought to have been exacerbated by a possible Personality Disorder and alcohol misuse. In 2000 Mr. W received a consultation from a Consultant Neuro Psychologist who was of the opinion that Mr. W may have been presenting with the early stages of dementia. This consultation was repeated in 2003 when it was also thought Mr. W may be dementing. Mr. W refused to have this condition confirmed by a CT scan.

Between 2000 and 2006 Mr. W often appeared to be confused and paranoid. It was also observed that he had difficulties in managing his behaviour, his alcohol intake and his social relationships. Mr. W's diagnosis over time did not appear to have been controversial or unclear in any way (although in early 2000 a post concussional syndrome resulting in a

cognitive deficit was considered).[220] Mr. W received a sustained degree of assessment and monitoring in keeping with his age, chaotic lifestyle, and possibly emerging dementia.

Medication and Treatment

Medication

Mr. W received Imipramine to treat his depression and Diazepam to treat his anxiety. He received the same medication regimen for a period of eight years. It is normally advised that Diazepam should be prescribed as a short-term solution due to the fact that it can become habit-forming. It is not advised to take Diazepam and alcohol together, something that Mr. W presumably did on frequent occasions as he was reasonably compliant with his medication and drank a great deal. Mr. W was on a relatively low dose, 5 mg twice a day, which was an appropriate dose for his age, however such a prolonged use of Diazepam may not have been advisable and it was evident from reading through the clinical records that the diazepam made Mr. W forgetful and confused on occasion.

Imipramine is used to elevate the mood of patients with depression. Imipramine also causes sedation. Therefore, it is useful in depressed patients with insomnia, restlessness, and nervousness. Diazepam and alcohol use can interact unfavourably with Imipramine in that it can slow down brain functioning. Whilst Mr. W did not appear to have had any problems with this medication it is possible, that together with his decreasing cognitive function and suspected early dementia, the medication regimen he was on at times exacerbated his confusion.

Mental Capacity Act (2005) and Safeguarding Vulnerable Adults

In 2000, the Government published a national framework, *No Secrets*, so that local councils with Social Services responsibilities, local NHS bodies, local Police forces and other partners could develop local multi-agency codes of practice to help prevent and tackle abuse. Codes of practice were to be in place by October 2001.The multi-agency codes of practice, developed in response to "No Secrets", have been evaluated by the Centre for Policy on Ageing on behalf of the Department of Health. Individuals identified under this framework are known as Vulnerable Adults. [221]

220 Case Notes W P302
221 Department of Health. National Archives.com

The Mental Capacity Act (2005) states that *"…everyone should be treated as able to make their own decisions until it is shown that they are not."* It also aims to enable people to make their own decisions for as long as they are capable of doing so. A person's capacity to make a decision will be established at the time that a decision needs to be made. A lack of capacity could be because of a severe learning disability, dementia, mental health problems, a brain injury, a stroke or unconsciousness due to an anaesthetic or a sudden accident. The Act also makes it a criminal offence to neglect or ill-treat a person who lacks capacity.[222]

As can be seen from the chronology above Mr. W was considered to be a Vulnerable Adult by his treating team. Despite making many referrals, and suggesting case conferences to review Mr. W, no formal actions appear to have been progressed. Mr. W continued to be physically attacked and threatened on a regular basis. He was also repeatedly financially exploited. This financial exploitation was seen as making a significant contribution to the death of Mr. W by the Detective Superintendent who led the murder investigation.

It was unclear from an examination of the clinical records how exactly the treating team made decisions regarding Mr. W's capacity during the last six months of his life. It was evident that he had difficulty in concentrating when asked questions and that his cognitive function was reducing. At interview with the Independent Investigation Team the treating Consultant explained that it was thought Mr. W had not yet reached the stage when he required Appointeeship. However it was the view of the Independent Investigation Team that this simple step may possibly have prevented his continued exploitation. It was evident that Mr. W had a degree of cognitive deficit, and may not have had the capacity to make an informed decision about this particular aspect of his life.

Mr. W was motivated strongly to live his life in the way that he wanted to, even though this led him at times into perilous situations. Over time the treating team providing care and treatment to Mr. W in a sensitive and service-user centered manner, taking full account of the fact that Mr. W had the right to live his life the way that he wanted to. It was evident however that Mr. W was probably coming to a stage where more assertive action was required.

222 National Archive.gov.uk

On the night of his death Mr. W fell prey to predatory people, a situation that was exacerbated by his own behaviour. Unfortunately this was not an 'out of the blue' situation. The situation was in fact totally predictable, and the possibility of such a situation had featured in nearly all of Mr. W's CPA reviews for a period of several years. It was evident, even without hindsight, that Mr. W was vulnerable and had reached the stage where he could no longer maintain his own safety.

Care Programme Approach (CPA) and Risk/Clinical Assessment

The Independent Investigation Team found that the CPA process was managed over time in a competent and rigorous manner. Multidisciplinary CPA meetings were held on a regular basis to which Mr. W attended. Risk assessment and care planning were kept up to date and were the result of detailed discussion and team working. The Trust CPA policy was adhered to in its entirety. Documentation was kept well and communication between primary and secondary care was maintained in an exemplary manner.

The Independent Investigation Team does however concur with the findings of the Internal Review in that staff appeared to focus on giving advice and warnings about Mr. Z's behaviour to Mr. W, who it appeared was oblivious to any risk, rather than focusing on practical actions to make him safe.

The issues relating to risk were mostly confined to those around Mr. W as a Vulnerable Adult. This has already been discussed above.

Service User Involvement in Care Planning and Treatment

Mr. W was an elderly man of Asian/West Indian descent. The Trust demonstrated a remarkable level of sensitivity to both Mr. W's ethnicity and to his needs as an individual.

Ethnicity

Mr. W received his Care Coordination from an individual who was also the Ethnic Services Coordinator. Mr. W attended the Ethnic Day Centre. It was evident that the Trust was able to provide a set of services to people that respected cultural diversity. On examining Mr. W's clinical records it would appear that clinicians took care to understand him in the context of his ethnicity and took this into account during assessment and care planning processes.

Service-User Centered Care

There was evidence to suggest that Mr. W was actively involved in all of the care and treatment decisions that were taken about him. Mr. W was always present at the CPA meetings, although it was frequently on record that he declined the offer of copies of the CPA paperwork. Mr. W often made lifestyle choices that were not in his best interests and he struggled to live independently. The care and treatment package that Mr. W received was comprehensive and enabled him to continue to live in the community.

The ethos of patient-centered care was strong within the treating team. It is sometimes difficult to balance patient choice with the statutory duty of care that all Trusts have to maintain. Mr. W provided a real challenge to the treating team over time as his behaviour consistently placed him at risk, both from himself, from others, and to others. The team attempted to meet this challenge in a manner that did not impinge upon Mr. W's autonomy by providing an intensive input into Mr. W's care and support in a way that was acceptable to him.

Documentation and Professional Communication

On the whole the standard of documentation and professional communication was deemed by the Independent Investigation Team to have been of an excellent standard. The only exception to this was the CMHT record which appeared often not to have been contemporaneously made. Date sequencing was found to be muddled and entries often not made on Trust paperwork. Whilst some of the disrupted paperwork could have been the result of photocopying in readiness for the Coroner and Criminal justice proceedings, it does not explain the extent of the date confusion that was identified during this Investigation. It would not appear that there was anything 'sinister' at play in the record keeping process as this date confusion was evident over several years' worth of entries and was not specific to entries made regarding clinical inputs in the lead up to the incident.

12.1.11.5. Conclusions of the Independent Investigation Team

It was the conclusion of the Independent Investigation Team that the care and treatment Mr. W received was patient-centered. It was evident that the treating team over time worked as a cohesive multidisciplinary team and adhered, on the whole, to Trust policy and guidance in an entirely appropriate manner. However Mr. W was a Vulnerable Adult due to his age, his

mental health and his cognitive deficits. The risks that Mr. W both faced and presented with were *actual* risks, not *potential* risks. It was a fact that Mr. W was financially exploited on a regular basis and had been physically assaulted on several occasions. Mr. W placed himself at risk further by his chosen lifestyle and his drinking. Mr. W was also an identified risk to other people and had been placed on the Sex Offenders' Register.

It is often difficult for treating teams to know when it is time to intervene actively in the best interests of a patient. Mr. W's risks had been known well to the treating team over a period of at least six years. The treating team had responded to the risks by constantly stepping up the levels of care and supervision Mr. W received in the community. By the time of his death Mr. W was being supported by his GP, a Consultant Psychiatrist, a Social Worker, a Community Psychiatrist Nurse and a Support Worker. As can be seen from the chronology Mr. W was being seen three to four times a week, sometimes more. All of this activity was not enough to keep him safe.

It was the conclusion of the Independent Investigation Team that whilst the treating team made every effort to provide a patient centered and comprehensive care and treatment package for Mr. W, the time had perhaps come for a set of formal measures to have to have been put into place to protect Mr. W better. It would have been good practice to have:

- no longer expected Mr. W to heed warnings and advice given to keep him safe as he appeared unable to comprehend the level of danger he was frequently in;
- set up a multiagency case conference to discuss Mr. W's situation;
- formally assessed Mr. W's cognitive function to ascertain whether this seriously impaired his ability to live independently and safely;
- formally assessed Mr. W's capacity with regard to his financial and lifestyle decisions which were placing him at risk;
- developed robust care and treatment, and contingency and crisis plans to specifically to maintain and review Mr. W's safety in the short, medium and long term, to which all appropriate agencies agreed to, and which could be implemented with immediate effect as Mr. W's emerging needs arose.

It is not the role of an Independent Investigation Team to state whether a person they have never met was a Vulnerable Adult or not. However it is the conclusion of the Independent

Investigation Team that whilst the activity (visits, monitoring and supervision) around Mr. W's case was laudable, the assessment, care planning and review mechanisms did not act to safeguard a person who had cognitive deficits and clearly placed himself in situation of exploitation and danger on a regular basis.

It can be difficult for statutory agencies to know when to intervene. Mental health services across the country valiantly struggle to maintain the rights and choices of individual service users on a daily basis, whilst keeping them safe. There is no simple solution or clear, predetermined path to follow. However with cases such as the one Mr. W represented the Mental Capacity Act (2005) and national Vulnerable Adults' guidance can be used to safeguard people who by virtue of their *"age, disability, mental state or illness are unable to take care of themselves, or protect themselves against significant harm or exploitation."*[223]

It cannot be known whether any additional actions on the part of the Trust could have prevented Mr. W's death. It was the view of the treating team that Mr. W had not yet reached the stage where he required Appointeeship or some kind of supervised accommodation. This may have been the case. However the Independent Investigation Team concluded that Mr. W was exploited and physically attacked on a regular basis and that the time had come for a formal case review and long-term strategic planning to have taken place. The current Safeguarding Vulnerable Adult multiagency guidance in operation the Kirklees area requires that:

- each act of exploitation or abuse should be reported to the Police if injury or theft has occurred;
- a strategy meeting should be held following each act of reported/identified abuse;
- a case conference should be held to determine future actions following an act of abuse.

Whilst this version of the guidance was not in place prior to Mr. W's death, a similar set of expectations was in place. Whilst the treating team discussed Mr. W's situation on a regular basis no formal action was taken. The Internal Review identified this as being due to poorly understood processes being in place at the time.[224] It was the conclusion of the Independent

223 Trust Safeguarding Vulnerable Adults Workbook
224 Internal Investigation Report P9

Investigation Team that by not formally assessing Mr. W's capacity and Vulnerable Adult status this made a direct contribution to his continued vulnerability.

- ***Contributory Factor 1. It was the conclusion of the Independent Investigation Team that by not formally assessing Mr. W's capacity and Vulnerable Adult status this made a direct contribution to his continued vulnerability.***

12.1.12. Adherence to Local and National Policy and Procedure

12.1.12.1. Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."*[225] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 12.1.13. below.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

225 Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) p. 328

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

12.1.12.2. Findings of the Internal Investigation

Both the Mr. Z and the Mr. W Internal Reviews concluded that on the whole the care and treatment given was in line with the Trust policies and procedures in place at the time.

12.1.12.3. Findings of the Independent Investigation Team

The Care and Treatment of Mr. Z

The most significant departure from Trust policy and procedure regarding the care and treatment of Mr. Z was with the implementation of the CPA policy. It was evident that Mr. Z in effect received no CPA between January 2003 and December 2007. Whilst the Independent Investigation Team acknowledges that this probably did not adversely affect Mr. Z's mental health in any way, it illustrates poor practice and provides evidence that Mr. Z's case was never subject to formal review.

Another departure from Trust policy and procedure was in relation to risk assessment. Mr. Z should have been risk assessed with immediate effect following the death of Mr. W once the Trust decided to continue providing his care and treatment. It would appear that an interval of some four months went by prior to this taking place.

The Care and Treatment of Mr. W

Trust policy and procedure appears to have been adhered to with the exception of the Vulnerable Adults' process. The Internal Review identified this as being due to poorly understood processes being in place at the time.[226]

Quality of Local Policies and Procedures

The Independent Investigation Team found that the relevant Trust clinical policies and procedures were appropriate and evidence based.

226 Internal Investigation Report P9

12.1.12.4. Conclusions of the Independent Investigation Team

The Independent Investigation Team found that Mr. Z's treating team over time failed to implement Trust policy and procedure. Whilst this did not adversely affect Mr. Z's mental state, or contribute to the incident, it illustrated a significant service issue regarding the way the CMHT operated up until the sentencing and disposal of Mr. Z in December 2007.

On the whole Trust policy and procedure was adhered to in an exemplary manner in the case of Mr. W. However the failure to implement extant safeguarding procedures served to leave Mr. W's vulnerability issues unresolved.

12.1.13. Clinical Governance and Performance

12.1.13.1. Context

'*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*'[227]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

The Care Quality Commission is the health and social care regulator for England. The vision of the Care Quality Commission is to *"... make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere."*

The Care Quality Commission grades Trusts with regard to their performance. A Trust can be scored 'weak' (this score means that a Trust performed poorly in terms of the overall quality

[227] Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

score), 'fair' (this score means that a Trust performed adequately in terms of the overall quality score), 'good' (this score means that a Trust received at least the second highest score for all applicable assessments that contribute to the overall quality score) or 'excellent' (this score means that a Trust received the highest score for all applicable assessments that contribute to the overall quality score).

During the time that Mr. Z and Mr. W were receiving care and treatment the Trust would have been subject to two main kinds of independent review from the NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation. The reader is asked to look at the Care Quality Commission website for more information as to how the national performance framework is managed.

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Mr. W. The issues that have been set out below are those which have relevance to the care and treatment that Mr. Z received.

12.1.12.2. Findings of the Independent Investigation Team

Clinical Governance Systems and Performance

The last Care Quality Commission report available for the Trust related to its performance during 2008/2009. The Trust scored a 'good' rating during this period for the quality of its services. The Trust was compliant with all 44 standards set out under the meeting of Core Standards. The Trust scored eight out of the nine standards set out under the National Priorities Standards. The Standard that the Trust failed to meet was *"best practice in mental health services for people with a learning disability".* The Trust was able to comply fully with all other national quality standards.

Clinical Governance process and strategy is overseen by the Clinical Governance and Clinical Safety Committee. The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference. The purpose of the Clinical Governance and Clinical Safety Committee is to provide assurance to Trust Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care coordination and evidence-based practice and focuses on quality improvement to ensure a coordinated

holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice.

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee has the following sub-committees reporting to it:

- Incident Review Panel;
- Health and Safety;
- Drugs and Therapeutics (Medicines Management);
- Safeguarding Children;
- Safeguarding Adults;
- Infection Prevention and Control.

The Committee provides assurance to Trust Board on service quality, practice effectiveness and the application of controls assurance in relation to clinical services and ensures the Trust is discharging its responsibilities with regard to clinical governance and clinical safety.

Strategy and Policy

1. To approve relevant strategies and policies on behalf of the Trust Board
2. To monitor implementation of significant strategic developments relevant to clinical governance, care delivery and practice effectiveness, such as implementation of care management processes and clinical information management, and equality and diversity, providing assurance to Trust Board that these are appropriately managed and resourced.

Clinical Governance

3. To provide assurance to Trust Board that appropriate and effective clinical governance arrangements are in place throughout the organisation through receipt of exception reports from relevant Directors to demonstrate that they have discharged their accountability for parts of their portfolios relating to clinical governance. This covers the areas of practice effectiveness, drugs and therapeutics, infection prevention and control, diversity, information governance and clinical documentation, managing violence and aggression, medical education, safeguarding children, research and development, compliance, and health and safety.

4. To provide assurance to Trust Board that the Trust is meeting national requirements for clinical governance and clinical safety.
5. To assure the Trust Board that the Executive Management Team and Service Delivery Groups have systems in place that encourage and foster greater awareness of clinical governance and clinical safety throughout the organisation, at all levels.

Compliance

6. To monitor, scrutinise and provide assurance to the Trust Board on the Trust's compliance with national standards, including the Care Quality Commission Essential Standards, NHS LARMS, the quality elements relating to Monitor's Compliance Framework and NICE guidance.
7. To provide assurance to the Trust Board that the Trust is compliant with relevant legislation, such as legislation relating to equality and diversity and human rights.
8. To provide assurance that the Trust has effective arrangements for the prevention and control of infection, safeguarding adults and children, information governance and records management, and the safety elements covered by the Health and Safety TAG.

Clinical Safety Management

9. To provide assurance to the Trust Board that environmental risks, including those identified as a result of PEAT inspections or environmental audit, are addressed and monitor appropriate action plans to mitigate these risks.
10. To provide assurance to the Trust Board that robust arrangements are in place for the proactive management of complaints, adverse events and incidents, including scrutiny of quarterly and annual reports on incidents and complaints and implementation of action plans.
11. To provide assurance to Trust Board that there are robust systems for learning lessons from complaints, adverse events and incidents, and action is being taken to minimise the risk of occurrence of adverse events.
12. As delegated by the Trust Board, to monitor implementation of action plans relating to reviews of complaints by the Health Service Ombudsman and of action plans identified through independent inquiry reports relating to the Trust.

Public and Service User Experience

13. To provide assurance that there are appropriate systems in place to enable the views and experiences of service users and carers, and clinicians to shape service delivery.

13.1.12.3. Conclusions of the Independent Investigation Team

It was apparent to the Independent Investigation Team that the South West Yorkshire Partnership NHS Foundation Trust has a fit for purpose set of governance arrangements which are overseen by the Trust Board. Documentation about the Trust in the public domain placed there by the Care Quality Commission indicates that the Trust is performing well. Trust governance arrangements are streamlined, and would appear to be able to achieve their aims and objectives.

However it was evident that CPA and risk assessment policy and procedure was not adhered to by the Adult CMHT in the case of Mr. Z, and that safeguarding procedures were not adhered to by the Older People's CMHT in the case of Mr. W. Whilst the extant clinical governance procedures may not have been able to address these adherence issues prior to the incident occurring, there is significant evidence to show that the Trust has developed a sure-footed serious untoward incident approach that has since enabled these issues to be both identified and rectified.

13. Findings and Conclusions Regarding the Care and Treatment Mr. Z and Mr. W Received

13.1. Findings

The findings of the Independent Investigation Team are set out in summary below.

1. **Referral, Transfer and Discharge Procedures.** It was the conclusion of the Independent Investigation Team that referral, transfer and discharge processes regarding Mr. Z's care and treatment were managed well in the context of the policy expectations in place at the time. It was acknowledged that the Trust has improved its processes since the time Mr. Z received his care and treatment in line with *New Ways of Working* and other service development initiatives. The Independent Investigation Team found that there was a degree of diagnostic ambiguity which may have led to keeping Mr. Z engaged with services when it was no longer necessary for him to be so, and when discharge was clearly indicated.

2. **Diagnosis.** It was the conclusion of the Independent Investigation Team that the failure to provide a diagnosis for Mr. Z led to a prolonged, and perhaps unhelpful, contact with a secondary care mental health service. A more sure-footed and timely diagnostic process would have prevented Mr. Z being in receipt of medication he did *not* need, and may have directed him more assertively to a range of services for his alcohol misuse which he *did* need. It was the conclusion of the Independent Investigation Team that the diagnostic ambiguity surrounding the care and treatment of Mr. Z did not in any way contribute to the death of Mr. W.

- ***Service Issue 1. Mr. Z did not receive a definite diagnosis between May 2002 and March 2007. Whilst this did not contribute to the death of Mr. W it was evident***

during the course of this Investigation that the assignment of a diagnosis is not always given priority by clinicians within the Trust. The continuation of this practice may lead to compromised, inappropriate or unnecessary care and treatment being delivered to other service users in the future.

3. **Medication and Treatment.** It was the conclusion of the Independent Investigation Team that Mr. Z probably did not require input from a secondary care service for the majority of the time between 2002 and March 2007. Initially the care and treatment Mr. Z was offered was generally appropriate and evidence-based regarding the symptoms he self-reported. However as time progressed a clear diagnosis would have focused both the service and Mr. Z in the pursuit of successful interventions for his alcohol problem. The aetiology of his symptoms was never explored and consequently Mr. Z received care and treatment he did not ultimately require. It was the conclusion of the Independent Investigation Team that the quality of the care and treatment provided did not in any way contribute to the events of March 2007 and the death of Mr. W.

- ***Service Issue 2. Mr. Z was kept on the outpatient caseload even when it was evident that he did not have a mental health condition that required treatment by secondary care. There did not appear to be a process in operation at the time to review cases and to ensure that service users were transferred back to primary care when clinically indicated.***

4. **Use of the Mental Health Act (1983).** It was the conclusion of the Independent Investigation Team that neither the Mental Health Act (1983) nor the Mental Capacity Act (2005) could, or should, have been considered in the delivery of care and treatment to Mr. Z between January 2002 and December 2007, and that no act or omission in this regard contributed to the events of March 2007 that led to the killing of Mr. W.

5. **Care Programme Approach (CPA).** It was the conclusion of the Independent Investigation Team that the clinicians involved in the delivery of care and treatment to Mr. Z over a five-year period did not adhere to the Trust CPA policy guidance. Had

the policy guidance been adhered to prior to the incident then in all probability Mr. Z would not have been retained by secondary services.

The decision to retain Mr. Z within secondary services after the incident placed the Trust in a position where they were responsible for the assessment and management Mr. Z's care, treatment and risk, regardless of the assurance of the Magistrate that Mr. Z was not the responsibility of the Trust. By retaining Mr. Z, had any further incidents occurred, the Trust potentially placed itself open to criticism by not adhering to its CPA policy.

- ***Service Issue 3. Whilst the Trust non-adherence to CPA policy in the case of Mr. Z did not contribute to the death of Mr. W, it has been recognised as a service issue by this Investigation. The Independent Investigation understands that since the time of the incident significant changes have been made to Trust CPA policy and the assurance mechanisms in which it operates.***

6. **Risk Assessment.** Risk assessment processes, as they related to Mr. Z's care and treatment, did not contribute to the circumstances that led to Mr. W's death. Whilst Mr. Z's actions *did* contribute directly to Mr. W's death, they were *not* in any manner exacerbated by the presence of a mental illness. Because Mr. Z's actions were not a consequence of a mental illness, any act or omission on the part of the Trust in relation to the management of his risk could not be seen to be relevant to Mr. W's death. However it is important to note that whilst under the care of the Trust Mr. Z did not received a regular risk assessment process in line with Trust policy and procedure expectations.

- ***Service Issue 4. Mr. Z did not receive risk assessments in accordance with extant Trust policy and procedure over a five-year period. Whilst this did not contribute to the death of Mr. W, it highlights a potential lack of risk assessment awareness within the treating team during the time Mr. Z was receiving his care and treatment from them.***

7. **Service User Involvement in Care Planning and Treatment.** It was the conclusion of the Independent Investigation Team that the care and treatment offered to Mr. Z was both service-user centered and sensitive to his needs.

8. **Carer Involvement and Carer Assessment.** The Independent Investigation Team found nothing remarkable about the fact that Mr. Z's mother was not identified as a carer by the Trust during the time that Mr. Z received his care and treatment from them. She did not appear to be involved with her son to any degree during this time.

   It was the conclusion of the Independent Investigation Team that the mother of Mr. Z had the right to an independent assessment of her need for support after the incident. This should ideally have been identified by a senior officer of the Trust. Support from the statutory agencies involved (the Trust and the Strategic Health Authority) should continue up until the time of the Independent Investigation Report publication if required by the family.

- ***Service Issue 5. The mother of Mr. Z should have been offered ongoing support throughout both the Internal and Independent Investigation processes by the involved statutory agencies. Failure to do this leaves individuals potentially uninformed about personal family information that may be disclosed, and vulnerable during a public process that may expose them to unwanted media attention.***

9. **Documentation and Professional Communication.** The Independent Investigation Team concurs with the findings of the Internal Investigation. The record keeping and communication between agencies and professionals was of a good general standard. The absence of CPA and formal risk assessment documentation, in line with Trust policy and national practice guidelines, was not thought to be a consequence of poor communication and record keeping. Rather it was thought to be reflective of a culture that was not adhering to CPA and risk assessment practices.

10. **Overall Management of the Care and Treatment of Mr. Z.** The Independent Investigation Team found no contributory or causal factors in relation to the care and treatment Mr. Z received and the death of Mr. W. However it also concluded that Mr.

Z's case was not managed well over time. It appeared that Mr. Z was not suffering from any form of severe or enduring mental illness and did not meet the criteria for the receipt of secondary mental health care services.

11. **Management of the Care and Treatment Received by Mr. W.** The care and treatment Mr. W received over time was generally of a high standard which took into account both his ethnicity and his individuality. It was evident that Mr. W was managed by a multidisciplinary team that adhered to CPA and risk policies and procedures. The main issue in the approach taken with Mr. W was the failure to instigate appropriate Safeguarding Vulnerable Adult measures. Whilst it cannot be determined with any degree of certainty whether these measures could have prevented Mr. W's death, the failure to do so was seen as a making a contribution to his continued vulnerability.

- ***Contributory Factor 1. It was the conclusion of the Independent Investigation Team that by not formally assessing Mr. W's capacity and Vulnerable Adult status this made a direct contribution to his continued vulnerability.***

12. **Adherence to Local and National Policy and Procedure, Clinical Guidelines.** The Independent Investigation Team found that Mr. Z's treating team over time failed to implement Trust policy and procedure. Whilst this did not adversely affect Mr. Z's mental state, or contribute to the incident, it illustrated a significant service issue regarding the way the CMHT operated up until the sentencing and disposal of Mr. Z in December 2007.

    On the whole Trust policy and procedure was adhered to in an exemplary manner in the case of Mr. W. However the failure to implement extant safeguarding procedures served to leave Mr. W's vulnerability issues unresolved.

13. **Clinical Governance and Performance**. It was apparent to the Independent Investigation Team that the South West Yorkshire Partnership NHS Foundation Trust has a fit for purpose set of governance arrangements which are overseen by the Trust Board. Documentation about the Trust in the public domain placed there by the Care Quality Commission indicates that the Trust is performing well. Trust governance

arrangements are streamlined, and would appear to be able to achieve their aims and objectives.

However it was evident that CPA and risk assessment policy and procedure was not adhered to by the Adult CMHT in the case of Mr. Z, and that safeguarding procedures were not adhered to by the Older People's CMHT in the case of Mr. W. Whilst the extant clinical governance procedures may not have been able to address these adherence issues prior to the incident occurring there is significant evidence to show that the Trust has developed a sure-footed serious untoward incident approach that has since enabled these issues to be both identified and rectified.

14. **Internal Investigation.** The Internal Reviews into the care and treatment of both Mr. Z and Mr. W were competently prepared and served their purpose well in that they instigated service improvement and ensured remedial safety measure were put into place.

13.2. Conclusions

Care and Treatment Provided to Mr. Z

The Independent Investigation Team found no factors relating to the care and treatment that Mr. Z received that either contributed to, or caused, the death of Mr. W. There were however some significant issues identified relating to the care and treatment that Mr. Z did receive.

It was evident that for most of the time Mr. Z received care and treatment from secondary care mental health services that he was not suffering from any detectable severe or enduring mental illness. Mr. Z did not receive a definitive diagnosis between January 2002 (when he was referred to the Trust) and March 2007 (when the incident occurred). Following the incident it was established by two Consultant Psychiatrists, one a Forensic Specialist, that Mr. Z did not have a condition that warranted care and treatment from the Trust. However it was decided that due to the unusual circumstances that Mr. Z found himself in, once charged with murder, that the Trust would continue to support him.

For most of the time between January 2002, (when Mr. Z was referred to the Trust) and December 2007 (when Mr. Z was sentenced for murder), it was not clear what the Trust was trying to achieve with Mr. Z. Diagnostic practices were vague between January 2002 and March 2007, consequently it was never clear what set of problems the treating team were trying to effect. Whilst it was evident Mr. Z did not have a mental illness that required specialist intervention, it was evident that he had a serious drinking problem. Unfortunately Mr. Z did not want the care and treatment that the Trust offered to him for this. Mr. Z was held on the caseload long after the time when he should have been discharged. During the time Mr. Z was with the Trust he was not subject to appropriate CPA practices or risk assessments. Whilst this did not have a negative effect on his mental wellbeing, it is a significant finding as it indicates that the Trust CPA policies and procedures were not being adhered to within his treating team.

It was the conclusion of the Crown Court at the time of the sentencing and disposal of Mr. Z that he had no abnormality of mind at the time of the murder of Mr. W. Mr. Z was found guilty of murder, not manslaughter, and sentenced to life imprisonment with a 14 year determination. Mr. Z was considered to be responsible for his own actions and was not thought to have acted as a result of an abnormal mental state. Consequently any act or omission on the part of the Trust regarding the care and treatment Mr. Z received cannot be identified as a making a contribution to the death of Mr. W.

Care and Treatment Provided to Mr. W

The care and treatment given to Mr. W was of a generally high standard. It was evident that the Trust provided a multidisciplinary and patient-centered approach. Mr. W was understood to be a vulnerable person and at risk due to his behaviour, cognitive deficits and chosen lifestyle. Mr. W had been physically attacked on many occasions and had also been financially abused by many people over a period of several years. In order to protect Mr. W the treating team took extraordinary efforts to monitor and supervise him the community. However the Trust did not implement any formal processes under extant Safeguarding Vulnerable Adults' guidelines. Had Mr. W been formally assessed and an action plan devised he may have been protected better against the exploitation and violence that eventually killed him. Formal measures could not have *guaranteed* Mr. W's safety, however an Appointeeship, for example, would have removed the immediate risk of financial exploitation which was deemed to have been a major motivation for his killing.

The Independent Investigation Team acknowledges the sensitive and compassionate approach that the treating team took over an interval of nine years when providing care and treatment to Mr. W. The CMHT endeavoured to support Mr. W, often in the face of his continued set of high risk behaviours. However The Trust should have implemented formal processes, even if it was not certain how effective they would prove to be. The failure to do so, whilst not directly contributing to Mr. W's death, was judged by the Independent Investigation Team to have made a contribution to his continued vulnerability.

14. South West Yorkshire Partnership NHS Foundation Trust Response to the Incident and Internal Review

The following information has been taken from the Trust Internal Investigation and Post Incident Archive and from interviews with witnesses to the Independent Investigation. At the time of the incident the Trust had a comprehensive and fit for purpose Incident Management and Patient Safety Policy and Procedure in place. It was the conclusion of the Independent Investigation Team that Trust personnel adhered to the policy and procedure in an appropriate and timely manner.

The Internal Investigation that is set out directly below in subsections 15.1.- 15-5. is the one pertaining to the care and treatment Mr. Z received. A short Internal Review was held into the care and treatment received by Mr. W. This is set out in subsection 15.6.

14.1. The Trust Serious Untoward Incident Process

The Trust managed this process in accordance with its policy and procedure. There was some delay in the commissioning of the internal investigation process as it was thought initially that Mr. Z was a witness to the murder only and not actively involved.

14.2. The Trust Internal Review

At the time the Internal Investigation Team prepared its report Mr. Z was on bail to his home address and had been charged with murder. The report was completed on the 20 August 2007 and Mr. Z was due to stand trial for murder on the 13 November 2007.[228]

14.2.1. The Internal Investigation Review Team comprised the following personnel:

The Internal Investigation was conducted by the Trust Root Cause Analysis Facilitator. This Facilitator met with key witnesses who comprised Mr. Z's Consultant Psychiatrist and other

228 Internal Investigation Report PP 1 and 14

Community Team staff. The Facilitator took independent advice from a Trust Drug and Alcohol Specialist in order to peer review the case file and seek an opinion regarding the care package. The Facilitator worked with Mr. Z's treating team to identify issues. This was done in order to emphasise the learning opportunities potential of an investigation rather than focusing upon blame and individual culpability.[229]

14.2.2. The Terms of Reference

The Internal Investigation was conducted in order to *"look more closely at the circumstances leading up to the serious incident in the community and Mr. Z's previous psychiatric care".*[230] The purpose of the Internal Investigation was to review Mr. Z's care and treatment in the light of Trust policy and procedure in order identify any lessons that needed to be learned and to highlight any areas of practice that required immediate action.

The terms of reference were:

To examine:

- the care that the service user, Mr. Z, was receiving at the time of the incident (including that from non-NHS providers such as the voluntary and private sectors);

- the suitability of that care in view of Mr. Z's history and assessed health and social care needs;

- the extent to which that care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies;

- the adequacy of Mr. Z's risk assessment and care plan and their use in practice;

- the exercise of professional judgement and clinical decision making;

- the interface, communication and joint working between all those involved in providing care to meet Mr. Z's mental and physical health needs, with particular reference to referral and discharge processes.

229 Internal Investigation Report P4
230 Internal Investigation Report P2

To identify:

- learning points for improving systems and services;

- developments in services since the user's engagement with mental health services and action taken since the incident;

To make:

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

14.2.4. Key Findings

1. The care and treatment that Mr. Z received was of a generally good standard.
2. Initial referral processes in 2002 suffered a degree of delay due to Trust working practices at the time which have since been addressed by *New Ways of Working.*
3. Detailed correspondence was maintained between secondary and primary care.
4. No definitive diagnosis was made.
5. No specialist dual diagnosis opinion was sought.
6. Mr. Z was correctly assigned to Standard Level CPA.
7. DNA processes were not adhered to.
8. Older Peoples' services did not have a sound understanding of the local Vulnerable Adults' Strategy.
9. The care offered to Mr. Z in the outpatient clinic supported concordance with his medication and attempted to engage him with alcohol services.
10. Risk assessment processes, whilst in keeping with outpatient practice at the time, may have failed to encompass Mr. Z's overall social situation.

14.2.5. Internal Investigation Analysis and Conclusions

The Internal Investigation concluded that whilst Mr. Z engaged with outpatient services he consistently refused help for his alcohol misuse, and that the care and treatment provided to Mr. Z were within the standards required by Trust policies and national guidance and there was no evidence of service or systems failure in providing care to Mr. Z.

"In undertaking this review of services in the context of the care provided to Mr. Z the RCA Facilitator did inevitably identify areas where services could be improved. However there was no evidence that these contributed to the very sad death of Mr. W. These included:

- *The safe management of individuals with alcohol problems within mental health services requires clear joint strategies with alcohol providers.*
- *Patients who lack motivation may require specialist input but ongoing support and encouragement may elicit motivation to change.*
- *In relation to alcohol, brief primary care interventions, such as an assessment of alcohol intake with feedback can help reduce excess consumption. Training for mental health staff and/or access to specialist services is required as part of a comprehensive strategy.*
- *Improved team working and supervision systems can enhance the process of risk assessment.*
- *The process of formulating decisions related to risk should be clearly documented.*
- *The interface with alcohol services has been a major issue in relation to the local provision of service links. It is clear that much work is ongoing to improve this situation.*
- *A recent Independent Inquiry (2005) has recommended that the Primary care Trust and partnership agencies should develop a mutually agreed strategy to oversee the development of dual diagnosis services including information sharing in Kirklees. This includes the appointment to a lead nurse for dual diagnosis, to lead on the implementation of the strategy."*[231]

14.2.6. Internal Investigation Positive Factors Identified

- *"Communication between mental health services and GP was clear and well documented.*
- *The Trust and partner agencies have ensured consistent support to Mr. Z following this untoward incident."*[232]

231 Internal Investigation Report PP12-13
232 Internal Investigation Report P13

14.2.7. Independent Investigation Team Feedback on the Internal Investigation Report Findings

It was the conclusion of the Independent Investigation Team that the Internal Investigation was prepared in a competent manner. Of particular note is the process that was employed which placed an emphasis on learning and improving services.

It is not unusual for an Independent Investigation Team to find additional factors, as was the case in this Investigation process, due to the fact that the terms of reference are wider. The differences between the Internal and Independent Investigation reports should not therefore be seen as implying criticism of the Internal Investigation process.

14.3. Being Open

Support to Relatives:

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress caused;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm.

In the Case of Mr. Z

The death of Mr. W and Mr. Z's involvement in it was regarded by both the Trust and the Strategic Health Authority as being a Serious Untoward Incident governed by both local and national procedure. Once the death of Mr. W had been categorised in this way statutory services had a responsibility to the family of Mr. Z, independent of his desire for them not to be contacted. The *Being Open* Guidance that was published by the National Patient Safety Agency in 2005 requires NHS Trusts to offer both communication and support to those affected, either directly or indirectly, by a serious untoward incident. This includes the families of service users who perpetrate homicides.

Once an incident has been deemed to be subject to a HSG 94 (27) investigation, the responsibility of statutory services extends beyond the time immediately after the incident and continues until the time of the publication of the Independent Investigation Report (the role for providing support at this stage transfers from the Trust to the Strategic Health Authority).

Family members of service users who commit a homicide are often subject to high degrees of stress and adverse media attention. They often require support, advice and reliable information. This input should not be 'blocked' by the service user not wishing for relatives to be involved. Inputs do not disclose confidential patient information, and family support should be organised as an issue entirely separate from the needs and desires of the service user.

It was the conclusion of the Independent Investigation Team that the mother of Mr. Z had the right to an independent assessment of her need for support after the incident. This should ideally have been identified by a senior officer of the Trust. Support from the statutory agencies involved (the Trust and the Strategic Health Authority) should continue up until the time of the Independent Investigation Report publication if required by the family.

In the Case of Mr. W

No immediate friends or family were identified in the case of Mr. W. It is unclear what communication, if any, took place between the Trust and Mr. W's nephew in America.

14.4. Staff Support

14.4.1. Prior to, and During, the Internal Investigation

The Internal Investigation maintained an attitude of enquiry during the entire process. It was made clear to witnesses that the focus was upon learning lessons and making the service safer. It was evident from examination of the Internal Investigation archive that clinical witnesses were supported throughout the process, that learning continued to be made and witnesses were involved in the formulation of recommendations and engaged throughout the whole process.

14.4.2. During the Independent Investigation

The Trust worked with the Independent Investigation Team in order to ensure that witnesses were prepared and supported throughout the process.

14.5. Trust Internal Review Recommendations

The recommendations from the Internal Investigation Team were as follows:

1. *"Following a recent Independent Inquiry (2005) an audit is to be undertaken across the Trust (September 2007) to identify the reasons for patients not attending for new and follow up appointments, and an action plan developed to address the issues identified. It is recommended that following this audit the Trust reviews all area DNA guidance to ensure consistency across the Trust. It is recommended that risk decisions taken when patients DNA should be documented.*

2. *Reviews into the care of Mr. Z and Mr. W have been conducted independently. It is recommended that managers from both services meet to review the findings and develop an action plan, with particular emphasis on communication between services and awareness of the Vulnerable Adult Strategy."*[233]

233 Internal Investigation Report P13

14.6. Internal Review Examining the Care and Treatment of Mr. W

The Internal Review into the care and treatment that Mr. W received comprised of a concise piece of work. The terms of reference were:

"Review case records to:

a) Confirm findings of initial investigation that the care provided by the Trust was appropriate and no omission of action contributed to the circumstances leading to the death of Mr. W.

b) Determine whether there is any cause to further interview staff over and above the Police Investigation.

c) Explore whether any lessons can be learned to inform improved care."[234]

The Issues for consideration were:

- *"There is clear evidence from case records that the CMHT made every effort to communicate with all agencies involved regarding the risks associated with Mr. W.*
- *The level of care provided to Mr. W remained significant despite his Depression being described as "in remission".*
- *There was no evidence of a change in the care provided to Mr. W following transfer of care co-ordinator.*
- *CMHT records were not always kept in chronological order.*
- *No action was agreed during CPA if care planning failed.*
- *Although frequent reference is made to Vulnerable Adults strategy there was no evidence of someone being identified as co-ordinating this nor any record of a multi-agency strategy meeting.*
- *Interventions were complicated for this individual by his reported cognitive impairment, the focus of CMHT staff appears to have been on providing practical assistance. However, Mr. W remained compliant with medication independently. Though indicated in care planning there was little evidence of interventions directed at Mr. W improving his life skills, staff appeared to focus on advice giving and*

234 Internal Review W P1

> *warnings about behaviour. Though it is extremely doubtful that this approach contributed to the circumstances leading to the murder of Mr. W, it does indicate a lack of confidence in skills for CMHT staff dealing with challenging clients.''*[235]

The Independent Investigation Team was in broad agreement with the findings of the Internal Review.

[235] Internal Review W P5

14.7. Progress against the Trust Internal Review Action Plan

The Independent Investigation Team can confirm that this action plan has been both completed and implemented.

Serious Untoward Incident 2007.5748- Recommendations and Action Plan – completed April 2010

Ref No	Area	SDG	Recommendations	Action Required / to be taken	Actions taken/completed to date	Lead Person (name/title)	Time Frame
1	NK	TW	The Trust should review its 'did not attend' (DNA) policies to ensure: • consistency across areas • that full documentation of decision making is undertaken	An audit is to be undertaken across the Trust (September 2007) to identify the reasons for patients not attending for new and follow up appointments, and an action plan developed to address the issues identified	**Update Jan 2008** - This audit will be completed and reviewed by March 2008. (The timescales have had to be revised due to capacity issues which prevented the Clinical Governance Support team enabling this in Oct 2007) **Update Aug 2008** Audit is in progress but not yet completed due to capacity within the CGST **Update March 2010** An audit was completed by the CGST. The audit was undertaken as a pilot throughout WAA in Kirklees. The data collection period was July to October 2008 and the report was completed November 2008. The results were presented to the medical audit committees throughout the Trust and the SDG. The recommendations included the following: - Present the report to the Working Age Adult Service delivery group. Review the current appointment system - The Trust to consider producing a stand-alone policy to provide all health practitioners with procedures governing the actions to be taken	Assistant Director, Adult Services with Clinical Governance Support Team	**Complete March 2010**

2	NK	TW		Following the audit the Trust should review all Trust service delivery group and area DNA guidance to ensure consistency across the Trust	when a service user loses contact with services. This policy should apply to any appointment with clinicians and not just medical out-patients - Trust should review methods of reducing DNA rates of both new and follow up patients - Review the location of clinics and times - Pilot ringing or texting prior to appointment The 'Non-adherence with treatment policy' has been approved, and a further audit (trust wide) of both WAA and OPS is currently underway. This has been delayed slightly as: - the audit tools have been designed in conjunction with the Dialogue groups and are linked to a separate project on cancelled appointments thereby giving a fuller picture of why service users either don't turn up or cancel their appointments - the policy was only issued in September 09 and was reviewed by the groups prior to the audits being agreed. These two audits have been commissioned by the Medical Director		**Complete March 2010**
3	NK	TW	Risk decisions taken when patients DNA should be fully documented	Relevant staff to be reminded of the importance of recording risk decisions when a patient DNAs. This requirement to be reinforced through the risk management	**Update Jan 2008** - This action has been completed as part of the Sainsbury risk assessment training, which is undertaken Trust-wide, and job planning of the medical workforce by the Associate medical Director and Assistant Director	Assistant Director, adult services	Oct-07 **Complete Jan 2008**

				training processes. To be included in processes for monitoring of risk assessment and management.			
2007 .5748	NK	TW	The Trust should ensure that when serious untoward incidents happen that involve services users from different service delivery groups that the review process is integrated to ensure joint learning	Senior Managers from both adult and older people's mental health services meet to review the findings of both reviews with particular emphasis on communication between services and awareness of Vulnerable Adult Policy	Separate reviews into the care of Patient X and Patient Y have been completed **Update Jan 2008** - This action has been completed. The Trust has a specialist adviser for Vulnerable Adults and SWYMHT has signed up to the Local Authority-led safeguarding Adults Policy with each of the partner Local Authorities (Calderdale, Kirklees and Wakefield). Staff are alerted to these policies, are introduced to the principles of safeguarding Vulnerable Adults during induction. The specialist adviser leads on multi-disciplinary training and advises staff with complex cases. The Trust supports each safeguarding board by ensuring an Assistant Director attends each meeting. At Board level the lead Director, the Chief Operating Officer, ensures the Board is aware of the policy and risks.	Assistant Director, older People's Services & the Assistant Director, Adult Services with Clinical Governance Support Team	Dec-07 **Complete Jan 2008**

Approved by:	Assistant Director, Adult Services with Clinical Governance Support Team.	**Complete April 2010**	Review Dates:	Jan-08
				Aug-08

15. Notable Practice

The following notable practice was identified.

Care Programme Approach Policy and Process

Of particular note is the work undertaken within the Trust during the last two years to develop and implement a new Care Programme Approach (CPA) policy and process. This is outlined below.

- All individuals referred into secondary mental health services delivered through South West Yorkshire Partnership NHS Foundation Trust will have their needs assessed by the appropriate service. The outcome of assessment will identify if the individual is in need of care coordination and service under CPA or standard care.

- Those individuals requiring CPA will have been assessed as having complex needs and presented with higher risks. Those individuals identified as requiring secondary mental health services but who do not present as having complex needs or high levels of risk will have their care managed through the Standard Care process. Both CPA and Standard Care have clear and robust processes for assessment, care planning, review and transitions in care. Both processes have identified professionally qualified clinicians who understand the role required of care coordinators. In the case of CPA this is usually a Community Mental Health Nurse or Social Worker attached to one of the Trust community specialist teams working within the context of a multidisciplinary team and are therefore best placed to undertake this role.

- When a service user is admitted to an inpatient facility following assessment and in the absence of already having an identified care coordinator, a care coordinator is be allocated from the admitting service until such time of an agreed transfer to a community service. The care coordinator works in partnership with the service user, identified carers and other professionals and undertakes specific responsibilities around care coordination. These include:
    - comprehensive needs assessment;
    - risk assessment and planning;

- crisis planning and management;
- assessing and responding to carers' needs;
- care review and planning;
- transfer and discharge.

All invitations to a review are recorded.

The following values and principles are embedded into the current policy.

1. It is the approach to individuals' care and support that puts them at the centre and prompts social inclusion and recovery. It is respectful - building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person.

2. Care assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self nurture; with the aim of optimising mental and physical health and well being.

3. Self care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.

4. Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.

5. Services should be organised and delivered in ways that promote and coordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and coordinated care. The quality of the relationship between service user and the care coordinator is one of the most important determinants of success.

6. Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting agencies, not just the planned occasions where people meet for reviews.

Best practice relating to the delivery of CPA and Standard care process is supported fully by Business Delivery Units (BDUs). CPA training, risk training and systems training supporting CPA is available to all staff. Effective monitoring of CPA includes:

- Monthly reporting on the Trust's Key Performance indicator relating to care plans being offered to service users. The Trust consistently reports figures above the 80% target and is constantly working to maintain and improve this. These monthly figures are reported to service managers and disseminate to teams to alert any significant changes relating to the key Performance Indicator.

- Annual audit of CPA based on good practice standards. The audit includes:
    - Interrogation of clinical recording from a random sample of electronic and paper records covering areas of demographic information, assessment standards, care plan standards and review standards. CPA registration and standards relating to effective delivery of care coordination.
    - Staff survey related to care coordination and training.
    - A service user and carer survey based on a random sample.
    - Triangulation of standards in relation to what the Trust says it is doing with patient experience.

16. Lessons Learned

There were several important lessons learned as a result of this Investigation.

First. Whilst the practice of providing a diagnosis is sometimes seen as providing an unhelpful label, a diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework to conceptualise and understand their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis is an important part of the process of understanding and determining the treatment and management of a service user. It is critical to see the individual in their own context, and not only understand what they want from treatment and recovery but also support them in being central in decisions made about their care including risk management issues.

The failure to provide a diagnosis in the case of Mr. Z led to a protracted episode of care that was neither in the best interest of the individual or the service. It was not in the best interest of the service in that it utilised an expensive resource unnecessarily. It was not in the best interests of Mr. Z in that it both fostered dependence, and subjected him to a treated regimen that he may not have required.

Second. The Care Programme Approach forms an essential safety net of care. In the case of Mr. Z this safety net was not utilised. Whilst Mr. Z's mental health did not suffer as a result, it is important to understand that these essential systems did not appear to work well over the five-year interval that Mr. Z received his care and treatment from the Trust. It can be difficult to make a generalisation based on the findings of a single case, however it would appear that formal CPA and risk assessment processes did not form part of the working culture of the treating CMHT.

The lesson to be learned is that CPA provides structure, review, and a time for reflection and multidisciplinary inputs. Without this process care and treatment processes can continue in an entirely inappropriate and ineffective manner. Whilst Mr. Z's condition was not such that it was negatively affected by this approach, other service users may find their care and

treatment significantly compromised with severe consequences for their mental health and well being.

Third. In the cases of both Mr. Z and Mr. W it was apparent that a significant level of sustained activity was maintained around each case. The Independent Investigation Team offers the following observation: activity alone does not equate to effective care and treatment. Teams can sometimes be lulled into a false sense of security when patients are regularly seen and followed up. However when there is a great deal of activity in the absence of robust assessment, planning and review, the efforts of a clinical team can be misdirected and patient care can suffer as a result. Care and treatment should not be provided outside of the appropriate systems.

In the case of Mr. Z CPA should have been the main vehicle of service delivery. This would almost certainly have led to a more coherent approach to his care and treatment and would probably have led to a discharge back to the care of his GP.

In the case of Mr. W had Safeguarding systems been followed then structured short, medium and long-term care plans could have been developed to promote his safety. In the absence of this approach a constant flurry of activity was required in order to manage Mr. W's crises and risks on a constant *ad hoc* basis.

Fourth. Safeguarding procedures and the Mental Capacity Act (2005) cannot always provide a guaranteed solution to ensuring a person's safety. There will always be situations when statutory services struggle to know how best to ensure each individual service user's safety is maintained. This is made more challenging when services try to balance the safety requirements of an individual against that person's often conflicting personal perspective, motivation and desire.

However Trusts should always follow formal processes. Sometimes a service user will appear to not 'fit' Safeguarding and/or Mental Capacity Act (2005) criteria, even when a treating team continues to hold concerns. Regardless of the requirements of each individual situation it is always necessary to adhere to formal processes and to maintain the regular assessment and review of such cases. This is essential in order to ensure that statutory duties are discharged appropriately.

18. Recommendations

Each recommendation is set out below in combination with the relevant contributory factor and has taken into account the progress that the Trust is already making in the area.

The Executive Directors of South West Yorkshire Partnership NHS Foundation Trust had the opportunity to review the recommendations required for this case at both the preliminary feedback stage and during the factual accuracy checking stage. The Trust should be given recognition for the work that it has put into this process and the progress that it has already put into place.

The Trust has conducted a substantial amount of work following the completion of its Internal Investigation Processes. A full action plan is provided in Section 15 of this report that details this work which has been implemented fully. The progress already made is set out directly below.

18.1. Progress

Care Programme Approach (CPA)

A new CPA policy and procedure has been developed and implemented in agreement with the Trust's three Local Authority Partners.

Risk Assessment

The Trust has implemented fully the use of the Sainsbury Risk Assessment across adults of working age and older people's services, and developed a risk assessment and risk training policy incorporating the principles of the Department of Health Good Practice Guidance.

Electronic Record System (RiO)

The Trust has implemented and rolled out an electronic record system (RiO) across the Trust. This system supports communication in relation to providing care as well as progress/history records, both CPA and risk assessment are integrated into this system. Electronic record keeping is monitored and audited through RiO data quality reports.

Did Not Attend (DNA) Policy

A new 'Did Not Attend' policy has been developed and implemented to support staff in managing situations safely, effectively and appropriately when service users do not attend appointments.

Medical Care Plans

The medical care plan now requires a diagnosis, which is supported by the use of the ICD 10 and reinforced through the medical education programme which has included specific topics on this issue including didactic teaching.

In addition there are now standardised CPA communications and a standardised discharge form and discharge letter in place.

Consultant Case Loads

There has been a review of medical caseloads.

Training, Supervision and Appraisal

Implementation of policies and procedures is supported by staff training, supervision and appraisal. Training programmes have been developed using the training needs analysis, and attendance is monitored.

An integrated (Trust and Social Services) supervision policy has been developed for staff working in integrated teams, and supervision and appraisal processes are in place.

Audit

The Trust has an annual programme to monitor the effectiveness of Trust policies and procedures, which is supported and monitored by the Clinical Audit and Practice Effectiveness group - a sub group of the Clinical Governance and Clinical Safety.

Safeguarding Vulnerable Adults

This process is closely supported and monitored within the Trust with robust links in place with Local Authority partners. This is also now supported by the implementation of Datix-web incident reporting, which allows immediate electronic incident reporting and has been set up to generate alerts to managers and specialist advisors when certain incidents are

reported ensuring that they can be managed appropriately. Safeguarding Vulnerable Adults training is available to all staff, and a workbook to support this training has been developed. Safeguarding is also now included in the Trust induction for all staff, when the workbook is given to new staff. An e-learning package is also available.

18.2. Recommendations

CPA

Recommendation 1

In line with current CPA guidance and the Trust's own current CPA policy the Trust should undertake regular quality audits to ensure that:

- all those referred to its secondary mental health services have a comprehensive assessment of their needs;
- there is a clear formulation of the individual's difficulties and needs;
- care plans are informed by appropriate assessment and formulation;
- all care plans have clear goals or outcomes;
- service users and, with their consent, their families and carers, are involved in the assessment of need, the planning of care, and any changes to either the care plan or the care co-ordinator;
- the agreement of families and carers is obtained before care plans are finalised which involve actions on their part;
- families and carers, with the agreement of service users, are provided with current care plans, including crisis management plans;
- where there is multidisciplinary or multi-agency involvement all those involved in delivering care and support are appropriately involved in the assessment and planning process with the knowledge and consent of the service user.

Risk Assessment

Recommendation 2:

Having revised its risk assessment, mangement and training policy the Trust should institue a regular quality audit to ensures:

- that the formulation of the individual's problems and needs informs the understanding of his/her risk;
- that robust and meaningful care plans are put in place;

- that the service user and other relevant individuals are involved in the assessment and planning process;
- that the risk management plan is appropriately disseminated.

Vulnerable Adults and Safeguarding

Recommendation 3:

The Trust should assure itself and its Local Authority partners that the Safeguarding policies and procedures which it has put in place and supported with training are being implemented. It should include audits of compliance with its Safeguarding policies in its regular audit cycle.

Glossary

Appointeeship	The Department of Work and Pensions can appoint someone else to receive a client's benefits and to use that money to pay expenses such as household bills, food, personal items and residential accommodation charges. An appointee should be someone who is regularly in contact with the client and could be a close relative or friend. When a client has no one who can take this on, it is possible in certain circumstances for an officer of the Council to become appointee.
Appropriate Adult	The Appropriate Adult role was created by the Police and Criminal Evidence Act (PACE) 1984, with the intention of safeguarding the rights and welfare of young people and vulnerable adults in custody.
Diazepam	Diazepam, or Valium as it is sometimes known, is a drug used for the short-term relief of symptoms related to anxiety disorders.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or peoples' own homes.
Chlorpromazine Hydrochloride	Chlorpromazine Hydrochloride is a type of medicine called a phenothiazine antipsychotic. It is used in the treatment of various psychiatric illnesses.
Imipramine	Imipramine is used to elevate the mood of patients with depression. Imipramine also causes sedation. Therefore, it is useful in depressed patients with insomnia, restlessness, and nervousness.

Mental Health Act (83)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition.
MIND	MIND is a mental health charity that provides information and advice, training programmes, grants and services through a network of local MIND associations.
Paroxetine	Paroxetine is used to treat major depression, obsessive-compulsive disorder, panic disorder, social anxiety, and generalized anxiety disorder in adult patients.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts.
PRN	The term "PRN" is a shortened form of the Latin phrase *pro re nata*, which translates roughly as "as the thing is needed". PRN, therefore, means a medication that should be taken only as needed.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a persons risk to both themselves and to others.
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.
Section 5 (2) Mental Health Act (1983)	**Section 5(2)** is a doctor's holding power. It can only be used to detain in hospital a person who has agreed to informal (wilful) admission but then changed his mind and wishes to leave. It can be implemented following a (usually brief) assessment by the Responsible Clinician or a deputy, which, in effect, means any hospital doctor, including psychiatrists but also those based on medical or surgical wards. It lasts up to 72 hours, during which time a further assessment may result in either discharge from the Section or detention under a Section 2 assessment order or Section 3 treatment order.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
Venlafaxine	Venlafaxine is an anti depressant drug which becomes

	effective within two-four weeks of commencement.
Zopiclone	Hypnotic used for the short-term treatment of insomnia (difficulty sleeping). It also has the effect of a tranquiliser. Overdose: Zopiclone when taken alone usually is not fatal, however, when mixed with alcohol or other drugs such as opioids, or in patients with respiratory, or hepatic disorders, the risk of a serious and fatal overdose increases.

Appendix One Timeline Mr. Z Investigation

Date	Event
28 July 1961	DOB
	Mr. Z did not know his father. His grandmother was the main care giver, he was bullied at school perhaps because of this. Mr. Z Gained five GCSEs and studied History and Religion at 'A' level but did not pass his examinations.
1979	Mr. Z left school. He never held a permanent job.
1987	Mr. Z left home and resided in the same tenancy from this time until he was sentenced for the murder of Mr. W. Mr. Z's Grandmother died, and at around this time he started drinking.
11 December 2001	Mr. Z's GP referred him to the Trust. He had been treated with Venlafaxine since August. He was diagnosed as having depression with anxiety.
17 December 2001	The Trust received the referral. The referral form stated that Mr. Z was experiencing low mood, lethargy and anxiety attacks.
24 January 2002	Mr. Z was assessed by a Community Psychiatric Nurse (CPN) attached to the GP surgery. Low mood, anxiety and lethargy were identified. Cognitive interventions to challenge negative thoughts and breathing and relaxation techniques to manage anxiety were suggested.
15 February 2002	Mr. Z disclosed to the CPN that he was hearing voices. This was discussed with the GP.
1 March 2003	A referral was sent from the GP for an urgent Psychiatrist assessment. It was noted that Mr. Z was depressed for several months and was experiencing panic attacks, anxiety and insomnia and had disclosed hearing voices that suggested he kills himself.

26 April 2002	Mr. Z was seen by the CPN. Mr. Z was unkempt and neglected. The plan was for the CPN to check on the progress of the Psychiatric referral.
29 April 2002	The CPN discussed the case at a team meeting with medical staff.
21 May 2002	An outpatient appointment with a Consultant Psychiatrist took place. It was noted that Mr. Z: • lived on his own; • had anxiety, panic attacks, depression, and had been drinking heavily for 18 months; • experienced the onset of current problems commenced 18 months previously, deteriorated since 1999; • had one night felt tense and wanted to die; • experienced his interest and motivation declining, social contacts decreased; • heard voices*: "You're god, you're worthless";* • heard voices tell him to kill himself but he would not obey; • felt nervous when going out/could only go out with other people; • sleep: Early and middle insomnia and early waking; • appetite: No Change; • drinking 2/3 pts 3-4 week or 6-7 pints/bottles of cider at night; • drank to control symptoms; • experienced no visual hallucinations but felt an *"evil presence"* in his room when on his own; • believed he could pick things up telepathically; people could put things in (to his mind); • was suspicious; • had suicidal ideation for 6-8 months – e.g. thought about hanging himself; • Venlafaxine (Dose?/3 months); • Olanzapine 5mg (3weeks); • Mr. Z felt medication had no effect; • had been drunk and disorderly - 1998 - one night in cells; • had no relationships.

	The Diagnosis: was depressive episode with psychotic symptoms, ? paranoid schizophrenia, harmful use of alcohol. The Plan: Paroxetine 20 mg, Olanzapine 5mg. Advised Contact CPN and GP in crisis. Inform CPN. **Emerging Issue. There was a substantial delay between the referral being made by the GP and the first outpatient appointment.**
6 June 2002	A letter was sent by the outpatient psychiatrist to the GP with the above information.
2 July 2002	An outpatient appointment took place. Mr. Z was a little better but not much. His voices were much the same. Someone was staying with him who he did not want there. Mr. Z was experiencing low mood and found this more difficult to deal with than the voices. Paroxetine: Increased to 30mg.
5 July 2002	Mr. Z was seen by the CPN. Mr. Z was more animated but still drinking excessive quantities of alcohol.
8 July 2002	Mr. Z was seen in the outpatient clinic. Mr. Z was: • a little better than when last seen; • low in mood; • hearing voices; • felt others were telling him what to do and imposing their will on him; • not able to stand up for himself. His medication: was increased Paroxetine: 30mg.
26 July 2002	A CPN review took place. Mr. Z continued to drink excessively. He was agitated about having an unwanted lodger.
13 August 2002	An outpatient appointment took place. It was noted that Mr. Z; • was intoxicated: drinking since 6.10 am; • was drinking 1-2 bottles of cider each day for past year; • had fleeting suicidal ideation, hang self - no plan;

	The plan was to: • inform CPN; • advise Mr. Z about the dangers of using alcohol as coping mechanism.
20 August 2002	An outpatient appointment as held. It was noted that Mr. Z: • Had hallucinations mainly at night when trying to sleep; • Heard voices: *"I'm Jesus. Kill yourself";* • Was considered *"Nil to harm others";* • Binges on alcohol, *"No sign of dependence now. Wants to try to abstain";* • Last week assaulted a friend while intoxicated. The Olanzapine was increased to 5mg in the morning and 10 mg at night. The risk of using alcohol as a coping mechanism was explained to Mr. Z.
20 August 2002	The CPN made a home visit. Mr. Z was sober but stressed by lodgers presence.
3 September 2002	The CPN made a home visit. Mr. Z had been drinking prior to the visit. It was decided to refer Mr. Z to the Mirfield Day Centre to provide structure to his day.
13 September 2002	A letter was sent from a neighbour to Social Services Dated 6 September 2002. The neighbour had concerns that Mr. Z was neglecting himself. No immediate action was taken as Mr. Z was already engaged with services.
1 October 2002	A home visit was made by the CPN.
22 October 2002	A home visit was made by the CPN.
22 October 2002	The outpatient appointment was cancelled as the psychiatrist was on sick leave.

24 October 2002	An appointment was made at the Mirfield Day Centre. A referral to 'Rendezvous' for social support was made.
1 November 2002	A letter was sent to Mr. Z from Mirfield Day Centre offering a place half a day/week starting on 11 November 2002.
19 November 2002	An outpatient appointment took place. Mr. Z said the voices in the middle of the night were growing louder. *"Thinks they might want him to kill himself but he doesn't want to*. *Thinks it might be evil forces tuning into his mind*". Mr. Z was Drinking 1-2 times week. 4-6 pints of lager. There was no change to medication made. A referral was made to MIND for counselling.
26 and 28 November 2002	The CPN made a home visit. Mr. Z was not at home. The CPN was leaving the service and Mr. Z's care needed to be transferred.
28 November 2002	A letter was sent to Mr. Z giving him the option to contact the new CPN.
2 December 2002	Mr. Z attended Batley Enterprises (Rendezvous).
12 December 2002	The new CPN made a home visit. Mr. Z confirmed that he was much better now that his lodger had left. Mr. Z was discharged by the CPN. Mr. Z was to continue attending outpatients.
13 December 2002	A letter was sent by the CPN to the GP. Mr. Z's problems were identified as being: isolation and sporadic excessive use of alcohol. Mr. Z had decided not to attend Mirfield Day Centre as it was too far away but willing to attend the Rendezvous. He had stated that he had *"ample support and social activities from his friends who live locally"*. Mr. Z said that he had reduced his alcohol intake and that his sleep was only *"occasionally"* disturbed due to voices in his head but he was able to cope by dismissing them. The decision to discharge Mr. Z was given.
17 December	Mr. Z was seen at outpatients. Mr. Z still Heard voices in the middle of the night. He was not sure what they said *but "they might*

2002	*want him to kill himself"* but he said he would not do that. Mr. Z suggested that evil forces might be tuning into his mind because of the influence of the person who lived with him. Mr. Z had reduced his alcohol intake to four-six pints once or twice a week. • Medication: Paroxetine 30mg; • Olanzapine 5mg twice a day; • Zopiclone 7.5mg (prescribed for one week); • Diagnosis; ? depressive illness, ? Schizophrenia; • Others involved: CMHT and MIND for counselling.
25 March 2003	An outpatient appointment was held. It was noted that: • Mood: *"depressed and stressed out";* • Not suicidal; • No thoughts of harm to others; • Afraid that the woman who lived with him will come back; • Voices; *"Inside my head" "Pseudo hallucinations";* • Sleep poor; • Drinking every day two-three bottles of cider to relieve stress and help sleep; • Not received word from Rendezvous; • Plans to attend MIND; • Given contact number for Lifeline (alcohol service). A letter was sent to the GP.
31 march 2003	Mr. Z attended Lifeline. He attended only once. He admitted drinking nine litres of cider each week. Mr. Z was offered two further appointments but did not attend.
10 June 2003	An outpatient appointment took place. It was noted that: • Still drinking five - eight pints of beer each day. Mr. Z denied cravings/withdrawal symptoms; • Auditory Hallucinations were still present; • Mr. Z was not suicidal; • Medication: No change; • Lifeline leaflet was given; explained that medication will not be effective if Mr. Z continues drinking;

	• Diagnosis: ?Schizophrenia, ?Depressive illness; • Medication: Paroxetine: 30mg, Olanzapine; 5mg (morning, 10mg (night).
12 August 2003	An outpatient appointment took place. It was noted that: • Flat broken into by squatters, boarded up for repairs. Staying with acquaintance; • No drinking for five weeks after a fall when drunk. Thinks he might have been pushed; • Pseudo-hallucinations - less frequent and less intense; • Motivation: down; mood down; not suicidal; • Medication; Paroxetine: 40mg, Olanzapine: 15mg, Zopiclone 7.5 mg. **Emerging Issue. Why was the diagnosis not reviewed? Pseudo-hallucinations are now being suggested.**
28 October 2003	An outpatient appointment took place. No notes were made.
7 November 2003	A letter was sent to the GP regarding the outpatient appointment held on the 28 October 2003. It was noted that: • No change in his mental state; • Five - six cans of beer each day, starting at midday; • If he takes alcohol he does not take his medication; • Has been contacted by Lifeline and is awaiting an appointment; • Auditory hallucinations much less that before; • No ideas of self harm; • Advised to go to Lifeline for detoxification. Mr. Z agreed to this; • Medication: unchanged.
12 January 2004	An outpatient appointment took place. It was noted that: • Feeling better; • Sleeping well; • Reduced alcohol; • Medication: unchanged; • No ideas of self harm;

	• Happy with his condition. **Emerging Issue. Should the case have been formally reviewed at this juncture?**
22 March 2004	An outpatient appointment took place. It was noted that: • No Change in mental state; • Voices at night; • Drinking eight - ten pints of lager a day; • No ideas of self harm; • No delusions; • Medication: No change; • Refused to contact Lifeline.
117 May 2004	An outpatient appointment took place. It was noted that: • No change in mental state; • Cut down alcohol; • Sleeping well, good appetite; • Takes medication; • No depression or psychotic symptoms present; • Medication: No change. **Emerging issue. Should Mr. Z have been discharged at this stage?**
9 August 2004	An outpatient appointment took place. It was noted that: • No change in mental state; • Good mood; • Takes medication; • Refused to have blood tests; • Medication: No change.

15 November 2004	An outpatient appointment took place. It was noted that: • No change in mental state; • Good mood; no delusions or hallucinations; • Mr. Z happy with his condition; • Sleeps well; • No psychotic symptoms; • Takes medication; • Medication: No change; • Denys self harm; • Still drinking.
21 February 2005	An outpatient appointment took place. It was noted that: • Feels better; sleeping well; good mood; • No drinking alcohol for four - five months; • No depression or psychotic symptoms; • Medication: unchanged; • Mood improved.
13 June 2005	An outpatient appointment took place. It was noted that: • Doing well; • Taking medication (unchanged); • Good mood; • No psychotic symptoms.
8 September 2005	An outpatient appointment took place. It was noted that: • No Change; no depression or psychotic symptoms; • Not drinking; • Good insight; • Taking Medication; • Medication: no change.

9 January 2006	An outpatient appointment took place. It was noted that: • In good mood; takes his medication; • Happy with his condition; • Medication Plan: reduce Olanzapine 10mg; • Paroxetine - no change; • No delusions or hallucinations; • Not drinking.
6 March 2006	An outpatient appointment took place. It was noted that: • No change to mental state; • Reduced Olanzapine to 10mg; • Paroxetine 30mg.
13 June 2006	An outpatient appointment took place. It was noted that: • Paroxetine 30mg; • Still doing well; • Not drinking alcohol; • Happy with his condition; • No psychotic symptoms; • Medication: No change; • Diagnosis: ?Depressive illness, ?Schizophrenia.
5 September 06	Mr. Z did not attend his outpatient appointment.
7 September 2006	Letter to GP to inform that Mr. Z had missed his appointment.
19 march 2007	Outpatient appointment cancelled by service.
March 2007	Mr. Z did not attend his outpatient appointment.

End March 2007	Mr. W was murdered.
21 March 2007	A Police Surgeon, requested information regarding Mr. Z's current medication. Mr. Z had been "arrested on suspicion of murder", services were informed.
21 March 2007	Appropriate adult requested: provided by Wakefield Social Services.
23 March 2007	A letter was sent from outpatients to the GP. It noted: • Appointment in response to being charged with murder. Mr. Z had declined earlier appointment; • *"Not doing to badly";* • Problems sleeping (when not drinking alcohol); • Does not take medication when drinking. Has not had *"any medication remaining in the house"* for the last two months; • Occasional voices inside head at night; • Alcohol: eight cans of high strength larger and two - three bottles 7.9% or Lambrini every couple of days; • No suicidal thoughts or psychotic features; • Unlikely that he has schizophrenia; pseudo-hallucinations are probably alcoholic hallucinosis. Medications: Paroxetine 30mg; Zopiclone 7.5; Olanzapine: Stopped; Diagnosis: alcohol misuse. Previously: ? depression/schizophrenia.
26 March 2007	A letter was sent from the CMHT manager to inform Mr. Z that he had an out-patient appt on 27 March 2007. He had tried several times unsuccessfully to contact Mr. Z.
30 March 2007	An outpatient appointment took place. It was noted that: • A meeting had been held with the Associate Director. At this meeting it was decided that Mr. Z should continue to be provided secondary care services even though outpatients had been in the process of discharging him prior to the incident.

	Emerging issue. The decision to retain Mr. Z should have been based on an assessment of his mental state, and not on the seriousness of the incident he had been involved in.
30 March 2007	An outpatient appointment took place. It was noted that: (regarding the incident itself) • A young woman came to Mr. Z's flat at 8.30am because he was due to go to pick up benefit at 1.00 pm. Her boy friend broke into Mr. Z's flat ? To get money. People came round when he had money or alcohol and took it from him *"Did not seem very concerned about this said it was a few people in the neighbourhood and had done it for a long time";* • Drank throughout the day; • At around 6.00 pm a man and a woman *"walked in".* Mr. Z continued drinking; • At around 7.00 pm Mr. W came in. He was "in *a state and started sexually abusing the young girl."* An altercation began. Mr. Z tried to stop then went out to get more drink; • When he got back Mr. W was injured. Mr. Z thought he was alive and tried to help. That is how he got blood on him; • Police had taken him for questioning. Flat a crime scene and so could not return. Placed in bed and breakfast accommodation; • Bailed until 4 May 2007; • Coping because had lots to do; • Prior to incident: had drunk on Saturday night, Monday night and from Tuesday afternoon; • 4.4%x 8 cans every couple of days; • 7.9% Lambrini x 2-3 bottles every couple of day (depending on money); • Could manage without drink for 4-5 days; • Drinking >20yrs. Stopped going to pubs around two years ago; • Drinks at home sometimes from morning as he has nothing else to do. Problems: • Since July 2001 anxiety, depression and panic attacks; • Can't identify triggers. Feels closed in and physical symptoms of anxiety when lots of people about; • Voices *"on and off",* in side head, not in English and can't understand; • Only occasionally at night when can't sleep;

	Forensic: • In cells twice last year February and April: For theft together with Mr. W (man who was killed); • Assault Sept20 02; • Had no medication for last two months; • Mr. Z does not believe that Olanzapine helps with voices.
1 May 2007	An outpatient appointment took place. It was noted that: • ? under the influence of alcohol; • *"Not too bad";* • Sleep - O.K; • Continues to drink: 2 bottles of Lambrusco; • Voices: *"now and again".* No worse since stopped Olanzapine; • No depression or psychotic symptoms; • Reported that Mr. Z had a panic attack first time he had visited his flat; • Has stopped Paroxetine *circa.* 10 days before - no withdrawal symptoms; • Stopped Zopiclone.
22 May 2007	Care Plan: • Arrested March 2007 for murder. Bailed until 18 June 2007; • Previous diagnosis of depression and schizophrenia. Anxiety and misuse of alcohol; • Does not engage with services; • Does not take medication as prescribed; • Care Coordinator: Social worker; • Outpatient doctor to see every six weeks.
22 May 2007	Mr. Z was referred to Supporting People.
12 June 2007	An outpatient appointment took place. It was noted that: • Mr. Z had been charged with murder two weeks ago and released on bail; • "Not feeling too bad";

	• Coping quit well; • Not used Zopiclone; • No sleep problems; • No Suicidal thoughts; • Mr. Z thinks it is unlikely that he will go to prison; • Discussed Discharge from outpatients; • No evidence of mental health problems, no medication; • Mr. Z does not want to be discharged from the Social Worker. **Emerging issue. Mr. Z probably should have been discharged at this point.**
27 June 2007	Housing support plan/tenancy support package was developed.
10 July 2007	Social Worker asked Mr. Z if his mother needed support during this period. (She had called at her house on two occasions to try to find Mr. Z. He said she did not. Mr. Z had said that he *"does not want his mother to be involved in any way or to be contacted under any circumstances."*
17 July 2007	An outpatient appointment took place. It was noted that: • Self report: *"Not too bad"* ; • Drinking 2-3 cans in 2-3 days. Stopped because he was vomiting. Denied any other physical symptoms or cravings; • Plan: Forensic assessment; • Medication: None; • Diagnosis: Unchanged.
26 July 2007	Risk assessment: • Aggression and Violence; self neglect; exploitation; • Friends have taken money from his account; call when he has received benefits and drink with him; • Misused alcohol since age 26; • Depressed in 2001 when woman moved out of his flat;

	• Also anxiety and panic, hallucinations related o misuse of alcohol. **Emerging issue. Why did it take so long to conduct a risk assessment following the time of the incident.**
25 July 2007	Appointment with forensic services took place. • Impression: Mr. Z *"has an established alcohol dependency syndrome"* and *"established a psychological dependency on alcohol";* • *"His premorbid personality is suggestive of a withdrawn and socially unskilled individual with schizoid trait.";* • *"It is probable that he suffered from a depressive episode at the time of his first presentation to services but this appears to have been in stable remission now for a number of years. There is no convincing evidence that he suffers from paranoid schizophrenia or other severe enduring psychotic illness. I would agree that the low grade hallucinatory experiences he describes are most probably alcohol hallucinosis."*
2 August 2007	Assessment for Housing support services was developed. This did not contain all of the known risks regarding Mr. Z. **Emerging issue. The risk assessment was not accurate and underplayed Mr. Z's risk. This could have potentially placed staff and fellow tenants at risk.**
21 August 2007	An outpatient appointment took place. It was noted that: • Coping *"not too bad";* • Unclear as to level of drinking; • No depression; • No psychotic symptoms.
1 October 2007	An outpatient appointment took place. It was noted that: • *"Mood - Not too bad";* • Sleep *"alright";* • Voices sometimes at night but ignore them; • Euthymic with no evidence of depression or psychotic features; • Attending Lifeline (Alcohol services) on a weekly basis.

12 November 2007	An outpatient appointment took place. It was noted that: • Trial tomorrow (13 November 2007); • Denied any alcohol since August, motivated by trial - been attending 'Lifeline'.
December 2007	Mr. Z was found guilty of murder and was sentenced to life imprisonment with a fourteen year determination. Mr. Z's place of disposal was prison.