VERITA

IMPROVEMENT THROUGH INVESTIGATION

An investigation into the care and treatment of Miss A

A report for NHS Yorkshire and the Humber

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Contents

1. Introduction

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

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

1.3 The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. While the independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident, it will usually find things that could have been done better without changing the course of events.

1.4 We were impressed by the standard of care provided in this case. We identified some learning for the trust but found no causal factors leading to the incident.

Background to the incident

1.5 Miss A, a 33-year-old woman, killed her grandmother in 2007. She was convicted of murder in 2008 and sentenced to life imprisonment with a minimum term of 20 years.

1.6 Miss A was receiving care and treatment from Leeds Partnerships NHS Foundation Trust (the trust).

1.7 The trust carried out an internal investigation into Miss A's care and treatment shortly after the incident in 2007.

Overview of the trust

1.8 Leeds Partnerships NHS Foundation Trust provides specialist mental health and learning disability services to over 610,000 adults within the Leeds metropolitan boundary.

1.9 Adult services, where Miss A was cared for, are available within the trust for people aged between 17 and 65 who suffer from serious and complex mental health problems. Care is delivered in a variety of settings ranging from service users' homes to acute inpatient wards. The adult service consists of community mental health teams, acute day services, inpatient facilities, psychological therapy services and rehabilitation and recovery services for people with severe and enduring mental illness.

2. Terms of reference

2.1 NHS Yorkshire and the Humber commissioned this independent investigation in accordance with guidance published by the Department of Health in HSG (94) 27 *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-6 issued in June 2005. It also takes into account the *Good practice guidance* issued by the National Patient Safety Agency in February 2008.

2.2 The terms of reference for this independent investigation, set by Yorkshire and the Humber Strategic Health Authority (the SHA) in consultation with NHS Leeds (the primary care trust) and Leeds Partnerships NHS Foundation Trust (LPFT), are given below.

Terms of reference:

To investigate:

The care and treatment the service user was receiving from the start of her contact with acute mental health services in September 2006 until the time of the incident and the suitability of the care and treatment in view of the service user's history, vulnerability and assessed health and social care needs.

The extent to which that care and treatment corresponded with statutory obligation and relevant guidance from the Department of Health at that time and how local operational policies and practices addressed such guidance, with particular reference to:

- Care Programme Approach
- DNA policy
- discharge policy
- risk of self harm protocol
- child safeguarding.

The role of LPFT and its staff in promoting communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs and social care and support.

The adequacy of the risk assessment and management plans of the service user including the risk posed to self and others. The involvement of carers and relatives when undertaking risk assessments, the resulting care plan and its use in practice during the review period.

The extent that services engaged with the family and carers and the impact of this.

The perceptions of the service user's family and carers of the level and quality of care and treatment provided.

To comment upon:

The degree to which mental health was considered a contributory factor by the judiciary.

To identify:

Learning points for improving systems and services.

Aspects of the services users' treatment and management which was of good quality or commendable practice.

To review:

The terms of reference during the progress of the investigation and to consider whether that scope addresses the potential causal and contributory factors to the incident, updating the SHA with your findings when appropriate and formally on a monthly basis.

Should such a review lead to any proposed changes to the terms of reference, NHS Leeds and LPFT would be made aware of any proposals and be given an opportunity to comment.

To produce:

Realistic recommendations for action in conjunction with NHS Leeds and LPFT and to address the learning points to improve systems and services.

A final report that complies with all relevant legislation to enable the publication of the report and to report these findings and recommendations to the board of Yorkshire and the Humber Strategic Health Authority via its Independent Investigations Committee.

3. Executive summary

Introduction

3.1 NHS Yorkshire and the Humber (the SHA) commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of a mental health service user, following her conviction for murder.

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

3.3 The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. While the independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident, it will usually find things that could have been done better without changing the course of events. There are usually lessons to be learned.

3.4 We were impressed by the standard of care provided in this case. We identified some learning for the trust but found no causal factors leading to the incident.

The incident

3.5 Miss A, a 33 year-old woman, killed her grandmother in 2007. She was convicted of murder in 2008 and sentenced to life imprisonment with a minimum term of 20 years.

Overall conclusions of the independent investigation

3.6 We found the main focus in this case was on treating Miss A's illness and observing any improvement in the symptoms of that illness. This was well managed but the approach may have blurred some of the other dynamics that were operating at the same

time. There was a lack of clarity about the provision of psychological interventions and staff concluded that Miss A's disabled child was well cared for without recording their reasons.

3.7 However, we are absolutely clear there is no evidence that anyone involved with Miss A's care and treatment could have anticipated that Miss A was capable of carrying out the murder of her grandmother. It is very unlikely that anything could have been done by trust staff that would have changed the course of events.

3.8 We have been impressed by the thoughtfulness, diligence and commitment of the staff who were involved in Miss A's care and treatment. She was fortunate to have been in their care but she chose not to take advantage of all they had to offer.

3.9 We have identified some learning for the trust from this investigation. Our recommendations are intended to address this learning but we emphasise that we found no causal factors leading to the incident.

3.10 We are grateful for the contributions and support of all the people we interviewed, those who provided documentary evidence, those who facilitated our investigation and those who commented on our draft report.

Summary of Miss A's contact with services

3.11 This investigation has focused on Miss A's contact with specialist mental health services from August 2006 to May 2007. She had two previous periods of contact: from October 1997 to July 1998 and from July 2000 to February 2001.

3.12 Miss A was referred to a consultant psychiatrist on 29 August 2006 by her general practitioner who was concerned about her symptoms of depression and risk of self harm. Miss A had been suspended from work following an assault on her ex-partner. Miss A was seen the same day and fully assessed two days later when she was referred to the acute day service. Miss A attended the acute day unit from 2 September to 22 November 2006.

3.13 Miss A was discharged from the day unit on an enhanced care programme with a care coordinator and regular outpatient appointments. She was last seen by her

consultant psychiatrist in April 2007 when she said she felt much better. That was nine days before the murder of her grandmother.

Diagnosis, treatment and psycho-social aspects

3.14 Miss A had a complex psycho-social situation with a history of self harm, a volatile relationship with her ex-partner, suspension from work, and a court case for an alleged assault; she also had responsibility for her severely disabled child.

3.15 Miss A's consultant considered her diagnosis carefully. He felt that Miss A had either type 2 bipolar disorder or unipolar depression and he believed her illness was the primary cause of her behaviour while he was treating her. The drug treatment and monitoring provided for the diagnosis cannot be faulted. We found it was possible Miss A also showed aspects of emotional instability but we have made no link between the lack of evidence that this was fully considered and the crime she later committed.

3.16 Staff at the day unit and in the community were diligent and persistent in making contact with Miss A despite her patchy attendance, but they found it difficult to engage Miss A in any therapeutic interventions other than her medication.

Risk management

3.17 The risk Miss A posed to herself was carefully assessed and thoroughly taken into account in her care and treatment. She did not come across as a violent person, despite the aggression she described towards her ex-partner and his girlfriend. Although staff could have explored the potential risk to these two people and documented their discussions, there was no indication that Miss A posed a risk of violence to anyone else and we have concluded the murder of Miss A's grandmother could not have been predicted.

3.18 The trust now has more robust systems and much higher expectations of risk profiling and management within clinical teams based on national guidance.

Care planning and the Care Programme Approach

3.19 Staff provided a high standard of care in the day unit and in the community, but none of the suggestions for additional therapies and interventions materialised, for a variety of reasons. It was not always clear how these additional inputs would be provided and who would provide them but Miss A was unlikely to have engaged well with any form of psychological therapy. There was a lack of consistency between the care plans of the medical staff and the rest of the MDT as well as other problems with the Care Programme Approach (CPA) in this team. We have been critical of the approach to care planning but this does not mean that any alternative action by the trust could have prevented the incident of 2007.

Did not attend (DNA) and discharge

3.20 The decisions made to discharge Miss A from the day unit to move towards potential discharge from her care coordinator's case load were well considered and appropriate in the circumstances. The discharge communications were of a reasonable standard, with some gaps and inconsistencies, but the information provided about Miss A's drug treatment was commendable.

3.21 The trust's new arrangement for detailed discharge summaries to be completed by the keyworker, and for the risk management plan to be more closely linked to the care plan, should bring immediate benefits. All staff should be congratulated on their determined efforts to maintain contact with Miss A.

Safeguarding children

3.22 Our concern in this case has been as much about the wellbeing of Miss A's child as about the risk Miss A posed to other people in her circle. Awareness, understanding, systems and practice in child safeguarding have all changed significantly since the death of Peter Connelly in August 2007 but the principles, framework and training have been in existence for much longer. Staff caring for Miss A thought about her child but did not demonstrate in the records that concerns around her child's welfare had been adequately

articulated or systematically considered within the MDT. They did not discuss the case with the named doctor or nurse. The trust's internal investigation of 2007 did not address the safeguarding issues and we hope the key messages about safeguarding children, in relation to this case, have now been fully heard.

3.23 The trust now has an extensive range of promotional and training activities on safeguarding children that should ensure good practice.

Promotion of communication

3.24 There were several examples of good communication and joint working such as the trust's immediate response to the GP's urgent referral and the care with which Miss A's discharge from the day unit was planned. However, we also identified instances of poor communication and joint working such as the lack of discussion within the MDT about risk assessment and the lack of coordination between the care plans of the nursing staff and the treatment plans of the medical staff.

3.25 The trust has already put in place a range of systems for improvement and we have made recommendations to support these initiatives.

Engagement with family and carers

3.26 According to the records, Miss A gave her consent to contact with her mother when she was admitted to the day unit in September 2006 and only withdrew this once briefly in January 2007. Staff intended to talk to Miss A's mother and ex-partner but only one meeting took place with Miss A's ex-partner, and they did not meet her mother. Miss A's ex-partner provided information which supported the possibility that she was suffering from type 2 bipolar disorder. It was regrettable that this opportunity was not seized, or another meeting set up, to explore the family situation, the well being of Miss A's child or Miss A's propensity for violence. However, we were told that Miss A's ex-partner did not want to be involved at one point after the assault on his girlfriend and we felt that Miss A's mother was ambivalent about having contact with trust staff.

3.27 Trust guidelines now emphasise the potential benefit of involving families and friends as well as carers.

Perceptions of the family and carers

3.28 When we met Miss A's mother she told us that she did not think anything could have been done differently. Her concern appeared to focus on the length of time taken to reach a diagnosis for Miss A but she was pleased that her medication had eventually been sorted out.

Consideration by the judiciary

3.29 Miss A was convicted in 2008 of the murder of her grandmother in 2007. The judge said he accepted that mental illness, falling short of diminished responsibility, was one of the factors in the crime. Miss A was sentenced to life imprisonment with a minimum term of 20 years, reduced to 18 years and 333 days for the time already in custody. The starting point for the sentence was 30 years taking into account the aggravating features of the offence. The judge reduced the sentence to 20 years to take into account the mitigating feature of Miss A's mental illness and the fact that *"your life was difficult and stressful because of your responsibility for your child and your illness made it difficult for you to sustain friendships"*.

Recommendations

R1 The trust should demonstrate that consultation and advice is readily available to clinicians via its personality disorder clinical network for people with features of emotional instability which significantly influence the clinical picture. There should be no need for a formal referral in order to draw on the expertise within the organisation. Views, including uncertainty, should be discussed within the MDT and recorded in clinical notes.

R2 The trust should ensure advice on the clinical management of self harm, based on national guidance, is available to each team within the trust and that this is reflected in its policy documents.

R3 The trust should clarify within relevant clinical teams the range of skills available in terms of talking therapies and other interventions and the capacity of staff to provide these. The trust should also clarify access beyond the teams to other therapies and

interventions in both statutory and non statutory services. The trust should ensure this information is understood by each qualified member of the teams.

R4 The trust should ensure there is a reliable system in all settings for tracking and monitoring fully integrated multidisciplinary care and treatment plans, including any additional proposals that arise from multidisciplinary team (MDT) and CPA reviews. The trust should ensure all teams are clear about who has overall responsibility for individual care and treatment plans within each setting.

R5 The trust should consult with clinical staff, including GPs via the local medical committee, to identify aspects of the CPA process that are not working well with a view to taking remedial action and auditing the results as part of the regular CPA audit cycle.

R6 The trust should check MDTs have a reliable system to monitor the standard and timeliness of written discharge communications and ensure medical, psychological and social issues are fully integrated with the CPA care plan, avoiding unnecessary duplication.

R7 The trust should ensure all staff are aware of the expectation that they seek advice on safeguarding children whenever there is the potential for concern or a difference of opinion, even if they have felt no actual concern.

R8 The trust should ensure the current e-learning level 1a child safeguarding training provides staff, who have regular contact with parents or children, with the knowledge and skills to carry out their safeguarding responsibilities.

4. Approach and structure

Approach of independent investigation

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

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

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

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

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

4.3 The trust wrote to Miss A and asked for permission to access her medical records. She gave her consent in February 2011 and our independent investigation started in May 2011 once all documentary evidence had been received from the trust.

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

- relevant trust policies and procedures
- a copy of Miss A's clinical records[1]
- the trust's internal investigation report.

4.5 We interviewed the following people:

- Consultant psychiatrist 1 who was responsible for the care and treatment of Miss A
- The trust's named doctor for safeguarding children
- The trust's medical director who was also the trust's lead director for risk management
- A staff nurse from the Acute Community Service who was also Miss A's keyworker (SN1)
- Miss A's first care coordinator (CC1).

We wanted to speak to Miss A's second care coordinator (CC2) who has retired from the trust but she chose not to meet us for reasons which we understand and respect.

4.6 We followed established good practice in conducting interviews. We gave interviewees the opportunity to be accompanied by a representative or a friend. We gave them the opportunity to comment on the accuracy of their interview transcripts, and where appropriate, on relevant extracts of our draft report.

4.7 We met Miss A to explain the purpose and process of the independent investigation and we shared the terms of reference with her. We met her again to share our findings.

4.8 We met Miss A's mother on a separate occasion to explain the purpose and process of the independent investigation and we shared the terms of reference with her. We met her again to share our findings.

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

[1] During the course of this investigation we discovered that the trust did not have Miss A's original case notes and did not know where they are. We have been assured that every effort has been made to trace the originals but without success. The last known location was with West Yorkshire Police who have no trace of them now. The trust has retained a good copy but a few sections appear to us to be incomplete or poorly copied from the originals. We were given a copy of this version.

Report structure

4.10 We investigated the care and treatment Miss A received from the start of her contact with acute mental health services in September 2006 until the time of the incident in 2007. We examined the suitability of the care and treatment in view of Miss A's history, vulnerability and assessed health and social care needs.

4.11 We considered Miss A's care and treatment within these key themes:

- diagnosis, treatment and psycho-social aspects
- risk management
- care planning and the Care Programme Approach
- did not attend (DNA) and discharge
- safeguarding children
- promotion of communication
- engagement with family and carers
- perceptions of family and carers
- consideration by the judiciary.

4.12 The terms of reference also require us to consider the extent to which Miss A's care and treatment corresponded with statutory obligations and relevant guidance from the Department of Health at that time and how local operational policies and practices addressed such guidance. We considered the key themes in relation to the specific policies and guidance set out in the terms of reference and have detailed our findings under the relevant heading.

4.13 We have identified aspects of Miss A's treatment and management that were good or commendable practice throughout this report.

4.14 The comments of the investigation team in this report are in bold italic script.

5. Diagnosis, treatment and psycho-social aspects

5.1 We have examined Miss A's diagnosis, treatment and the psycho-social aspects of her situation in considerable detail in relation to her contact with mental health services.

Early history

Evidence

5.2 Miss A's clinical notes record that she left school with some GCSEs and worked at the Royal Mail sorting office. She had a volatile relationship with her partner, who was nine years older. Miss A's first confirmed contact with specialist mental health services was in October 1997 when she took an overdose of 75 paracetamol tablets, after an argument with her partner who said he was leaving her. Her partner reported that Miss A frequently threatened to kill herself when they argued. He said the recent problems were precipitated by Miss A having an affair. At the time Miss A's 13-month-old child was being assessed for possible developmental delay.

5.3 Miss A spent one night in a general hospital after taking the overdose and was assessed by the liaison psychiatry service. She failed to attend a follow up appointment a week later but was seen by a consultant psychiatrist as an outpatient after a further two weeks. At this stage it was felt Miss A's only symptom was of low mood related to the breakdown of her relationship with her partner and that she would benefit from contact with a community psychiatric nurse (CPN) or social worker.

5.4 In the meantime, early in 1998, Miss A was devastated to learn that her child had serious developmental delay. Her health visitor was concerned about Miss A's ability to bond with the baby or to cope without significant input from her own mother. Miss A and her child were living with her mother but Miss A wanted to move back to her partner. Miss A was reviewed by a different consultant psychiatrist in February 1998, as she had moved catchment area. He also spoke to her health visitor and concluded there was no evidence of mental illness but he felt Miss A was not coping well with difficulties in her life and might respond by self harming. He recorded that she had no thoughts of harming the baby. He referred her to a community occupational therapist (OT) who saw her in March 1998. The OT felt she was tearful, frustrated and angry but not depressed. Miss A did not attend

her next two appointments with the OT in March, or her next two consultant appointments in March and May 1998, despite the efforts of staff to stay in touch and good liaison with the health visitor. In April 1998 a letter was sent to the medical advisor of Miss A's employers saying she had *"recently been suffering from stress secondary to relationship difficulties."* Miss A was discharged on 22 May 1998.

5.5 In July 1998 Miss A's health visitor informed the OT that she felt Miss A was not depressed but obsessed with her partner and she had attacked him. Miss A told the police she had post natal depression (she was convicted of battery for this assault). She had fallen out with her mother; gone to live with her grandmother and gone back to work. The community mental health team (CMHT) discussed Miss A on 16 July 1998 and the OT told the health visitor she could contact the GP for a referral. There was no further contact with the mental health service at this time.

5.6 In July 2000 Miss A was referred by her GP to a consultant psychiatrist. The GP said she had suffered from depression over the last year, had variable moods, short temper and difficulty sleeping and was finding separation from her partner very difficult. The GP had prescribed an antidepressant. Miss A did not attend the appointment she was offered; was re-referred in September 2000 at her own request; did not attend the two appointments she was offered and was discharged in December 2000. She was re-referred in January 2001 and discharged when she failed to respond to the CPN's invitation to make contact.

5.7 We understand from an extract of the court proceedings of 2008 that Miss A received a police caution for stabbing her ex-partner in 2005 but the mental health team who treated her from August 2006 did not appear to be aware of this.

August 2006 onwards

Evidence

5.8 Miss A's third episode of contact with specialist mental health services was triggered on 29 August 2006 by an urgent referral from her GP who was treating her with sertraline, an antidepressant. The GP recorded that Miss A was seriously considering suicide but was held back by the thought of how it would affect her family. In his referral

letter the GP said he was *"now quite concerned about her risk of self harm"*. He said Miss A had long standing recurrent depression for which she had been admitted to the local mental health hospital in 1992, with flare ups ever since. (We have seen no corroboration of this admission, although consultant psychiatrist 1 tried to obtain the records.) The GP said Miss A had split up with her ex-partner 18 months ago and was currently suspended for hitting him at work (they both worked at the Royal Mail sorting office). He enclosed a copy of her computer profile which mentioned depression, but not an admission, in 1992.

5.9 Later that day Miss A was seen by a senior house officer (SHO) who recorded that Miss A had a ten year history of recurrent depression and anxiety and had taken an overdose of paracetamol during post natal depression in 1997. (We have seen no corroboration that Miss A suffered from post natal depression after the birth of her child in 1996. The GP record mentioned "*neurotic (reactive) depression*" in 2000, 2001, 2002 and 2006.) The SHO also recorded that Miss A's mood had deteriorated over the last six weeks. She had relationship difficulties, having split up with her ex-partner eight months ago but with the relationship "*on and off since then*". The SHO recorded that Miss A had gone back to her GP today "*with increasing distress"* and *"? suicidal"*.

5.10 Miss A told the SHO she couldn't cope at work. On her first day back after four weeks off there was an incident when she was aggressive to her ex-partner. She felt worthless, had constant low mood, with no enjoyment, was very tearful with generalised anxiety and felt worse since she saw her ex-partner with another woman. Her appetite was poor; she had lost some weight; she slept five hours at night with initial insomnia; her concentration and energy were poor; she had depressive thoughts about the past, present and future and had fleeting suicidal thoughts but was stopped by thoughts of her mother and her child. Miss A felt she needed counselling and anger management. She said she had had three periods off work with depression. Her child was now 10 years old and had a learning disability. Miss A denied having any thoughts of harming her child. The SHO recorded: *"no forensic history (?caution for throwing cup at partner some years ago)"*. (There was a conviction for battery in 1998). Miss A had no debts apart from her mortgage but was worried about losing her job. She had an appointment at Relate[2] that afternoon. The SHO felt Miss A needed urgent assessment by the CMHT.

[2] Relate is a charity providing relationship counselling for individuals, couples and families.

5.11 Two days later, on 31 August 2006, Miss A was assessed by a staff grade doctor who recorded that Miss A described constant low mood since the birth of her disabled child. The doctor recorded that Miss A was tearful; had reduced energy; lacked enjoyment; had a poor appetite; had lost 6lb over the past few weeks; had initial insomnia, disturbed sleep and early morning wakening; poor concentration and confidence. Miss A told the doctor: *"I can't see myself ever being happy, I don't want to be here but I've got* [my child] *to care for."* Miss A's mother looked after Miss A's child while Miss A was at work and also looked after her own mother who had Alzheimer's disease.

5.12 Miss A told the staff grade doctor that she and her ex-partner found their child's disability stressful and they had had relationship problems since she was born. Miss A and her ex-partner had argued excessively about his mother. She said that his mother never thought she was good enough for him. *"I came from a council estate; his family are very wealthy, I feel very insecure."* She said they had separated in November 2005 but saw each other once a week and she would like to get back together. She said there had been some violence between them.

5.13 The staff grade doctor recorded that Miss A had been suspended five weeks previously when she assaulted her ex-partner at work. She was given two weeks work at another base but was sent home when she was too tearful. Miss A and her ex-partner had attended Relate but he would not return as he did not want a reconciliation. She had bought several boxes of paracetamol the previous week but had not taken them because of her mother and child. Miss A had self harmed in the past by cutting her wrists, pulling her hair and banging her head. Miss A had taken a serious overdose of 75 paracetamol tablets in 1997 after an argument with her ex- partner. Miss A told the doctor she was in hospital for more than a week on that occasion and was seen by a psychiatrist but no follow up was arranged. (This was the episode described in paragraphs 5.2 to 5.5 above when records indicated she was discharged the day after her admission and attended several follow up appointments). Miss A also told the doctor she had had two periods off work with depression and had no forensic history. She said antidepressants had not been effective in the past, but sertraline over the past five weeks had helped initially.

5.14 The staff grade doctor noted that Miss A lived in her own house with a mortgage. Her ex-partner paid maintenance but she struggled to make ends meet. She rarely drank alcohol and took no illicit drugs. Miss A had not seen her father since she was six when he had often been violent towards her mother. She was close to her mother. Her adult brother lived with their mother. Miss A was bullied at school about being overweight. She

left school at the age of 17 having given up A-level art. She worked full time at the Royal Mail.

5.15 The staff grade doctor felt Miss A had "*a moderate to severe depressive disorder with suicidal thoughts that she is currently able to resist.*" The doctor increased the dose of the antidepressant and referred Miss A to the acute community day service[3]. In this report we refer to this service as 'the day unit'.

5.16 Miss A first attended the day unit on Saturday 2 September 2006. A staff nurse (SN1), who was her keyworker, assessed Miss A and identified:

- *"not coping at home; issues with ex-partner; low mood; hopeless; tearful; depressed; helpless*
- *thoughts of self harm and suicide with no exact plans*
- *previous overdoses approximately 10 years ago; prior postnatal depression*
- *diagnosis of severe depression*
- *feels drained by social situation*
- *lives alone in week and has disabled child at weekends, extra care provided by mother*
- *finances ok but potential to lose job in future*
- *ex-partner hostile but no violence*
- *feels the medication is beneficial."*

5.17 Miss A next attended the day unit on 5 September. She was reviewed by an SHO who wrote:

> "*Worrying about job, on suspension, needs money from job - unable to pay mortgage; worried about relationship with* [ex-partner] *... she wants to get back, has hit her and verbally abused her, feels he doesn't care. Thinking about another overdose - can't for* [child] *and mother; sees no future, very tired all the time; hard to resist thoughts of self harm; unable to sleep; no appetite; low energy levels; unable to concentrate; unable to enjoy anything*"

5.18 The SHO prescribed zopiclone, a sleeping tablet.

[3] The acute community service provides acute day treatment seven days a week as an alternative to inpatient admission.

5.19 Miss A missed her multidisciplinary team (MDT) review on 6 September. Ward staff tried to contact her several times and spoke to her in the evening. Miss A said she had been at work and busy in the afternoon but would like to see the doctor the following day. Entries by nursing staff on 7 and 8 September referred to Miss A looking tired, not sleeping, being worried about work and having lots of stresses at home. She was prescribed zopiclone, slept for 12 hours and missed work. She was not enjoying anything and lacked motivation and energy but had no thoughts of harming herself. Nursing staff suggested she take annual leave or sick leave and her GP gave her a sick note for two weeks citing depression.

5.20 On 11 September Miss A attended the day unit and said she had taken six sertraline tablets the previous evening and had been very sick. She should have had two zopiclone tablets left but said she had none left. She said it had not been a suicide attempt but thought it would make her feel better. She was tearful and quite tense with nursing staff, talking about her ex-partner and her social situation, but was seen to smile and laugh during a group session. The SHO who saw her noted that she appeared tired, not tearful and was well dressed. The SHO felt she was unlikely to take any more tablets.

5.21 The FACE[4] risk profile completed by SN1 on 12 September recorded:

> "*Miss A has expressed that she finds the future hopeless and sees no positives in her life at present. Currently Miss A is the main carer for her disabled child and has expressed issues over coping with her home situation.*"

5.22 Consultant psychiatrist 1's first contact with Miss A was on 13 September in the MDT meeting. Consultant psychiatrist 1 noted: "*Lots of problems – 1. Separation from partner, 2. Coping with disabled child, 3. Suspended from work*". He also noted that Miss A had a mood problem; she said she got very angry for no reason at all; she sometimes had faster thoughts and the rest of the time she was depressed, constantly worrying about her daughter and her ex-partner. She reported that her ex-partner said she was "*like Jekyll & Hyde*". She was normally quiet but sometimes talked so much she could not keep quiet. This would last an hour or two, once every few weeks. She experienced "*speed of thoughts*". She was never too full of energy and could never do without sleep. Treatment had neither helped nor made it worse. She was able to resist suicidal ideas. She had no confidence and felt guilt for her child's disability. She had several phobias. Consultant

[4] Functional Assessment of the Care Environment

psychiatrist 1 felt she was experiencing a depressive episode and may have type 2 bipolar disorder. He arranged for blood tests and he wanted to access her old case notes, obtain a treatment history from her GP and talk to her ex-partner.

5.23 Miss A's ex-partner came with her when she was reviewed by consultant psychiatrist 1's specialist registrar (SpR) on 20 September. The SpR noted that Miss A's ex-partner reported that Miss A:

> *"... totally loses it, pulling hair out, eyes popping, triggered by argument with partner. Can last for one hour. Mood – up and down most of the time. Good mood – really happy. When down – really down. Really giddy. Can last for days* [rather] *than weeks. Not over talkative when really happy. Overspending when giddy. Buy things that she already had."*

5.24 The SpR felt that Miss A had type 2 bipolar disorder with obsessional/compulsive symptoms. After blood tests, Miss A was prescribed lithium as a mood stabiliser. Consultant psychiatrist 1 told us he believed the SpR also decided to prescribe lithium to augment the effect of the antidepressant medication. A week later the SpR felt Miss A was moderately depressed.

5.25 On 4 October Miss A asked to see consultant psychiatrist 1 on her own for her review. She felt she was *"not getting any help"* and told him in more detail about her problems with her ex-partner. Consultant psychiatrist 1 noted that she was "*getting to the point where she resents* [her child]". He wanted Miss A's mother and her ex-partner to attend separate subsequent ward rounds.

5.26 Consultant psychiatrist 1 next saw Miss A on 17 October. She told him about an incident two days earlier when she had assaulted her ex-partner's new girlfriend and about kicking her ex-partner's door and car the week before. Miss A said she felt agitated and angry all the time. She was angry with herself for losing her temper because she had been controlling it. She was worried she might lose her job as a result. She was also depressed, with initial insomnia, early morning waking and no enjoyment. Consultant psychiatrist 1 noted:

> *"Above incidents could be seen as a normal reaction but I think her mood disorder contributed to her losing her temper. NB Diagnosis of type 2 bipolar is a*

differential only. Insufficient evidence for this at present ... Working diagnosis at present is unipolar depression, though she does have racing thoughts. I think some sedative medication & something to slow thoughts down while waiting for lithium to work."

5.27 He prescribed olanzapine, an antipsychotic, and stopped her zopiclone sleeping tablets.

5.28 Consultant psychiatrist 1 saw Miss A again on 1 November and noted that she had been charged with battery for the assault on her ex-partner's girlfriend. Consultant psychiatrist 1 felt that there was not much change but made a further entry in the notes which is not dated. In this later entry he recorded:

"*Reports 'high' moods since child born. High mood = buzzing, wants to go out spending loads of money on e.g. loads of coats/or jackets/or boots when does not need them. Tends to concentrate on a certain item. Kicks off. If things out of place plays on her mind. Wants to do stuff, can't rest. Duration: up to a week. Not felt like this for a while ... Impression: Does sound more like type 2 bipolar disorder, current episode mixed affective state. Obsessional symptoms. Consider OCD."*

5.29 When consultant psychiatrist 1 saw Miss A again on 8 November he felt that she looked brighter although her mood was still "*up and down*". He recorded: "*mixed affective state - improved*". Her mind was still racing at night, she was not sleeping, she was not happy and her appetite had been excessive over the past week. He also recorded that Miss A was to return to court later in the month. He requested a CPA meeting with a view to discharge and continued treatment in the community.

5.30 Miss A did not attend the day unit for the next four days and then missed her next MDT review on 15 November when nursing staff reported that she had been low and tearful and her attendance had been poor. They also reported that Miss A did not feel ready for discharge and found the day unit a respite from psycho-social issues. They noted: "*feels would be more 'angry/daft' without contact."* Consultant psychiatrist 1 planned to discharge her the following week. Miss A attended the day unit once more on 16 November but did not attend again. A staff nurse (SN1) visited her at home on 21 November and she was discharged in her absence the following day. Consultant psychiatrist 1 recorded: *"Differential diagnosis: depressive disorder or type 2 bipolar*

disorder". Miss A's first care coordinator noted that SN1 told him: *"Miss A has been occasionally tearful and down due to life's problems".*

5.31 Over a period of nearly three months Miss A attended the day unit on approximately half of the days that it was available to her. She said she had child care responsibilities at the weekends and also gave this as a reason for attending only briefly or not at all on other days. She sometimes reported that physical illness prevented her attending. Consultant psychiatrist 1 told us that, amongst other reasons, there was also the distance between the unit and her home. Overall her attendance was patchy and staff regularly tried to contact her when she did not attend as expected.

5.32 SN1 told us that staff found it difficult to engage and assess Miss A because of her limited attendance. He said they felt there was "a *pattern of not really wanting to engage with us in the full sense."*

5.33 Miss A's mother told us that Miss A sometimes collected her child from school, gave her child tea and then took her child to her mother's house.

5.34 Whilst there were regular references in the case notes to Miss A feeling low, tearful and hopeless, there were also several notes from the nursing staff about Miss A being in a cheerful mood. For example on 15 September 2006: *"Spent time with other service users laughing and joking, watching tv".* On 25 September: *"Miss A spent time chatting with fellow service users ... fairly bright".* On 2 October: *"Miss A declined offer of 1:1 and spent time socialising with others in the kitchen ... spent afternoon socialising".* We asked SN1 about this and about his overall impression. He recalled that when Miss A first came to the day unit she had been quite tearful for a couple of weeks and he did feel she was depressed, although he was not sure how much psychosocial issues were impacting on her baseline mood. He told us:

> *"I think when she was referred to us she was in more of a crisis period than as time went on and I think just us being involved ...reduced somewhat her levels of distress because she had somebody to talk to ...*
>
> *"She was still having periods of flatness and periods of not coping ...and she felt her mood wasn't as good as it could be ... but just with somebody getting better they may not be better from depression. They might start showing increased social function, but it doesn't necessarily mean that they are well.*

"... we only saw her in the low phase of her potential bipolar illness so her being aggressive was when she was low. When she smashed her partner's car up, that incident was when she was low so we didn't see any evidence of elevated mood or out-of-control irritability or anything like that."

5.35 Miss A's first care coordinator (CC1) was identified on 22 September, two and a half weeks after her admission to the day unit. CC1 met her for the first time on 11 October to undertake an initial assessment. He was also present at the MDT review on 15 November and the CPA discharge meeting on 22 November – neither of which Miss A attended. He met her for the second and last time for her seven day follow-up meeting on 29 November.

5.36 Miss A's second care coordinator (CC2) took over from CC1 who went on sick leave in December 2006 and it was decided that she would continue in the role following CC1's return. When we interviewed CC1 he told us that he had an unclear recollection of feeling uneasy about working with Miss A in a community setting and that it would be better if Miss A had a female care coordinator. He was unable to recall any detail of their meetings.

5.37 CC2 first contacted Miss A by telephone on 12 December after Miss A had called to ask for a repeat prescription. There were then three failed home visits, followed by three successful home visits – the last one on 14 February 2007. After that Miss A did not attend an appointment with CC2 at the resource centre and there were three more failed home visits – the last one on 18 April 2007. Unfortunately we did not have the opportunity to talk to CC2 who has retired from the trust and declined our invitation to meet with us.

5.38 Miss A's first outpatient appointment after her discharge from the day unit was on 19 December 2006 when she saw SHO1. Miss A reported mood swings and SHO1 felt she was in a depressive stage of her bipolar disorder with low risk.

5.39 Miss A told CC2 on more than one occasion that she did not feel responsible for her anger and for the attack on her ex-partner's girlfriend, blaming others for this. CC2 recorded this on a FACE risk profile on 29 January 2007. When we saw consultant psychiatrist 1 he was not aware of this discrepancy with Miss A's expression of regret to himself. He said he had not noted CC2's comment on the FACE risk profile.

5.40 CC2 informed consultant psychiatrist 1 in a letter dated 14 February that Miss A attributed her low mood to the imminent court case and employment issues. She also said in her letter that Miss A wanted consultant psychiatrist 1 to know that she wanted to return to work and not be retired on medical grounds.

5.41 Miss A did not attend her outpatient appointment with consultant psychiatrist 1 on 19 February 2007. She was expected to attend with her mother but neither of them came. Miss A's mother wrote to consultant psychiatrist 1 on 22 February and apologised for missing the appointment. In this letter she referred to herself as *"Miss A's mum and main carer"* and said her experience of Miss A's behaviour over the years could have a bearing on *"any report you may be in the process of writing"*. (At this time consultant psychiatrist 1 was preparing a report for Miss A's employer's occupational health physician.)

5.42 In her letter Miss A's mother said Miss A's mental health problems started after the birth of her child; she had attempted to take her own life twice; over the years her behaviour had been unstable and erratic and Miss A had been violent towards her, although not for a few years. She said Miss A's mental health issues had been exacerbated by her ex-partner's mental cruelty which contributed towards her violence to her ex-partner and his new girlfriend. She said she had seen a big improvement in Miss A's mental health over the past two or three months and her ex-partner no longer had any influence. Miss A wanted to get back to work and her mother felt if she lost her job it would be detrimental to her health. She said she would like to talk to consultant psychiatrist 1 before he finalised his report. Consultant psychiatrist 1 did not respond to the letter or arrange to see Miss A's mother again. He apologises for not having responded to her letter and we have conveyed his apology to Miss A's mother.

5.43 Miss A saw consultant psychiatrist 1 on 23 March when he felt she was *"improved but not recovered. I do not think her symptoms are simply a reaction to circumstances"*. In a letter to her employer's occupational health physician, consultant psychiatrist 1 said her diagnosis had changed from depressive disorder to type 2 bipolar disorder while she was at the day unit. He planned to reduce her medication to a single mood stabilising drug. He wrote:

> *"It does not appear that the circumstances of the assault at work had been enquired about in any detail by any member of my team. However ... I think it quite conceivable that the alleged assault by Miss A occurred as a direct*

consequence of bipolar disorder ... from Miss A's report she has been in an emotionally abusive relationship for many years, this relationship having ended recently ... if the reports are accurate then this abuse is likely to be a major precipitating and maintaining cause of Miss A's mental ill health over the years."

5.44 Consultant psychiatrist 1 saw Miss A on 3 April to prepare a court report following the assault on Miss A's ex-partner's girlfriend. He wrote in his report:

"*The diagnosis is type 2 bipolar disorder and she is currently in the depressed phase of this illness. ... at the time of the alleged offence her mood was in the elevated phase of type 2 bipolar disorder. Irritability, anger, impulsivity and impaired judgement are characteristic of this phase of bipolar disorder. It is beyond reasonable doubt in my mind that these symptoms substantially affected Miss A's actions on that day and led directly to those actions. Miss A has expressed remorse for the alleged offence. ... I think that Miss A does pose a risk of violence to others in the future, but only when mentally ill. I think the severity of this risk is relatively low and can be reduced further by appropriate treatment of her mental illness."*

5.45 Consultant psychiatrist 1 also wrote in this report:

"*During her time at the Acute Day Service, Miss A's attendance was rather irregular and a number of staff found Miss A rather difficult to deal with. This appeared to be because of Miss A's irritability, impatience and what was seen as a rather demanding attitude. I thought this reflected Miss A's abnormal mental state at the time."*

5.46 Consultant psychiatrist 1 saw Miss A for the last time on 27 April and found her much better. She told him that for the last month she had felt entirely well; she had stopped taking lithium; she had not needed sleeping tablets. Consultant psychiatrist 1 noted the court had been *"very sympathetic"* about the alleged assault. He felt Miss A was in remission and ready for a phased return to work. It was nine days later that Miss A murdered her grandmother.

5.47 Consultant psychiatrist 1 confirmed to us that he believed Miss A's symptoms were to be explained in terms of her mental illness. He explained that his opinion was based on evidence from Miss A herself, from her ex-partner and from the letter from her mother.

He told us that their evidence indicated that, until her pregnancy, Miss A had been a very different kind of person. They said she had been placid, even-tempered and not at all irritable or violent as she had been after the birth of her child, at least intermittently. Consultant psychiatrist 1 felt *"as a result of treatment her mood was very much more settled and stable and she was no longer irritable and violent and that view was confirmed by the letter her mother wrote"*.

5.48 Consultant psychiatrist 1 told us that at various points he was less than convinced that Miss A had type 2 bipolar disorder as opposed to major depression, but later on he thought it probable she did have type 2 bipolar disorder. He told us:

> *"I don't think that I thought that she had ever been manic. I thought it was reasonable or probable, or perhaps even was confident that she had relatively mild periods and relatively short periods of hypomania. In other words, elevated mood which was abnormal for her, but which did not cause significant impairment of functioning ... perhaps such patients may respond rather better to mood stabilising medication or to antidepressants if they are combined with mood stabilising medication. At no point did I think that Miss A had a period of mania sufficient to cause significant impairment of functioning. At various points I was in doubt even that the periods of hypomania really were there."*

5.49 Consultant psychiatrist 1 told us later that when he saw Miss A on 3 April 2007 to prepare a court report, he was confident that an appropriate diagnosis was bipolar 2 disorder with periods of recurrent major depression and evidence of relatively mild and brief periods of elevated mood.

5.50 We asked consultant psychiatrist 1 about the influence of Miss A's complex psycho-social situation on his view of her illness. He said:

> *"I don't take the view with Miss A or any other patients that illness means that psycho- social issues are unimportant or should not be addressed, or may not precipitate or worsen the illness and that illness may not cause or worsen psycho-social problems. ... I don't think I lost sight of the presence of those other problems and the impact they may have on her."*

5.51 Consultant psychiatrist 1 said in a follow-up letter to his interview: "*I think I would accept that more may have been recorded about the reasoning for the view taken and treatment offered.*"

5.52 Consultant psychiatrist 1 told us he was very surprised to hear Miss A had been arrested and charged with murder. We asked him if he felt Miss A was ill when she killed her grandmother. He said he did not. We commented that it appeared therefore that Miss A was capable of violence without being ill. Consultant psychiatrist 1 said: "*So it seems, yes. That wasn't what I thought at the time.*" He told us later that he believed the crime was carefully planned and potentially committed at a time when she was 'well'.

5.53 When we met Miss A on 30 March 2011 she told us she felt she should not have been discharged from the day hospital and she felt not enough was done to follow her up. She said she had stopped taking lithium and her other medications about a month before the offence. She felt she did not need them as she was feeling a bit better. She told us that when she last saw consultant psychiatrist 1 she was not feeling very good. Her employers were trying to retire her on ill health grounds but she wanted to get back to work. She said: "*So I made out I was better than I was. I wanted him to write to work to say I was better.*"

5.54 We asked consultant psychiatrist 1 what he made of this assertion in retrospect. He agreed he mostly finds out about somebody's mental state by asking them but he also picks up clues from their appearance and behaviour. He did not consider at the time that Miss A might have been saying something with a particular aim in mind. He felt on balance it was more likely Miss A was well at the time but she has other reasons now for saying that she wasn't. He was not surprised to find her a lot better at her last appointment. He said "*I was encouraged and hoped that the treatment had something to do with it. I don't really know.*"

5.55 The trust's medical director (who is also the trust's lead on risk management) told us that, with the benefit of hindsight, "*there are certainly elements of this case which make me think of emotional instability*". He said:

> *"We have very significantly developed our personality disorder clinical network since that time. I think the assessment skills of our personality disorder clinical network and their ability to engage with people with emotional instability has significantly improved. Therefore considering whether somebody has personality difficulties is now a much more positive thought. I think there probably have been*

significant developments in the past four or five years, which would influence the way in which people consider that diagnosis. I don't see anything in this which means that I think the diagnosis was wrong. There does appear to be a level of social and sort of personality instability that would make me wonder about that either as primary diagnosis or as an additional diagnosis, probably as an additional diagnosis."

5.56 The trust's medical director told us later that he did not feel a referral to the personality disorder clinical network was indicated in this case as the full criteria for emotionally unstable personality disorder were not met.

5.57 Consultant psychiatrist 1 told us later that he did consider and discuss with the rest of the team the potential that Miss A was suffering with a borderline personality disorder or emotional unstable personality disorder. However his differential diagnosis included major depressive disorder in view of the various symptoms reported by Miss A and by her GP. He told us he accepts that features of emotionally unstable personality disorder were present but that, having considered all aspects of Miss A's presentation, this was not his preferred diagnosis.

5.58 Type 2 bipolar disorder is included in the American Diagnostic and Statistical Manual (DSM-IV) but it is not included as a separate diagnosis in the International Classification of Diseases (ICD-10). The main difference between the two types in DSM-IV is that evidence of major depression or of manic episodes is not needed for type 2 bipolar disorder. Mild to moderate episodes of depression, along with episodes of elevated mood are sufficient. Guidance from the National Institute for Health and Clinical Excellence (NICE) on bipolar disorder covers the diagnosis and management of type 2 bipolar disorder.

Findings

5.59 The urgent referral from Miss A's GP on 29 August 2006 was picked up immediately and Miss A was assessed by an SHO the same day. She then had a full assessment two days later by a staff grade doctor within the community team who referred her to the day unit. Miss A first attended the day unit two days after that assessment.

5.60 Even before consultant psychiatrist 1 had seen Miss A for the first time, medical and nursing staff had indentified a host of personal and social issues that were clearly affecting Miss A and her mental state. At the conclusion of consultant psychiatrist 1's first

contact with Miss A as part of a MDT meeting, he identified the main issues as: separation from ex-partner, coping with disabled child and suspension from work. She also had a mood problem.

5.61 Consultant psychiatrist 1 sometimes doubted that Miss A had periods of hypomania but he was confident that she suffered episodes of depression and that is the condition in which he always found her when he saw her, except for the last contact on 27 April 2007 when he found her well. He believed at the time that Miss A was only likely to be violent when she was mentally ill.

5.62 Despite his doubts about the periods of hypomania, consultant psychiatrist 1 was confident when he wrote his court report that Miss A had bipolar 2 disorder. He said in the report that he believed Miss A's actions were influenced by symptoms of the elevated phase of type 2 bipolar disorder.

5.63 Nursing staff at the day unit also felt that Miss A was depressed, despite sometimes being in a more cheerful mood, and attributed her reported aggression to low mood.

5.64 There was evidence of Miss A's emotional instability and denial of responsibility for her violent behaviour, although she expressed remorse to consultant psychiatrist 1 about the assault on her ex-partner's girlfriend. She herself attributed her low mood later on to the imminent court case and her employment situation.

5.65 Consultant psychiatrist 1 told us he discussed with the MDT the possibility of borderline personality disorder or emotional unstable personality disorder. He accepts that features of emotionally unstable personality disorder were present but this was not his preferred diagnosis. There was no record of these discussions.

5.66 Miss A's attendance at the day unit and her contact with her care coordinator was sporadic despite the efforts of all staff to engage her. This reflected the pattern of her earlier contacts with mental health services.

Comment

5.67 ***The trust's response to the urgent referral from Miss A's GP was commendable as was the thoroughness of the staff grade doctor's assessment of 31 August 2006. The rapid admission to the day unit was also excellent practice.***

5.68 *We understand how consultant psychiatrist 1 came to the view that Miss A suffered from periods of depression with some episodes of hypomania and that she was only likely to be violent when she was mentally ill. Miss A was also angry and frustrated that her ex-partner had ended the relationship and found another girlfriend; she remained suspended from work and was experiencing financial difficulties and there was the court case in the latter part of her involvement with the services. These aspects taken together could also explain irritability, low mood, tearfulness, anger and so on. Indeed CC2 noted that Miss A attributed her low mood to the imminent court case and employment issues. In fact the improvement consultant psychiatrist 1 observed in April coincided with the resolution of her court case and her strong desire to return to work. By this time Miss A had also begun to come to terms with the break up of her relationship.*

5.69 *There was other information that might have shed some doubt on the view that Miss A was consistently clinically depressed throughout her stay at the day unit, which lasted almost three months. Clinical depression can, in some cases, bring with it guilt. Although Miss A expressed remorse to consultant psychiatrist 1 about the assault on her ex-partner's girlfriend, when he was preparing the court report, she expressed the opposite to CC2 - that she did not feel responsible. There was little to suggest that Miss A felt any guilt about having assaulted her ex-partner at work or on many other occasions in the past.*

5.70 *Depression also brings with it dented self-confidence and a sense of helplessness. While it was sometimes noted that Miss A felt helpless and her confidence was low, she reported that this improved as she started to come to terms with the separation from her ex-partner. Miss A appeared quite confident in her insistence that she did not need any help with the care of her child and in engaging selectively in the treatment offered.*

5.71 *Miss A's GP said she had long standing recurrent depression for which she had been admitted in 1992, with flare ups ever since. We recognise that the GP treated her for recurrent depression, and Miss A claimed later to have suffered from post natal depression, but the specialist mental health team who saw her in 1997 did not find that she was depressed. Consultant psychiatrist 1 was unable to obtain any records of an admission in 1992.*

5.72 *Miss A sometimes claimed that child care issues were a key reason for her patchy attendance at the day unit. It appeared that Miss A looked after her child most weekends and during half term. She sometimes collected her child from school in the afternoons before taking her child to her mother's house. Even so, these duties would not have prevented Miss A from attending the day unit in the morning and early afternoon each weekday.*

5.73 *Consultant psychiatrist 1 noted that staff found Miss A irritable, impatient and demanding, although he attributed this to her mental state. There may have been practical reasons why Miss A could not attend the day unit but the evidence suggests that Miss A never felt inclined to engage with therapy. In our view she engaged with services when it suited her purpose and otherwise did not.*

5.74 *We feel that it may have been in Miss A's own interests to see herself as ill. It could have been a way of influencing her ex-partner; of being away from the problematic situation at work (until that in itself became a problem and she suddenly said she felt much better); of dealing with the court case and of avoiding responsibility for her outbursts of anger.*

5.75 *We see as significant the frequency with which the nursing staff found Miss A to be bright and cheerful compared with her presentation in one-to-one and MDT meetings, despite the genuine concern expressed about her symptoms of depression.*

5.76 *The issue of whether Miss A had a personality disorder of the emotionally unstable type came up during discussions around this case, the idea being suggested during interviews with key players. Consultant psychiatrist 1 was clearly aware of many of the key features of Miss A's psycho-social situation; he drew up a clear and comprehensive list of the issues in Miss A's life that were likely to impact on her mental condition; he considered her diagnosis very carefully, and was encouraged by the improvements that she reported. Consultant psychiatrist 1 and other staff kept track of much of what was happening for Miss A.*

5.77 *We agree that the core features of personality disorder were not found – for example Miss A had formed a fairly long-lasting relationship with her ex-partner and she had previously had stable and continuous employment – but there were certainly features of emotional instability, even though they might not have amounted to a full*

diagnosis of emotionally unstable personality disorder. Miss A's relationship with her ex-partner lasted 13 years or so, but appeared to be unstable and fraught with danger. We wondered to what extent the endurance of the relationship was owed to Miss A's ex-partner. There were Miss A's overdoses and repeated threats of self-harm over the years and her great difficulty in accepting the end of her relationship. There was the information from Miss A's mother about her unstable and erratic behaviour. There was the reported early difficulty in bonding with her disabled child (although many otherwise mentally healthy mothers have difficulty bonding with a disabled child), and her resort to violence when she did not get her own way. There was also her unwillingness to take responsibility for her actions.

5.78 *This was a complex case and we would like to have seen more evidence that these features of emotional instability were considered carefully by the MDT. This might have influenced Miss A's care plan but we are making no link between the lack of evidence that these aspects were fully considered and the murder of her grandmother.*

5.79 *The drug treatment and monitoring of Miss A for the condition diagnosed (which veered between unipolar depression and type 2 bipolar disorder), including the prescribing of lithium, cannot be faulted. Given the diagnosis, the prescribing of lithium, antipsychotics and antidepressants was as would be expected, and adhered to NICE guidelines. However, we suggest that, had the idea of at least some features of the unstable personality type been adopted, the psycho-social features would perhaps have been seen in a different light and the need to engage Miss A in some form of psychological treatment might have been explored with more vigour.*

5.80 *Other therapies were regularly suggested by consultant psychiatrist 1 and his team but none materialised and we will consider this in more detail in the section below on care planning. Nursing staff clearly struggled even to engage Miss A in discussing the need for other therapies. It might have been more productive for consultant psychiatrist 1 to pursue these suggestions himself with Miss A, but we are far from convinced this would have made any difference to the outcome.*

Conclusion

5.81 Consultant psychiatrist 1 considered Miss A's diagnosis carefully and concluded that she was mentally ill and that her illness was the primary cause of her actions prior to the incident. The drug treatment and monitoring for the diagnosis cannot be faulted. We would like to have seen more evidence of a discussion within the team about the possibility that Miss A had features of emotional instability that might have influenced her care plan, but we are making no link with the crime she eventually committed. Miss A appeared determined not to engage fully with staff, despite their obvious concern and persistence. She chose not to avail herself of much of the support they could offer.

Recommendation

R1 The trust should demonstrate that consultation and advice is readily available to clinicians via its personality disorder clinical network for people with features of emotional instability which significantly influence the clinical picture. There should be no need for a formal referral in order to draw on the expertise within the organisation. Views, including uncertainty, should be discussed within the MDT and recorded in clinical notes.

6. Risk management

Evidence

6.1 Our examination of Miss A's case notes has identified three main areas of risk for Miss A – harm to others; self harm; and the vulnerability of her child. We will examine the first two in this section and the third in the section on safeguarding children.

6.2 At some point in 2007 the trust issued its *Effective care coordination policy and practice guidelines*. Section 14 of this document covered *Risk assessment and management for CPA*. It said:

> "*Assessing the risk a person poses … is a very difficult, uncertain and complex task. However it is an essential and important role for all mental health professionals. There are no research instruments, no scales and scores, that will enable anyone to say with complete accuracy that one service user is at risk and another is not. However, there is a considerable body of evidence that indicates which factors are associated with risk and how prediction of risk can be made on the basis of assessment information. In reality, all mental health professionals are involved in making these judgments of risk, based on assessment information, virtually every working day.*
>
> *"Even with the best risk assessment practice, suicides and violent incidents will still occur. What matters is that professionals use their knowledge to the best of their ability and are able to demonstrate that they have done so. It is important that a thorough risk assessment is undertaken and a clear reasoned judgment developed and documented which demonstrates that the best possible practice has been followed."*

6.3 The FACE risk profile has been in use at the trust since April 2002. The document entitled *Clinical risk management - FACE risk profile - Guidance for staff* dated April 2002 set out the technical process of completing the forms. This was updated in February 2007 to include details of training requirements. The updated document required all service users to have a FACE risk profile completed except in specialist areas where alternative assessments had been approved. It said that the MDT should contribute to the assessment

and management of risk. It also said that the need for training would be determined by the training needs analysis for each directorate.

6.4 We requested but did not receive guidance on the assessment of clinical risk (as opposed to the process of completing the forms) to cover the period of Miss A's admission to the day unit in September 2006 until new guidance was available in 2007. We understand that the trust has had problems with accessing archive paper copies of previous policy documents but current policies and procedures are now available via the trust's intranet.

6.5 In the trust's *Effective care coordination policy and practice guidelines* of 2007 the process of risk assessment was described in general terms and the arrangements were set out for patients in the community and in hospital. Although not specified, the arrangements for inpatients appeared to apply to day patients. For inpatients the primary nurse should take an active role in the completion of the risk profile soon after admission. For patients in the community the responsibility lay with the care coordinator *"who should be supported by the multi-disciplinary team. Service users on Enhanced CPA should usually be subject to at least a level 2 risk assessment in which the service user's history and current risks are recorded."* Level 2 risk assessments required all four pages to be completed. The guidelines confirmed that FACE was an integral part of the CPA and the risk profile should be reviewed at every CPA review; in response to changing symptoms and before discharge from hospital and community services (amongst other criteria). Paragraph 14.5.5 said: "*The risks to carers and children should be considered and documented throughout the process in the service user's notes*". We will return to the issue of Miss A's child in the section on safeguarding children below.

6.6 Instructions on the first page of the FACE forms give ratings from 0 to 4.

> "*1 = Low apparent risk. No current indication of risk but history and/or warning signs indicate possible risk … no special risk prevention measures or plan required. 2 = Significant risk. History and condition indicate the presence of risk and this is considered to be a significant issue at present. Requires a contingency risk management plan."*

6.7 The trust's medical director told us that around the time of Miss A's treatment the trust started team-based clinical risk training with a focus on the FACE risk tool and all

clinical teams within adult mental health had received this training. Most staff found this beneficial for promoting learning between the professions.

6.8 The trust's current *Procedure for assessing and managing clinical risk* is based on the previous document of February 2007 with a new section on the principles of working with risk and additional advice on the value of information from carers, families and friends. The document is based on guidance from the Department of Health in 2007 and the work of Steve Morgan on risk in mental health settings.

6.9 We asked the trust's medical director about current practice in risk management. He told us about the electronic system for recording risk profiles which helps to ensure that identified risks are not lost over time. He said risk management had developed over the last four or five years and is now more in the front of clinicians' minds. Although it would have been an integral part of clinical assessment, it is now more objective. He told us the trust now has clear and well developed clinical risk management systems to ensure thorough and systematic risk management within teams.

6.10 The trust's medical director explained later that the keyworker has day to day responsibility for completing the FACE risk profile, following discussion within the MDT, and maintaining an overview of risk for people attending the day unit, under the supervision of the clinical team manager. The risk assessment is corroborated within the MDT and facilitated by the electronic system. The responsibility for the risk profile and the overview of risk transfers to the care coordinator on discharge.

6.11 He also explained that medical staff will intentionally focus on issues relating to symptoms of mental illness during a medical review and that issues relating to risk and safeguarding can often be addressed at review by a senior qualified member of nursing staff. There is a clear expectation that these issues are also discussed within the MDT.

6.12 We asked how he assures himself that staff are looking at risk in a satisfactory way. He told us that he and the director of care services jointly chair the trust incident review group which looks at serious untoward incidents. They look at how regularly and how thoroughly risk is assessed in cases where something has gone wrong. They also conduct random audits of risk assessments in order to satisfy themselves that the routine activity is conducted according to policy. The findings are disseminated through the individual

directorate clinical governance groups, with a clear indication that they expect them to be cascaded to individual clinical teams.

6.13 He also said that clinical team managers are expected to scrutinise everyday practice to ensure that risk profiling and management is embedded in clinical practice within individual teams, so that risk assessment is done routinely *"and we do take an extremely dim view of occasions on which we* [find] *that it has not been or that it has not been done right."*

6.14 The trust now has an electronic holistic assessment tool in use in acute community services and the crisis resolution team. It is designed to complement the FACE risk profile with a series of prompts in the risk section and specific prompts about children in the social section. There is a plan to adopt this approach across all teams by August 2012 to standardize the gathering of assessment information.

Risk of harm to others

Evidence

6.15 We have seen two completed FACE risk profiles for Miss A. The first was completed by SN1, Miss A's keyworker, on 12 September 2006, within two weeks of her admission to the day unit. At this stage Miss A had told staff she had received a caution for throwing a cup at her ex-partner some years previously (she was convicted of battery in 1998). The MDT was also aware that she had recently been suspended for hitting her ex-partner at work.

6.16 On the first risk profile SN1 noted significant risk (2) of suicide and deliberate self harm (DSH) and low risk (1) of harm to others. He did not note any persons potentially at risk or the existence of a dependent child on the first page. He noted as historical indicators of risk: DSH and conviction for violent offences. Current indicators of risk were: ideas of self harm/suicidal ideation; plans or preparations to commit suicide; and recent severe stress. However, in 'Main Risks Identified' on the third page he noted:

> "*Miss A has expressed that she finds the future hopeless and sees no positives in her life at present. Currently Miss A is the main carer for her disabled child and*

has expressed issues over coping with her home situation. Ex-partner and mother provide some respite. Miss A has reported that she has assaulted her ex-partner."

6.17 SN1 also noted on the risk profile:

- carer's view of risk: "*None known*"
- protective factors: attending day unit and some family/ex-partner input
- plan: risk reduction in regard to suicide and DSH; on-going support from day unit; given crisis numbers for contact out of hours.

6.18 No intention was expressed at this stage of contacting Miss A's mother for more information.

6.19 SN1 told us he could not recall having had any training in risk assessment and management at the time. He confirmed that he had identified the key risks for Miss A as suicide and self harm. He felt that any risk of harm to others was focused around Miss A's ex-partner within the context of the breakdown of the relationship. He said:

"The relationship between her partner and her was fraught because of many different issues. There was the childcare involved, but also she felt she had been pushed aside for her ex-partner's new partner. She felt worthless and things like that. Even though we had been told about the assault at the Post Office as well, I don't think we ever had any details about how serious it was because the police were never involved. It was purely what she said, and because her ex-partner refused to come into the unit we never heard his side of it really other than there was some kind of altercation between them."

6.20 SN1 said that in retrospect he could have scored the risk of harm to others as 2 or even 3 but he said: "*We never had the impression that she was an imminent and serious risk to somebody else."*

6.21 The second FACE risk profile was completed by Miss A's care coordinator (CC2) on 29 January 2007. By this time the MDT was aware that, in addition to the two known incidents of aggression towards her ex-partner, Miss A had lashed out at her ex-partner on other occasions; had caused damage to his car and the door of his house and had been charged with an assault on his girlfriend.

6.22 On the second risk profile CC2 noted: low risk (1) of suicide, DSH and harm to others. She did not note the risk of relapse or the existence of a dependent child on the first page but she noted the person at risk as Miss A's ex-partner. She noted as historical indicators of risk: ideas of self harm/suicidal ideation, physical harm to others, threats, DSH, damage to property, poor compliance with medication, failure to attend appointments, charged with violent offence, recent severe stress, and recurrence of circumstances associated with risk. She noted as current indicators of risk: discontinuation of medication, failure to attend appointments, recent severe stress/life events, lack of meaningful occupation, recurrence of circumstances associated with risk, and social isolation. However, in 'Main Risks Identified' on the third page she noted:

> *"Believes she is not responsible for recent attack on ex-partner's girlfriend – "loses it and doesn't know what she is doing". ... Also suspended from work for attacking ex-partner (currently on sick leave). Disabled child (10) stays once or twice a week – spends most of the time with Miss A's mum. Extremely worried about work and court case."*

6.23 CC2 also noted on the risk profile:

- carer's view of risk: "*Not known*"
- protective factors: feels isolated – can talk to mum and friend & now accepting input from CMHT
- action: engagement/support from CMHT, particularly until court case and decision about work.

6.24 In addition to these formal risk assessments and the entries about Miss A's assaults on her ex-partner and his girlfriend, there were several other references in Miss A's case notes to her volatility. For example on 4 October 2006 consultant psychiatrist 1 noted:

> *"Frustration has caused her to lash out & become 'more and more manic"*

6.25 On 11 October CC1 noted:

> "*keep lashing out and hitting him ... can't get on with my life for fear I'm to blame for losing control and going for him."*

6.26 Miss A herself wrote about her relationship with her ex-partner and his mother. This undated document was filed with the care plan of 12 September 2006. She wrote:

> "*Things became worse and worse and I started to become more and more paranoid and started hitting* [him] *and doing daft things which I had no control over.*"

6.27 When consultant psychiatrist 1 wrote his court report following the assault on the girlfriend of Miss A's ex-partner, he was also aware that the incident when Miss A said she threw a cup at her ex-partner's head had resulted in a conviction for battery in 1998.

6.28 We learned from an extract of the court proceedings of 2008 that Miss A received a police caution for stabbing her ex-partner in 2005. There is no reference to this in Miss A's case notes and consultant psychiatrist 1 told us he was not aware of this incident. He said there were cases where he would approach the police for information about a patient's forensic history but he did not consider making such an approach in this case.

6.29 We asked consultant psychiatrist 1 about the significance of the FACE risk profiles for him at the time. He said:

> *"They probably didn't play a greatly significant role. My input to those assessments will have been, or at least should have been, that the information which I had gathered together with others about Miss A and the risks that were covered, would inform the FACE risk assessments during her time at the acute day hospital and on discharge. That is all."*

6.30 We asked consultant psychiatrist 1 if he would have seen them when they were written, or been consulted about them. He said:

> *"Probably not, though it was very clear that at the point of discharge from the day hospital, we all know the FACE risk assessments should be completed ... Generally these days I will always see the FACE risk assessment when someone is admitted. In those days I didn't."*

6.31 Consultant psychiatrist 1 confirmed to us later that he now uses the FACE risk assessment in all cases to ensure he is aware of risk factors.

6.32 We asked SN1 about his view of the FACE risk profile process. He told us that the risk profile documentation has always been a nursing process and still is, unless it has been completed by a doctor as part of a referral into the day unit. SN1 was clear that the consultant contributes to the risk assessment via the MDT process. He felt that the process had become more robust over the last couple of years.

Findings

6.33 There was no indication that Miss A posed an extreme risk of violence to others and little evidence that her violence and aggression was directed at anyone other than her ex-partner and his girlfriend.

6.34 The scoring of the risk of harm to others at each assessment was 1 out of a maximum of 4 points.

6.35 At the time of the first risk assessment it was known that Miss A had assaulted her ex-partner at least twice, resulting in formal action. By the time of the second assessment it was also known that she had lashed out at her ex-partner on other occasions; that she had caused damage to his car and the door of his house and that she had been charged with assaulting his girlfriend.

6.36 Consultant psychiatrist 1 was not aware that Miss A had previously received a police caution for stabbing her ex-partner or that she said she did not feel responsible for the attack on her ex-partner's girlfriend.

6.37 Consultant psychiatrist 1 did not pursue the history of violence towards Miss A's mother (raised in her mother's letter in February 2007) either with Miss A herself or with her mother.

6.38 Consultant psychiatrist 1 did not seek a history of violence and aggression from the police or from anyone else. The only information that anyone had about this came from Miss A herself.

Comment

6.39 ***We have found no evidence that Miss A's killing of her grandmother could have been foreseen. The care and management of Miss A cannot, therefore, be faulted in any way because of a failure to anticipate this act.***

6.40 ***However, the act raises the question of what violence Miss A was capable of and to what extent the available information was used to obtain a picture of the risk posed to others by Miss A. We have, therefore, considered the overall standard of risk assessment in this case.***

6.41 ***Even without the knowledge of the previous stabbing, there was evidence from Miss A herself that she was capable of violent behaviour. We feel that this evidence taken together could have pointed to Miss A as posing more risk to others – significant others, like her ex-partner, rather than to the public at large – than she was deemed to have been by both consultant psychiatrist 1 and the team.***

6.42 ***It would have been useful to obtain more information about Miss A's history of violence and aggression from a source other than Miss A herself.***

Risk of suicide and self harm

Evidence

6.43 We requested but did not receive any specific guidance from the trust on the clinical management of people who self harm, once such a risk has been identified. We do not know whether there were any written guidelines in place at the time of Miss A's care and treatment. We asked the trust's medical director if he could recall what advice or guidelines would have been available at the time on the risk of self harm. He did not think there was a separate document beyond those we had been given.

6.44 The FACE risk profiles identified the risk of suicide and self harm for Miss A. The first FACE assessment identified the risk as significant and this had reduced to low on the second assessment.

6.45 These risks were frequently recorded and considered in the case notes by medical and nursing staff. Staff were aware of Miss A's serious overdose in 1997 and the doctor who assessed her before her admission to the day unit described her history of self harm and her recent purchase of several boxes of paracetamol.

6.46 Just over a week after her first visit to the day unit Miss A told her GP and the staff at the day unit that she had taken six sertraline tablets. She said it was not an attempt at suicide, she thought it would make her feel better. A few days later she was reporting suicidal ideas but felt able to resist them. Further evidence of the awareness of Miss A's risk of self harm is included in the extracts quoted in the evidence for the risk of harm to others above.

6.47 On most of the occasions that consultant psychiatrist 1 saw Miss A at the day unit he recorded that she had suicidal ideas that she was able to resist, although this concern had reduced significantly by the time she was discharged. It was regularly noted by various staff that Miss A said she resisted these ideas because of thoughts of her mother and her child.

6.48 We asked SN1 about his recollection of Miss A's risk of self harm. He said that when Miss A was attending more frequently in the first few weeks, the focus of her care was on the risk of self harm with her low mood, tearfulness, some suicidal ideation, and hopelessness. He said these issues were addressed with general talking therapy and medication and appeared to resolve during her stay.

Findings

6.49 Miss A's GP identified a serious risk of self harm and made an urgent referral to the trust.

6.50 The referral was picked up immediately and a decision was made to admit Miss A to the day unit which was open seven days a week.

6.51 There was no trust guidance in place at the time on the clinical management of people who self harm but consultant psychiatrist 1 and the team were fully aware of the risk of Miss A harming herself and took it seriously. Medical staff always recorded their

views on her mental state and nursing staff recorded their observations and their frequent attempts to contact Miss A when she was not in the day unit.

6.52 Miss A was treated with antidepressant medication and encouraged to attend the day unit, particularly while the medication was taking effect.

Comment

6.53 ***Miss A's GP was clearly concerned about the risk of suicide when he made an urgent referral at the end of August 2006. The referral was acted on immediately and appropriately. The risk was promptly identified and strategies were put in place to address the risk.***

6.54 ***Staff at the day unit focused on this risk and demonstrated their concern by their diligence in making contact with Miss A when she did not attend as expected. SN1 drew up a clear and detailed care plan to engage her and to provide opportunities both to express her feelings and to distract her with purposeful activity.***

6.55 ***In the absence of any trust guidance on the management of self harm, staff were dependent on their own and each other's expertise in dealing with the risk of self harm on a day-to-day basis. They managed this well in Miss A's case and gave her every opportunity to talk about her feelings and concerns.***

6.56 ***We were impressed by all aspects of this issue – the speed of the response and admission to the day unit, the fact that the day unit was available for Miss A, the clear documentation and the compassionate attitude of the staff who spoke to us.***

Recommendation

R2 The trust should ensure advice on the clinical management of self harm, based on national guidance, is available to each team within the trust and that this is reflected in its policy documents.

Involvement of carers and relatives in risk assessment

Evidence

6.57 We have seen no trust guidance on risk management that would have applied before 2007.

6.58 The FACE risk profile forms in use at the time included a section for the carer's view of risk. This section said:

> "*Give details, including carer's view of what is needed to reduce risk. Are the service user's carer(s)/family aware of possible risks?*"

6.59 Further guidance was given in the trust's *Effective care coordination policy and practice guidelines* of 2007 in section 14 on risk assessment. Paragraph 14.10.3 said:

> "*The views of the service user, the carer and involved professionals should also be considered.*"

6.60 Paragraph 14.11.2 said:

> "*The carer should also be involved in drawing up the risk profile, as long as the service user has no objection. Carers must be consulted or informed about aspects of the management plan that are concerned with their safety.*"

6.61 The trust's medical director told us that carer support was firmly established in that area at the time. It would have been routine practice in care programme meetings to establish what the caring relationships were and to establish whether the identified carer required any additional support.

6.62 The trust's current *Procedure for assessing and managing clinical risk*, issued in March 2009, says in paragraph 5.3.2 j:

> *"The views of carers/families and friends, where these are available may be crucial in highlighting risk issues either from the past or present. Carers are often very skilled in noticing early warning signs or triggers and chains of events leading*

to relapse. They may also provide information about successful risk management and recovery plans. These may not be presented in a 'professional format' and carers/families and friends will have their own support needs."

6.63 Two aspects are important in this case. First, no carer was ever formally identified for Miss A, and secondly attempts to involve Miss A's mother in her care were unsuccessful. The authors of both FACE risk profiles noted that the carer's or family's views were not known.

6.64 The registration form completed in September 2006, when Miss A was first admitted to the day unit, gave her mother as next of kin and the question "*notify next of kin?*" was answered *"yes"*. The section about a carer was left blank. We saw no evidence that Miss A did not want her mother to be involved with her treatment until CC2 noted on the CPA plan of January 2007 that Miss A did not want her mother to be contacted.

6.65 When consultant psychiatrist 1 saw Miss A at her MDT review on 13 September he noted in his plan: "*Information from informant* [ex-partner]". It was also noted on the MDT form: "*Ex-partner to attend next week*". Miss A's ex-partner did attend the next MDT review meeting with Miss A on 20 September when they were seen by the SpR. The record focused on Miss A's symptoms of elevated mood and obsessional and compulsive behaviours. There was no note of any discussion about self harm, violent and aggressive behaviour or the care of Miss A's child.

6.66 Consultant psychiatrist 1 then noted in his plan at the MDT review on 4 October that Miss A's ex-partner would like to discuss their problems with him. He wrote: "[Ex-partner] *to be offered appointment in ward round. Mother to be asked to attend a subsequent ward round"*. This was the occasion when Miss A had asked to see consultant psychiatrist 1 on her own. The nurse who completed the MDT form afterwards (presumably based on feedback from consultant psychiatrist 1) did not record these requests.

6.67 Consultant psychiatrist 1 next saw Miss A on 17 October and noted in relation to his uncertainty about Miss A's diagnosis that he would like "*informant history and old notes*". This time a staff nurse recorded that consultant psychiatrist 1 "*would like Miss A to invite her mum to see consultant psychiatrist 1 in MDT review in 2 weeks time, as he is on holiday next week. Consultant psychiatrist 1 would like to talk to Miss A's Mum about …*" but the record stopped there. We do not know if there was a page missing from the notes

or if the nurse was distracted when turning the page. We have seen no further record of consultant psychiatrist 1's intention to see Miss A's mother or ex-partner while she was at the day unit and no record that this ever happened.

6.68 SN1 noted on 11 October that Miss A's ex-partner was not attending the MDT review, but there was no other information on this attempt to see him.

6.69 SN1 told us Miss A's ex-partner had been invited to come to some of the meetings because they wanted to know more about Miss A's ongoing mood problem. He did not recall what had happened about inviting Miss A's mother. He told us he knew consultant psychiatrist 1 wanted them involved because of "*this potential history of ten years*" and they needed information beyond that provided by Miss A. SN1 recalled that Miss A's ex-partner refused to come in at one point, possibly just after she had damaged his car.

6.70 SN1 told us Miss A initially reported that she did not start the incident when she assaulted her ex-partner's girlfriend and it did not become clear until towards the end of her time at the day unit that the police were taking action against her.

6.71 We asked SN1 if he thought it was necessary to contact Miss A's mother. He did not think it was vital, but it would have been useful for diagnosis, by providing a view of Miss A's mental health over a longer period of time.

6.72 We asked SN1 if anyone regarded Miss A's mother as her carer. He did not think so as they felt Miss A's mother was more her grandchild's carer. She was spending more time with Miss A's child rather than with Miss A herself.

6.73 When Miss A was discharged from the day unit on 22 November there was no mention of Miss A's mother or of a carer in any of the documentation. The idea of contact with Miss A's mother was not recorded again until CC2 completed her CPA care plan on 29 January 2007. CC2 noted that Miss A did not identify a carer and did not want her mother to be contacted. However, by 14 February CC2 noted that the plan was to see Miss A with her mother at the next session. This never happened as Miss A and her mother did not attend the appointment booked for 6 March at the Resource Centre and CC2 did not see Miss A again despite several attempts.

6.74 As we have not had the opportunity to meet CC2, we could not ask her what she recalled about Miss A's reluctance to involve her mother or why CC2 wanted to meet her.

6.75 In the meantime consultant psychiatrist 1 had invited Miss A's mother to attend an outpatient appointment with Miss A. It appears she was to come to the appointment on 19 February that Miss A did not attend because she was "*stuck in traffic*". Miss A's mother wrote to consultant psychiatrist 1 on 22 February. In this letter she referred to herself as "*Miss A's mum and main carer*" and gave information about Miss A's history of mental health problems, her instability, her unstable and erratic behaviour and her previous violence towards her mother. She said she would like to talk to consultant psychiatrist 1 before he finalised his report. He did not contact her or respond to her letter. Consultant psychiatrist 1 told us: "*I did wonder in retrospect how much a letter might be relied upon.*"

6.76 Consultant psychiatrist 1 told us he accepts that he should have responded to the letter but remains unsure that a further invitation would have resulted in a meeting.

6.77 We asked consultant psychiatrist 1 what he wanted to explore with Miss A's mother. He said:

> "*... whether Miss A was her usual self at the moment, if not how long she had not been her usual self for, in what way she was not her usual self, what she was like when she was her usual self and then ... to ask rather more about Miss A's mood over the years ... the outward appearance, the depressed mood and the severity of that and how long it had been there and ... any abnormal periods of elevated mood and how long they seemed to last. Very often, when seeing patients who report mood problems, one of the things that can be very useful to ask relatives is about their alcohol and drug-taking habits and that is something I would expect to have done with Miss A's mother. Of course Miss A had been asked herself about that ... although those questions were asked and some blood test results are available ... they are hidden because of the photocopy. Later on when I was seeing the court report - it was clear that there were times when she drank heavily and in retrospect I think that alcohol may have been a rather bigger issue than I believed at the time.*"

6.78 There appeared to be a retrospective impression that Miss A did not want her mother to be involved in her care, but, as outlined above, the records show that Miss A

gave her consent to contact when she was first admitted to the day unit and only withdrew it briefly in January 2007. Consultant psychiatrist 1 told us he made a number of attempts to speak to Miss A's mother and her ex-partner. He accepts that these attempts should have been more carefully documented in the records.

6.79 When we met with Miss A's mother she told us she regarded herself as Miss A's carer but she would not have been keen to meet the day unit staff. She had not been aware of Miss A having any problems with alcohol. We asked if she felt anything could have been done differently. She did not think so and was glad Miss A's medication was sorted out in the end. Miss A was desperate to get back to work. Miss A's mother heard nothing back from consultant psychiatrist 1 after she wrote to him.

6.80 CC1 told us that, if he had continued in the role of care coordinator for Miss A, he would have tried to persuade Miss A that it would be good to be in touch with her mother in order to see if she needed any support, in view of the heavy burden of care that her mother was carrying with her own mother who had Alzheimer's disease and her disabled grandchild. He said:

> *"Looking at the notes now, I am just thinking about the stress levels of the carer and so we might begin to think ... 'It would be really useful if we could get support in for the carer. Let's look at that and that will have a positive knock-on effect for not only Miss A but her child and other people' and from that might come other things; other supports might be put into place as well."*

6.81 We pointed out that Miss A's mother was not identified as her carer. CC1 said:

> *"But she was in a caring role ...so the caring role may be much wider than just Miss A and some psycho-education might be really useful, and understanding what effect a service user has on the carers or those they live with can be really useful. It can make the difference between moving forward and not and the emotional impact in the home and things like that.*
>
> *"Nowadays, would we have done anything different? I would have been tempted to say to Miss A nowadays ... 'I really do think your Mum should be in contact with carer services just for her own health needs'. Usually people would acknowledge that and accept that advice and allow me to contact them and send them some information."*

Findings

6.82 There was clear evidence in the case notes that Miss A's mother was a key figure in her life and played a significant role in the care of her disabled child.

6.83 There was no evidence in the case notes that the team discussed whether Miss A's mother was or was not her carer; whether Miss A's mother might have needed any support or what Miss A's attitude to her mother's involvement might have been, apart from one note on the CPA care plan in January 2007 that Miss A did not want her mother to be contacted. Prior to this note there was no evidence that Miss A objected to her mother being involved and she gave consent to contact when she was admitted to the day unit.

6.84 The authors of both FACE risk profiles noted that the carer's or family's views were not known, but included no comment about seeking their views.

6.85 Miss A was relatively independent and did not identify her mother as her carer but CC1 felt in retrospect that her mother should have been regarded as a carer because of her caring role in the whole family.

6.86 Miss A's ex-partner attended an MDT review with the SpR. He described her fluctuating mental state but there was no record that he was asked about her violence towards him or about the care of their child. We were told that, at one point after the assault on his girlfriend, Miss A's ex-partner did not want to be involved with the service.

6.87 Miss A reported two weeks later that her ex-partner wanted to meet consultant psychiatrist 1 to discuss their problems but no further meeting took place.

6.88 Consultant psychiatrist 1 intended to meet Miss A's mother and ex-partner but this did not happen. He said he made several attempts to meet them that were not documented.

6.89 It was not clear from the case notes why consultant psychiatrist 1 wanted to meet Miss A's mother and ex-partner but he told us in retrospect that he would have asked about Miss A's mental health history and drug and alcohol use.

6.90 CC2 also intended to meet Miss A's mother but this did not happen and we have not had the chance to ask her why she wanted to meet her.

6.91 There was no evidence of any intention to seek information from Miss A's mother and ex-partner about Miss A's history of violence and aggression or about the well being of her child.

6.92 Miss A's mother was never seen by any members of the team but she wrote a letter to consultant psychiatrist 1 requesting a meeting to which she received no reply.

6.93 Trust guidelines now emphasise the benefit of involving families and friends as well as carers.

Comment

6.94 ***Consultant psychiatrist 1 never saw Miss A's ex-partner or her mother and they may not have been keen to be involved but Miss A did not object to their involvement while she was attending the day unit and a meeting with her mother was planned in February 2007. We feel an opportunity should have been created to ask Miss A's ex-partner about their volatile relationship and about the care of their child – even if this meant meeting him without Miss A being present. This could have been attempted, as Miss A told consultant psychiatrist 1 that her ex-partner wanted to meet him to discuss their troubled relationship.***

6.95 ***If the term 'carer' did not carry such a specific definition, earlier efforts might have been made to persuade both Miss A and her mother of the value of her mother's engagement with the service in order to consider the needs of the family as a whole. Miss A appeared to be relatively independent as far as her own needs were concerned but her mother did, after all, regard herself as Miss A's carer. After Miss A's discharge from the day unit both consultant psychiatrist 1 and CC2 tried to meet Miss A's mother and nearly succeeded. CC2 had clearly managed to shift the ground from Miss A saying in January 2007 that she did not want her mother involved to being able to arrange a meeting, but we do not know if Miss A and her mother ever intended this to happen.***

6.96 ***The letter from Miss A's mother did not shed much light on the critical issues. She said she believed Miss A had been 'abused' by her ex-partner and made no comment on Miss A's own propensity for violence, apart from her reference to Miss A's violence towards her mother which she said had not occurred for a few years.***

However, Miss A's mother made it clear she was providing consultant psychiatrist 1 with information for the report he was writing for Miss A's employers and Miss A was keen to retain her job.

6.97 ***Consultant psychiatrist 1 accepts it would have been helpful to obtain information about Miss A's history of violence and aggression from a source other than Miss A herself. However, we recognise that a further invitation to Miss A's mother may not have resulted in a meeting.***

6.98 ***We were pleased that the trust's current guidance on risk management emphasises the potential benefit of seeking the views of carers, families and friends on past and present risk factors.***

Overall approach to risk management

Findings

6.99 Both FACE risk profiles observed some of the key principles and were undertaken at an appropriate time by an appropriate person. Despite being incomplete in places, both correctly identified the key sources of stress for Miss A at the time.

6.100 Both risk profiles identified the risk of harm to others as low. Neither clearly identified any potential risk to Miss A's child, although the disability was mentioned.

6.101 No risk profile was undertaken when Miss A was discharged from the day unit.

6.102 Risk profiling was seen by both consultant psychiatrist 1 and the nursing staff as primarily a nursing process. Consultant psychiatrist 1 expected the information he and others had gathered to inform the risk assessment but he did not expect to be consulted about the risk profile or to check what was written. There was no evidence of multidisciplinary discussion about risk.

6.103 The trust expected the keyworker and care coordinator, as senior qualified nursing staff, to take the lead role in recording the risk profile following a multidisciplinary discussion.

6.104 Information to inform the risk assessment was obtained solely from Miss A herself and not from any other source. Staff did not enquire separately about Miss A's history of violence and aggression or about the care of her child.

6.105 The trust now has more robust systems and much higher expectations of risk profiling and management within clinical teams based on national guidance. There is a process for checking that risk management is undertaken to a satisfactory standard.

Comment

6.106 ***The trust expected the keyworker and the care coordinator to take the lead in completing the risk profile and maintaining an overview of risk but we saw and heard no evidence of any discussion about risk within the MDT. Each party may have fulfilled their basic obligations but there was no documented discussion between them about any concerns they may have had or indeed the rationale for the absence of any concern. Risk management should involve the gathering and assimilation of information from individual members of the MDT into a coherent joint overview which is endorsed by the most senior and experienced members of the team.***

6.107 ***We were encouraged to hear about the improved systems for risk management, the current expectation that risk assessment and management is embedded in clinical practice within each team and that random audits are carried out of FACE risk profiles. We were also encouraged to hear about the trust's holistic assessment template which is to be rolled out to all teams by August 2012.***

Conclusion

6.108 Risk management did not appear to be a genuinely cooperative activity within the teams caring for Miss A and staff did not create opportunities to obtain further information about Miss A's situation, history and behaviours. Nevertheless, the risk that Miss A posed to herself was carefully assessed and thoroughly taken into account in her care and treatment. She did not come across as a violent person, despite the aggression she described towards her ex-partner and his girlfriend. Although staff could have explored the potential risk to these two people, there was no indication that Miss A posed a risk of violence to anyone else and we have concluded that the murder of Miss A's grandmother could not have been predicted.

7. Care planning and the Care Programme Approach

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

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

Evidence

7.2 The trust's document *Effective care coordination policy and practice guidelines* was dated 2007. In paragraph 1.5 it said: "*This policy guidance sets out the way that the Care Programme Approach and Care Management are being integrated to achieve a single care coordination system across Leeds. It outlines the changes to CPA since the publication of the CPA guidance manual in January 2000".* We have been unable to discover when this guidance was implemented within the trust and therefore do not know if it applied during any part of the period that Miss A was in contact with the trust. However, we have assumed for the sake of this investigation that similar expectations would have been in place at the relevant time.

7.3 This document set out the criteria and process of care coordination and in section 8 clarified the responsibilities for establishing the care plan in each setting including day care services. It said: "*It is the responsibility of the day hospital/centre team member to initiate, establish and coordinate the CPA care plan.*" For CMHTs the person who carried out the initial assessment should initiate the care plan and the care coordinator should be decided at a subsequent meeting.

7.4 This section also emphasised the need for a flexible approach to CPA reviews around the needs of the service user. Paragraphs 8.4.2 and 8.4.4 said:

> *"There are many factors which need to be considered when deciding where and when to hold a CPA meeting. These will include the needs and wishes of the service user, how formal the meeting should be, confidentiality and the time constraints on professionals including the needs of primary care staff and carers. It is important to adopt a flexible approach."*
>
> *For some mental health service users a multidisciplinary CPA meeting may not be required or be appropriate. In these circumstances contact between the care coordinator, the service user and, where appropriate, their carer and other professional staff may be all that is required to initiate CPA or undertake a review."*

7.5 Paragraph 9.1 said:

> *"An individual service user's care plan will be based on a thorough assessment of their health and social care needs, including risk factors identified through the risk assessment process, which will have been carried out ensuring that the service user and where appropriate the carer(s) are central to the process."*

7.6 The trust's medical director explained that the care coordinator would normally be identified from within the CMHT and would share responsibility for care coordination with the keyworker during day treatment, under the guidance and supervision of the consultant psychiatrist. He said this meant the keyworker had day to day responsibility for the care plan in the day unit. The care coordinator would normally be involved in discharge planning but this might sometimes be done by another member of staff on their behalf.

7.7 He also explained that different professions within the MDT take on different roles with medical staff focusing on medical issues and nursing staff focusing on psychological and social issues. He said this demonstrates good MDT practice and there is an expectation that these aspects are integrated by the care coordinator. At the time of Miss A's contact with the trust, nursing and medical notes were recorded in separate sections of the case notes. There is now one multidisciplinary clinical record used by nursing and medical staff.

7.8 We asked him about the overall responsibility for the service user and whether this was held by the consultant psychiatrist. He said the consultant psychiatrist provides clinical leadership for the MDT and works in partnership with the clinical team manager to provide a clinical and managerial partnership. The care coordinator is responsible for coordinating the day to day management of individual service users on their caseload. He explained that care coordinators are senior and experienced clinicians with a degree of autonomy who would consult and involve the consultant psychiatrist. They are expected to work in collaboration, with the CPA review providing the opportunity to check on progress and influence the care plan. He confirmed that senior responsibility for people in the community rests with the care coordinator, with input from the consultant psychiatrist.

7.9 On Miss A's first day at the day unit on 2 September 2006 SN1, who was her keyworker, undertook a holistic assessment and an initial assessment summary. He started but did not complete a FACE risk profile.

7.10 The following day Miss A did not attend the day unit as expected but SN1 drew up a care plan for her (Care plan No.1). This covered Miss A's need for support, activity and distraction from negative thoughts; engagement to assess her mood and mental state; contact with Miss A each shift to identify a person to provide support; offering group work and activity to aid in distraction and provide a framework at the day unit. Miss A was expected to attend each afternoon for seven days a week. She had her own transport.

7.11 Miss A did not attend her MDT review on 6 September 2006 but she was seen by a doctor the following day and again on 11 September after she reported taking six sertraline tablets the previous evening. She also had one-to-one time with SN1.

7.12 The following day SN1 undertook a FACE risk profile (see paragraph 6.16 for details). He also drew up Care Plan No. 2 which included the following points.

- Expressed needs: support, distraction/activity from negative thoughts, respite from home situation, to address low mood/depression. Strengths: feels mother and child reduce risk of suicide/DSH, able to engage with day unit.
- Aims: Assess needs and baseline mood, support with mood and select psycho-social issues, refer to support services in preparation for discharge.

- Attendance: at present off sick from work. Attendance should be in morning. If no attendance by 11am attempt telephone contact. Miss A has childcare responsibilities at 3pm every weekday. Miss A has agreed to attend approx 7 days per week.
- Medication: sertraline 200mg, lactulose 10mls, zopiclone 3.75mg. Collect medication post MDT review each Wednesday. Initial stock of one collection every two days. Open to review dependent on risks.
- Key worker team: assess baseline mood through range of interventions; reformulate care plan as needed, with input from Miss A; perform allocated worker interventions each day, also check additional interventions and complete as needed; prepare MDT review sheet each Wednesday.
- Allocated worker: each shift introduce themselves to Miss A as point of contact for support and information and to provide sense of on-going support; offer 1:1 time each shift, to aid Miss A in expressing any negative thoughts/feelings, also to allow better understanding of Miss A's situation and mental state; make Miss A aware of any group activities, to enable engagement with service users and staff and to provide information on mental health issues and sense of purposeful activity. Each shift note overt low mood, tearfulness, hopelessness, indications of thoughts of suicide/self harm, general levels of motivation, sleep and diet.

7.13 After the establishment of this second care plan Miss A had regular MDT reviews while she was at the day unit and various suggestions were made for further interventions. For example on 4 October consultant psychiatrist 1 noted in his plan: "*Some form of talking treatment may be needed - individual"* and nursing staff noted on the MDT review form: *"Agreed action: referral to 'talking' services - psychology?"* On 11 October the SHO noted *"discussed starting some art therapy, Miss A says she will try"* and nursing staff noted on the MDT review form: *"Low level attempt to contact psychology. Need feedback from* [Miss A] *… Agreed action: continue with referral to psychology, refer to art therapy."* On 1 November consultant psychiatrist 1 noted in his plan: *"Anger management work"* and SN1 noted on the MDT review form "*Contacted psychology six month wait"* and "*Referral to anger management asap".*

7.14 There was no further mention of these interventions until the MDT review of 15 November (with consultant psychiatrist 1, an SHO, CC1 and a staff nurse) which was held in Miss A's absence. Consultant psychiatrist 1 noted in his plan "*Appointment with*

keyworker to discuss referral to Day Centre, CAT[5]*, women's groups"*. SN1 had noted on the MDT review form "*Was to attempt referral to STOP*[6] *project for anger management – no attendance thus yet to complete – tel number passed on.* [Miss A] *willing to contact"*. There was a note on the same form that CC1 suggested "*Link into Home Support/women's groups run by CAT"* and CC1 made a separate note "*anger management referral to be made"*.

7.15 Miss A's first care coordinator (CC1) was identified on 22 September 2006. He met Miss A at the day unit on 11 October to undertake an initial assessment and planned to see her again on 23 October but she did not come to the day unit on that day. He attended her MDT review on 15 November when Miss A was not present.

7.16 When Miss A was discharged in her absence on 22 November a CPA meeting was held the same afternoon between consultant psychiatrist 1, CC1, an SHO and a staff nurse. There was no indication that the GP had been invited. Consultant psychiatrist 1's own notes focused on the medication plan and did not mention talking treatments, but CC1 recorded "*Suggested anger management at STOP"* and included this on Miss A's CPA care plan. Miss A was discharged on enhanced CPA as this was trust policy for all discharges from acute care. Consultant psychiatrist 1 noted in his plan "*If fails to engage envisage regrade to standard CPA"*.

7.17 The CPA documentation for 22 November was incomplete but included in the plan:

- anger management with STOP
- outpatient appointments
- refocus offer of help
- weekly collection of medication from hospital pharmacy for four weeks
- monitoring of lithium levels by City Wide Treatment Unit (CTU), if fails to attend for monitoring stop lithium, consider tapering it off as now on olanzapine
- offer seven day follow up plus further appointment if does not attend
- outline contingency arrangements (the separate crisis plan was blank).

We do not know if this care plan was actually sent to the GP as it was incomplete. We saw no evidence in the GP records that it was received.

[5] Community alternatives team
[6] STOP – Start Treating Others Positively – women's support group for victims of domestic violence and a women's anger management group

7.18 Miss A met CC1 for a seven-day follow-up on 29 November. He noted "*risks reduced, not self harmed for some time. Talked about engagement with STOP for anger management"*. CC1 went on sick leave in early December and did not meet Miss A again.

7.19 CC2 took over as Miss A's care coordinator and rang her on 12 December to arrange a home visit for 18 December at Miss A's request. CC2 noted that when she visited on 18 December the house lights were on but there was no answer. CC2 rang Miss A again on 19 December and arranged another home visit for 27 December. This time CC2 noted that there was a car in the drive but there was no reply. CC2 tried to visit again on 17 January 2007 and again noted that the lights were on but there was no reply. CC2 did manage to speak to Miss A on 25 January and arranged to meet at the Resource Centre on 31 January but in the meantime Miss A requested an urgent home visit on 29 January and CC2 went to see her that day.

7.20 At the home visit on 29 January CC2 completed a FACE risk profile (see paragraph 6.22 for details) and undertook a CPA review. The care plan included:

- structure time, refer to CAT, further education courses
- feels unable to control anger, particularly towards ex-partner - contact SHIP[7] for anger/anxiety management group work
- outpatient appointments
- visits by community mental health team (CMHT) worker
- "*Miss A does not identify a carer. Does not want her mum contacted"*
- input from city-wide treatment team to monitor lithium levels
- contingency arrangements but no crisis plan.

The GP practice noted they had received the care plan.

[7] Self Help Initiatives Project with Leeds MIND - support for personal development including activity groups for anger management.

7.21 At the same visit CC2 also completed the 'Initial Assessment Conclusion' and 'Next Steps' form that was part of the initial assessment undertaken by CC1 in October. She included:

- *"Main difficulties: Wants to do FE course – eventually psychology*
- *Worrying about court case and situation at work*
- *Difficulty controlling anger, particularly towards ex-partner*
- *Nothing to fill time*
- *Needs lithium bloods (regularly)*
- *Problems keeping appts*
- *Agreed to do next: Miss A to drop in at St Barts – enquire about courses*
- *Enquire about moving GP to Aireborough (Miss A)*
- *Agree to meet CPN – anger/anxiety management 1:1 & group*
- *Ring SHIP (Miss A)*
- *Attend Resource Centre next Friday for bloods – check on referral to city wide treatment service*
- *Buy a diary to plan ahead (Miss A). Get a* [local amenities] *card (Miss A) – refer to CAT C/J."*

7.22 In the meantime Miss A had attended an outpatient appointment with an SHO on 19 December 2006 who did not mention any psychosocial issues or the proposal for anger management either in the case notes or in the letter to the GP.

7.23 CC2 saw Miss A at home again on 6 February and noted that Miss A's mood and mental state had settled with no thoughts of self harm for the last week and Miss A wished to continue seeing CC2. She included in the plan:

- *"to buy a diary*
- *to contact Pudsey FE*
- *to ring SHIP re appropriate courses*
- *Miss A intends to rejoin gym asap."*

7.24 CC2 also noted *"Began work on managing anger/anxiety – breathing exercises etc. Occupational health suggested medical retirement – doesn't want that – wants to return to work".*

7.25 The next home visit on 14 February was CC2's last successful contact with Miss A. CC2 noted:

> *"Believes she is not responsible for anger but agreeable to anger/anxiety management & looking at structuring time. Plan: See with mum next session; to buy a diary; to ring SHIP; to visit leisure centre."*

7.26 CC2 followed this up with a letter to consultant psychiatrist 1 to update him about the difficulties she had been having with meeting Miss A. In this letter she reported that she was now working with Miss A on ways to control her anger and reduce anxiety.

7.27 Miss A then failed to attend an appointment with CC2 at the Resource Centre on 6 March. CC2 tried to visit Miss A at home on 13 March and again on 17 and 18 April without success and she received no response to her telephone messages. On 18 April CC2 noted "*Discussed with* [consultant psychiatrist 1]. *Plan: If I haven't made contact in a couple of weeks arrange CPA - reduce to standard and discharge*". In the meantime Miss A saw consultant psychiatrist 1 on 23 March and on 3 and 27 April. Again his plans for Miss A focused on her drug treatment and made no mention of any other interventions.

7.28 We asked consultant psychiatrist 1 about the suggestions for other therapies and interventions. He said:

> *"I am certain that I thought Miss A's irritable mood and her violence were important things to be addressed, but I expect in her case, as in other cases, referrals to an agency called STOP for anger management were not made at my suggestion, or with my support. The reason for that is ... it is an organisation that offers anger management to people who do not have a serious personality disorder or serious mental health problems. I have had discussions some years ago with the manager of that service who has told me very clearly that her service cannot help people with those kinds of problems and they cannot understand why our service make referrals there.*
>
> *"Anger management can be an important part of helping someone with these kinds of problems, whatever their diagnosis ... but I would expect any help in that area to come from acute day hospital staff and the community mental health teams staff, or from our psychology service. At the time I expected that a referral of somebody with these kinds of problems to psychology would not have been fruitful*

at the time. My experience was that those kinds of problems were simply not seen in psychology, but there is some CBT[8]-based work delivered by health professionals, such as a day hospital worker or a community mental health team worker which might have been helpful ... [Psychology] *generally would not offer that in my experience, at least to people who had a diagnosis of depression and bad temper and carried out violence. That position seems to have changed over the last year.*

"...my expectation will have been that it will be done by a member of the acute day hospital staff, not by a STOP worker."

7.29 Consultant psychiatrist 1 told us later that enquiries to the psychology department indicated a six month wait for treatment. He said his view was that a referral to psychology was not appropriate while Miss A was not settled and her symptoms were more prevalent. The issue was to be reviewed when her symptoms had settled and discussions therefore took place within the MDT about referrals for other forms of intervention. He said there were regular discussions with the day unit and the community team about psychological intervention and he accepts there could have been clearer documentation about this.

7.30 The trust's medical director felt that psychological therapies would have been actively considered by this team, even though this was not recorded.

7.31 We asked SN1 about the proposed other therapies. He told us referrals did not take place because Miss A was not keen on some suggestions and her low level of attendance did not enable staff to complete the required referral documentation. SN1 felt such referrals are now easier to make electronically. He told us that staff at the day unit ran art therapy and other groups but Miss A did not engage well with group work. SN1 expected a referral to STOP to be made either by himself or by the care coordinator after discharge. We asked SN1 if he or any of the other staff at the day unit could have offered anger management. He said:

"Not really, no, because we weren't trained in it as such. We could give general counselling – not counselling with a big 'C' but counselling with a small 'c' in regards to distraction and alternatives to being angry as activity and things like

[8] Cognitive behavioural therapy

that, but it wouldn't have been called official anger [management] in the same way as say the STOP project would be. We are not a service like that. I don't think we were doing anger management as a group at the time, so it would have been a one-to-one discussion-based intervention rather than 'this is counselling' or 'this is anger management' because we are not counsellors, and we are not anger management specialists, we are mental health nurses."

7.32 We also asked CC1 about the proposed other therapies. He felt people would need to be motivated before a referral could be made or they were ready to refer themselves. CC1 told us the CAT preferred self referrals. He confirmed he would not have undertaken any form of psychological therapy himself but that sometimes the role of community staff is to prepare people for psychological therapy. If community staff have undertaken cognitive behavioural therapy formulation training they may be able to work under the supervision of a psychologist.

7.33 The trust's medical director told us that STOP and SHIP are voluntary sector agencies providing psychological support and counselling. They both expect people to refer themselves, demonstrating motivation to receive help and support. They do not accept referrals from professionals.

7.34 We examined the evidence for who was expected to approach the providers of psychological therapy. Sometimes staff appeared to be taking the initiative, sometimes the responsibility appeared to shift to Miss A and sometimes Miss A was expected to make the approach herself. For example: on 1 November the MDT review form said "*referral to anger management asap*"; on 15 November the consultant noted "*appointment with keyworker to discuss referral to day centre, CAT, women's groups*"; the MDT form said "*was to attempt referral to STOP project for anger management – no attendance thus yet to complete – tel number passed on.* [Miss A] *willing to contact*" and CC1 noted "*anger management referral to be made*"; on 22 November the CPA plan just said "*anger management STOP*"; on 29 November CC1 noted "*talked about engagement with STOP for anger management*"; on 29 January the CPA plan said "*refer to CAT... contact SHIP for anger/anxiety group work*" and the 'Next Steps' form said "*ring SHIP* [Miss A] ... *refer to CAT CC2*/[Miss A]"; on 6 and 14 February CC2 noted "*to ring SHIP*".

7.35 We asked consultant psychiatrist 1 about the differences between his plans for Miss A and her CPA plan. He said he felt he had a habit of not expanding sufficiently in his own notes on the work which would be done by the community mental health team worker,

partly to give them some scope to decide themselves what work might be done. He agreed that his own notes focused on medical issues and things he thought were less likely to be noted in the care plan. He told us he does now try to ensure his records give more detail about all aspects of care and all matters considered and discussed.

7.36 We asked consultant psychiatrist 1 what contact he expected to have with the care coordinator for someone on enhanced CPA in the community. He said he expected to be invited to regular CPA review meetings and for there to be a discussion with him if things were not going according to plan. He told us he is often not invited to CPA meetings and not told about the failure of a patient to keep appointments. He said "*They very often involve only the care programme coordinator and the patients – the decisions are made without reference to me.*" Consultant psychiatrist 1 explained he has a CPA clinic each month and CMHT colleagues are also welcome to arrange a CPA meeting during any of his clinics. Consultant psychiatrist 1 was not invited to Miss A's unplanned CPA review on 29 January but was invited to a CPA meeting planned for 3 July 2007, as was Miss A's GP.

7.37 Consultant psychiatrist 1 told us later that, while trust policy allows for CPA meetings to be held without the consultant, he feels consultants should be invited and should attend when they can.

7.38 We asked consultant psychiatrist 1 how he expected the GP to be involved with someone on enhanced CPA. He said he expected the CMHT worker to contact the GP if there were any significant changes in the person's condition. He said:

> *"Generally the contact between community team members and GPs has never been, as far as I know, subject to very clear guidance to community team members. It probably might be a little bit variable. Generally I would expect the GP to be prescribing medication that I had recommended, or at least deciding whether or not to do that. Some GPs like to remain at the centre of their patient's care and review the patient regularly themselves, seeing the secondary care team as advisers to a certain extent. Other GPs seem to prefer that they take a back seat in the management and the responsibility is very much something which the secondary care service does. I will be in contact with GPs when necessary, but they phone me up sometimes about patients, but it is something which happens only if either of you thinks there is a need for it."*

7.39 Consultant psychiatrist 1 told us later that it would have been appropriate for Miss A's GP to be fully informed about her care plan. He said GPs are invited to CPA meetings to ensure a holistic approach to service users' care.

7.40 We asked consultant psychiatrist 1 about the rationale for the proposal to regrade Miss A to standard care if she failed to engage. He explained that Miss A seemed to be more stable and people cannot stay on enhanced care for ever. He said:

> *"… there is a real difference between what care programme policy documents say about the people who should be on enhanced care programme and what can happen in the real world … the way it generally works, at least in my experience, is that if a patient is only managed by a doctor in clinic, the community team are no longer providing anything, then they are regraded to standard. It is about the complexity in terms of the number of people involved, that is often the deciding factor."*

7.41 The trust's medical director confirmed it was normal practice to regrade to standard CPA if someone was only seeing the consultant psychiatrist as an outpatient.

Findings

7.42 The trust expects members of the MDT to focus on their own professional roles in terms of care planning with the care coordinator taking responsibility for the overall approach.

7.43 CPA processes were generally adhered to although the documentation was not always fully completed.

7.44 Nursing staff both at the day unit and in the community were diligent in making contact with Miss A and in formulating care plans.

7.45 Risks identified in the FACE risk profile as level 2 required a contingency risk management plan. Suicide and self harm was identified as a level 2 risk in September 2006 and the second care plan at the day unit thoroughly covered this risk.

7.46 The second care plan at the day unit was drawn up on 12 September but was never revised to take account of later proposals.

7.47 Medical staff at the day unit suggested that Miss A needed talking therapy, art therapy, psychology and anger management but nothing materialised.

7.48 Consultant psychiatrist 1 said there were discussions within the MDT about the provision of psychological therapy but they were not recorded. It was not always clear from the records who was expected to approach other providers. The responsibility for the referral to CAT and for anger management appeared to shift from staff to Miss A. Day unit staff expected to make a referral to STOP but we were told STOP did not accept referrals from professionals.

7.49 It was not clear from the records that Miss A actually agreed to refer herself to any form of therapy after her discharge from the day unit, or that she was motivated to do so.

7.50 Consultant psychiatrist 1 did not intend a referral to be made to STOP as he believed STOP would not accept Miss A. He expected anger management work to be undertaken by day unit or community staff. SN1 expected staff to make a referral to STOP and did not feel staff at the day unit were qualified to provide anger management. CC1 did not expect to provide psychological therapy himself.

7.51 Nursing staff interpreted consultant psychiatrist 1's suggestion for talking therapy as a need to refer to psychology but consultant psychiatrist 1 did not expect psychology to accept Miss A and he did not think she was settled enough to be referred.

7.52 From the time of Miss A's discharge, consultant psychiatrist 1's plans for Miss A focused on her medication. He made no further suggestions for other therapies, nor did he include the proposal for anger management in his plans, although anger management continued to be proposed by Miss A's care coordinators.

7.53 CC2 was the only person who undertook any form of anger management which she started at what turned out to be her penultimate home visit on 6 February 2007.

7.54 Miss A requested a home visit on 29 January 2007 after CC2 had made three failed home visits. CC2 went to see her the same day and carried out a CPA review. There was

no evidence that she tried to contact consultant psychiatrist 1 before she went to see Miss A.

7.55 The GP should have received copies of the CPA care plans but there was no evidence he received the first one in November 2006 which was never completed. He did receive the second one in January 2007. He was not directly involved in any aspect of Miss A's care planning and would not have been aware of the proposal for anger management until he received the CPA care plan of 29 January 2007.

7.56 Miss A would have been regraded to standard care if she was no longer seeing her care coordinator and only seeing the consultant as an outpatient.

7.57 There are aspects of the CPA process that still do not appear to be working well within this team, such as the inclusion criteria for a care programme, involvement of the consultant in CPA review meetings wherever possible, multidisciplinary agreement on the care plan and clarity about the role of the GP.

Comment

7.58 ***We were at first struck by the gap between the content of Miss A's care plans in terms of the additional interventions suggested and the failure of any of them to materialise until CC2 made a start on managing anger and anxiety at her penultimate home visit. We were then surprised by the different expectations of consultant psychiatrist 1 and his team about how these interventions should be delivered. There should have been clear evidence of an understanding within the team of what Miss A needed, what was available, how it could be accessed and whether Miss A was likely to approach services herself.***

7.59 ***The onus appeared to shift from staff intending to making referrals to an expectation that Miss A would refer herself for further therapy and support. If she was suffering from episodes of major depression for which she needed medication, she may well have lacked the motivation to take the initiative in approaching other services. She would have needed significant encouragement and practical support to make contact and attend sessions away from her home. On the other hand it might have been helpful for the team to consider why Miss A appeared to engage with***

consultant psychiatrist 1, who focussed on treating her mental illness, rather than the rest of the team who wanted to focus on psychosocial issues.

7.60 *We understand that medical and nursing staff have different professional roles but we were concerned about the variation between the consultant's own plans for Miss A and those prepared by her care coordinators. Consultant psychiatrist 1 acknowledged this variation and felt that it was partly to leave scope for the care coordinator to decide what needed to be done. The result was a division of labour operating within the team with the consultant concentrating on the medical aspects and the care coordinator picking up on the psycho-social issues. However, if such a principle was operating, there was little evidence of discussion and agreement on an integrated approach or of anyone taking responsibility for an overview. We suggest that there needs to be much closer liaison between the consultant and the care coordinator to ensure that they are both fully involved with and committed to the care plan.*

7.61 *CC2 was clearly skilled and experienced in her role as care coordinator and she initiated six documented contacts with medical staff and one with the day unit. We fully understand why only CC2 and Miss A were present at the CPA review 29 January 2007 as it appears to have been an opportunistic decision by CC2 in view of the difficulty she was experiencing in making contact with Miss A. This demonstrated good practice in accordance with trust policy, which required thoughtful flexibility with CPA reviews and was an appropriate choice in this case, but it meant that the consultant was not involved in a joint review of progress with Miss A's care plan. A CPA meeting which included the consultant would have been an opportunity for him to endorse the potential value of CC2's role but we recognise that a further meeting might have been difficult to achieve with Miss A. We were also concerned to hear about the current problems with the operation of CPA within this team, as described by consultant psychiatrist 1.*

7.62 *We understand the rationale for regrading people to standard care when a care coordinator is no longer involved, especially if all efforts to engage them have failed and no serious risk is apparent. However, we feel the trust needs to assure itself that current practice is in accordance with current policy.*

7.63 ***We have been critical of care planning for Miss A but we emphasise that we have focused on lessons to learn and are not suggesting that any alternative action by trust staff could have prevented the incident of 2007.***

Conclusion

7.64 While staff provided a high standard of care, none of the proposals for additional therapies and interventions ever materialised, for a variety of reasons, but we recognise that Miss A was unlikely to have taken the initiative or engaged well with any form of psychological therapy. We found a gap between the expectations of the consultant and his team about how these interventions should be delivered both at the time and still to this day. We found a lack of unity and consistency between the care plans of the medical staff and the rest of the team. This may have been due to the different roles of the professions but there should have been more evidence of an integrated approach. We also found that, despite examples of good practice, there are still problems with the CPA process in this team.

Recommendations

R3 The trust should clarify within relevant clinical teams the range of skills available in terms of talking therapies and other interventions and the capacity of staff to provide these. The trust should also clarify access beyond the teams to other therapies and interventions in both statutory and non statutory services. The trust should ensure this information is understood by each qualified member of the teams.

R4 The trust should ensure there is a reliable system in all settings for tracking and monitoring fully integrated care and treatment plans, including any additional proposals that arise from MDT and CPA reviews. The trust should ensure all teams are clear about who has overall responsibility for individual care and treatment plans within each setting.

R5 The trust should consult with clinical staff, including GPs via the local medical committee, to identify aspects of the CPA process that are not working well with a view to taking remedial action and auditing the results as part of the regular CPA audit cycle.

8. Did not Attend (DNA) and discharge

Evidence

8.1 We have not seen a trust policy on DNA or discharge arrangements that would have applied when Miss A was discharged from the day unit in November 2006. The trust's *Management of did not attends policy* issued in March 2007 set out the approach for new patients according to whether it was an urgent referral or not. For follow-up patients it said:

> *"Similar considerations should be given to known patients who fail to attend follow up appointments. The underlying principle should always be acting in the patient's best interest. Key considerations should include contacting the patient by telephone to establish the reason."*

8.2 The trust's *Effective care coordination policy and practice guidelines* of 2007 said in section 11:

> *"If a service user does not attend, withdraws or refuses treatment, the care coordinator must try and make contact through home visits, letters, telephone or other means appropriate to the needs of the service user. The care coordinator should discuss the circumstances with the consultant psychiatrist and other involved professionals and carers and in cases of potential risk should arrange an urgent MDT review."*

8.3 This document also said in section 12:

> *"Care coordinators in collaboration with their manager and/or team colleagues will often need to make decisions about the length of time a service user should remain on their case load. Regular reviews should be held for service users who are either difficult to engage or who have lost contact with services before any decision is taken to discharge from the case load. There may be appropriate reasons to keep service users on the case load though contact may be infrequent."*

8.4 When Miss A was discharged from the day unit in her absence on 22 November 2006 she had only attended three times in the previous two weeks. Her discharge had been discussed at her MDT review on 8 November when consultant psychiatrist 1 told her it might be better for her to be looked after by the community team and a CPA meeting was booked for 15 November. Miss A did not attend on 15 November so an MDT review was held in her absence and discharge was proposed for the following week after planning and finalising aftercare. Miss A was informed about this at her last attendance on 16 November. She said she did not feel ready for discharge but did not attend for the next four days. On 21 November she was visited at home by her key worker and agreed to attend the following morning. On 22 November she did not attend and in her absence consultant psychiatrist 1 discussed her discharge in a ward round with the SHO and SN1 and again in a CPA meeting with the SHO, CC1 and another staff nurse.

8.5 We have already considered the CPA documentation (which was incomplete and did not appear to have been sent to the GP) in section 7 above.

8.6 A preliminary discharge letter was completed by SHO1 on 22 November. It included:

- outpatient follow up in four weeks
- diagnosis: 1. depression disorder, 2 bipolar disorder
- enhanced CPA [but CPA coordinator not noted]
- medication listed.

8.7 A discharge summary form was completed by SN1 but not dated. It gave the name of the care coordinator (but not the level, which was not prompted by the form) and set out the reason for admission and the key problems of coping at home due to the breakdown of her relationship, being the main carer for her disabled child, and the risk of losing her job due to attempting to physically assault her ex-partner at work. The summary also included the initial diagnosis of severe/moderate depression which changed to possible bipolar affective disorder whilst at the day unit. It set out the interventions and outcomes as:

- general support over issues at home – outcome: uncertain but level of support found to be beneficial

- initiate medication regime to stabilise/improve mood – outcome: more stable and improved in mood
- increase level of activity – outcome: some movement but slightly resistive due to issues over child.

8.8 This summary noted a seven-day follow-up with CC1 and listed the discharge medication but did not mention the proposal for anger management.

8.9 The full discharge letter was written by SHO2 on 19 January 2007, nearly two months after Miss A's discharge from the day unit. It said the diagnosis was depressive disorder or type 2 bipolar disorder and listed the discharge medication and the required blood tests. It set out the follow up arrangements and a crisis plan. It set out the circumstances of admission; mental state on admission; a brief history; and progress at the day unit. The CPA level and care coordinator were not noted. For follow up arrangements it said: "*Stop further CMHT work as indicated*" which was presumably a misunderstanding of the proposed referral to STOP for anger management or a typing error.

8.10 Consultant psychiatrist 1 told us that he and the team tried to ensure that Miss A was discharged in a planned way. He said there was no feeling of exasperation with Miss A's failure to attend and explained his responsibility to ensure the day unit is used for the good of everyone who needs it. He felt that if Miss A was not attending the day unit it would be better for her to have a care plan and a community team worker.

8.11 Consultant psychiatrist 1 told us later that he had some concerns about discharge communications. He said that often only brief summaries are sent and these are often sent late because SHOs have duties outside the sector. He accepts that discharge communications in Miss A's case did not cover key information and did not mention the need for anger management. He said he would now check all discharge summaries to ensure they include the relevant information.

8.12 The trust's medical director told us later that detailed discharge summaries have now become the responsibility of the keyworker instead of the medical team and that any checks would be carried out by the clinical team manager. He also said work is in hand to ensure the risk management plan is closely linked to the care and treatment plan to ensure they are integrated and to avoid duplication.

8.13 We have already described CC2's recorded attempts to establish and maintain contact with Miss A, despite many failed home visits and unanswered messages. At the time of CC2's final run of failed visits in March and April 2007, Miss A was still seeing consultant psychiatrist 1 and CC2 discussed the next steps with him. They agreed that if CC2 had not made contact in a couple of weeks she would arrange a CPA meeting with a view to reducing to standard CPA and discharging Miss A from her case load. Consultant psychiatrist 1 intended to continue seeing Miss A as an outpatient and planned to see her again three months after her last appointment with him on 27 April.

8.14 Consultant psychiatrist 1 told us if he or CC2 had felt it was essential for Miss A to maintain contact with the team then further active steps would have been taken such as arranging a home visit or asking the GP to encourage her to attend. In Miss A's case he felt it was reasonable for Miss A to agree with CC2 whether CC2 still had something to offer her, rather than just making a decision to continue.

Findings

8.15 The decision was made to discharge Miss A considering her use of the day unit and the potential benefit to her of a community team worker.

8.16 The discharge from the day unit was carefully planned despite Miss A's absence from key meetings.

8.17 Staff at the day unit regularly recorded their attempts to contact Miss A when she did not attend as expected.

8.18 The drug treatment plan was set out comprehensively in the discharge communications and included details of the required blood tests. There was no evidence of a letter to the GP when Miss A was first prescribed lithium in September 2006, although she was still seeing him as she was living at home. Consultant psychiatrist 1 accepts that the GP should have been informed.

8.19 Discharge communications did not cover all the key information and did not mention the need for anger management. A preliminary discharge letter and a discharge summary were sent but the full discharge letter was written almost two months after discharge and included a misunderstanding about STOP.

8.20 Detailed discharge summaries are now the responsibility of the keyworker instead of the medical team. Work in hand to link the risk management plan to the care and treatment plan to ensure they are integrated and to avoid duplication.

8.21 CC2 made many attempts to contact and engage Miss A with some limited success. When she failed to make contact over a period of two months she discussed the situation with consultant psychiatrist 1 and agreed the next steps. She did not get as far as discharging Miss A from her case load before the incident occurred.

8.22 Consultant psychiatrist 1 intended to continue seeing Miss A as an outpatient at three monthly intervals.

Comment

8.23 ***We feel the decision to discharge Miss A from the day unit was appropriate in the circumstances and consultant psychiatrist 1 did everything possible to ensure it was carefully planned, with full involvement of the MDT, despite Miss A's non attendance.***

8.24 ***The comprehensiveness of the medication plan provided the clarity needed by trust staff and the GP to monitor Miss A's drug treatment. There should have been a letter to the GP when lithium was first prescribed.***

8.25 ***Although none of the discharge communications referred to the need for anger management, this was clearly set out in the CPA care plan of November 2006. Unfortunately we saw no evidence that this was actually sent to the GP.***

8.26 ***The discharge communications did not appear to have been checked by the consultant. Although of a reasonable standard, they did not include key CPA information nor did they fully reflect the content and intention of the CPA care plan. Those written by the junior medical staff appeared to represent a separate process. The full discharge letter was late and did not clarify the proposed referral to STOP. In our view, these have been common problems in many trusts and there should be immediate benefits from the trust's new arrangements for detailed discharge summaries to be completed by the keyworker and for the risk management plan to be more closely linked to the care plan.***

8.27 ***Day unit staff and CC2 were persistent and diligent in their attempts to maintain contact with Miss A and to engage with her. CC2 in particular demonstrated good practice in her flexible and considerate approach to working with Miss A.***

8.28 ***We feel the decision to move towards potential discharge from CC2's case load was appropriate in the circumstances.***

Conclusion

8.29 We found the decisions made to discharge Miss A from the day unit and to move towards potential discharge from CC2's case load were well considered and appropriate in the circumstances. The information provided about Miss A's drug treatment was commendable. We felt the discharge communications were of a reasonable standard with some gaps and inconsistencies and changes have been made to address this. All staff should be congratulated on their determined efforts to maintain contact with Miss A.

Recommendation

R6 The trust should check MDTs have a reliable system to monitor the standard and timeliness of written discharge communications and ensure medical, psychological and social issues are fully integrated with the CPA care plan, avoiding unnecessary duplication.

9. Safeguarding children

Evidence

9.1 The trust's child protection policy dated September 2002 was in place at the time of Miss A's contact with the trust. It set out the actions to be taken where abuse is confirmed or suspected and the actions to be taken where a child is felt to be in need. It said on page 8:

> *"There will be circumstances where you consider a child NOT to be at risk of continuing significant harm but that a family would benefit from inter-agency intervention and support."*

9.2 The policy made it clear that a disabled child would be a child in need and a telephone referral could be made to social services but only with consent from the parent. It advised contacting the senior or designated child protection professionals if unsure about the need for a referral with consent.

9.3 This policy included *Good practice guidance* which described the categories of child abuse and set out in detail the five main sources of stress for children and families as: social exclusion, disabled children, mental illness of a parent or carer, drug and alcohol misuse and regular exposure to domestic violence.

9.4 The trust's *Effective care coordination policy and practice guidelines* of 2007 set out details of the requirement to consider the needs of children in the family. It said in paragraph 7.7.5: *"The welfare and safety of children in the service user's family should always be discussed in the CPA meeting and included in the CPA care plans."* It also said in paragraph 9.2 that "*arrangements to support child care and parenting*" may need to be considered and incorporated into the written care plan.

9.5 As we have already noted, these same guidelines also mentioned the need to consider the risks to children as part of the ongoing process of risk assessment. The FACE risk profile forms included several questions about risks to children.

9.6 The trust's current *Procedure for assessing and managing clinical risk*, issued in March 2009, says in paragraph 5.3.2 m:

> *"Where the client is a carer for children (not only main carer), or is in contact with children, consideration should be given to referring child protection issues highlighted in the FACE risk assessment to children and young people's social care. If there is a decision not to refer a discussion should take place with the trust's named doctor or the named nurse."*

9.7 The trust's current *Safeguarding children policy*, issued in August 2009, says in paragraph 5.8 that it is the responsibility of all staff to bring to the attention of the named doctor or nurse: "*cases where there is a difference of opinion in relation to the diagnosis, safety or welfare of a child."*

9.8 We asked the trust's named doctor for safeguarding children about current practice within the trust. He told us about the electronic FACE and CPA documentation with required sections on safeguarding. He told us about the mandatory on-line level 1 safeguarding training for all staff and the recommended level 2 training for certain senior staff.

9.9 As mentioned in the section on risk management above, the trust now has a holistic electronic assessment tool which includes a set of prompts about children in the home of the service user. The tool will be rolled out to all teams by August 2012.

9.10 The trust's named doctor for safeguarding children also told us about current activities to promote awareness of safeguarding within the trust which include: an induction event for new staff; cards with essential contact numbers for the safeguarding children team; talks by the named doctor to medical trainees; distribution of NICE guidance; regular updates to the executive team and consultants' committee; presentations of audits to the professional nurse advisory forum and the adult directorate clinical governance council; plans to provide reminders and support to staff invited to child protection conferences; learning from local and national serious case reviews; a same-day response to all requests for advice from the named doctor and nurse or another member of the team; feedback from service users; and presentations of local cases.

9.11 We asked the trust's named doctor for safeguarding children how he assures himself that the messages are getting across. He said that this is mainly through training

and the use of assessment templates. He explained that audit of case files is undertaken but has limitations in view of the relatively low number of cases where potential safeguarding issues exist but there are plans to audit referrals to social care.

9.12 The trust's medical director told us that adult social care staff formed part of the CMHT and provided advice and input to the day unit. He said the arrangement worked well. Advice about housing, benefits and money was also available on the same site.

9.13 The fact that Miss A had a disabled child was well known to all staff from the very beginning of her contact with the trust. The letter the staff grade doctor wrote to Miss A's GP following her urgent assessment on 31 August 2006 included a description of her child's significant disabilities.

9.14 During Miss A's contact with the trust there were frequent references in the case notes to her child and the fact that Miss A's mother provided much of her child's care. Early in Miss A's time at the day unit staff noted that Miss A did not want any additional help for her child.

9.15 The FACE risk profile undertaken on 12 September did not identify a dependent child on the first page but stated as one of the main risks "*Currently Miss A is the main carer for her disabled child and has expressed issues over coping with her home situation. Ex-partner and mother provide some respite.*"

9.16 At Miss A's MDT review on 27 September the SpR noted that Miss A wanted her ex-partner to help look after her child and did not want services to be involved in her child's care. The SpR also noted "*Find out what services are currently involved with child (with her consent).*"

9.17 On 4 October consultant psychiatrist 1 noted Miss A was spending a lot of time at home with her child and "*only had* [her child] *because she thought it would make* [her ex-partner] *love her …. Getting to the point where resents* [her child]."

9.18 When Miss A met CC1 for the first time on 11 October she asked for information about support groups for carers of disabled children and he sent her some relevant information the following day.

9.19 On 23 October Miss A said she had sole care of her child for the week of half term. When she did attend later in the week she was very low and tearful.

9.20 Clinical records showed that, at her MDT review on 8 November, Miss A said she left her child with her ex-partner at the weekend "*despite his anger and protests"*. She said he threatened to ring social services and Miss A collected her child. There was no record that this was explored further.

9.21 The FACE risk profile undertaken on 29 January also did not identify a dependent child on the first page but stated as one of the main risks "*Disabled child stays once or twice a week – spends most of the time with Miss A's mum."*

9.22 CC2 saw Miss A's child at her last home visit on 14 February but did not record any observations about the child's well being.

9.23 When we met Miss A she told us her mother helped her a lot but she still found it hard to look after her child.

9.24 Consultant psychiatrist 1 said that Miss A might have been more willing to discuss her need for support with caring for her child once she had got to know and trust the staff. He told us he decided Miss A's child may have been in need rather than at risk and therefore further steps would not have been appropriate. We asked him where he would have gone for advice if he had any doubts about the 'in need' category. He said he would have contacted the named doctor:

> *"Our discussion would have been if I had doubts about whether or not the child was at risk rather than in need. If I was confident that the child may only be in need, but had no valid reason to think the child was at risk, then I wouldn't have that conversation."*

9.25 We asked consultant psychiatrist 1 if there is now more of an emphasis on having a discussion anyway. He said:

> *"Perhaps you are right, perhaps there is more emphasis on having a discussion, even if you think the child may only be in need. Perhaps there is. It is not something I generally do. It is only if I think that the child may be at risk, because I am not certain of that."*

9.26 Consultant psychiatrist 1 told us later that he and his team did consider whether there were any safeguarding issues for Miss A's child. He reached the view that, as Miss A refused further assistance with the care of her child and as there was no indication in the course of his assessments of Miss A that there was a risk to her child, there would be no need to discuss matters with the named doctor. However, he does accept that a discussion with the named doctor or nurse might also have helped to verify his decision that there were no safeguarding issues needing further action and to ensure there was a record that safeguarding had been considered.

9.27 SN1 told us he did not recall having had any safeguarding training at the time of Miss A's attendance at the day unit. The trust's named doctor for safeguarding children confirmed it would not have been mandatory at the time.

9.28 SN1 told us that because Miss A turned down the offer of support with child care and identified her child as a positive factor in her life, staff did not take any further action. He said having now had safeguarding and risk management training he would discuss this case with his manager with a view to further discussion within the trust and a possible referral to social care. However he also said he would not expect the safeguarding services to take any action because there had been no reports of concerns from family members or from Miss A herself.

9.29 The trust's named doctor for safeguarding children told us that, although he had not seen the case notes, he felt it was obvious from the report of the internal review that there were good reasons for a referral to social care. He noted the history of impulsivity, self harm, violence towards people in the home, poor engagement, an extremely vulnerable child, and a grandmother who was overloaded with caring responsibilities. He felt it would have been very important to talk to Miss A's mother about Miss A's ability to care for her child even without any specific concerns. He also felt that, unless a very different picture emerged, it would have been appropriate to make a referral even if Miss A disagreed. He told us it would have been easy at the time to contact the named nurse to discuss the case. He said they had been saying:

> *"If you are not sure about making a referral, you must contact us. Particularly if you are thinking of not making a referral, contact us because those are the risky times. If you are going to make a referral, fine. If you are not sure or you decide against it, run it past us."*

9.30 The trust has been unable to confirm if there was any social care involvement with Miss A and her child prior to the incident in 2007 but we have seen no evidence that there was and Miss A's mother told us there was no involvement until after the incident.

Findings

9.31 Miss A's child had experienced three of the five main sources of stress for children and families described in the trust's child protection policy. The child was disabled, Miss A had been diagnosed with a mental illness and there had been domestic violence between Miss A and her ex-partner.

9.32 After Miss A's initial assessment, which included information about her child's disability, there was no further description of her child's needs or the level of care that Miss A provided.

9.33 Staff thought about Miss A's child but did not appear to think about the needs of the whole family – especially Miss A's mother who provided much of her grandchild's care.

9.34 Staff were told by Miss A in September that she did not want any additional help with her child but we saw no evidence that they asked her again. They did not record any discussion within the MDT about the welfare of the child or any re-evaluation of the situation as more information emerged about Miss A's behaviour.

9.35 We found no evidence that staff knew what other support was available to the family, or whether Miss A's child had a social worker.

9.36 There was no further mention of the SpR's plan to find out what services were involved with Miss A's child.

9.37 Staff did not seek information from any other source about the welfare of Miss A's child. They only had Miss A's own reports.

9.38 Indications of potential risk were regularly recorded in the case notes in terms of Miss A's volatile behaviour, her mental state and, occasionally, her attitude towards her child but staff saw her child as a protective factor for Miss A.

9.39 Unspecified risks to Miss A's child were identified on both the FACE risk profiles but were not addressed by the care plans.

9.40 The trust encouraged staff to contact the named doctor or nurse to discuss any doubts about whether to make a referral to social care or about a decision not to make a referral.

9.41 Consultant psychiatrist 1 did not feel at the time that there was a need to discuss the case with one of the named professionals because Miss A refused further assistance and he did not identify any risks to the child during his assessments of Miss A. He accepts that a conversation with one of them would have helped to verify and record his decision.

9.42 Current trust policy is that if safeguarding issues are highlighted in the risk assessment but there is a decision not to refer to social care, or if there is a difference of opinion about the welfare of a child, there should be a discussion with the named doctor or nurse.

9.43 The trust's internal review did not identify any safeguarding concerns.

9.44 The trust's named doctor for safeguarding children felt it was apparent from the internal review that a referral to social care should have been made.

9.45 The trust currently has an exceptional range of activities to promote safeguarding awareness. It also has a holistic assessment tool with helpful prompts about children in the home of the service user.

9.46 Advice and input was readily available to the day unit from adult social care staff but we found no reason for their involvement with Miss A herself.

Comment

9.47 ***The impression on reading Miss A's case notes is that more attention should have been given to ascertaining the nature of her child's disability and needs. In any case, there was sufficient cause to be concerned about the welfare of her vulnerable child, given Miss A's mental health problems and the tensions between the parents. There were plenty of indications that Miss A found it difficult to cope despite significant input from her own mother. All staff appeared to have been reassured by***

Miss A's insistence that her mother did most of the caring and she did not want any other help, but they did not ask anyone else. Indeed the very fact that Miss A was so adamant she did not need or want any help with her child, on top of all the other indicators of risk, should have indicated a need to enquire further.

9.48 *Miss A's child clearly fitted the definition of a child in need. Although that precluded contact with social services without Miss A's consent it did not preclude returning to the discussion with Miss A herself, or being more proactive about engagement with Miss A's mother, which might have shed some light on the situation within the family and brought some more justified reassurance or otherwise. In addition it would have been easy to talk to the GP and there should have been a conversation with one of the named professionals within the trust.*

9.49 *Although consultant psychiatrist 1 wanted to meet Miss A's mother and ex-partner this was primarily to obtain a better history of her mental illness.*

9.50 *We were concerned about the lack of narrative in Miss A's case notes about the welfare of her child. That is not to say staff did not consider this but they did not document any discussion within the MDT, even to rule out the need for concern. However, staff would have expected Miss A's ex-partner and mother, who were each involved in the care of her child and each had some form of contact with the MDT, to have raised their concerns if they had any.*

9.51 *There was a lack of clarity about the amount of time Miss A spent looking after her child. On the one hand we were told that staff understood Miss A's mother to be providing most of the care but consultant psychiatrist 1 felt child care issues were one of the main reasons for Miss A's patchy attendance at the day unit. We have commented further on this issue at the end of section 5 above.*

9.52 *Once again a proposal from the MDT review had no recorded outcome – this time it was the SpR's plan to find out about the services involved with Miss A's child.*

9.53 *Whilst we accept that understanding of safeguarding has developed significantly over the last four years, the policy and framework have been in place for much longer. Not only were the risk factors there - they were identified in various ways by the team. This should at the very least have led to further enquiries about the child's needs and about who was caring for the child and when.*

9.54 ***We were also concerned that the trust's internal review of this case did not identify any safeguarding concerns.***

9.55 ***Given the commendable range of promotional and training activities on safeguarding within the trust and the holistic assessment tool, we are confident staff are now more aware of the need to make enquiries about the welfare of vulnerable children and to document their discussions.***

Conclusion

9.56 Our concern in this case has been as much about the well being of Miss A's child as about the risk Miss A posed to other people in her circle. Awareness, understanding, systems and practice in child safeguarding have all changed significantly since the death of Peter Connelly in August 2007 but the principles, framework and training have been in existence for much longer. We accept that staff caring for Miss A thought about her child, but they did not demonstrate in the records that concerns around her child's welfare had been adequately articulated or systematically considered within the MDT. They did not discuss the case with the named doctor or nurse. We were concerned that the internal investigation in 2007 did not address the safeguarding issues and hope the key messages about safeguarding children in relation to this case have now been fully heard. The trust now has an extensive range of promotional and training activities on safeguarding children that should ensure good practice.

Recommendations

R7 The trust should ensure all staff are aware of the expectation that they seek advice on safeguarding children whenever there is the potential for concern or a difference of opinion, even if they have felt no actual concern.

R8 The trust should ensure the current e-learning level 1a child safeguarding training provides staff, who have regular contact with parents or children, with the knowledge and skills to carry out their safeguarding responsibilities.

10. Promotion of communication

10.1 We were asked to consider the role of the trust and its staff in promoting communication and joint working between all those involved in providing care to meet Miss A's mental and physical health needs and social care and support.

Findings

10.2 We identified several examples of good communication and joint working in earlier sections of this report. For example.

- The urgent referral from Miss A's GP was picked up immediately and Miss A was assessed on the same day. She had a full assessment two days later and was admitted to the day unit two days after that.
- Miss A's discharge from the day unit was carefully planned with full involvement of the MDT.
- Day unit and CMHT staff were diligent and persistent in their efforts to maintain contact with Miss A.
- CC2 demonstrated good practice in her communication with colleagues.

10.3 We also identified several examples of poor communication and joint working. For example:

- There was no record of discussions within the MDT about features of emotional instability.
- The GP was not informed when Miss A was first prescribed lithium.
- There was no evidence of joint discussion about risk assessment within the MDT.
- Information about Miss A's history of violence and aggression was only obtained from Miss A and was not sought from any other source.
- There was evidence of a lack of joint understanding within the teams both at the day unit and in the community about the provision of therapy other than medication.
- The care plans of the nursing staff and the treatment plans of the medical staff were not coordinated.

- Concerns were expressed about the way CPA functions in this team.
- There were some gaps and inconsistencies in CPA and discharge communications to the GP.
- There was no record of any discussion within the MDT about the welfare of Miss A's child, even to rule out any concerns.

Comment and conclusion

10.4 ***We have mixed views on this issue. There is no doubt in our minds about the professionalism and commitment among the staff involved in Miss A's care and treatment and there were several examples of good communication and joint working. However, we also identified instances of poor communication and joint working. The trust has already put in place a range of systems for improvement and we have made recommendations to support these initiatives.***

11. Engagement with family and carers

11.1 We were asked to consider the extent of services' engagement with the family and carers and the impact of this.

Findings

11.2 We have covered the engagement with Miss A's family earlier in this report in the section on the involvement of carers and relatives in risk assessment and in the section on safeguarding children. In summary we found that.

- According to the records, Miss A gave her consent to contact with her mother when she was admitted to the day unit in September 2006 and only withdrew this once briefly in January 2007.
- Miss A was relatively independent and did not identify her mother as her carer.
- Consultant psychiatrist 1 intended to talk to Miss A's ex-partner and mother, primarily to learn more about her history of mental ill health, but he did not meet either of them. He said he made several attempts to meet them that were not documented.
- CC2 also intended to meet Miss A's mother but we have not had the chance to ask her about this.
- The only meeting that took place was between the SpR, a staff nurse and Miss A's ex-partner relatively early in Miss A's time at the day unit. Information from her ex-partner supported the possibility that she was suffering from type 2 bipolar disorder. There was no record of any other information gleaned or sought at this meeting. We were told that, at one point after the attack on his girlfriend, Miss A's ex-partner did not want to be involved with the service.
- Miss A reported two weeks later that her ex-partner wanted to meet consultant psychiatrist 1 to discuss their problems but no further meeting took place.
- Miss A's mother was invited to attend an outpatient appointment with Miss A but neither of them came. Consultant psychiatrist 1 accepts he should have responded to the letter from Miss A's mother in February 2007 asking to see him, but we recognise that this might not have resulted in a meeting taking place.

Comment and conclusion

11.3 ***Only one meeting took place with Miss A's ex-partner, and staff did not meet her mother. It was regrettable that there was no other opportunity to explore the family situation, the well being of Miss A's child or Miss A's propensity for violence. However, we were told that Miss A's ex-partner did not want to be involved at one point after the assault on his girlfriend and we felt that Miss A's mother was ambivalent about having contact with trust staff.***

11.4 ***Trust guidelines now emphasise the potential benefit of involving families and friends as well as carers.***

12. Perceptions of the family and carers

12.1 We were asked to consider the perceptions of the service user's family and carers of the level and quality of care and treatment provided.

Findings, comment and conclusion

12.2 ***We met Miss A's mother as part of this investigation. She told us she did not think anything could have been done differently. Her concern appeared to focus on the length of time taken to reach a diagnosis for Miss A but she was pleased that*** **"her medication was sorted out in the end".**

13. Consideration by the judiciary

13.1 We were asked to comment on the degree to which mental health was considered a contributory factor by the judiciary.

Findings, comment and conclusion

13.2 ***In 2008 Miss A was convicted of the murder of her grandmother in 2007. The judge said he accepted that mental illness, falling short of diminished responsibility, was one of the factors in the crime. Miss A was sentenced to life imprisonment with a minimum term of 20 years, reduced to 18 years and 333 days for the time already in custody. The starting point for the sentence was 30 years taking into account the aggravating features of the offence. The judge reduced the sentence to 20 years to take into account the mitigating feature of Miss A's mental illness and the fact that*** **"your life was difficult and stressful because your responsibility for your child and your illness made it difficult for you to sustain friendships."**

14. Overall conclusions

14.1 The purpose of an independent investigation is to discover not only whether any acts or omissions led to the adverse event but also to undertake a thorough audit of the standard of care provided to the service user. The independent investigation may not identify any root causes and may find that nothing in the provision of healthcare directly caused the incident. All the same, the investigation will usually find things that could have been done better without changing the course of events. There are usually lessons to be learned.

14.2 We found the main focus in this case was on treating Miss A's illness and observing any improvement in the symptoms of that illness. This was well managed but the approach may have blurred some of the other dynamics that were operating at the same time. There was a lack of clarity about the provision of psychological interventions and staff concluded that Miss A's disabled child was well cared for without recording their reasons.

14.3 However, we are absolutely clear that there is no evidence that anyone involved with Miss A's care and treatment could have anticipated that Miss A was capable of carrying out the murder of her grandmother. It is very unlikely that anything could have been done by trust staff that would have changed the course of events.

14.4 We have been impressed by the thoughtfulness, diligence and commitment of the staff who were involved in Miss A's care and treatment. She was fortunate to have been in their care but she chose not to take advantage of all they had to offer.

14.5 We have identified some learning for the trust from this investigation. Our recommendations are intended to address this learning but we would like to emphasise once more that we found no causal factors leading to the incident.

14.6 We are grateful for the contributions and support of all the people we interviewed, those who provided documentary evidence, those who facilitated our investigation and those who commented on our draft report.

Appendix A

Documents reviewed

Clinical records

Mental health inpatient, outpatient and day patient records
General practitioner records

Trust internal investigation documents

Incident form - 2007
Management fact finding report – 2007
Critical incident review report – 2007
Extract of minutes of SUI review panel - 2007
Critical incident review report following SUI review panel – 2007
Evidence to support action plan – 16 April 2008
Management report sent to SHA – 25 July 2007
Updated management report – 25 July 2007

Trust policy documents

Effective care coordination policy and practice guidelines – 2007
Care programme approach template – March 2010
City wide care programme approach policy – April 2010
Management of did not attends – March 2007
Draft did not attend procedure – April 2011
Clinical risk management FACE risk profile – April 2002
Clinical risk management and assessment – February 2007
Procedure for assessing and managing clinical risk – March 2009
Child protection policy – September 2002
Safeguarding children policy – August 2009
Procedure for the management of incidents – December 2008

Other documents

Extracts of the transcript of Miss A's trial in 2008

Appendix B

Biographies

Sue Bos

Now based in the north of England, Sue is a graduate of the NHS national training scheme. Sue spent most of her career working in hospitals in senior operational roles and was director of specialist mental health services at Leicestershire Partnership NHS Trust for many years. In this role she was responsible for a group of clinical directorates, including forensic psychiatry, psychotherapy, drug and alcohol services, child and adolescent services, eating disorders and specialist psychotherapies. Throughout this time she was a member of the trust's senior management team and undertook many investigations and reviews. She has also carried out work as an independent consultant for the National Patient Safety Agency and for the Health Service Commissioner and is a non-executive director of Compass, an independent provider of drug treatment services. Sue has completed a number of investigations for Verita, most recently two independent management reviews relating to Peter Connelly. Sue's special interests include clinical governance, mental health and child safeguarding.

Chris Brougham

Chris is an experienced investigator, and has conducted some of Verita's most high-profile mental health reviews. In addition to her investigative work, Chris advises trusts on patient safety issues and has recently worked with the executive team of a large mental health trust in London to produce a quality and patient safety strategy. In addition she has supported NHS trusts to carry out their own systematic internal incident investigations. Chris is also head of training for Verita where she has developed and delivered courses on systematic incident investigation. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people.

Dr Mostafa Mohanna

Mostafa Mohanna gained his basic training in psychiatry in Leicester after graduating with an MB Bch. He subsequently became a member of the Royal College of Psychiatrists and lecturer with the Leicester Medical School. He took up his first consultant post in Lincoln in 1990. He combined this role with various management positions. In 2001 he became the medical director for the newly formed Lincolnshire Partnership Trust. As medical director, Mostafa is joint lead, with the director of nursing, on clinical governance and quality, and has the lead on research and clinical effectiveness. Mostafa was recently made a Fellow of the Royal College of Psychiatrists (FRCPsych).