Independent Investigation

Into

SUI 2008/10741

Commissioned by

Yorkshire and the Humber

Strategic Health Authority

September 2011

Independent Investigation: HASCAS Health and Social Care Advisory Service
Report Author: Dr. Androulla Johnstone

Contents

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. X was commissioned by NHS Yorkshire and the Humber Strategic Health Authority pursuant to *HSG (94)27*[1]. This Investigation was asked to examine a set of circumstances associated with the death of Mrs. X the wife of Mr. X who was found killed on, or around, the 23 December 2008.

Mr. X received care and treatment for his mental health condition from the South West Yorkshire Partnership NHS Foundation Trust. He was found dead at his home together with the body of his wife who had died after receiving blows to the head. It was the conclusion of the Coroner's Inquest that Mr. X had killed his wife and had then taken his own life. It is the care and treatment that Mr. X received from this organisation that is the main subject of this Investigation.

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

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

1. Health service Guidance (94) 27

2. Condolences

The Independent Investigation Team would like to extend their condolences to the family and friends of both Mr. and Mrs. X.

The Independent Investigation Team thanks the family of Mrs. X for their contribution to this report and has found the thoughtful insights offered to be invaluable. It is the hope of the Team that this report will address any outstanding questions that the family may have.

3. Incident Description and Consequences

Background for Mr. X

Mr. and Mrs. X were born in 1927 and 1928 respectively. Mr. X had a history of mental ill health since 2002 when he was first diagnosed as having extreme anxiety and depression. In 2002, Mr. X accepted help from his GP and mental health services, and was discharged back into the sole care of his GP in 2005.

On 1 December 2008 Mr. X was again referred by his GP to mental health services as he was low in mood and depressed, feeling that life was not worth living.

On 2 December 2008, North Kirklees Older Persons South (OPS) Community Mental Health Team (CMHT) started processing the referral. On 3 December 2008, Mr. X's case was allocated to a Community Psychiatric Nurse (CPN), who arranged a home visit to Mr. X on 8 December 2008. During this visit the CPN saw Mr. X both with his wife, Mrs. X, and on his own.

On 9 December 2008 the CPN commenced Mr. X's Care Programme Approach (CPA) documentation along with various assessments including an initial Risk Assessment and Management Plan. During this visit the CPN made arrangements to visit again on the 18 December to complete her assessment. Shortly after this visit the CPN telephoned and left a message for Mr. X to say that she planned to visit the next day on 10 December 2008 to assess him further. Mr. X telephoned the CPN back stating that he would rather this assessment happened on 18 December 2008, as arranged previously.

On 17 December 2008 Mrs. X rang the CPN to check the time of the appointment for the next day. She expressed concern regarding her husband's behaviour. On 18 December 2008 the CPN and an Associate Specialist Registrar visited Mr. X at his home. Mr. X's medication was reviewed by the Doctor who also asked him whether he would like to come into hospital for a period of assessment. Mr. X refused this offer and the CPN and the Doctor considered this refusal to be made by a person with full capacity and that a section under the Mental Health Act 2007 was not indicated at that time. Mr. X had expressed thoughts about suicide

but during the assessment at his home it was ascertained that he did not have active plans for this. The next visit by members of the team was arranged for 23 December 2008.

On 22 December 2008 the CPN started to prepare a Multi-Disciplinary Risk Assessment along with a Risk Management Plan.

Incident Description and Consequences

On 23 December 2008 at 14.05 hours the CPN, accompanied by a Support Worker, visited Mr. X and Mrs. X at their home. There was no answer at the door which was not locked. After looking through windows and noticing five pints of milk were left out on the doorstep, the CPN telephoned the house and got no answer, and then telephoned her Team Manager to enquire how to proceed. The CPN telephoned the Police at 14.29 hours who subsequently arrived at 15.40 hours. The CPN and the Support Worker followed the Police into the kitchen where they were told to remain. Police Officers went into the main body of the house where they discovered the bodies of Mr. X and Mrs. X. Mrs. X had suffered fatal injuries to her head and Mr. X was found dead face down in the bath. No third party was identified as being involved.

4. Purpose of Report

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

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

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

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

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

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

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

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

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

5. Terms of Reference

The Terms of Reference for this Investigation were set by NHS Yorkshire and the Humber Strategic Health Authority. The Terms of Reference were as follows:

Terms of Reference – Independent Investigation SUI 2008/10741

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

To examine the care and treatment of the service user by means of a documentary review, making recommendations for further investigation should the investigator believe this to be necessary.

In particular, to take account of and comment on:
Application of the SUI (serious untoward incident) Policy.

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

The quality of the internal action plan.

The review of the service user's care and treatment should include assessment of:

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

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

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

- The exercise of professional judgment and clinical decision making and the quality of clinical supervision provided, with particular consideration of:

    - the quality of the referral from the GP practice
    - diagnosis
    - family history taking
    - handling of truncated treatments
    - identification of relapse factors and planning for relapse
    - the regard given to verbal statements of intent of suicide
    - the impact on the service user's mental health and well being of restrictions on his activities due to his medication

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

- The extent of services' engagement with the service user's wife and the impact of this, in particular the explanation to her of her husband's care and treatment and consideration and action to address her own needs.

***To identify*:**

Developments in services since the incident and in particular progress made on implementation of the internal action plan, including assessment of the impact on frontline clinical practice.

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

Any additional learning points for improving systems and services.

***To make*:**

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

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

To report:

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

6. The Independent Investigation Team

Members of the Investigation Team

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

Independent Investigation Team Leader and Chair

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

Investigation Team Members

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

Support to the Investigation Team

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

7. Investigation Methodology

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

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

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

A 'C' type review does not seek to reinvestigate a case from the beginning if it can be ascertained that the internal review was robust. In a 'C' type review the Independent Investigation is charged with building upon any investigative work that has already taken place. After careful consideration the Independent Investigation Team found that the work of the Internal Investigation to have been sound. This work examined two episodes of care, the first being between 2002 and 2005, and the second being December 2008. Because of this it was not thought necessary to re-examine in-depth the earlier episode of care and treatment Mr. X received between 2002 and 2005 as it did not appear to have any bearing upon the events of December 2008.

The Independent Investigation Team decided to interview the two key members of the CMHT who provided care and treatment to Mr. X during December 2008, and the North Kirklees CMHT Team Manager. The Trust Corporate Team was also interviewed. This decision was made in order to ensure that the documentary analysis was conducted within a Scott and Salmon compliant process that was both fair and transparent. In the event CPN 2 could not be seen as she is now domiciled in New Zealand.

It is usual for a 'C' type review to be conducted by a single person with the support of a peer reviewer. As the Health and Social Care Advisory Service had been asked to work on two

other Investigations within the Trust at the same time it was decided that a multidisciplinary team would be recruited to work upon all three cases simultaneously.

The Investigation Methodology is set out below.

Communication with the Victim's Family

As the lead commissioning body for the Independent Investigation process NHS Yorkshire and the Humber wrote to previously identified family members of Mrs. X to invite them to participate in the Independent Investigation process. This initiated the communication process that is required by HSG 94 (27) and the National Patient Safety Agency Guidance to ensure that families are consulted with in relation to:

- contributions they may wish to make to the Independent Investigation;
- dissemination and sharing of the findings of the Independent Investigation;
- publication and distribution of the report.

The Independent Investigation Team met with the family of Mrs. X on the 13 June 2011.

Communications with the South West Yorkshire Partnership NHS Foundation Trust

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

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

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

On the 27 September 2010 a preliminary meeting was held between Senior Officers from NHS Yorkshire and the Humber, South West Yorkshire Partnership NHS Foundation Trust, NHS Kirklees, and the Health and Social care Advisory service. The purpose of this meeting was to discuss the Independent Investigation Process and to determine key actions, roles and functions.

On the 6 December 2010 the Independent Investigation Team Chair and Social Worker Member of the Team visited the South West Yorkshire Partnership NHS Foundation Trust headquarters. This was in order to meet with the nominated Trust liaison person and to conduct a workshop for the witnesses who had been identified as requiring an interview with the Independent Investigation Team. The purpose of the meeting was to clarify the arrangements that were required for the forthcoming Investigation interviews planned to be held on the 11, 12 and 13 January 2011. The purpose of the workshop held for witnesses was to ensure that they understood the process, were supported and could contribute as effectively as possible.

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

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

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

Communication with NHS Kirklees (Primary Care Trust)

The Independent Investigation Team Chair made contact with NHS Kirklees and a liaison person was identified.

Senior Members of the Health and Social Care Advisory Service Team met with the NHS Kirklees Director of Nursing, and Associate Director of Clinical Governance on the 27 September 2010. On the 12 January 2011 another meeting was held between the Independent Investigation Team Chair and the Associate Director of Governance to discuss progress and additional process requirements.

On the 13 June 2011 a meeting was held with members of the Independent Investigation Team and the Associate Director of Governance to discuss the headline findings and recommendations.

Witnesses Called by the Independent Investigation Team

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

Table One

Witnesses Interviewed by the Independent Investigation Team

Date	**Witnesses**	**Interviewers**
12 January 2011	Trust Acting Chief Executive Trust Acting Director of Nursing Trust Medical Director Service Director Consultant Psychiatrist Associate Specialist Psychiatrist CMHT Team Leader	Investigation Team Chair (Nurse) Investigation Team Social Worker Investigation Team Clinical Psychologist In attendance: Stenographer

Salmon Compliant Procedures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Independent Investigation Team Meetings and Communication

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

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

The Team Met on the Following Occasions:

22 October 2011. On this occasion the Investigation Team met to discuss the timeline and to identify issues that required further examination.

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

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

Other Meetings and Communications

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

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

Root Cause Analysis (RCA)

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

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

RCA is a four-stage process. This process is as follows:

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

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

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

8. Information and Evidence Gathered (Documents)

During the course of this investigation 562 pages of clinical records have been used and some 4,000 pages of other documentary evidence were gathered and considered. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

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

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

Profile of South West Yorkshire Partnership NHS Foundation Trust

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

The Trust strategic vision is *"enabling people with health problems and learning disabilities to live life to the full".* The Trust seeks to place service users at the centre of the service and to put people in control of their lives.[2] The Trust vision is to be:

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

2 Trust Presentation to the Independent Investigation

The Trust values are:

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

The Trust goals are:

- *develop a robust service strategy based on a sound understanding of stakeholder expectation and market opportunities;*
- *ensure that organisational systems are working to best effect to support effective service strategy;*
- *maintain and develop an organisational culture that reflects the Trust's values and promotes effective delivery of services for the diverse population served by the Trust, including challenging stigma and discrimination in mental health and learning disability services;*
- *develop a clear organisational structure which promotes accountability and responsibility at all levels;*
- *seek out opportunities to develop new services and approaches which support the Trust's strategy and its core business and help maintain a strong market position;*
- *ensure partnerships are developed which support the core business of the Trust and bring benefits for the communities served.*[3]

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

Table Two Showing Staff in Post by Occupational Group

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

The Trust employs *circa.* 2,500 staff, who provide services from over 40 sites. 98 per cent of care is delivered in the community. During 2009/2020 the Trust had direct contact with approximately 26,000 people. During 2009/2010 the Trust had an annual turnover of £123.8m.[4]

Mental Health Service Provision: Kirklees Older Peoples' Service Community Mental Health Team.

The framework underpinning Community Mental Health Team (CMHT) practice in Kirklees is, and was at the time of the incident, based upon an interdisciplinary biopsychosical model of care. This means that mental health problems are assessed for their biological, psychological and social impacts upon an individual in a holistic manner.[5]

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

1 whole time equivalent Band 7 Team Manager;

1 whole time equivalent Consultant Psychiatrist;

(Junior Doctor cover);

1 whole time equivalent Band 6 Nurse;

2 whole time equivalent Band 5 Nurses;

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

5 CMHT Older People Kirklees Operational Policy Review 2008 PP4-5

1 whole time equivalent Level 3 Social Worker;
1 whole time equivalent Band 6 Occupational Therapist;
1 whole time equivalent Band 3 Support Worker;
0.4 whole time equivalent Band 3 Support Worker/Community Assistant.[6]

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

The CMHT was expected to aspire to the provision of a seven-day a week service. However it was recognised that a seven-day response to crisis situations was not always possible. Out of hours work was possible, for example at weekends and in the evenings, but only on a pre-planned basis.[7]

Referrals were categorised as follows:
'immediate' referrals were to be seen within 24 hours;
'urgent' referrals were to be seen within three days;
'routine' referrals were to be seen within 28 days.[8]

At the time of the incident specialist assessment depended upon the needs and presentation of the person being referred. The 2008 Operational Policy stated that *"for urgent referrals, verbal feedback will be provided within 24 hours of first contact, depending on the availability of the referrer. Written report will follow within 14 days. The results of all other assessments will be made in writing within 14 days of first contact."*[9]

6 CMHT Older People Kirklees Operational Policy Review 2008 P8
7 CMHT Older People Kirklees Operational Policy Review 2008 P12
8 CMHT Older People Kirklees Operational Policy Review 2008 P13
9 CMHT Older People Kirklees Operational Policy Review 2008 P14

10. Chronology of Events

This Forms Part of the RCA First Stage

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

Background Information

Background Information

Mr. X was born on 24 July 1927. He had one sister and a brother who had predeceased him. Mr. X had been married to Mrs. X for over 50 years. They had no children.[10] Mr. X had experienced good mental health throughout his life although he had a history of *"low reactive depression due to business concerns".*[11]

Mr. X had been a Managing Director of a plastics fabrication company which he had owned.[12] He had retired from his business in 2001.[13] This came about because he had lost a big order and he thought he would lose the business and so decided to retire earlier than he had originally planned. Mr. X thought that the speed with which his retirement from work happened did not allow him time to come to terms with it.[14]

From 2002 onwards Mr. X and Mrs. X went away on several cruises, which Mr. X in particular enjoyed. Mr. X used to walk the family dog each day for two hours. Latterly Mr. X had found a voluntary job in a plastics moulding factory, but he had to give this up due to his deteriorating physical health.

In recent times, Mrs. X was content to stay at home and not go on holiday. The family dog was incontinent, and Mrs. X did not feel happy to go away and leave it. She also believed that she and her husband should be slowing down at their age. Mr. X did not agree. Since the time

10 Case Notes P77
11 Case Notes P77
12 Case Notes P77
13 Case Notes P78
14 Case Notes PP64-5

of his retirement Mr. X began to feel increasingly anxious, and at times, suicidal due to what he perceived as the lack of worthwhile activities in his life.

Clinical History with the South West Yorkshire Partnership NHS Foundation Trust

Mental Health Chronology

May 2002 - April 2005 (First Episode)

7 May 2002. Mr. X was referred by his GP at the Paddock Surgery, to the South West Yorkshire Partnership NHS Foundation Trust for assessment due to anxiety and agitation of some three-four months duration. Mr. X's mental ill health appeared to emerge at the time of surgery for a carcinoid tumour on his right lung.[15] Mr. X made a complete physical recovery following his operation.

24 May 2002. After an initial assessment on the 23 May, the allocated Community Psychiatric Nurse (CPN 1) wrote to the GP. The CPN wrote that Mr. X was low in mood and had *"extreme and radical"* thoughts of suicide. He stated that *"both the Dewsbury Risk Assessment and direct questioning proves that he is a threat to himself." "He will not admit that he will try again but in my opinion should this man not improve or we intervene on a very professional basis then I think it would be inevitable that this man will kill himself."*[16] Mr. X was offered both an inpatient assessment and community follow up. Mr. X readily accepted this. The plan was for CPN 1 to meet with Mr. X again on the 27 May at his home and for an Associate Specialist Psychiatrist to also be present.

27 May 2002. Mr. X was seen at his home by CPN 1 and the Associate Specialist Psychiatrist. A number of treatment options were discussed with him. Mr. X was referred to Priestley Day Unit (PDU) for relaxation and anxiety management classes due to *"extreme anxiety and depression"*.[17] He was noted as being on Mirtazapine 45 mg daily, Lorazepam 1 mg twice daily, and Zopiclone 7.5 mg at night. The plan was for CPN 1 follow up to continue and a future inpatient admission to be considered if Mr. X's condition merited it.

15 Case Notes P77
16 Case Notes P78
17 Case Notes P70

11 June - 4 September 2002. Mr. X attended the PDU. During this period Mr. X was subject to a comprehensive and regular series of mental state examinations, risk assessments, activities of daily living assessments and care planning approaches.[18] The Associate Specialist Psychiatrist continued to have input during this period.

5 September 2002. A letter was sent to the GP by a staff nurse at the PDU. It was recorded that *"he (Mr. X) has been an active participant throughout the programme but I have to admit there has been very little real change in his mood and on the whole remains very negative about what the future has in store for him".*[19] It was decided to discharge Mr. X from the PDU as he was making little progress. The GP was advised to refer Mr. X to the Outpatient Clinic for follow up by the Associate Specialist Psychiatrist. A Cognitive Behaviour Therapy referral was also made by the PDU.

17 September 2002. Mr. X was referred by his GP to the Associate Specialist Psychiatrist's Outpatient Clinic.[20]

30 September 2002. The Associate Specialist Psychiatrist reviewed Mr. X at his Outpatient Clinic. Mr. X was accompanied by his wife and CPN 1 was also present.[21] A letter was sent to the GP summarising the outcome of the review. The letter confirmed that arrangements had been made for Cognitive Behaviour Therapy. The Associate Specialist wrote that he felt a different approach to the pharmacotherapy should be taken and recommended that the Mirtazapine should be replaced by Venlafaxine 75 mg daily. One month's supply of medication was issued.

September 2002 and 2005. Mr. X was seen as an outpatient every two-three months alongside Mrs. X who accompanied him.[22] It was noted on the 4 November 2002 that there appeared to be an improvement to Mr. X's mood following the change to his medication.[23] As the months progressed the improvement in Mr. X's mood was maintained. Mr. X and his

18 Case Notes PP 90-113
19 Case Notes P79
20 Case notes P69
21 Case Notes P68
22 Case Notes PP48-52 & 61-68
23 Case Notes P67

wife went on regular cruises during this period and by the 27 April 2004 Mr. X reported himself to be *"feeling 100%".*[24]

This improvement continued. On 23 November 2004 Mr. X was seen again and was *"Very well."*[25]

13 April 2005. Mr. X attended as an outpatient for the last time and was discharged back into the care of his GP. On this occasion the Associate Specialist Psychiatrist noted that Mr. X had successfully stopped taking his Venlafaxine over a six-month period as agreed during the last review.[26] There were no signs of any mood fluctuations and Mr. X was enthusiastically planning a trip to China.

December 2008 (Second Episode)

1 December 2008. The GP referred Mr. X to South West Yorkshire Partnership NHS Foundation Trust mental health services.[27] The referral papers were faxed to the Community Mental Health Team (CMHT). In answer to the question 'previous psychiatric history' on the referral form a *"No"* was filled in by the GP. The referral form also stated that Mr. X was started on Fluoxetine 20mg on 28 November 2008 and that the referral was primarily to request counselling.[28]

2 December 2008. The GP referral was received by the CMHT and a CPN at the team base completed the referral screening form. The screen recorded that Mr. X had a *"presenting mental health problem"* of *"low mood".* In regard to Mr. X's mental health there was *"no details on referral"* about risk recorded. Mr. X was recommended to be seen *"within 14 days".*[29]

It was recorded in Mr. X's case notes *"referral received".* The RiO entry had Mr. X accepted to the Older Peoples Service with the North Kirklees South CMHT.[30]

24 Case Notes 52
25 Case Notes 53
26 Case Notes P57
27 Case Notes PO
28 Case Notes PP26-27
29 Case Notes P28
30 Case Notes P5

Mr. X visited his GP on this date because he was experiencing some unpleasant side-effects from his medication. The GP decided that Mr. X still required antidepressant medication and it was changed to Venlafaxine. He was asked to return for a review after one week.[31]

3 December 2008. Mr. X's case was allocated to CPN 2.[32] In the Communication Record it was recorded at 13.30 that CPN 2 made a telephone call to establish contact with Mr. X. CPN 2 spoke to Mrs. X. It was recorded that Mrs. X said *"he's really down in the dumps, he's been to Huddersfield about voluntary work. He's decided that he can't eat or sleep, watching TV during night. Visit to GP yesterday – he's changed the medication. Spending his time sighing and says there's nothing to live for".*[33]

8 December 2008. CPN 2 visited Mr. X and Mrs. X for the first time. She made an appointment to visit again on the 18 December 2008.[34]

9 December 2008. Mr. X returned to his GP. On this occasion his main concern was insomnia and urinary problems. The GP prescribed 14 Zopiclone 3.75mg capsules. This prescription was repeated on the 18 December 2008.[35]

10 December 2008. CPN 2 wrote up her notes about the previous day's visit. It was recorded in the Communication Record *"home visit to Mr. X. Mrs. X was present through some of the visit but I felt I had to ask her to let me speak to her husband alone as she was talking over him and I felt he'd be more open without her. Mr. X feels he 'went to pot' when he stopped work. Feels there is nothing in their life, no point in going on. He has thought about taking his life and has thought about how he'd do it but says he has not got to that point yet."* Text inserted after this states that *"He also promised me he would not do anything before my next visit on Thursday 18/12/08".*[36]

The clinical record also noted the conversation held with both Mr. X and Mrs. X. It said *"Mrs. X feels she is forced to do what her husband wants, feels she's having her arms forced".* The record also noted that Mr. X *"has found himself a voluntary job working in a*

31 GP Letter to the Internal Investigation Team P446 Investigation Archive
32 Case Notes PO
33 Case Notes P29
34 Case Notes PO&P6
35 GP Letter to the Internal Investigation Team P446 Investigation Archive
36 Case Notes PP29-30

plastics moulding factory which he started yesterday" and that *"he says he feels very anxious about being depressed, feels horrible and miserable all the time, is not sleeping".* Mr. X also stated that he was *"not eating anything".*[37]

CPN 2 recorded that *"after I'd spoken to Mr. X we went through to the kitchen and Mrs. X was livid saying it was her house and I had no right to speak to her husband on his own. I explained it was important to have spoken to Mr. X on his own. She seemed to think he's been talking about her, which I said he hadn't. I then suggested she could speak to me alone if she wanted. She said she'd like to and told me that she'd put up with her husband for the 50+ years of their married life..."*[38]

CPN 2 commenced the Care Programme Approach (CPA) paperwork. CPN 2 was listed as the Care Coordinator, but the CPA level was not stated at this stage. Care Plans were developed to address three identified issues:

1. **Depression and suicidal ideation.** Mr. X was identified as being depressed and suicidal and it was recorded that he had plans to commit suicide, but that he declined to disclose what he intended to do. The plan was to provide support by visiting on a weekly basis. A 'BASDEC' assessment (Brief Assessment Schedule for detecting depression in the elderly) was to be undertaken in order to assess the level of Mr. X's depression. A therapeutic relationship was to be built up with Mr. X to aid in-depth questioning about suicidality. Medical staff were to be involved to ensure both ongoing assessment and medication review.[39]
2. **Keeping busy and finding a purpose to life.** Mr. X expressed a need to keep himself occupied and the plan was to support him in exploring activities with which he could engage and look forward to.[40]
3. **Friction between Mr. X and his wife.** It was noted that Mr. X and his wife wanted different things from life and that this was causing difficulties between them. The plan was to suggest a referral to Relate for counselling to support a dialogue between Mr. X and his wife.[41]

37 Case Notes PP30-31
38 Case Notes P32
39 Case Notes P22
40 Case Notes P22
41 Case Notes P22

As part of the CPA both a contingency and a crisis plan were developed. The contingency plan focused on actions which needed to be considered if Mr. X disengaged from the service. Relapse indicators were identified as Mr. X having feelings of depression and believing that he had nothing to live for.

The crisis plan recorded that in crisis *"Mr. X or his wife to contact CPN 2, Care Coordinator, or the Consultant Psychiatrist. For Mr. X to contact his GP. In emergency, contact emergency services. If Mr. X needs to talk urgently out of hours to contact Samaritans or NHS Direct".*[42]

The CPA Review date was listed as being 9 June 2009. At this stage the CPA assessment was not signed off so that it could be amended once more information had been collected.[43]

Also on 9 December 2008 CPN 2 completed the Health of the Nation Outcome Scale (HoNOS Plus form)**.** Mr. X received a score of '3' for suicidal behaviour and '2' for problems with depressed mood. Other entries had either a '0' or a '1' against them.[44] The HoNOS Plus employs a five point rating scale 0-4.

CPN 2 started to complete but did not finish a 'Comprehensive Health and Social Care Needs Assessment'. In the 'Presenting Circumstances and Precipitating Factors' section she noted: *"Depression over past month. Feels there is nothing in their life and no point going on. Has plans to end his life but has not got bad enough to act on this yet. Did not disclose what his plans are. Feels anxious about his depression, is not sleeping or eating properly. Feels horrible all of the time, is miserable. Has been prescribed Venlafaxine 75mg once daily, recently changed from Fluoxetine which was prescribed by the GP on 28/11/08. Mr. X's wife says she has to put up with his depression for years and went through it all 5 years ago."*[45]

Under the 'History of Present Circumstances' section it said: *"Wife refusing to go on holiday again as their dog is 14 and incontinent and she refuses to put it in kennels. Volatile relationship between Mr. X and his wife, they want very different things from life."*[46]

42 Case Notes P24
43 Case Notes PP21 & 24
44 Case Notes P9
45 Case Notes P10
46 Case Notes P10

Under the 'Mental State Examination' section the following was recorded about Mr. X. *"Good eye contact, good posture, attentive, able to concentrate, intelligent and articulate. Slight agitation and restlessness. Speech level, context and content normal. Depressed mood and anxious about his depression but is motivated to find voluntary work and still takes dog out for 2 hours each afternoon and admits this makes him feel better."*[47]

This assessment was not completed by CPN 2 as more information was being sought at this stage.

Again on 9 December 2008 CPN 2 started to complete, but did not finish, an 'Initial Risk Assessment/Management Plan'. Different headings contained the following detail.

- **Risk Indicator - Suicide.** It was recorded that Mr. X had made no previous attempts on his life and that he had not previously abused either drugs or alcohol. It was also recorded that Mr. X was currently expressing suicidal ideas and that he also had a plan in place to put his ideas into practice. Mr. X was assessed as feeling hopeless and to be expressing high levels of distress. It was noted that Mr. X had promised not to act upon his plans for suicide. It was also noted that Mr. X often became angry with his wife who showed a lack of understanding of his depression.[48]
- **Risk Indicator – Neglect.** It was noted that Mr. X was not eating properly and that he had a lack of positive social contacts. However no other indicators of neglect, or potential neglect, were identified. The assessment under this section summarised that Mr. X found eating difficult as everything he put into his mouth tasted *"like cardboard".* Mr. X was trying to eat porridge and was supplementing his diet with 'Build Up'. CPN 2 suggested that he also try soup.[49]
- **Risk Indicator - Aggression/Violence.** It was recorded that Mr. X showed signs of anger and frustration and there were known personal trigger factors. However these personal trigger factors were not described. It was also recorded that there had been no previous incidents of violence and no previous history of impulsive acts. Mr. X was not assessed as experiencing paranoid delusions or command hallucinations.[50]

47 Case Notes PP10-11
48 Case Notes P12
49 Case Notes P13
50 Case Notes P13

- **Risk Indicator - Other.** It was identified that Mr. X had some risk relating to his memory and that he had some short term memory problems.[51]
- **Risk Indicator - Physical-Environmental Problems.** It was assessed that Mr. X had slight sensory impairments with both his sight and his hearing. It was noted that he was having problems with urination and that he intended to visit his GP about this. Problems were also identified regarding Mr. X's ability to find his way around his local environment.[52]
- **Risk Indicator - Care related Problems.** No areas of risk were identified under this section.

The summary stated that Mr. X had *"current suicidal thoughts and ideation, can't see any point to his life. Mr. X gets angry with his wife who shows a lack of understanding of his depression. Says he has a plan but has promised not to act on it. Previous depression in 2002 following unplanned retirement in 2001. Slight short-term memory problems. Mr. X currently finds eating difficult, saying everything he puts into his mouth feels dry and like cardboard. He is trying to eat porridge, has build up type supplement and I have suggested soup. Wears glasses and hearing aid, currently having difficulty passing urine, intends to visit GP about this".* No initial management plan was developed at this stage as the assessment was still being completed.[53]

At 15.35 on 9 December 2008 CPN 2 put in the Communication Record *"Message left for Mr. X about possible visit tomorrow to do BASDEC etc"*[54]

10 December 2008. It was entered in the Communication Record *"phone call from Mr. X, he'd rather wait until our appointment on Thursday 18/12/08 as he has plans for today".* Later that day at 12.50, CPN 2 received another telephone call from Mr. X. CPN 2 recorded her conversation with Mr. X as follows: *" his wife felt very put out by me wanting to talk to him alone, he thinks she is very jealous. She feels I [CPN 2] am against her. I explained that I am not and on my next visit I plan to spend some time with her as I realise she too needs support. Mr. X said he'd found the conversation we'd had very useful and supportive. I offered to talk to my manager about his situation. I suggested the possibility of a male worker*

51 Case Notes P14
52 Case Notes PP14-15
53 Case Notes P15
54 Case Notes P33

and perhaps doing a joint visit on Thursday. I also suggested that Relate counselling could be useful to both Mr. X and his wife. He said he was too old to start a new life, I explained that Relate would help them find a way to get along better together".[55]

15 December 2008. CPN 2 wrote in the Communication Record that *"Future communication notes on RiO".*[56] The rest of that record is crossed through to show no further entries were made.

16 December 2008. Mr. X visited his GP because he was experiencing leg cramps for which he was prescribed Quinine Sulphate. The GP reported Mr. X as saying he *"was feeling calmer."* The GP did not see Mr. X again after this date.[57]

17 December 2008. CPN 2 received a telephone call from Mrs. X to check the time of her husband's appointment the next day. CPN 2 also recorded *"she told me Mr. X had gone to Filey to walk the dog and that he tried to go there on Saturday and had got lost on the way, missing the turning off the motorway. He also said he would not mind dying in a car crash if it happened accidentally. I spoke to her about us not hitting it off very well on my initial visit but she said she was looking forward to my visit and the chance to talk to me."*[58]

18 December 2008. At 15.00 CPN 2 and the Associate Specialist Psychiatrist visited Mr. X and Mrs. X at home.[59] CPN 2 recorded that Mr. X *"is still very depressed and feels he has nothing to live for"*. He also said *"he was old and decrepit and had no purpose in life".* CPN 2 recorded a discussion about Mr. X's sleeping difficulties and noted that he had been prescribed *"Zopiclone 3.75mg dose, 1 or 2 per night as necessary"* by the GP and that she gave *"a lot of information… to Mr. X and his wife about sleep hygiene"*. The Associate Specialist Psychiatrist advised Mr. X against driving whilst taking the medication he was on.[60]

It was recorded that Mr. X was awaiting the results of a cardiac monitor test and that *"any increase in medication will be dependent on the results and a change in medication may be*

55 Case Notes P34
56 Case Notes P34
57 GP Letter to the Internal Investigation Team P446 Investigation Archive
58 Case Notes P8
59 Case Notes PO, P6, P8
60 Case Notes P8

indicated, the Associate Specialist Psychiatrist to monitor. Mr. X to be referred to the Associate Specialist Psychiatrist's out-patient clinic".[61]

The Associate Specialist Psychiatrist asked Mr. X if he would *"like to come into hospital".* Mr. X refused but stated that *"if he didn't improve he would come".* CPN 2 recorded that *"Mr. X was not sectionable under the Mental Health Act and did have the capacity to make the decision himself"*. CPN 2 gave the rationale that *"when asked about suicidality Mr. X said he didn't feel life was worth living, he had thought about suicide and thought he would probably drown himself in the canal or river. He said he did not have active plans for this".* After the Associate Specialist Psychiatrist left at 16.00, CPN 2 carried on in conversation with Mr. X. *"We discussed the possibility of voluntary work, Mr. X had some information about jobs. He had made a few phone calls but no satisfactory replies. The voluntary job Mr. X found for himself in a plastic fabrication factory had not been suitable as he found his hands, knees etc aching due to production line work. I offered him help in finding voluntary work but told him it was unlikely this could be arranged before the New Year. Mr. X and his wife are still planning to go away for a few days over Christmas."* [62]

CPN 2 made the next appointment to visit Mr. X on 23 December 2008 at 14.30.[63]

19 and 22 December 2008. CPN 2 made one telephone call on 19 December and two on 22 December. The purpose of these calls was not recorded but it would appear that neither Mr. X nor his wife answered the telephone.

22 December 2008. CPN 2 started to fill in a 'Multi-disciplinary Risk Assessment'. Under the main heading 'Categories of Risk Identified' the boxes for 'Suicide and Self Harm', and 'Other' were ticked. This was qualified in the 'Historical Information' box with *"Depression 2002, expressed suicidal ideation and plan to tie a rope around his neck and drop from the balcony (Balcony no longer exists) did not carry it out…".*

In the 'Health Related Factors' section, it was recorded that Mr. X had *"Current problems urinating, seeing GP. Recent 7 Day cardiac trace, results due 29.12.08".*[64]

61 Case Notes P8
62 Case Notes P8
63 Case Notes P36
64 Case Notes P16

In the 'What Risks has the Client Experienced from Others' section, it was reported that *"his wife no longer wishes to partake in foreign holidays as she is no longer happy to leave the dog".*

In the 'Summary of Positive Resources and Potentials' section it was recorded that Mr. X *"Walks his dog 2 hours each day, actively seeking voluntary work to give purpose to his life. Has enjoyed regular foreign holidays in the past, his wife is now reluctant to leave the ageing dog. Wife generally supportive and vigilant. Planned hotel break over Christmas. Mr. X had the motivation to find voluntary work in a local …factory but then found he could no longer do such work as his hands and legs ached. He is desperate to find activities to keep him busy".*[65]

In the section titled 'Are there any Factors that Indicate Preferred Staff Allocation' it was recorded *"wife initially resistant to me seeing Mr. X alone but now sees therapeutic reason for this. Plan to give her time and support too, support worker to be taken on visits to facilitate this".*[66]

The section titled 'Planned Intent to Engage in Risk Related Behaviour' recorded *"says he thinks he may drown himself in canal or river, no active plans voiced"*.[67]

The Risk Management Plan followed on from the above. This was started but not signed off by CPN 2. In this plan the CPA level was recorded as 'Enhanced'.

In the section 'Opportunities for Risk Prevention' it was recorded *"Support for Mr. X and his wife in the form of weekly visits by care coordinator to build a therapeutic relationship individually and together. Home visit from Associate Specialist Psychiatrist then follow up in outpatients clinic. Encourage Mr. X to walk dog regularly. Support Mr. X in finding voluntary work."*[68]

In the section 'Short-Term Crisis Management Options' the plan was for *"weekly visits from care coordinator to monitor mood and offer support. Regular outpatients appointments.*

65 Case Notes P16
66 Case Notes P16
67 Case Notes PP16-17
68 Case Notes P18

Basdec to aid mood monitoring, suicide risk factors checklist. Adjust medication as necessary."[69]

In the section 'Long-Term Management Options' it was recorded *"hospital admission if Mr. X feels he is not getting any better. Support Mr. X in finding voluntary work and being creative in the kind of work he looks for. Support Mr. X to find activities and possibly holidays he can pursue alone if his wife feels she does not want to accompany him."*[70]

The Next Review was planned for 27 January 2009 at a CMHT meeting.[71]

23 December 2008. CPN 2 accompanied by a Support Worker went to the home of Mr. X and Mrs. X at 14.05. There was no answer at the door which was unlocked. After looking through windows and noticing five pints of milk had been left on the doorstep, CPN 2 rang the house from which she received no answer. The Support Worker went to the rear of the property and tried the back door and found it to be unlocked, the sound of a dog barking could be heard, but it was decided not to enter the house. CPN 2 then rang her Team Manager to ask advice about how to proceed. The Team Manager and CPN 2, following a telephone discussion, decided the correct course of action was to telephone the Police for support.[72]

Account of the Incident

CPN 2 called the Police from her mobile telephone at 14.29. The Police arrived at 15.40. The Police gained access to the house where Mr. X and Mrs. X were found dead. Mrs. X was found to have fatal injuries to her head, and Mr. X was found dead face down in the bath. Subsequently the Police did not find evidence of any third party involvement.

The Coroner ruled a verdict of unlawful killing for Mrs. X. He was satisfied that no third party other than Mr. X had been involved. The Coroner ruled that Mr. X had died from

69 Case Notes P18
70 Case Notes P18
71 Case Notes PP18-19
72 Case Notes P8

drowning and that he had taken his own life. Mr. X was 81 years of age at the time of the incident, his wife was 80 years of age.[73]

73 MGN 13 August 2009.

11. Identification of the Thematic Issues

12.1. Thematic Issues

The Independent Investigation Team identified 13 thematic issues that arose directly from analysing the care and treatment that Mr. X received from the South West Yorkshire Partnership NHS Foundation Trust. These thematic issues are set out below.

1. **Referral Procedures.**
2. **Diagnosis.**
3. **Medication and Treatment.**
4. **Use of the Mental Health Act (2007).**
5. **Care Programme Approach (CPA).**
6. **Risk/Clinical Assessment.**
7. **Service User Involvement in Care Planning and Treatment.**
8. **Carer Involvement and Carer Assessment.**
9. **Documentation and Professional Communication.**
10. **Clinical Management of the Case.**
11. **Adherence to Local and National Policy and Procedure, Clinical Guidelines.**
12. **Clinical Governance and Performance.**
13. **Internal Investigation.**

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

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

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

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

- Mr. X killed Mrs. M (ask why?)
- Because the balance of his mind was disturbed (finding of the Coroner) = root cause.

The fact that the balance of Mr. X's mind was disturbed could reasonably be seen to have made a significant contribution to the death of both himself and his wife. However Mr. X had been assessed six days before he was found dead as having capacity and as such he retained a high degree of self-determination and control over his actions. Mr. X was receiving an appropriate and evidence-based care and treatment package which was based upon his presentation and symptomology. The root cause for the deaths of Mr. X and his wife cannot be logically routed back to any act or omission on the part of the treating team.

RCA Third Stage

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

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

In the interests of clarity each critical issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms 'key causal factor', 'influencing factor' and 'service issue' are used in this section of the report. They are explained below.

Contributory factors can either be identified as either being 'influencing' or 'causal'.

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

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

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

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

The findings in this chapter analyse the care and treatment given to Mr. X by the South West Yorkshire Partnership NHS Foundation Trust.

12.1.1. Referral Procedures

12.1.1.1. Context

South West Yorkshire Partnership NHS Foundation Trust Operational Policy 2008

At the time of the incident the Trust had an Operational Policy in place for the North Kirklees Older Peoples' Community Mental Health Team. The policy stated that:

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

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

'routine' referrals were to be seen within 28 days.[74]

The North Kirklees Community Mental Health Team, whilst acknowledging the Operational Policy, always tried to see all routine referrals within a fourteen-day interval as a point of best-practice working.

At the time of the incident specialist assessment depended upon the needs and presentation of the person being referred. Under 'communication' the 2008 Operational Policy stated that *"for urgent referrals, verbal feedback will be provided within 24 hours of first contact, depending on the availability of the referrer. Written report will follow within 14 days. The results of all other assessments will be made in writing within 14 days of first contact."*[75]

Relevant Events relating to the Referral: December 2008

1 December 2008. The GP referred Mr. X to South West Yorkshire Partnership NHS Foundation Trust mental health services.[76] The referral papers were faxed to the Community Mental Health Team (CMHT). In answer to the question 'previous psychiatric history' on the

74 CMHT Older People Kirklees Operational Policy Review 2008 P13
75 CMHT Older People Kirklees Operational Policy Review 2008 P14
76 Case Notes PO

referral form a *"No"* was filled in by the GP. The referral form also stated that Mr. X was started on Fluoxetine 20mg on 28 November 2008 and that the referral was primarily to request counselling.[77]

2 December 2008. The GP referral was received by the CMHT and a CPN at the team base completed the referral screening form. The screen recorded that Mr. X had a *"presenting mental health problem"* of *"low mood".* In regard to Mr. X's mental health there was *"no details on referral"* about risk recorded. Mr. X was recommended to be seen *"within 14 days"*.[78]

It was recorded in Mr. X's case notes *"referral received"*. The RiO entry had Mr. X accepted to the Older Peoples Service with the North Kirklees South CMHT.[79]

3 December 2008. Mr. X's case was allocated to CPN 2.[80] In the Communication Record it was recorded at 13.30 that CPN 2 made a telephone call to establish contact with Mr. X. CPN 2 spoke to Mrs. X.

8 December 2008. CPN 2 visited Mr. X and Mrs. X for the first time. She made an appointment to visit again on the 18 December 2008.[81]

Patient Health Questionnaire 9

The Patient Health Questionnaire, or PHQ9, is a nine-point depression rating scale developed specifically for assisting primary-care clinicians in the identification of depression. This rating scale can also be administered by the service user. The scale is used to understand the severity of symptoms and to also identify appropriate treatment. A score of 16 would indicate a moderately severe depression being present.

General Health Questionnaire

The General Health Questionnaire, or GHQ, is a screening device used for detecting minor psychiatric disorder. This assessment device is available in several different versions, the

77 Case Notes PP26-27
78 Case Notes P28
79 Case Notes P5
80 Case Notes PO
81 Case Notes PO&P6

purposes of which are primarily to detect the inability to carry out normal daily-living functions and the appearance of new and troubling symptomology.

12.1.1.2. Findings of the Internal Investigation Team

GP Referral

The Internal Investigation Team found that the referral from Mr. X's GP prepared was *"barely legible, referred to a questionnaire that was not understood by the CMHT, and upon allocation was found to be inaccurate with regard to past psychiatric history".*[82]

The point was made by the Internal Investigation Team that the incompleteness of the referral information could have led to a delay in the allocation of Mr. X's case and that this could have resulted in the CMHT responding less swiftly than it did. This delay could potentially have led to a serious incident occurring before anyone at the CMHT had taken the opportunity to assess the patient.

The GP had utilised the Patient Health Questionnaire 9 (PHQ9) which had scored Mr. X's depression as being 16 out of 27, which indicated a moderate severity. However the PHQ assessment was not one with which the CMHT was familiar. The GP did not append the PHQ assessment to the referral form, instead he transcribed the PHQ score '16' onto the referral documentation.

The GP faxed the referral form to the CMHT requesting *"counselling and a routine response time of 14 days".*[83]

CMHT Response

The referral form arrived at the CMHT base during the late afternoon of the 1 December 2008. It was dealt with promptly first thing the following morning by the Duty Worker. The Duty Worker made the incorrect assumption that the PHQ assessment score related to the GHQ, a 'functional test'. The Internal Investigation Team made the observation that had the Duty Worker contacted the GP then the clinical significance of the assessment would have been made available to the CMHT. However the GP was not contacted. The Duty Worker did

82 Internal Investigation Report P54
83 Internal Investigation Report P54

not transfer the PHQ information onto the CMHT screening form as its relevance was not appreciated.[84]

At the time of Mr. X's referral there was no process in place to search routinely for previous medical records when a referral was received. The Duty Worker checked to see if Mr. X had been known previously to services, but did not search for any extant medical records. Following this the CMHT screening form was passed to the CMHT Manager who allocated the referral to CPN 2 on the basis of the details received.[85]

12.1.1.3. Findings of the Independent Investigation Team

GP Referral

The referral made by the GP requested that Mr. X be treated as a routine referral (within 14 days) and that he required counselling. Mr. X was described as *"low, depressed, life not worth living, PHQ score 16/27."* The information on the referral form set out the psychiatric medication that Mr. X was prescribed as being Fluoxetine 20 mg which had been commenced on the 28 November 2008. No specific risk details were listed, and previous psychiatric history was cited as being absent.[86]

The GP also noted that Mr. X had been referred for a cardiology appointment and had a history of ischaemic heart disease and hypertension. Previous blood screens had been undertaken eight months previously and nothing abnormal had been detected.

The Independent Investigation Team found the information on the referral form to be basic in nature and difficult to read. However the central message was clear, Mr. X was low in mood and depressed and was being referred to secondary care services for counselling.

CMHT Response

The CMHT processed the referral on the 2 December 2008 and completed a Referral Screening Criteria Form. The Screening Criteria Form identified that there were no risk behaviours identified on the referral form and that the referral was for *low mood".*[87] Mr. X was allocated a Community Psychiatric Nurse who made telephone contact with Mrs. X on

84 Internal Investigation Report P55
85Internal Investigation Report P54
86 Case Notes PP26-27
87 Case Notes P28

the 3 December in order to arrange a home visit to Mr. X on the 8 December. When Mr. X's case was entered onto RiO on the 2 December 2008 the entry *"(OPS) CMHTS*" was made.[88] At interview with the Independent Investigation Team clinical witnesses recalled that initially the plan was for Mr. X to be assessed in the Outpatient Clinic on the 16 December, however CPN 2 was able to arrange a home visit prior to that date for the 8 December.

In the intervening interval, between the 1 and 3 December, the CMHT realised that Mr. X had been known to them previously and his past clinical records were secured prior to the first domiciliary visit being made.

12.1.1.4. Conclusions of the Independent Investigation Team

When examining a case of this kind it is important not to reach conclusions, or place potential significance, on events with the benefit of hindsight. At the point of the referral it would appear that Mr. X presented to his GP with low mood and depression. The GP commenced Mr. X on Fluoxetine 20 mg and referred him to the CMHT for counselling. The GP had conducted a PHQ assessment which suggested to him that Mr. X was in need of a secondary mental health care referral. The PHQ assessment scale has as its primary function the role of assisting primary care clinicians in the diagnosis and treatment of depression. It would appear that the GP utilised this assessment to good effect and made the decision to refer Mr. X to the Trust.

The CMHT acted swiftly in the processing of the referral and Mr. X was seen within eight days of the referral being accepted by the team, this was well within the Operational Policy Guideline.

PHQ Assessment

There are issues relating to the disregarded and misunderstood PHQ assessment form, and the fact that no previous psychiatric history was identified on the referral form by the GP. However these issues alone have not been assessed by the Independent Investigation Team as being of significance at the point of referral in the management of Mr. X's case.

88 Case Notes P5

Mr. X was assessed as having a moderately severe depression by his GP. He was commenced on Fluoxetine 20 mg and referred for secondary care input. This was entirely appropriate based on Mr. X's presentation at the time. It would appear the PHQ 9 assessment was utilised as being more of a guide to the GP than as a 'heads up' to the CMHT. However PHQ 9 is part of the IAPT minimum data set and so GPs locally may be required to use it routinely as part of the referral to IAPT/mental health services. If this is the case then CMHT will need to become familiar with it. It was difficult to identify what further clinical information could have been gleaned by the CMHT had they understood the PHQ 9 assessment score, as the GP had written *"low, depressed, life not worth living"* which the Independent Investigation Team understood to indicate a moderately severe depression was present.

Communication with the GP

Possibly, had CMHT clinicians contacted the GP, more information may have been made available about Mr. X. However this is an assumption. When assessing the reasonableness of any clinical activity or omission the Independent Investigation Team have to ask *"what was known at the time, and should have been known at the time?"*

Without the benefit of hindsight, at the time of referral, the information from the GP did not single this case out as being a high priority. The GP had commenced anti-depressant medication and was making a referral for counselling only. It would not have been usual, or expected, practice for a CMHT to have made telephone contact with a GP at this stage. The Operational Policy extant at the time of the incident instructed the CMHT to make written communication with the GP within 14 days of the first visit. This aspect of communication will be addressed further on in the report, as it is not strictly speaking, part of the referral process which is being examined in this subsection.

Summary

The GP made the correct decision to refer Mr. X to secondary care services in December 2008. At the time of the referral Mr. X did not appear to be presenting with a depression that required urgent intervention and the CMHT acted appropriately based on what was known to them at the time. The CMHT made telephone contact within two days of the referral being made and undertook a domiciliary visit within eight days. This is to be commended.

As a point of learning it would be sensible for both the South West Yorkshire Partnership NHS Foundation Trust and NHS Kirklees to ensure that all assessment documentation and rating scales currently in use across both primary and secondary care services are identified. Following this it would be sensible for senior clinicians to determine whether or not the assessments and scales are validated for clinical use. Once this has been achieved decisions need to be made regarding how these assessments and scales are to be used in future in ensuring safe and effective patient care is achieved.

- ***Service Issue Number 1. The PHQ 9 assessment is being used with in primary care contexts. A ratification of clinical assessments and scales has not taken place across primary and secondary care and this could lead to confusion and miscommunication in the future.***

12.1.2. Diagnosis

12.1.2.1. Context

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

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

health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

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

Background Information

Mr. X had a history of depressive illness between 2002 and early 2005 for which he was treated successfully by the Trust. Apart from this episode Mr. X had not suffered from any identified mental illness during his long life. At the age of 81 years Mr. X experienced a reoccurrence of his depression for which he sought help from his GP on the 28 November 2008.

Depression

Diagnostic criteria for depression ICD-10 uses an agreed list of ten depressive symptoms

Key symptoms:

- *persistent sadness or low mood; and/or*
- *loss of interests or pleasure;*
- *fatigue or low energy.*

(at least one of these, most days, most of the time for at least 2 weeks)

If any of above present, ask about associated symptoms:

- *disturbed sleep;*
- *poor concentration or indecisiveness;*
- *low self-confidence;*
- *poor or increased appetite;*
- *suicidal thoughts or acts;*
- *agitation or slowing of movements;*
- *guilt or self-blame.*

The 10 symptoms then define the degree of depression and management is based on the particular degree:

- *not depressed (fewer than four symptoms)*
- *mild depression (four symptoms)*
- *moderate depression (five to six symptoms)*
- *severe depression (seven or more symptoms, with or without psychotic symptoms)*

Symptoms should be present for a month or more and every symptom should be present for most of every day.[89]

12.1.2.2. Findings of the Internal Investigation Team

The Internal Investigation Team agreed with the Associate Specialist Psychiatrist's clinical impression formed on the 18 December 2008. This impression was that there were no signs of dementia present and that further cognitive testing should be deferred until Mr. X's depression had been improved as depression can reduce cognitive functioning, thereby making assessment unreliable. The Associate Specialist Psychiatrist could not detect the presence of a psychosis and following assessment concluded that Mr. X had the mental capacity to refuse the hospital admission which was offered.[90]

12.1.2.3. Findings of the Independent Investigation Team

At the point of referral the GP made a diagnosis of 'moderately severe' depression based upon the PHQ 9 rating scale. This diagnosis may not have been explicit on the referral documentation, but the GP did make it clear that the referral was made because of Mr. X's low mood and depression. It would have been unlikely for a primary care referral to have been made for CMHT input had the depression not been deemed to be of a moderate or severe nature.

Following the visit made by CPN 2 on the 8 December 2008 under 'Mental State Examination' the following was recorded in the clinical record: *"good eye contact, good posture, attentive, able to concentrate, intelligent and articulate. Slight agitation and restlessness. Speech level, content and context normal. Depressed mood and anxious about*

89 NICE (December 2004). Management of Depression in Primary and Secondary Care
90 Internal Investigation Report PP60-61

his depression but is motivated to find voluntary work and still takes the dog out for 2 hours each afternoon and admits this makes him feel better".[91]

The Associate Specialist Psychiatrist did not make an entry in the clinical record, and neither did he write to the GP in the interval between the referral being made and the incident occurring. This meant that there was no medical record with regard to diagnosis. However CPN 2 wrote up the visit made with the Psychiatrist on the 18 December 2008 and wrote that Mr. X is *"very depressed"* in the clinical record.[92]

The Associate Specialist Psychiatrist had been the lead medical clinician who had treated Mr. X for his earlier depression between 2002-2005. On the 18 December 2008 he was able to renew his professional acquaintance with both Mr. X and Mrs. X who remembered him well and felt comfortable in his presence. When interviewed by the Independent Investigation Team the Associate Specialist Psychiatrist described Mr. X as not being unduly anxious. Mr. X said that he had been unwell for a period of some four weeks and could not think of any triggers for his current depression. Mr. X appeared to be well nourished and did not appear to be restless or agitated. During the assessment Mr. X spoke *"feely, coherently, logically"* he was able to answer questions appropriately and there was no evidence of psychomotor retardation or cognitive impairment. The Associate Specialist Psychiatrist thought that Mr. X was experiencing something more than a mild depression because of his suicidal thoughts, fatigue and loss of appetite. It was because of this an inpatient admission was offered, not because Mr. X presented a high degree of risk, but because anti depressant medication could have been administered more quickly under supervision thus alleviating his symptoms more quickly.[93] This offer was refused by Mr. X.

12.1.2.4. Conclusions of the Independent Investigation Team

It is the conclusion of the Independent Investigation Team that Mr. X's diagnosis was appropriate in the light of his presentation. The GP had correctly identified the presence of a depression of moderate severity and made the appropriate referral. The CMHT processed the referral in a timely manner and ensured that a prompt initial assessment was undertaken which confirmed the diagnosis of the GP.

91 Case Notes P10
92 Case Notes P8
93 Witness Transcription

It was evident to the Independent Investigation Team that the care and treatment which ensued was based upon a diagnosis appropriately made.

12.1.3. Medication and Treatment

12.1.3.1. Context

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

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

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

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

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

When a patient is detained under the Mental Health Act under a treatment order (Section 3 or 37), medication may be administered without the patients' consent for a period of up to three

months. Thereafter the patient must either give valid consent to treatment or must be reviewed by a Second Opinion Doctor (SOAD). The SOAD Service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed for them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient. The SOAD is an independent consultant psychiatrist appointed by the Care Quality Commission.

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

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

12.1.3.2. Findings of the Internal Investigation Team

Medication

Mr. X was prescribed Fluoxetine 20 mg (an anti depressant) by his GP on the 28 November 2008, he was also prescribed Zopiclone (a hypnotic used to treat insomnia). On the 2 December Mr. X went back to his GP because he thought he was experiencing side effects from the medication. On this occasion the GP altered the anti depressant medication to Venlafaxine which was the medication that had been used to treat Mr. X successfully during his depressive illness between 2002 and 2005.[94]

94 Internal Investigation Report P59

Care and Treatment

On the 18 December Mr. X was offered an admission to a psychiatric hospital and/or referral to a psychiatric day care unit. Neither of these options were acceptable to Mr. X although he indicated that he would reconsider these options after Christmas if he was feeling no better.[95] At this juncture the Psychiatrist did not assess Mr. X's condition as requiring a hospital admission under the Mental Health Act. Mr. X's suicide risk was assessed as being of moderate to high risk with no plans of intent. The Associate Specialist Psychiatrist was of the opinion that this risk could be managed within a community context and that Mr. X could remain in his home.[96]

12.1.3.3. Findings of the Independent Investigation Team

Medication

At the point Mr. X was assessed by the CMHT he was being treated by his GP with Venlafaxine 75 mg once daily and Zopiclone 3.75mg at night.[97] The Associate Specialist Psychiatrist was aware that Mr. X had been referred for a seven-day cardiac trace, the results of which were due on the 29 December 2008. He recognised that any review, or increase, of medication should wait until after the results were ascertained which was a sensible precaution as an uncommon side effect of this medication is cardiac arrhythmia.[98] It was understood that Mr. X had responded well to this medication during his previous depressive episode. The Associate Specialist Psychiatrist gave Mr. X sensible advice regarding the medication and suggested that Mr. X did not drive at that time as it may affect his concentration.

Care and Treatment

As has been identified by the Internal Investigation Mr. X was offered an inpatient admission. The Independent Investigation Team learnt that this offer was not made because of any undue concerns about Mr. X's mental state or levels of presenting risk, but due to the fact that he would have been able to receive an 'accelerated' medication regimen in a safe and supervised environment. The Associate Specialist Psychiatrist was of the view that Mr. X was suffering from a degree of depression that was significant and required further treatment. An inpatient admission would have allowed for a more rapid increase of medication, more intense

95 Internal Investigation Report P60
96 Internal Investigation Report P60
97 Case Notes P10
98 Witness Transcription

assessment and observation, and generally, a shortened duration of the symptoms could have been expected. Unfortunately Mr. X refused this offer, as was his right to do.[99]

The short-term plan was to offer Mr. X regular assessment and review at the Outpatient Clinic and for CPN 2 to continue to offer regular support to Mr. X and his wife in their home environment. The offer of an inpatient admission or a day unit referral was left as an open option for Mr. X after the Christmas period if his depression remained unabated.

The longer-term plan was to assess Mr. X in a more holistic manner to take into account his physical health and to assess his cognition. Cognitive Behaviour Therapy had been understood to have helped Mr. X in the past and was to be considered as part of his future care and treatment package.[100]

12.1.3.4. Conclusion of the Independent Investigation Team

Mr. X was commenced on the recognised 'starter' dose of 75 mg Venlafaxine which was a sensible precaution as an uncommon side effect of this medication is cardiac arrhythmia. It was appropriate for the Associate Specialist Psychiatrist to wait until Mr. X's cardiac trace results arrived prior to considering an increase in medication. The medication was suitable for the diagnosis and had been found to work well for Mr. X during his previous depressive illness.

The offer of an inpatient admission and referral to a day unit was entirely appropriate. The Independent Investigation Team understood this approach was not considered because it was thought that Mr. X presented any unacceptable level of risk either to himself or to his wife at the time, but because it was thought to be a means of offering him a more direct and effective resolution of his depressive illness. However Mr. X did not feel this to be an option that he wished to consider at that time. Mr. X was assessed as having the capacity to make this decision.

Mr. X was offered a combination of Outpatient Clinic review and CMHT support which has accepted. The offer of an inpatient admission and referral to a day unit was left as an option in the new year if Mr. X's condition had not improved. Mr. X and his wife were an articulate

99 Witness Transcription
100 Witness Transcription

and well-informed couple who were able to engage with both primary care and secondary care services. Mr. X had been motivated to seek help from his GP rapidly following the onset of his depression. He voiced his feelings openly, was compliant with his medication and appeared to be action and solution focused.[101]

During the 17 day interval that Mr. X received his care and treatment from the Trust he was actively seeking help and support, was engaged with the process, and was able to voice his preferences regarding the interventions that were offered to him. The Independent Investigation Team concluded that the medication, care and treatment offered to Mr. X was evidence-based and in keeping with both his diagnosis and his presentation. The Independent Investigation Team also concluded that the care and treatment offered to Mr. X met national best practice guidelines and the Trust was to be commended for being able to offer such a comprehensive range of service.

12.1.4. Use of the Mental Health Act (2007)

12.1.4.1. Context

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

At any one time there are up to 15,000 people detained by the Mental Health Act. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.[102]

101 Case Notes and Witness Transcriptions
102 Mental Health Act Commission 12th Biennial Report. 2005-2007

The Mental Capacity Act (2005) states that *"…everyone should be treated as able to make their own decisions until it is shown that they are not*." It also aims to enable people to make their own decisions for as long as they are capable of doing so. A person's capacity to make a decision will be established at the time that a decision needs to be made. A lack of capacity could be because of a severe learning disability, dementia, mental health problems, a brain injury, a stroke or unconsciousness due to an anaesthetic or a sudden accident. The Act also makes it a criminal offence to neglect or ill-treat a person who lacks capacity.[103]

12.1.4.2. Findings of the Internal Investigation Team

The Internal Investigation Team did not specifically examine this issue *per se*. However Mr. X's capacity was considered in the light of his refusal to accept an inpatient admission when it was offered to him on the 18 December 2008. It was the view of the Internal Investigation Team that the clinical opinion of the Associate Specialist Psychiatrist was sound regarding Mr. X's diagnosis and mental state.[104]

12.1.4.3. Findings of the Independent Investigation Team

The Independent Investigation Team concurs with the view that Mr. X had capacity and that an admission to a psychiatric inpatient unit under a section of the Mental Health Act was not clinically indicated on the 18 December 2008.

The Independent Investigation Team found that Mr. X was assessed by a senior medical clinician (the Associate Specialist Psychiatrist) who had a detailed knowledge of Mr. X and his wife due to the previous work he conducted with them between 2002 and 2005. The Associate Specialist Psychiatrist was able to meet Mr. X in his own home and carry out an unhurried assessment. As has already been noted above, Mr. X presented as being articulate, logical and motivated to seek help. Mr. X was engaged with services and fully compliant with his care and treatment plan.

12. 1.4.4. Conclusions of the Independent Investigation Team

During the 17 day interval that Mr. X received his care and treatment from the Trust there was no evidence to support the notion that he should have been detained under the Mental Health Act. Mr. X was found to have capacity. An assessment was conducted by an

103 National Archive.gov.uk
104 Internal Investigation Report PP59-61

experienced and suitably qualified senior medical clinician who knew the patient well. The subsequent decision not to admit Mr. X was made in accordance with Mr. X's presentation and the ethos of the Mental Capacity Act (2005) and the Mental Health Act (2007).

12.1.5. The Care Programme Approach

12.1.5.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness[105]. Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach*[106].

"*The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services*[107]." (Building Bridges; DoH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

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

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function

105 The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990
106 Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008
107 Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH 1995

is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

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

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

South West Yorkshire Partnership NHS Foundation Trust CPA Policy

The Trust had a comprehensive CPA policy in place at the time Mr. X was receiving his care and treatment in December 2008 which set out the key aims and objectives of CPA together with the roles and responsibilities of those involved in ensuring its delivery.

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

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

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

- *systematic and carried out with the individual concerned, enabling them to identify their own needs;*
- *undertaken with due regard to confidentially;*
- *thorough and comprehensive;*
- *a unified health and social care assessment, joint (between health and social services) to prevent duplication for the service user and carer and commonly agreed;*
- *a single assessment to facilitate access to both health and social services, based on one point of access;*
- *the quality of initial assessments is enhanced when multi disciplinary and undertaken in partnership between health and social care staff, and information is gathered from all those involved including the service user and carer;*
- *explained to the service user in as simple terms as necessary;*
- *carried out in the most appropriate setting."*[108]

The Trust policy in place at the time of the incident did not take into account the national changes to CPA that had taken place in October 2008. In December 2008 the policy still made the differentiation between 'Standard' and 'Enhanced' CPA.

12.1.5.2. Findings of the Internal Investigation Team

CPA

The Internal Investigation Team found that during Mr. X's first depressive episode in 2002 he was placed on 'Standard' CPA. It was noted that during his second depressive episode in December 2008 he had been correctly placed on CPA (the equivalent of the old 'Enhanced' CPA level) following the changes to the national CPA guidance two months earlier.

Mr. X had an allocated Care Coordinator and care planning interventions were put into place for:

a) risk prevention;

b) short-term crisis management;

108 CPA the Journey. 2006 P6

c) risk prevention.

It was noted that the risk management plan had identified the clinicians and their responsibilities, and that the crisis and contingency plan had been adequately completed by the Care Coordinator, CPN 2. The Internal Investigation team were of the opinion that the interventions identified by CPN 2 were prompt and appropriate and reflected standard and reasonable care in respect of Mr. X's presenting problems and his circumstances.[109]

Care Planning

The Internal Investigation Team thought that care planning had been generally managed well during the first episode of care between 2002 and April 2005, with the exception of a lack of recognition of Mr. X's relapse signature on his discharge from day care.

During the second episode of care CPN 2 sought guidance from her senior clinical colleagues, including those who had previous knowledge of Mr. X. CPN 2 gave Mr. X and his wife out-of-hours contact numbers for other services, such as the Samaritans, should an emergency arise.

It was noted that the 'Comprehensive Health and Social Care Assessment' could have been more comprehensively completed. However the Internal Investigation Team acknowledged that the case had only been open a period of 17 working days prior to the incident occurring. It was also noted that the initial risk assessment had been completed and that some 'no' answers were documented when 'not known' or 'yes' answers would have been more appropriate.

It was the opinion of the Internal Investigation Team that Mr. X's care plan and care package were appropriate and that the plan was informed by the assessment conducted by the Associate Consultant Psychiatrist and CPN 2. The Internal Investigation Team did have some concerns regarding CPN 2's practice regarding her role as a Care Coordinator and these were referred on to her line manager. These concerns were not made clear in the CPA section of the report.[110] The conclusion was that CPN 2's clinical practice was sound and much of it was commendable.

109 Internal Investigation Report P62
110 Internal Investigation Report PP 64-65

12.1.5.3. Findings of the Independent Investigation Team

CPA and Care Planning

Mr. X was placed on CPA, which in December 2008 was the equivalent of being placed upon the old 'Enhanced' level. The Trust CPA policy in place at the time indicated that individuals required Enhanced CPA if they:

- *"have complex multiple needs which involve a number of agencies e.g. housing, employment, criminal justice system, etc.;*
- *present difficulty with engagement, compliance, and cooperation;*
- *may have co-existing difficulties with drug and/or alcohol misuse;*
- *have a disorganised or chaotic lifestyle;*
- *present a serious risk to themselves or others;*
- *history of violence and/or persistent offending;*
- *fail to respond to care/treatment from general psychiatric services."*[111]

The treating team appear to have followed the requirements of the CPA policy. The decision to place Mr. X on Enhanced CPA was made due to his risk of suicide.

The Independent Investigation Team concurred with the findings of the Internal Investigation Team with one exception. The main outstanding area of concern that the Independent Investigation identified was that of timely communication with the GP. Whilst it is acknowledged that the Care Plans and the Contingency and Crisis Plan were still in a state of development, no contact had been made with the GP. The Operational Policy stated that the GP should have received a full written set of documentation within 14 days of the initial visit being made. The CMHT were operating on the cusp of this timeline when the incident occurred. The Contingency and Crisis Plan identified the GP (alongside the CPN and the Associate Specialist Psychiatrist) as a key resource for Mr. X to contact in an emergency. The GP had also been identified as key contact point for the CMHT if Mr. X ceased to engage with the service.

111 CPA the Journey. 2006 P6

12.1.5.4. Conclusions of the Independent Investigation Team

The Independent Investigation Team concluded that CPA was conducted based upon sound assessment principles. The assessment had been multidisciplinary and was conducted in accordance with Trust policy and procedure.

However it would have been sensible to have communicated with the GP at an earlier date especially as he had been identified as a key part of the Contingency and Crisis plan. Christmas was approaching and it was evident that the case that had been referred by the GP was of a more complex nature than had first been thought. It would have been better practice to have given the GP an earlier indication of how Mr. X's mental state was presenting to the CMHT, especially given that an extensive holiday period was about to begin. It is of course entirely possible that CPN 2 was planning to do this after the visit that had been planned for the 23 December, even so this would have been 'cutting the opportunity a little fine' for the practice to be involved if a crisis was to have occurred over the Christmas period.

In the event the delay in communicating with the GP did not contribute in any way to the incident occurring. However it is a point of learning that communication with all members of a care network should be made in a timely manner, especially when a case appears to be of a more complex nature than the referral initially indicated, and also when public holidays are due to commence.

- ***Service Issue Number 2. Communication between the CMHT and the GP was set at an interval which may have caused significant confusion over the Christmas period had Mr. X's health broken down further . The identified communication interval between CMHTs and GPs, following referral, set out in the Operational Policy may be too long when dealing with service users with rapidly emerging mental health problems.***

12.1.6. Risk/Clinical Assessment

12.1.6.1. Context

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

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

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

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

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

- *it conforms with relevant guidelines;*

- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed'*[112].

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

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

South West Yorkshire Partnership NHS Foundation Trust Policy 2008

The Trust policy stated the following:

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

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

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

112 Best Practice in Managing Risk; DoH 2007

The HoNOS Plus risk tool was utilised as part of the initial screening process on referral.

Suicidality in the Elderly

"Suicidal behaviour in the elderly is undertaken with greater intent and with greater lethality than in younger age groups, and health care staff play a vital role in the recognition and prevention of suicide in this age group…Males aged 75 and over have the highest rates of suicide in nearly all industrialised countries, and among many of these nations suicide rates rise with age".[113]

Homicide in the Elderly

"…perpetrators aged 65 and over were most likely to use strangulation/suffocation and the victim was more often a female and a family member or spouse. In younger perpetrators, drug and alcohol misuse and previous violence were more common. Older perpetrators had high rates of affective disorder and were more likely to be mentally ill at the time of the offence. Targeting substance and alcohol misuse and street violence may reduce homicide risk in younger people. Preventing homicide among the elderly might be best achieved through more specialised GP training to improve recognition and treatment of depression."[114]

Combined Incidents of Homicide and Suicide

Combined incidents of homicide and suicide whilst not common are far from unique with the likelihood increasing slightly in populations aged 55 years and over. The incidence rate is so low that few studies have been conducted. However studies conducted to date in the United States of America suggest that the perpetrator is likely to be male and the homicide victim is likely to be a female member of his family, most often the spouse.[115]

12.1.6.2. Findings of the Internal Investigation

The Internal Investigation Team wrote that when the initial risk assessment was conducted on the 9 December 2008 that it had been done without gaining a full history from either Mr. X or his wife. The Internal Investigation Team were of the view that had this been completed based on a more comprehensive set of information then a different picture with regard to risk

113 http://apt.rcpsych.org/cgi/content/full/6/2/102
114 Homicide convictions in different age-groups: a national clinical survey
Journal of Forensic Psychiatry & Psychology
Volume 21, Issue 3, First published 2010, PP 321 - 335
115http://ajp.psychiatryonline.org/cgi/content/full/155/3/390

may have emerged. It was thought that some boxes on the risk screening tool had been ticked with 'no' answers when 'don't know' would have been a more accurate response.
The Internal Investigation Team stated that *"…risk assessment should be repeated once missing information becomes available, through further probing and exploration. Any risk assessment tool is a dynamic document which records information which is valid at a single point in time."*[116] It was unclear whether or not the 'missing' information would have been forthcoming had the risk assessment process been completed.

There was speculation regarding the level of risk that Mrs. X was subject to during this period. The treating team at the CMHT were not alerted by the inputs from either Mrs. X or Mr. X's GP with regard to any potential violence being offered to Mrs. X at this time. The Internal Investigation Team interviewed some members of Mrs. X's family and the Pastor of both Mr. X and his wife. The Internal Investigation reported that Mrs. X's family were of the view that Mrs. X had confided her fears to her GP and that Mrs. X's sister was of the impression that Mrs. X had told her GP that she was *"scared to death"* of her husband. The terms of reference of the internal investigation would not allow it to access Mrs. X's GP records and this could not be verified.[117] However Mr. X's GP was seen by the Internal Investigation Team and he stated that Mrs. X (who frequently accompanied her husband to the surgery) had never reported any concerns to him about her own safety and latterly the family have commented that they did not believe that Mrs. X would have disclosed her fear of her husband while he was present. The Internal Investigation Team thought that had the CMHT been aware of the degree to which Mrs. X reportedly lived in fear of her husband, this could have been managed in a more appropriate way.

It was noted that CPN 2 had taken up her post within the CMHT in June 2008 as a recently registered nurse, but had not yet undertaken any formal risk training. Clinical risk management training across the Trust had been subject to change and development during 2008 and the CMHT Managers interviewed by the Internal Investigation Team had not been aware of the training dates that had been made available. The Internal Investigation Team stated that whilst this kind of training was not mandatory it was important that it should be made available to staff, especially new starters. The Team acknowledged that CPN 2 was

116 Internal Investigation Report P66
117 Internal Investigation Report P67

considered to be competent by her manager with regard to risk assessment and she demonstrated a good theoretical application of it when interviewed.

The Internal Investigation Team thought that the advice given to Mr. X by the Associate Specialist Psychiatrist about not driving was not considered in the context of the impact it may have had upon him. It was thought that this factor may have *"altered the perception of risk and the resultant care and management plan"*.[118]

In summary the Internal Investigation Team were satisfied that CPN 2 made reasonable attempts to make sure that the risk management aspect of the care plan was adhered to.

12.1.6.3. Findings of the Independent Investigation Team

Risk Assessment Processes

CPN 2 commenced the risk assessment and management process on the 8 December 2008 when she met with Mr. X for the first time. In accordance with the Trust CPA policy the HoNOS Plus assessment tool was used for initial screening purposes. The HoNOS Plus is a triage assessment tool and is designed to be used with individuals entering a service. On the 9 December 2008 CPN 2 filled in the HoNOS Plus as follows:

Item[119]	**Score**
1. Overactive, aggressive, disruptive behaviour	**1**
2.a. Suicidal behaviour	**3**
2.b. Repeat self harm	**0**
3. problems drinking or drug taking	**0**
4. Cognitive problems	**1**
5. Physical illness or disability problems	**1**
6.a. Problems with hallucinations and delusions	**0**
6.b. Strong unreasonable beliefs	**1**
7. problems with depressed mood	**2**
8. Other mental and behavioural problems	
If 'Other' please specify	

118 Internal Investigation Report P68
119 Case Notes P9

8. Score for 'Other mental and behavioural problems'	**0**
9. problems with relationships	**1**
10. Problems with activities of daily living	**0**
11. Problems with living conditions	**0**
12. problems with occupation and activities	**1**
13. Child Protection risk assessment	**0**
14. Problems with engagement	**0**
15. Vulnerability	**1**

Scoring for the HoNOS

0 = no problem

1 = minor problem

2 = mild problem

3 = moderately severe

4 = severe

CPN 2 continued to assess Mr. X in the light of his risk and utilised the Sainsbury Risk Assessment tool between the 8 and 23 December 2008. During this period CPN 2, in conjunction with the Associate Specialist Psychiatrist, came to the following conclusion: *"current suicidal thoughts and ideation, can't see any point to his life. Mr. X gets angry with his wife who shows lack of understanding of his depression. Says he has a plan but has promised not to act upon it. Previous depression in 2002 following unplanned retirement in 2001. Slight short-term memory problems. Mr. X currently finds eating difficult, saying everything he puts into his mouth feels dry and like cardboard. He is trying to eat porridge, has build up type supplement and I have suggested soup. Wears glasses and hearing aid, currently having difficulty passing urine, intends to visit GP about this."*[120] Based on what was known to the treating team at the time the risk assessment appears to have been both accurate and comprehensive.

Whilst it is acknowledged that the risk assessment process was not completed by CPN 2 the Independent Investigation Team were confident that Mr. X's risk, to both himself and to

120 Case Notes P15

others, was assessed accurately in the context of both his presentation and what was known to the treating team at the time.

The Internal Investigation Team expressed concerns that the risk assessment was made without the benefit of a full psychiatric history. However it is the conclusion of the Independent Investigation Team that this concern was not justified. The Associate Specialist Psychiatrist who accompanied CPN 2 on the home visit to Mr. X and his wife on 18 December 2008, was the same doctor who had led the care and treatment during the previous episode of care between 2002 and April 2005. Continuity of care was thus ensured. The Independent Investigation noted that the Multidisciplinary Risk Assessment form drew upon Mr. X's past psychiatric history and detailed appropriately his previous suicide plans (which had been very detailed and specific) and precipitating factors. The December 2008 assessment detailed Mr. X's current 'plans' for committing suicide which were vague and non specific and differed greatly from his presentation between 2002 and April 2005. It would appear that the 2008 treating team did reasonably take into account Mr. X's previous history when assessing his risk in December 2008.[121]

The Internal Investigation Team raised concerns regarding the amount of time Mrs. X was given to discuss any worries she may have had about her safety. The Independent Investigation Team thought that the treating team did provide sufficient opportunity for Mrs. X to voice any concerns that she may have had.

- she spoke to CPN 2 in the kitchen of her home alone;
- she spoke to the Doctor alone when showing him out of her home;
- she telephoned CPN 2 on her own initiative to discuss Mr. X.

Mrs. X had several opportunities to raise concerns and did not. She demonstrated by telephoning CPN 2 that she was aware of how to contact the services if she felt this was necessary but did not do this to raise concerns about her own safety. Mrs. X would appear to have been an assertive person, and the Independent Investigation Team concluded that had she needed to disclose this kind of information she would have done so without prompting.

121 Case Notes PP16-17

Management of Risk

The risk management plan for Mr. X identified the following;

*"**Opportunities for Risk Prevention***

Support for Mr. X and his wife in the form of weekly visits by Care Coordinator to build a therapeutic relationship individually and together. Home visit from Associate Specialist Psychiatrist then follow up in outpatients clinic. Encourage Mr. X to continue walking his dog regularly. Support Mr. X in finding voluntary work.

Short-term Crisis Management Options

Weekly visit from care Coordinator to monitor mood and offer support. Regular Outpatients appointments Basdec assessment to aid mood monitoring, suicide risk factors checklist. Adjust medication as necessary.

Long-term Management Options

Hospital admission if Mr. X feels he is not getting any better. Support Mr. X in finding voluntary work and being creative in the kind of work he looks for. Support Mr. X to find activities and possibly holidays he can pursue alone if his wife feels she does not want to accompany him.

Responsibilities for Actions

Support and regular visits, CPN 2, Outpatient appointments, Associate Specialist Psychiatrist."[122]

CPN 2 developed a three-point Care Plan to address Mr. X's depression. A Contingency and Crisis Plan was also developed which identified the GP, the Care Coordinator and the Associate Specialist Psychiatrist as being the main care network members to be contacted in the case of any future non engagement with secondary care services. The care network members were also identified as being key contacts for Mr. X in the event of a crisis. Mr. X and his wife were also given the telephone numbers of the Samaritans and NHS Direct in the event that he needed to talk to someone urgently out of hours.[123] At the time of the incident these risk and care management plans were still undergoing the final stages of development and had not been communicated to the GP.

122 Case Notes P18
123 Case Notes PP22-24

There was no identified risk with regard to the safety of Mrs. X, as a consequence, quite reasonably, no care plan was developed to manage this. Mrs. X may have told her GP that she was *"scared to death"* but this information was not made available to the treating team in December 2008. Mrs. X presented as being smiling and in control. She did not express any concerns regarding her own safety and therefore there was no indication that this was an issue. Without the benefit of hindsight, the treating team could not possibly have been alerted that there was any potential risk of harm to her presented by her husband. The treating team at the CMHT were not alerted by either by the behaviour of Mr. X, or the inputs from Mrs. X or Mr. X's GP with regard to any potential violence being offered to Mrs. X.

No risk training was given to CPN 2, however there was evidence to demonstrate that she was supervised and supported by senior colleagues. The quality of the risk assessment process was deemed to be sound by the Independent Investigation Team which suggested that CPN 2 was competent when conducting her work.

12.1.6.4. Conclusions of the Independent Investigation Team

The Independent Investigation Team found that the risk assessment process was managed well by the treating CMHT. Mr. X was assessed as a new referral, however there was evidence to demonstrate that the treating team also reviewed him in the light of his previous history.

The risk assessment process was appropriately commenced with the HoNOS Plus risk screening tool and then progressed on to the Sainsbury Assessment Tool. Management plans and care plans were developed as a result based appropriately on what the treating team knew about Mr. X at the time. The risk assessment process was made more reliable by the contribution of the Associate Specialist Psychiatrist, who not only was an experienced senior member of the team, but also knew both Mr. X and his wife well.

Risk of Suicide

It cannot be known exactly what transpired between Mr. X and his wife on the day that they died. The Coroner ruled that the tragic events took place *"whilst the balance of his [Mr. X's]*

mind was disturbed".[124] It is known that men over the age of 75 when depressed have the highest incidence of suicide within the general population. Therefore the potential risk Mr. X presented to himself could be seen as having been statistically significant. It is important to note that the healthcare professionals involved acted swiftly and took the potential risk seriously. The GP, quite correctly made a referral to secondary care services. The CMHT responded to the referral in a timely manner. Mr. X's risk to himself was assessed and planned for in an appropriate manner based on the information that was available to the treating team at the time. Mr. X and his wife sought out actively help and support for his depression. Prior to the incident taking place Mr. X was:

- assessed as having capacity;
- compliant with medication;
- actively pursuing care and treatment.

There was no indication to suggest that Mr. X was so depressed and suicidal that he would not seek help if his situation deteriorated. Quite the reverse was true, as Mr. X and his wife had assertively pursued help from the outset of his recent depressive episode and continued to do so.

Risk of Homicide

Statistically the United Kingdom has one of the lowest homicide rates in the world. In this country the act of homicide is a rare event with an average of 731 people being unlawfully killed each year.[125] Although the figures are widely contested, somewhere between 50 and 100 homicides are perpetrated each year in this country by people in receipt of mental health services. Rarely are these homicides perpetrated by individuals over 75 years of age.

At the time Mr. X was receiving his care and treatment from the CMHT no member of the treating team was given any information to indicate that Mrs. X was at risk of violence from her husband. Family witnesses to the Internal Investigation expressed their surprise about this as she had mentioned to her sister that she had told her GP that she was afraid her husband would harm her. There is no record of this concern ever having been expressed to any member of the treating team who provided care and treatment to either Mr. X or Mrs. X.

124 Coroner Transcription
125 Home Office figures between 1997-2011

It was the conclusion of the Independent Investigation Team that the treating team could not reasonably have foreseen the murder of Mrs. X.

Summary

As has been stated above, it cannot be known what exactly transpired between Mr. X and his wife the day that they died. It is a fact that an individual's mental state can deteriorate swiftly. It is also a fact that individuals, whether mentally ill or not, can become angry and violent. The Coroner ruled that Mr. X acted as he did whilst the balance of his mind was disturbed. That being said, the Independent Investigation Team could not find any act or omission on the part of the CMHT risk assessment process that contributed to the tragic events of late December 2008.

12.1.7. Service User Involvement in Care Planning

12.1.7.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:

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

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *"people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care"*. It also stated that it would *"offer choices which promote independence".*

12.1.7.2. Findings of the Internal Investigation

The Internal Investigation Team did not specifically review this aspect of Mr. X's care and treatment.

12.1.7.3. Findings of the Independent Investigation Team

It was evident that CPN 2 was still in the process of completing her assessment at the time Mr. X and his wife died. From the documentation that was compiled it was evident that CPN 2 and the Associate Specialist Psychiatrist had spoken at length with Mr. X in order to understand his mental state and to access his hopes, fears and preferred care and treatment options.

It was evident that Mr. X was given a wide range of care and treatment options. These included an inpatient admission, day hospital placement, outpatient clinic assessment and monitoring, and CMHT home-based support. As he was assessed as having capacity, Mr. X was supported in making the care and treatment decision that was most acceptable to him.

Care plans were in the process of being constructed around realistic targets that dovetailed with Mr. X's chosen lifestyle. Whilst the Independent Investigation Team acknowledges these plans were embryonic, they were obviously developed after listening to Mr. X carefully.

12.1.7.4. Conclusions of the Independent Investigation Team

It is the conclusion of the Independent Investigation Team that the care and treatment offered to Mr. X was service-user centered and offered him a range of inputs that were both appropriate to Mr. X's presentation and acceptable to him as an individual.

12.1.8. Carer Involvement and Carer Assessment

12.1.8.1. Context

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

promote independence' and '*be accessible so that help can be obtained when and where it is needed*'.

Carer involvement

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

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

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

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

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

12.1.8.2. Findings of the Internal Investigation

The Internal Investigation Team found *"there were a number of opportunities when staff could have asked Mrs. X about how she was coping and if she had any particular concerns but these were not taken."*[126] Mrs. X had told CPN 2 that she was finding it hard to continue

126 Internal Investigation Report P69

supporting her husband. However on the 18 December when visited by the Associate Specialist Psychiatrist and CPN 2 she was described as being *"pleasant, jovial and smiling".* CPN 2 reported to the Internal Investigation Team that on the 18 December Mrs. X appeared to be *chirpy…happy with good eye contact and that there was no indication to suggest that Mrs. X was subdued or living in threat of her husband".*[127]

During the first visit that CPN 2 made to Mr. X and his wife she witnessed some marital disharmony and noted some conflict and verbal volatility. However she did not perceive this as requiring major intervention other that to suggest a referral to Relate.

The Internal Investigation Team speculated as to the nature of the underlying dynamic between Mr. X and his wife but was unable to draw any definitive conclusion in respect of this matter. It was acknowledged that both Mr. X and his wife had opportunities to raise any concerns that they had but chose not to do so. It was thought that more in-depth probing could have taken place.

It was noted in the Internal Investigation report that a Carer Assessment by Social services had been identified as being part of the plan of action but had not been initiated prior to the incident as it was not seen to be critical by CPN 2.

12.1.8.3. Findings of the Independent Investigation Team

There are two main issues here. First: that of communication and relationship building with Mrs. X. Second: formal carer assessment. It is important not to confuse the significance of these two separate practice issues.

First: Communication and Relationship Building

The Independent Investigation Team could not agree with the finding of the Internal Investigation that there had been a number of missed opportunities in communicating with Mrs. X. It is unclear when 'a number' of lost opportunities could have been identified. The contacts with Mrs. X were as follows:

- 3 December 2008: CPN 2 made a Telephone call to book an appointment and spoke to Mrs. X who discussed her husband's mental state;

127 Internal Investigation Report P69

- 8 December 2008: CPN 2 made a domiciliary visit and spoke with both Mr. X and Mrs. X;
- 17 December 2008: Mrs. X telephoned CPN 2 to confirm the next home visit and discussed her husband's mental state;
- 18 December 2008: CPN 2 and the Associate Specialist Psychiatrist made a domiciliary visit and spoke with both Mr. X and Mrs. X at length.

CPN 2 made two domiciliary visits prior to the incident occurring, the second of which when she was accompanied by the Associate Specialist Psychiatrist. On each occasion Mrs. X had been vocal and had expressed freely her views, often overriding Mr. X's opportunity to speak. It was evident that Mrs. X was in the habit of speaking over her husband and that the issue was not so much in providing her with the opportunity of speaking to healthcare professionals alone, but in being able to speak to Mr. X by himself without his wife's interruptions in order to assess him.

It was evident that Mrs. X accompanied Mr. X to all of his GP appointments and had even accompanied him to his Cognitive Behaviour Therapy sessions in 2002. This was considered by the Independent Investigation Team as being unusual. It was apparent to CPN 2 that Mrs. X intended to be present during every assessment Mr. X had with CMHT professionals, and became *"livid"* when it was suggested to her that this was not appropriate. [128]It is a fact that Mr. X killed his wife. It would appear however to the Independent Investigation Team that too much 'hindsight bias' has been placed on this by the Internal Investigation Team with regard to her potential vulnerability. Whilst it is not the role of an Independent Investigation Team to speculate, the following observations are made.

At the time Mr. X was receiving his care and treatment from the CMHT during December 2008:

- There was no evidence available to those assessing and treating Mr. X that Mrs. X was at risk from her husband;
- Mrs. X was perceived as controlling and unwilling to let him speak for himself;
- Mrs. X was reluctant to let him be assessed without her being present;

128 Case Notes P31

- Mrs. X was extremely vocal and articulate and did not hesitate to say aloud what she was thinking or feeling;
- Mrs. X initiated a telephone conversation to CPN 2 on the 17 December during which time she discussed Mr. X's mental state and had she wanted to discuss any fears she could have done so.

CPN 2 very sensibly realised after her first visit on the 8 December 2008 that future home visits should be made with two CMHT workers in order to give both Mr. X and Mrs. X an opportunity to be met with as individuals. This is indeed what would have continued to happen had Mr. X and his wife not died. It was evident that CPN 2 made every effort to build up a therapeutic relationship with Mrs. X and to provide her with the opportunity to discuss her concerns, thoughts and feelings regarding her husband's health and wellbeing.

Second: Carer Assessment

The principal purpose of a Carer Assessment is not to provide an opportunity for risk assessment and neither should it be seen as replacing the ordinary day-to-day therapeutic input from either health or social care professionals. The principal purpose is to ensure that carers (people who are providing regular and substantial care to someone) are supported in the following ways:

- provided with advice on financial, housing and employment matters;
- provided with information about what to do in an emergency situation;
- provided with information about appropriate secondary care services;
- provided with a care plan to address their own physical and mental health needs if any exist;
- provided with information about the health needs and treatment of the person they care for (if appropriate and if the service user gives consent);
- provided with respite care if required.[129]

A Carer Assessment should be offered at least once a year. CPN 2 planned to refer Mrs. X to Social Services for a formal Carer Assessment and set this down in the action plan. The Internal Investigation Team stated *"this was not initiated in the time available which amounted to twelve working days from the first point of contact…as it was not seen to be*

129 NHS Choices Carer Assessment

critical by CPN 2".[130] This would imply a degree of criticism. However Mr. X had only been suffering from his depression for some six weeks prior to the incident occurring. Mr. X remained self-caring to high degree, and whilst Mrs. X may well have required some level of support, she did not appear to specifically require assistance with respite care, housing or finance and could not be described as having to provide a 'substantial' level of care to Mr. X. Mrs. X and her husband had already been told what to do in an emergency situation and both of them had been talked though the care and treatment options available. The CMHT planned to make weekly visits to assess and monitor Mr. X and to provide support to him and his wife, both as a couple and individually.

Whilst a Carer Assessment for Mrs. X was indicated, the level of support that both Mr. X and his wife required was still in the process of emerging. It was not unreasonable for such an interval of time to transpire prior to the referral to Social Services being made in the circumstances.

12.1.8.4. Conclusions of the Independent Investigation Team

It was the conclusion of the Independent Investigation Team that CPN 2 worked in an appropriate manner to engage with and provide support to Mrs. X. It was evident that Mrs. X felt the need to retain a high degree of control over the contact that Mr. X made with services. This need was managed by CPN 2 in a sensitive and professional manner in that she worked to ensure the best interests of both Mr. X and his wife were met. It is difficult to see what more could have been achieved without the benefit of hindsight.

The plan to refer Mrs. X for a formal Carer Assessment to Social Services was entirely appropriate. There did not appear to have been any indication that a more timely or urgent assessment was required. CPN 2 is to be commended for ensuring that the need for a Carer Assessment was identified at such an early stage, and that steps were taken to ensure it was arranged.

It was evident to CPN 2 that Mr. X and his wife wanted different things from life and that there was a degree of marital disharmony between them. However at the time CPN 2 witnessed this interplay it did not appear to have any significance other than marital

130 Internal Investigation Report P70

bickering. It is unclear whether the "*in-depth probing"* advocated by the Internal Investigation Team would have been indicated without the benefit of hindsight. It was evident that Mr. X and his wife had different points of view on a variety of issues, however CPN 2 managed this in a professional and sensible manner.

When interviewed by the Internal Investigation Team the family and friends of Mrs. X were of the view that she was at significant risk of harm from her husband and that she was scared to death of him. Unfortunately, neither the family or friends of Mrs. X, or Mrs. X herself ever indicated this concern to any person from any statutory body. The Independent Investigation Team does not seek to imply that the failure to disclose this information infers any degree of blame. However this Investigation seeks to assess the quality of the care and treatment Mr. X and his wife received without the benefit of hindsight based on what was known to the treating team at the time. It is the conclusion of the Independent Investigation Team that Mrs. X received an appropriate and professional service from the North Kirklees CMHT and that no act or omission regarding carer support and involvement on its part contributed to the incident which led to her death.

12. 1.9. Documentation and Professional Communication

12.1.9.1. Context

Documentation

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

The General Medical Council (GMC) states that:

'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off [131] *,*

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

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

'Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised.[132]

Professional Communication

'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion.'[133]

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone[134]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively[135]. The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

12.1.9.2. Findings of the Internal Investigation

There was no communication from anyone in the CMHT with the GP following the referral of the 1 December other than confirmation that the referral had been received.

The Internal Investigation Team noted that the Associate Specialist Psychiatrist did not make a contemporaneous record of the meeting that took place on the 18 December 2008. This was examined in the light of *New Ways of Working,* the Trust's policy on record keeping and relevant professional guidance.[136]

132Pullen and Loudon, *Advances in Psychiatric Treatment,* Improving standards in clinical record keeping, 12 (4): (2006) PP 280-286
133 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) P121
134 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing,* Institute of Health Services, (1999). P144.
135 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)
136 Internal Investigation Report P57

The conclusion of the Internal Investigation Team was that the Psychiatrist should have made a record of the meeting. It was also noted that CPN 2 could have completed the assessment documentation more fully within the timeframe available.

The Internal Investigation also noted, amongst other examples, that CPN 2 was diligent in recording her finding following her first meeting with Mr. X on 8 December 2008[137] and in recording her plans for engaging Mr. X in meaningful activity.[138] The Internal Investigation concluded "*Apart from specific omissions referred to previously in this report,* [noted above] *there are excellent examples of high quality record keeping in respect of this patient's care and treatment.* [139]

The Internal Investigation Team also considered the effectiveness of the Trust electronic record system (RiO system). At the time Mr. X was receiving care and treatment for his second episode of depression with the Trust in 2008 the RiO system was relatively new. Some of the witnesses who were interviewed by the Internal Investigation Team said that they found RiO to be time consuming and that there was a lack of appropriate codes to use.[140]

12.1.9.3. Findings of the Independent Investigation Team

The written referral from the GP should have contained more detailed information about Mr. X's presentation, the reasons for the referral being made, and the expected treatment inputs from the CMHT. The referral form should also have been prepared in a manner that would have made it more legible to the CMHT. The receiving CMHT could have taken the opportunity to contact the GP in order to gain more information about Mr. X as part of the referral screening process. That being said Mr. X received appropriate and timely interventions from the CMHT and his care and treatment was not impacted upon negatively by the quality of the written referral process.

It was evident that CPN 2 was still in the process of completing her assessment when the incident occurred. The extant record demonstrates that she made every effort to complete her work in a more timely manner but was unable to meet with Mr. X and his wife between the 8

[137] Internal Investigation Report P 45
[138] Internal Investigation Report P 46

139 Internal Investigation Report P58
140 Internal Investigation Report P71

and 18 December as they were not available. CPN 2 was undertaking a comprehensive assessment whilst also building up a therapeutic rapport with her patient and his wife. The standard of record keeping was deemed to be of a good standard by the Independent Investigation Team.

The Associate Specialist Psychiatrist did not make a record of the medical assessment made on the 18 December. However on this occasion the doctor had made the visit in order to support CPN 2, it was not intended to be in lieu of a full psychiatric assessment at the outpatient clinic. On this occasion CPN 2 was acting in her role as the designated Care Coordinator. She discussed the visit fully with the Associate Specialist Psychiatrist and wrote up the notes of their joint visit. This practice was in accordance with the expectations of *New Ways of Working.*

The Independent Investigation Team understood that the assessment process was still in the process of completion, however it would have been good practice for CPN 2 to have notified the GP in advance of the Christmas period that he was part of both the Contingency and Crisis Plan for the ongoing management of Mr. X. However it was possible that the GP would have been notified had the planned meeting of the 23 December 2008 taken place. Trust policy and procedure expected written communication to have been sent to the GP within 14 days of the initial assessment visit being made by the CMHT. The CMHT had, for understandable reasons, gone past this timeframe.

12.1.9.4. Conclusions of the Independent Investigation Team

It was the conclusion of the Independent Investigation Team that the general standard of CMHT record keeping was good and in keeping with local policy and procedures and *New Ways of Working.*

It would have been sensible to have ensured that the GP was kept informed regarding the outcome of the assessment process in a more timely manner. This was of particular relevance in that he was identified as having a role in both the Contingency and Crisis Plan for the ongoing management of Mr. X. The Christmas holiday was due to commence which may have led to increased anxiety for Mr. X and his wife. The Christmas period always presents with an additional challenge in the accessing of out of hours services and the GP surgery

should have been adequately forewarned that Mr. X, or his wife, may have been contacting them over the holiday period.

In the event communication with the GP did not occur prior to the incident, but this did not appear in any way to contribute to the circumstances which led to the death of Mr. X and his wife.

- ***Service Issue Number 3. Delays when communicating with General Practice may be unavoidable when the assessment of a patient is still in the process of being completed. However when embryonic Contingency and Crisis Plans require inputs from a GP delays in communication may lead to confusion and the timely delivery of appropriate care and treatment may be compromised.***

12.1.10. Management of the Clinical Care and Treatment of Mr. X

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

12.1.10.1. Findings of the Internal Investigation

The Internal Investigation Team found that the first episode of care and treatment that Mr. X received between 2002 and 2005 was managed well. However the documentation of future relapse and warning signals were not documented and this was seen as an omission in the light of the severity of Mr. X's depressive illness.[141]

During the second episode of care and treatment the Internal Investigation Team found that the medication prescribed was appropriate and that the clinical decision to defer cognitive testing, until Mr. X's depressive symptoms improved, was in keeping with standard and reasonable clinical practice. The diagnostic conclusions of the Associate Specialist Psychiatrist were seen to be sensible and based appropriately upon Mr. X's presentation. The

141 Internal Investigation Report P59

care and treatment alternatives offered to Mr. X were judged to have been reasonable and the decision regarding Mr. X's capacity to be sound.[142]

The Internal Investigation Team speculated as to whether the medical risk assessment could have been informed more fully in the light of the marital relationship difficulties that had been evident to CPN 2 on her visit on the 8 December. It was noted that CPN 2 had not discussed this with the Associate Specialist Psychiatrist prior to, or after, the joint visit that was made to Mr. X and his wife on the 18 December 2008. CPN 2 had written in the notes that the conflict between Mr. X and his wife could exacerbate his depression. CPN 2 told the Internal Investigation Team that this information had not been discussed as she had visited *"people who were much worse".* The Internal Investigation Team decided that as Mrs. X had the opportunity to talk alone to the Associate Specialist Psychiatrist during the visit on the 18 December about any fears she may have had, that this information was probably not relevant to the risk assessment.[143]

12.1.10.2. Findings of the Independent Investigation Team

Following the GP referral of the 1 December 2008 Mr. X was allocated a Care Coordinator in a timely manner. Contact was made with Mr. X and an appointment was offered to him well within the timeframe detailed within the operational policy.

Mr. X received a nursing and medical assessment in order to establish a diagnosis and the appropriateness of his medication regimen. Mr. X was also offered a range of suitable interventions to ensure that he received the appropriate care and treatment for his condition. The interventions offered to Mr. X were made once it had been ascertained that he had the capacity to make an informed choice. The service offered to Mr. X was sensitive to both his personal preference and appropriate to his clinical need.

Risk assessment and care planning were conducted in a systematic manner that complied with local policy requirements. Every effort was made to respond to Mr. X and his wife in a timely manner that also ensured a therapeutic relationship was built.

142 Internal Investigation Report P60
143 Internal Investigation Report PP60-61

The plan to provide outpatient medical follow up and weekly CMHT monitoring and support was appropriate. It was evident that CPN 2 also took the needs of Mrs. X into full account as she had ensured from the 18 December 2008 onward that there would always be two members of the CMHT to make a joint visit to Mr. X and his wife in order to provide a sensitive and professional service to them both.

Prior to the incident occurring the CMHT had offered:

- an inpatient admission;
- a day hospital place;
- outpatient clinic follow up;
- CMHT home visits.

The CMHT were also in the process of:

- conducting a comprehensive assessment;
- developing service-user centered care plans;
- developing Contingency and Crisis plans;
- making a referral for Cognitive Behaviour Therapy.

The CMHT were also planning to:

- review Mr. X's medication once his cardiac results had been received;
- assess Mr. X's cognitive function once his depressive symptoms had abated.

12.1.10.3. Conclusions of the Independent Investigation Team

The Independent Investigation Team concluded that Mr. X and his wife received a timely and entirely appropriate service from the North Kirklees CMHT. The Independent Investigation Team was impressed with the range of eveidence-based interventions that were offered to Mr. X. The Team was also impressed with the efforts that were made to ensure that Mr. X and his wife were offered a care and treatment approach that offered choice and was sensitive to both their need and preference.

It was the conclusion of the Independent Investigation Team that the overall management of the clinical care and treatment that Mr. X received was of a good standard and that it did not

make a contribution to circumstances which led to the tragic deaths of either Mr. X or Mrs. X.

12.1.11. Adherence to Local and National Policy and Procedure

12.1.11.1. Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."*[144] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 12.1.11. below.

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

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to

144 Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) P328

report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

12.1.11.2. Findings of the Internal Investigation

The Internal Investigation did not specifically address this issue.

12.1.11.3. Findings of the Independent Investigation Team

Quality of Local Policies and Procedures

The Independent Investigation Team found that the relevant Trust clinical policies and procedures were appropriate and evidence based. At the time of the incident the Care Programme Approach policy had not been updated following the national changes that took place in October 2008, however clinical teams were able to adapt the extant policy.

Non Adherence Issues

There was no evidence to suggest that Trust policy and procedure was not adhered to by members of the CMHT. Care Programme Approach, Risk and Operational policies were all followed. The only possible omission was with regard to the response time when communicating with Mr. X's GP.

12.1.11.4. Conclusions of the Independent Investigation Team

It was the conclusion of the Independent Investigation Team that the relevant Trust policies and procedures and were appropriate and fit for purpose and that the CMHT staff adhered to them appropriately.

12.1.12. Clinical Governance and Performance

12.1.12.1. Context

'*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish*'[145]

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

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

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

The Care Quality Commission grades Trusts with regard to their performance. A Trust can be scored 'weak'(this score means that a Trust performed poorly in terms of the overall quality score), 'fair' (this score means that a Trust performed adequately in terms of the overall quality score), 'good' (this score means that a Trust received at least the second highest score for all applicable assessments that contribute to the overall quality score) or 'excellent' (this score means that a Trust received the highest score for all applicable assessments that contribute to the overall quality score).

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

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

12.1.12.2. Findings of the Internal Investigation

Clinical Governance Systems and Performance

The Internal Investigation did not specifically address this issue.

Clinical Supervision and Leadership

The Internal Investigation Team found that CPN 2 received structured caseload supervision for her practice on the 16 December when she discussed Mr. X with her Team Manager. At the time Mr. X was receiving his care and treatment from the Trust CPN 2 had 16 service users on her caseload and she described her caseload as *"busy".*[146] However caseload committements did not impact upon her ability to deliver timely care and treatment to Mr. X.
The Associate Specialist Psychiatrist told the Internal Investigation Team that as a senior grade doctor he functioned autonomously, working with two Consultants in the locality. Whilst there were no recognised clinical supervision sessions with either of the Consultants, the Associate Specialist Psychiatrist did meet with them on a regular basis and liaised with them in the event of complex cases.

12.1.12.3. Findings of the Independent Investigation Team

Clinical Governance Systems and Performance

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

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

146 Internal Investigation Report P70

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

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

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

Strategy and Policy

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

Clinical Governance

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

5. To assure Trust Board that the Executive Management Team and Service Delivery Groups have systems in place that encourage and foster greater awareness of clinical governance and clinical safety throughout the organisation, at all levels.

Compliance

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

Clinical Safety Management

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

Public and Service User Experience

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

Clinical Supervision and Leadership

At the time Mr. X was receiving his care and treatment from the Trust a robust Clinical Supervision policy was in place. Distinction was made appropriately between Managerial Supervision (focussed upon functioning within the team and maintaining clarity about role, responsibilities and accountabilities), Practice and Clinical Supervision (focussed upon the working relationship between the clinician/professional and individual service user) and Professional Supervision (focussed upon professional identity and professional development needs).

The Independent Investigation Team was not able to interview CPN 2 as she is now located in New Zealand. However the Team did have access to her Internal Investigation Team interview transcription and was also able to interview her Team Manager. It was evident that CPN 2 received appropriate clinical supervision of both a formal and informal nature. This was evidenced by CPN 2 recording contemporaneously in Mr. X's clinical record that she had discussed the case with her Team Manager. It was also evident that professional leadership with the CMHT was robust and that CPN 2 had also discussed the case at length with the Associate Specialist Psychiatrist. From the evidence supplied to the Independent Investigation Team it would appear that individuals were supported well and that supervision and consultation was very much part of the culture of the CMHT.

12.1.12.4. Conclusions of the Independent Investigation Team

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

It was the conclusion of the Independent Investigation Team that no failures in the Trust Clinical Governance system were apparent when seen through the lens of this single case. It has to be acknowledged that Mr. X's episode of care in December 2008 was of only 23 days

duration, from the day of the GP referral on the 1 December, to the day that Mr. X and wife were found dead, on the 23 December.

During this period the North Kirklees CMHT staff appear to have worked appropriately to the extant Trust clinical policies and procedures. Staff members worked within a culture of both peer consultation and supervision. No evidence could be brought forward to the Independent Investigation Team to indicate that Trust Clinical Governance systems were other than robust as they related to older peoples services in North Kirklees.

13. Findings and Conclusions Regarding the Care and Treatment Mr. X Received

13.1. Findings

The findings have been identified following a full review of the care and treatment that Mr. X received from the South West Yorkshire Partnership NHS Foundation Trust. These have been set out below together with their accompanying relevant causal, contributory and service issues.

1. **Referral Procedures.** The GP made the correct decision to refer Mr. X to secondary care services in December 2008. At the time of the referral Mr. X did not appear to be presenting with a depression that required urgent intervention and the CMHT acted appropriately based on what was known to them at the time. The CMHT made telephone contact within two days of the referral being made and undertook a domiciliary visit within eight days. This is to be commended. The referral process would have benefitted had the GP provided more information and ensured that the form was legible. However this omission did not prevent Mr. X's referral being processed appropriately.

2. **Diagnosis.** Mr. X's diagnosis was properly made in the light of his presentation. The GP had correctly identified the presence of a depression of moderate severity and made the appropriate referral. The CMHT processed the referral in a timely manner and ensured that a prompt initial assessment was undertaken which confirmed the diagnosis of the GP. The treating team understood that there may have been problems with Mr. X's cognition, but sensibly deferred further assessment until his depressive symptoms had a chance to respond to treatment.

3. **Medication and Treatment.** During the 17 day interval that Mr. X received his care and treatment from the Trust he was actively seeking help and support, was engaged with the process, and was able to voice his preferences regarding the interventions that were offered to him. The Independent Investigation Team concluded that the medication, care and treatment offered to Mr. X was evidence-based and in keeping with both his diagnosis and his presentation. The Independent Investigation Team also concluded that the care and treatment offered to Mr. X met national best practice guidelines and the Trust was to be commended for being able to offer such a comprehensive range of service.

4. **Use of the Mental Health Act (2007).** During the 17 day interval that Mr. X received his care and treatment from the Trust there was no evidence to support the notion that he should have been detained under the Mental Health Act. Mr. X was found to have capacity. An assessment was conducted by an experienced and suitably qualified senior medical clinician who knew the patient well. The subsequent decision not to

admit Mr. X was made in accordance with Mr. X's presentation and the ethos of the Mental Capacity Act (2005) and the Mental Health Act (2007).

5. **Care Programme Approach (CPA).** CPA was conducted based upon sound assessment principles. The assessment was multidisciplinary and was conducted in accordance with Trust policy and procedure. It would have been sensible to have made a more timely communication with the GP given that he featured in the embryonic Contingency and Crisis Plan. However this omission did not make a contribution to the deaths of either Mr. X or his wife.

6. **Risk/Clinical Assessment.** The Independent Investigation Team found that the risk assessment process was managed well by the treating CMHT. Mr. X was assessed as a new referral, however there was evidence to demonstrate that the treating team also reviewed him in the light of his previous history. The risk assessment process was appropriately commenced with the HoNOS Plus risk screening tool and then progressed on to the Sainsbury Assessment Tool. Management plans and care plans were developed as a result based appropriately on what the treating team knew about Mr. X at the time. The risk assessment process was made more reliable by the contribution of the Associate Specialist Psychiatrist, who not only was an experienced senior member of the team, but also knew both Mr. X and his wife well.

7. **Service User Involvement in Care Planning and Treatment.** The care and treatment offered to Mr. X was service-user centered and offered him a range of inputs that were both appropriate to Mr. X's presentation and acceptable to him as an individual.

8. **Carer Involvement and Carer Assessment.** It was the conclusion of the Independent Investigation Team that CPN 2 worked in an appropriate manner to engage with and provide support to Mrs. X. It was evident that Mrs. X felt the need to retain a high degree of control over the contact that Mr. X made with services. This need was managed by CPN 2 in a sensitive and professional manner in that she worked to ensure the best interests of both Mr. X and his wife were met. It is difficult to see what more could have been achieved without the benefit of hindsight.

9. **Documentation and Professional Communication.** It was the conclusion of the Independent Investigation Team that the general standard of CMHT record keeping was good and in keeping with local policy and procedures and *New Ways of Working.* Communication between the CMHT and the GP could have been used to better effect. There was no communication with the GP regarding the CMHT work with Mr. X between the time of the referral and the 23 December 2008. Delays when communicating with General Practice may be unavoidable when the assessment of a patient is still in the process of being completed. However when embryonic Contingency and Crisis Plans require inputs from a GP (as was the case) delays in communication may lead to confusion and the timely delivery of appropriate care and treatment may be compromised.

10. **Clinical Management of the Case.** The overall management of the clinical care and treatment that Mr. X received was of a good standard and that it did not make a contribution to circumstances which led to the tragic deaths of either Mr. X or Mrs. X.

11. **Adherence to Local and National Policy and Procedure, Clinical Guidelines.** The relevant Trust policies and procedures and were appropriate and fit for purpose and the North Kirklees CMHT staff adhered to them appropriately.

12. **Clinical Governance and Performance**. The Trust has a fit for purpose set of governance arrangements which are overseen by the Trust Board. The North Kirklees CMHT staff appear to have worked appropriately to the extant Trust clinical policies and procedures. Staff members worked within a culture of both peer consultation and supervision. No evidence could be brought forward to the Independent Investigation Team to indicate that Trust Clinical Governance systems were other than robust as they related to older peoples services in North Kirklees.

13. **Internal Investigation.** The internal investigation was competently prepared. The Independent Investigation Team concurs largely with the findings of the internal review.

13.2. Conclusions

Mr. X received care and treatment for a second episode of depression from the South West Yorkshire Partnership NHS Foundation Trust in December 2008. He had been treated for a previous depressive episode between 2002 and April 2005 by the Trust. This previous treatment had been successful and achieved a positive outcome.

Mr. X was referred to the North Kirklees CMHT by his GP on the 1 December 2008. At the point the GP had conducted an assessment and determined that Mr. X had a moderately severe depression which required secondary care assessment and treatment. Prior to this Mr. X had been leading an active life and maintained many interests.

The CMHT managed the referral in a timely manner and allocated a Care Coordinator with immediate effect. Contact was made with Mr. X and an appointment was arranged for the 8 December to meet with him and his wife at their home. The CMHT commenced an appropriate assessment process between the 8 and 18 of December which was due to have been concluded on the 23. The care and treatment options that were made available to Mr. X were evidence based, varied and offered a high degree of servicer-user choice. Mr. X was assessed as having the capacity to make an informed choice about his care and treatment. Mr. X was actively seeking out help and support and was compliant with his medication and was positively engaging with the service. The care plans and the contingency and crisis plan were appropriate and there was evidence to show that both Mr. X and his wife had been involved fully in their development and were in agreement as to the proposed care and treatment package.

During this second depressive episode there was no overt indication that Mr. X was suffering from either dementia or psychosis. It was evident however that he had feelings of hopelessness and that he also had suicidal ideation. It is not possible to understand with any degree of certainty the circumstances that led to the deaths of Mr. X and his wife. The Internal Investigation Team speculated that Mr. X's hopelessness may have been underestimated by the treating team and that this may have made a contribution. The Coroner recorded a verdict of unlawful killing on Mrs. X and ruled that her husband had taken his own life whilst the balance of his mind was disturbed.

The Internal Investigation Team identified the following "*potential causal or contributory factors"* :

- *the referral information which the GP made available to the CMHT;*
- *the severity of Mr. X's illness and the degree to which this could have impacted on events during the second episode of care;*
- *the volatile marital relationship which progressively deteriorated over time, the significance of which, was never brought to the attention of the mental health service;*
- *the degree to which Mr. X's second episode of depression impacted on the marital relationship;*
- *the degree to which Mr. X's second episode of depression impacted on his desire to get better and return to meaningful occupation, which may have contributed to feelings of hopelessness on his part;*
- *the impact of Mr. X's pre-morbid personality on Mrs. X;*
- *Mr. X's level of risk in respect of suicide;*
- *The quality and appropriateness of the assessments and interventions by the CMHT within 17 working days from referral by the GP to the date of Mr. and Mrs. X's deaths;*
- *Whether the fatal incident could have been predicted or prevented.* [147]

The Internal Investigation Team went on to identify "*three possible contributory factors, namely:*

I. *that Mr. X's level of hopelessness in December 2008 was not fully recognised and was complicated by his mixed presentation;*

II. *the risks associated with the advice given to Mr. X not to drive, went unquestioned, (although the advice itself was standard and reasonable practice);*

III. *the controlling aspects of Mr. X's personality and the consequences of this on his wife's well-being."*[148]

However the Internal Investigation concluded there was "*no definitive evidence to indicate that any of these factors had any direct adverse impact on the management plan instigated by the clinical team, or on the eventual outcome."*[149]

147 Internal Investigation Report P71
148 Ibid P72

The Independent Investigation Team's observations with regard to the Internal Investigation findings are that they represent a high degree of speculation derived from the benefit of hindsight, and that the Internal Investigation Team quite rightly stated that it could find no *"definitive evidence"* to prove that any identified factor adversely impacted upon the plan instigated by the clinical team. Several of the identified issues are 'service issues' rather than 'contributory or causal factors' in that they cannot be proven to have impacted directly upon the deaths of Mr. X and his wife. Whilst the use of hindsight may be usefully deployed to understand a situation better, it should not be used to make a judgement regarding the reasonableness of the care and treatment that was delivered by a clinical team who were working without the benefit of it.

It is the conclusion of the Independent Investigation Team that it is not possible to speculate with any degree of accuracy with regard to the circumstances that led to this tragedy. A person's mental state can vary greatly within a very short space of time. Based on what the treating team knew at the time, and what they should have known at the time, everything that could have been reasonably done was done to ensure that Mr. X received a robust assessment and appropriate care and risk management plans. It was evident that the Trust had in place appropriate clinical policies and procedures and that the treating team adhered to them.

An Independent Investigation of this kind must refrain from the use of hindsight when evaluating the effectiveness of the care and treatment offered to a mental health servicer user who then goes on to perpetrate a homicide. It is the conclusion of the Independent Investigation Team that no act or omission on the part of the treating team contributed to the deaths of either Mr. X or his wife.

149 Ibid P72

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

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

14.1. The Trust Serious Untoward Incident Process

Initial Reporting of the Incident

On the 23 December, immediately following the discovery of the bodies of Mr. X and his wife, the North Kirklees CMHT Manager utilised the 'Actions to be taken by the Person in Charge of Unit/Team (Checklist B)' form which is part of the Trust's management of serious untoward incidents procedure. This Checklist provided a clear and comprehensive guide for action. It was evident from the records that were developed at this time that the checklist was utilised fully.

On the 23 December 2008 the CMHT Manager ensured that the incident was referred with immediate effect to the 'General Manager'. The healthcare records were 'locked down' and copies were made. Arrangements were made to alert all of the CMHT staff about the incident and to provide support to them as necessary. The Incident Report Form was commenced on the 23 December and was completed and sent to the 'General Manager' by fax on the 24 December 2008. The Adverse Incident Form gave a full account of the visit made by CPN 2 on the 23 December 2008 and set out all known Police liaison and activity known at the time.

The Trust is to be commended for developing such a comprehensive and helpful guide for managers which was obviously used to good effect in this case.

The 72 Hour Report Process

It was the Trust's expectation that the Management Fact Finding Form should be completed within 24 Hours of 'Red' incident or 48 hours of an 'Amber ' incident, and 72 hours for a 'Green' incident. 'Red' and 'Amber' incidents included homicide incidents. This form ensured that all information regarding the incident was captured. This form captured information regarding actions taken with service user relatives and actions taken regarding staff support. The deaths of Mr. X and his wife were graded a being a 'Red' incident. The CMHT Manager offered the following reflection on how the incident was managed during the first 24 hours:

- *"As a manager I was not aware that I could have sought advice directly from senior managers, this would have helped on the evening of the 23 December 2008, as staff were giving statements to the Police when they need not be;*

- *Photocopying notes - I was unsure who should do this, I did photocopy all the notes and ensured they reached the appropriate people, however the Admin. Supervisor in the Outpatient Department was sure this whole process should have gone through her so she can ensure confidentiality and safety of notes;*
- *Wednesday 24 December 2008 - as a manager I had to ensure that all incident forms, reports etc. were completed. This was nearly impossible due to the influx of telephone enquiries from the Trust about the incident. It may have been beneficial to have one person coordinating the incident."*[150]

The Management Fact Finding Report was completed on the 24 December 2008 and sent to the General Manager. This form is important in that it identifies key remedial actions that have been identified as requiring urgent attention in order to reduce the risk of a similar occurrence from taking place prior to an Internal Review taking place. However it was evident that the North Kirklees CMHT commenced a reflective process to review the service with immediate effect in order to ascertain learning from the incident prior to the Internal Investigation taking place. This is commendable practice.

14.2. The Trust Internal Review

The Trust decided to recruit an external Investigation Chair to lead the internal review process. This was for two reasons. First, the Trust had limited experience in managing serious untoward incidents of this kind as they are rare events in the Trust. Second, the Trust wanted to ensure a high degree of objectivity and decided that an external Chair would provide an additional level of challenge and scrutiny.

14.2.1. The Internal Investigation Review Team comprised the following personnel

External Consultant – Chair

150 Investigation Archive P68

Consultant Psychiatrist, Older People's Services
CMHT Team Manager, (Registered Nurse)
Senior Portfolio Manager Risk[151]

14.2.2. The Terms of Reference

To examine:

1. The care service user X was receiving at the time of the incident (including any from non-NHS providers e.g. social services, which are identified).
2. The suitability of that care in view of X's history and assessed health and social care needs.
3. The extent to which his care corresponded with statutory obligations, relevant national guidance, Trust policies, including any team or service operational policies and professional standards.
4. Relevant professional and clinical judgments and decision making.
5. The adequacy of the risk assessment and care plan and their use in practice.
6. The interface, communication and joint working between all those involved in providing care to meet X's mental and physical health needs, with particular reference to the Care Programme Approach (CPA), referral and discharge processes.

To identify:

7. Actions taken following the incident to manage the immediate situation, provide support to those affected and to improve services.
8. Any significant care concerns including:
    a. those that had a direct impact on the outcome of the incident;
    b. those that did not have an impact on the outcome of the incident.
9. Any areas of particularly good practice.
10. Findings and learning points for improving systems and services.

To undertake:

11. A root cause (causal) analysis of the significant care concerns that had a direct impact on the incident and outcome.

151 Internal Investigation Report P 4

To provide:

12. A report of the investigation process and findings, which includes realistic recommendations to address any learning points to improve systems and services, within the timescales set by the Strategic Health Authority.

To ensure:

14. That the findings and recommendations of the investigation are appropriately shared with relevant people including:

a. Relatives of the deceased;

b. Staff involved in the incident investigation;

c. Trust managers. [152]

14.2.3. Methodology

The internal investigation reported that it conducted its investigation in accordance with the Trust's incident management policies and procedures.

An external Chair with experience in conducting the investigation of Serious Untoward Incidents was appointed by the Trust to chair the internal investigation.

Consonant with the terms of reference for the internal investigation (terms of reference number 11) the internal investigation employed a "*root cause (causal) analysis"* methodology to investigate this incident. In particular the internal investigation team selected a number of root cause analysis tools including the construction of a narrative chronology; the development of a tabular timeline in discussion with the clinical team; the application of the "5 Whys" and the "Contributory Factor Check List".

The internal investigation reported that it was unable to inspect Mr. X.'s original Trust clinical record as these were held by the Coroner's Office at the time of the investigation. However photocopies of all clinical records and other information were made available to the internal investigation. The internal investigation recorded that it had access to:

152 Internal Investigation Report P3

- *"Medical and Nursing records, including the Community Mental Health Team, Day Care, Psychological Therapies, Out-patient treatment and domiciliary assessment, together with other relevant clinical documentation from the Trust, in conjunction with the referral information from the GP.*

During the course of this internal investigation further documentation was requested, namely:

- *Psychiatrist (1)'s report to Her Majesty's Coroner dated 15 January 2009;*
- *Mr. X's GP's records or summary of the GP's involvement 2002-2008;*
- *information on the availability and access to clinical risk training in 2008 provided by the Trust;*
- *records of staff training;*
- *records relating to clinical supervision;*
- *a note summarising the contact which CMHT Manager (1) had with one of Mrs. X's nieces on 30 December 2008;*
- *a Post Incident Management Report from CMHT Manager (1) submitted on 2 February 2009, outlining actions which had been taken to address changes in practice, initiated by the CMHT in response to the fatal incident;*
- *relevant Trust policies and procedures;*
- *email exchange from CMHT Manager (1) and the Trust's Training Department regarding access to clinical risk training in 2008;*
- *email exchange from CMHT Manager (1) confirming the outcome of a review of referrals from Mr. X's GP between March 2008 and March 2009 to ascertain the frequency of reference to PHQ (9) (Primary Health Questionnaire - a screening tool used in primary care to screen for depression);*
- *email exchange from CMHT Manager (1) regarding record keeping;*
- *transcriptions from recorded interviews with some witnesses and/or written submissions from others."*[153]

153 Internal Investigation Report P6

The Internal Investigation reported that it interviewed eleven witnesses including the relatives of the late Mrs. X, and *"a Baptist Pastor who had regular contact with Mr. and Mrs. X since the autumn of 2001, until the time of their deaths in December 2008."*[154]

Some of the interviews were recorded and professionally transcribed. These witnesses were provided with a transcript of their evidence and given the opportunity to check for accuracy and to amend if they wished to do so.

14.2.4. Key Findings

The Internal investigation recorded its findings under the following thematic headings:

- Referrals:
  - quality of referral;
  - referral process.
- team communication and joint working.
- liaison with other agencies:
  - *GP and CMHT;*
  - Police.
- Documentation – recording, storage and access;
- Diagnosis and medical management;
- Care Programme Approach (CPA);
- Adequacy of care plan, care package and care provided;
- Risk assessment, formulation and management;
- Carer's needs and assessment;
- Clinical supervision and workload;
- Training;
- Systems – RiO.

14.2.5. Internal Review Team Analysis and Conclusions

Causal & Contributory Factors identified by the Internal Investigation

The Internal Investigation identified:

"The following potential causal or contributory factors:

154 Ibid. P7

- *the referral information which the GP made available to the CMHT;*
- *the severity of Mr. X's mental illness and the degree to which this could have impacted on events during the second episode of care;*
- *the volatile marital relationship which progressively deteriorated over time, the significance of which, was never brought to the attention of the mental health service;*
- *the degree to which Mr. X's second episode of depression impacted on the marital relationship;*
- *the degree to which Mr. X's second episode of depression impacted on his desire to get better and to return to meaningful occupation, which may have contributed to feelings of hopelessness on his part;*
- *the impact of Mr. X's pre-morbid personality on Mrs. X;*
- *Mr. X's level of risk in respect of suicide;*
- *the quality and appropriateness of the assessments and interventions by the CMHT within 17 working days from referral by the GP to the date of Mr. and Mrs. X's deaths;*
- *whether the fatal incident could have been predicted and or prevented."*[155]

It went on to identify "*three possible contributory factors, namely:*

I. *that Mr. X's level of hopelessness in December 2008 was not fully recognised and was complicated by his mixed presentation;*

II. *the risks associated with the advice given to Mr. X not to drive, went unquestioned, (although the advice itself was standard and reasonable practice).*

III. *the controlling aspects of Mr. X's personality and the consequences of this on his wife's well-being."*[156]

155 Internal Investigation.P71
156 Ibid P72

However the Internal Investigation concluded there was "*no definitive evidence to indicate that any of these factors had any direct adverse impact on the management plan instigated by the clinical team, or on the eventual outcome."*[157]

14.2.6. Internal Review Team Positive Factors Identified

- *"timely response to a routine referral;*
- *coherent team working and systems and processes in place for generally effective verbal communication and case management;*
- *evidence that the CMHT is committed to and open to learning, including the initiation of their own team review processes to reflect on the care provided to Mr. X, prior to the commencement of the Internal Investigation;*
- *flexibility in the CMHT's working practices to accommodate a joint visit - Psychiatrist (1) with CPN(3) at short notice;*
- *CPN (3) espoused the principles of the recovery model in drawing up the Care Plan;*
- *CPN (3) was able to regain the confidence of Mrs. X after the initial on 8 December 2008;*
- *the application of clinical supervision, in accordance with Trust Policy;*
- *the appropriate application of CPA."*[158]

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

It was the conclusion of the Independent Investigation Team that the Internal Review was managed in a competent and comprehensive manner. The Independent Investigation Team's observations with regard to the Internal Investigation findings are that they represent a high

157 Ibid P72
158 Internal Investigation report P72

degree of speculation derived from the benefit of hindsight, and that the Internal Investigation Team quite rightly stated that it could find no *"definitive evidence"* to prove that any identified factor adversely impacted upon the plan instigated by the clinical team. Several of the identified issues were 'service issues' rather than 'contributory or causal factors' in that they could not be proven to have impacted directly upon the deaths of Mr. X and his wife. Whilst the use of hindsight may be usefully deployed to understand a situation better, it should not be used to make a judgement regarding the reasonableness of the care and treatment that was delivered by a clinical team who were working without the benefit of it.

The Internal Investigation Team was both diligent and thorough and provided an excellent review with regard to service issues that required attention, development and learning, even though these issues were not found to have been direct causal or contributory factors to the death of Mr. X and his wife.

14. 3. Being Open

Support to Relatives:

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

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

The Police assisted the Trust in locating and making contact with one of Mrs. X's nieces. Mr. X had no surviving family.

Once the family whereabouts was confirmed the CMHT Manager made immediate contact with one of Mrs. X's nieces from whom she gathered vital information. Contact was subsequently made with Mrs. X's wider family, and a meeting with the wider family took place before any evidence had been heard so that the Internal Investigation Team could hear what they had to say from the outset of the Internal Investigation.

The Senior Portfolio Manager for Risk was designated as the Trust's liaison officer with the family during the course of the Internal Investigation. She made available to the Police information on the Zito Trust, an independent charity set up in 1994 which provides advice and support to victims of homicide, committed by service users known to mental health services. Unfortunately this Trust no longer exists.

During the Internal Investigation process the family of Mrs. X were offered the opportunity of an interview, which they accepted. The family had the findings of the Internal Investigation shared with them.

14.4. Staff Support

14.4.1. Prior to, and During, the Internal Review

Measures were taken to ensure that all North Kirklees CMHT staff were kept informed and that support was offered to them as required.

The Chair of the Staff Side (trades unions/professional bodies) was briefed in advance of staff being invited to give evidence. In addition, staff were advised that they could be accompanied by their trades union representative, colleague or friend, not acting in a legal capacity.
It was evident that Scott and Salmon compliant procedures were adhered to by the Internal Investigation Team. Witnesses were given an opportunity to see the draft report and to comment upon its accuracy. It was decided that witnesses could view the report on the 14 and 16 April 2009 at set times under controlled circumstances in order to read it and make any

additional comments that required. On the 21 April 2009 a feedback workshop was held with the Internal Investigation Team.

14.4.2. During the Independent Investigation

The Trust worked with the Independent Investigation Team to support staff in practical ways to ensure that:

1. information was sent, and received, to advise each witness what was expected of them;
2. information was sent, and received, regarding the purpose of the investigation;
3. support was given if required in the writing of a witness statement;
4. witnesses received support during the day of their interviews and had the offer of a debriefing session afterwards;
5. witnesses received the opportunity to attend a findings workshop at the end of the process.

14.4.3. Independent Investigation Team Feedback upon the Post Incident Management Process

Timeliness

The Trust worked through the post incident management process in a timely manner. The Internal Investigation was thorough and meticulous and was able to complete its work by the end of April 2009. This was of particular note due to the fact that the Christmas and New year period occurred directly after the incident, which could reasonably have been a cause for delay.

Staff Support

Witnesses were supported by the Trust Senior Management Team throughout both the Internal and Independent Investigation processes. The Independent Investigation Team however made the observation that the Internal Investigation process was at times unduly confrontational and this caused a degree of unnecessary distress for the witnesses. Whilst an investigation has to be rigorous, witnesses should not be subject to questioning that is either aggressive or lacking in courtesy.

Detail and Focus

The Internal Investigation was extremely detailed and focused and was able to provide a sound base upon which the Independent Investigation was able to work. This is to be commended.

Feedback to Witnesses

Whilst the GP was given the opportunity to make factual accuracy comments regarding the draft report, it is not certain what degree of feedback was given to the General Practitioner who contributed a written statement to the Internal Investigation, or whether he was given an opportunity to see a copy of the final report.

Trust witnesses were given an opportunity to view the draft Internal Investigation report. The Trust gave witnesses a very short window of opportunity to do this and would have been better practice for individuals to have been given at least five working days in which to read the report and consider any further response they wished to make.

All witnesses were invited to a feedback workshop with the Internal Investigation Team. This was a sensible approach in order to ensure that all witnesses had an opportunity to reflect upon the findings and understand fully the learning from the Investigation process.

14.5. Trust Internal Review Recommendations

The recommendations from the Internal Investigation Team were as follows:

14.5.1. Supporting and Protecting Staff

1. The Trust has very recently issued a policy regarding supporting staff following a traumatic incident, which includes reference to the support available to staff when asked to provide a statement to the Police. Staff should be reminded of this new policy and the Trust should consider if the content is sufficiently robust to support staff who find themselves in such circumstance.
2. Where possible Senior Managers should be physically present to offer support and advice to staff immediately following and beyond very serious incidents.

14.5.2. Referrals Management

3. There should be local systems that identify where responsibility for checking for previous records lie and for verifying referral details with the GPs in any referral process, whether this be the current system or the Single Point of access (SPA).

4. The Trust should work with the PCT to secure a plan of action which facilitates high quality referral information from local GPs.

5. Clinical Managers should, as a matter of routine, ensure that contact with the referring agency/GP is made to clarify anything which is unclear at the time the referral is received.

14.5.3. Risk Assessment, Management and Training

6. The Trust should secure the availability of regular risk assessment training, both in relation to the correct use of the Sainsbury Risk assessment Tool (the agreed risk tool for use in adult and older people's services in the Trust) and also the use of this tool in the context of risk assessment, formulation and management planning, in accordance with the Departments of Health's good practice guidance on clinical risk dated 2006.

7. Team Managers should ensure that Risk assessments are fully completed in accordance with Trust policy and recognised good practice and that this is monitored through supervision and other regular systematic processes.

8. The Trust should agree on the risk assessment tools which are to be applied by clinical staff in respect of suicide assessment.

9. The Trust should ensure that all clinicians undertake the relevant risk assessment and management course, and updates, as soon as is practicable.

10. Team Managers, in conjunction with the Training Department, should continue to monitor the availability, access and uptake of essential training for new and existing staff.

14.5.4. Communication, Record Keeping and Documentation

11. The Trust should agree a protocol about how joint assessments are documented when doctors are involved in joint visits with other members of the CMHT.

12. The Trust should take steps to resolve the issue of 'joined up' documentation in the context of *new ways of Working* for psychiatrists and other professional groups and determine lines of responsibility in ensuring that documentation by all clinical staff is relevant, appropriate and medico-legally defensible, including the documentation of joint visits.

13. The Trust should identify standards for documentation in electronic records and undertake regular audit of electronic record keeping.

14. Team Managers should be alerted to the importance of maintaining accurate records of team discussions and meetings.

15. The Trust should explore whether RiO (electronic clinical information system) is able to highlight any 'unknowns' in the initial risk assessment/management plan when this is reviewed later.

16. Following the introduction of RiO, in particular the documentation of assessments and progress notes on the system, all staff should be advised that they should include the date and time of the material to which they are referring in the body of the text so that there is no confusion as to the chronology of events.

14.5.5. Carer's Need and Assessment

17. Staff should be reminded of the importance of assessing the needs of carers both in terms of referrals for such an assessment to social Services but also in terms of the journey of clinical enquiry so that it is an integral part of clinical practice and that it is gathered in a timely way and monitored on a regular basis.

14.5.6. Police

18. The Trust should liaise with the Police to provide feedback on the experience of the staff involved in this incident in respect of the Police investigation.

14.5.7. Securing GP Involvement and Access to Records

19. The Trust should work with the PCT to secure a Memorandum of Agreement which facilitates the early involvement of GPs in the investigation of serious untoward incidents and access to essential clinical information.

14.5.8. Post-Incident Management

20. The Trust should clarify the Trust's post-incident guidance on the photocopying of records, taking account of the situation when the Coroner's Office of Police may be waiting to remove such records.

It was the conclusion of the Independent Investigation Team that the recommendations were both appropriate and comprehensive.

14.6. Progress against the Trust Internal Review Action Plan

Post Internal Review the Trust has carried out the following actions.

Serious Untoward Incident investigation - Action Plan Updated 3/11/10	**STEIS Ref no.**	*2008/10741 OPS*
	General manager	
	Assistant Director (at time)	
	Head of service (current)	
	Director (current)	

Ref No	Recommendations	Action Required/Taken	Lead	Time-scale	Progress/ completion	Completion /comments
1.0 Supporting and protecting staff						
1.1	The Trust has very recently issued a policy regarding supporting staff following a traumatic incident, which includes reference to the support available to staff when asked to provide a statement to the Police Staff should be reminded of this new policy and the Trust should consider if the content is sufficiently robust to support staff who find themselves in such	1. Current policy to be circulated to Assistant Directors, Associate Medical Directors and General Managers (for further circulation to team managers for information 2. Policy to be reviewed to clarify this information in the policy and circulate the new policy when approved 3. Work to be undertaken to develop information sheets to sit out with the policy (eg checklist for supporting staff,	Director of Nursing, compliance & innovation Senior Portfolio Manager Risk All Assistant Directors & General Managers		1. Policy re-circulated to all Assistant Directors, Associate Medical Directors and General Managers for circulation to Team Managers (May09) 2. Item placed in Operational Policy local team briefing to alert people to the policy and provide information on how to access it (July09) 3. Amendments made to policy including checklist for managers. Circulated widely for comments (including to Managers involved in	**1, 2, 3, 4, 5, completed** Sept 2009

Ref No	Recommendations	Action Required/Taken	Lead	Time-scale	Progress/ completion	Completion /comments
	circumstances.	police involvement, Coroners involvement and inquests) for managers, on call managers and staff to access through intranet or be sent electronically post-incident 4. To consider developing a Middle ground or other course re serious incident management eg a 'table-top' scenario exercise			this incident). 4. Monitored through managers fact-find reports 5. Plan made to initiate work on checklist/ information sheets - to be included in next version of Supporting Staff policy Continues to be work in progress – has been considered and is recognised as a useful training exercise for some point in the future, but will require a lot of resources to develop.	**Completed** as far as possible at this time
		5. Community Teams to include information about 'incident management in the community' in the local induction for new staff eg when to enter premises, when not, police involvement	Assistant Directors & General Managers	31 Dec 2009	April 2010 - Discussed at Risk Sub Group and confirmed that this is included in local induction	**Completed** April 2010
1. 2	Where possible Senior Managers should be physically present to offer support and advice to staff immediately following and beyond very serious incidents.	1. As above in 1.1 2. General Managers to monitor staff support 3. IMST to continue to monitor through fact find and SUI reports	All General Managers & IMST	Ongoing	Completed & ongoing	**Completed** June 2010
		1. The incident management policies will be amended to	Clinical Governance		**June 2010** Incident management policy updated and approved May	**Completed**

Ref No	Recommendations	Action Required/Taken	Lead	Time-scale	Progress/ completion	Completion /comments
		recommend that SUIs will have: • a single point/person identified for communication and co-ordination with the local incident manager • on site senior management support for the team where possible Staff support provided will be monitoring through SUI/RCA reports	Leads		2010	June 2010
1.3	***(This was recommendation 6.0 in the report)*** The Trust should liaise with the Police to provide feed-back on the experience of the staff involved in this incident in respect of the Police investigation	1. To contact Police to explore how and where to provide feedback re staff experience *(check Memo of Understanding)* **20/1/10** Further consideration of this issue has led to a view and decision that the most effective and appropriate approach to addressing this issue (re experience of staff in relation to the Police investigation in this case, and improving this for staff in future) is to provide staff with better information re: dealing with the Police. This was a potential murder case – and it	Clinical Governance Leads	31 Jan 2010 20/1/10 Amend-ed to 30/6/10	**20/1/10** Meeting arranged for 1/2/10 to discuss and start development of information for staff **Update April 2010** At the meeting identified a file of information previously developed by the Legal Team – to be updated and police will be consulted through existing network re content before included on the intranet **Update Sept 2010** Work has been undertaken to establish links with the Business Development Units and local Police, including an agreement with the police to make contact at a more formal	**Completed** Sept 2010

Ref No	Recommendations	Action Required/Taken	Lead	Time-scale	Progress/ completion	Completion /comments
		is unlikely that the Police would be able or willing to change their approach in these circumstances ***New action*** – to develop information sheet for staff re Police investigations 2. To consider consulting police re information sheet for staff re post-incident Police investigations			director level when undertaking investigations, such as a homicide Work is also ongoing to develop information for staff which will be available of the intranet Both these actions may help to prevent staff being asked to give statements by the Police without support	

Ref No	Recommendations	Action Required/Taken	Lead	Time-scale	Progress/ completion	Completion &comments
2.0	**Referrals Management:**					
2.1	There should be local systems that identify where responsibility for checking for previous records lie and for verifying referral details with the GPs in any referral process, whether this be the current system or the Single Point of Access (SPA)	1. To include this recommendation in the work currently being undertaken into referrals in Older Peoples Services 2. Older Peoples Services to use the SPA to undertake this function wherever these are already in place	Older Peoples Services Assistant Directors & Older Peoples Services General Managers	31Dec 2009	1. North Kirklees Older Peoples Services have developed a local system for checking • rewritten duty worker protocols (fulfils role of SPA) • check new referral against previous system (signposts something on system) and medical notes 2. South Kirklees - the Single Point of Access service in South Kirklees undertakes this function **March 2010 update** Wakefield and Calderdale confirmed completed **17/6/10** Following further service developments further work will be undertaken to strengthen SPA systems Kirklees-wide in the next few months	**Completed** March 2010
2.2	The Trust should work with the PCT to secure a plan of action which facilitates high quality referral information from local GPs	Issue to be raised with PCT through the new quality board/s for joint action to address this as a learning point from the incident *(Note: in the past referrals have been returned; but this led to delays in assessment)*	Clinical Governance Leads	28 Feb 2010	**15/1/10** Discussions to be commenced at the Quality Board meeting. **June 2010 update** Referral quality issues are now discussed at the quarterly contractual meetings, and this issue has been shared through that	**Completed** June 2010

Ref No	Recommendations	Action Required/Taken	Lead	Time-scale	Progress/ completion	Completion &comments
					meeting. Work is being undertaken by the PCT to address this by taking the issue to the GP forum	
2.3	Clinical Managers should, as a matter of routine, ensure that contact with the referring agency/GP is made to clarify anything which is unclear at the time the referral is received.		Older Peoples Services General Managers	31Dec 2009	Included in work under 2.1 Local improvements made in North Kirklees South Kirklees – undertaken by SPA Team/service Team Leaders will monitor/audit – workshop held with Band 7 managers 5th October 2009 **March 2010 update** Wakefield and Calderdale confirmed completed	**Completed** March 2010

Ref No	Recommendations	Action Required/Taken	Lead (name/title)	Time-scale	Progress/ completion	Completion & comments
3.0	**Risk Assessment and Management and Training:**					
3.1	The Trust should secure the availability of regular risk assessment training, both in relation to the correct use of the Sainsbury Risk Assessment Tool (the agreed risk tool for use in adult and older people's services in the Trust) and also the use of this tool in the context of risk assessment, formulation and management planning, in accordance with the Department of Health's good practice guidance on clinical risk dated 2006	1. To be included in risk assessment and management training discussions at SDG risk sub-group – include specific issues re: Older Peoples Services risk 2. Ongoing availability of risk training for 2010 to be discussed to ensure that appropriate risk training is provided and evaluated by SWYPFT	General Managers	31 Jan 2010	1. Older Peoples Services risk and care planning workshop held 21/9/09 2. In 2009 the Clinical Risk Training was reviewed & evaluated and is now provided as 2 separate courses: • One for new starters or staff who haven't received the training which does focus on the use of the Sainsbury tools • One for existing staff & focuses far more on the DoH Good Practice Guidance and risk management 2009 sessions evaluated well. **12/1/10** Training for 2010 confirmed and risk training programme to be evaluated and reviewed again February 10	**Completed** 12/1/10
3.2	Team Managers should ensure that Risk Assessments are fully completed in accordance with Trust policy and recognised good practice and that this is monitored through supervision and other regular systematic processes.	1. Clinical risk training is mandatory training for clinical staff – attendance to be monitored by team managers through the electronic staff record system, and local records 2. Risk assessment practice to be monitored	SB		Workshop for Older Peoples Services Band 7 staff held 5th October 2009 which emphasised the importance of monitoring training and practice re clinical risk management **Update 17/6/10** New supervision policy implemented which includes clinical risk	**Completed** June 2010

Ref No	Recommendations	Action Required/Taken	Lead (name/title)	Time-scale	Progress/ completion	Completion & comments
		through supervision 3. To be included in work planned with Band 7 team leaders to include (Supervision-led process re: identifying who is good/less good re: risk assessment and supporting skill development rather than training on a tool)			assessment monitoring and supervision through random selection of cases	
3.3	The Trust should agree on the risk assessment tools which are to be applied by clinical staff in respect of suicide assessment	To be addressed through Care Programme Approach, care planning and risk assessment policies, procedures and training processes.	General Managers	31 January 2009 Amended to 31 May 2010	**Update June 2010** The new Care Programme Approach policy approved June 2010 – clearly describes the process for care planning based on assessment including risk assessment. (Interim key policy bulletin was issued prior to this.) Both emphasise the importance of using the 2 levels of Sainsbury risk assessment appropriately - which include suicide assessment Trust clinical risk training covers suicide risk Introduction to Care Programme Approach courses being provided Attendance on both courses is monitored and the training is	**Completed** June 2010

Ref No	Recommendations	Action Required/Taken	Lead (name/title)	Time-scale	Progress/ completion	Completion & comments
					evaluated and subject to regular review.	
3.4	The Trust should ensure that all clinicians undertake the relevant risk assessment and management course, and updates, as soon as is practicable	Clinical risk training is mandatory training for clinical staff – attendance to be monitored by team managers through the electronic staff record system, and local records Risk assessment and management workshop to be arranged for Older Peoples Services staff to consolidate awareness of risk assessment issues Workshop for Older Peoples Services Band 7 managers to be arranged to clarify roles and responsibilities	Older Peoples Services General Managers		Older Peoples Services risk and care planning workshop held 21/9/09 which clarified roles and responsibilities Workshop for Older Peoples Services Band 7 staff held 5th Oct 2009 **June 2010 update** Clinical risk training attendance is monitored through Electronic Staff Record system as a mandatory course for clinicians Clinical supervision policy approved June 2010 which clarifies supervision and monitoring of clinical risk training and practice (through random review of cases and records)	**Completed** June 2010
3.5	Team Managers, in conjunction with the Training Department, should continue to monitor the availability, access and uptake of essential training for new and existing staff	Ensure clinical risk training courses are available and attendance is monitored	Older Peoples Services General Managers		See above (3.2)	**Completed** June 2010

Ref No	Recommendations	Action Required/Taken	Lead	Time-scale	Progress/ completion	Completion & comments
4.0	**Communication, Record Keeping and Documentation:**					
4.1	The Trust should agree a protocol about how joint assessments are documented when doctors are involved in joint visits with other members of the CMHT	1. Trust to develop a protocol/guidance for staff around joint visits and assessments which addresses 4.1 and 4.2 2. To explore option of jointly validated entries following joint visit/ assessment 3. Rio Medical Group to consider undertaking a survey re making entries in notes and whether this should be a team entry or individual entries 4. Relevant issues have been forwarded to the RiO group and to the Trust's Care Programme Approach lead for comment	Medical Director	31 March 2010 Amended to 31/8/10	**30/4/10** A meeting is planned with the medical Director and Director of Nursing Innovation and Compliance to clarify Trust policy on this issue (which will reflect the new DoH Best Practice Guidance re this issue) Action and completion date amended to 31/8/10 to take into account the new national guidance **3/11/10** Medical Director and Acting Director of Nursing Compliance and Innovation to update on this action **Dec 2010** RiO medical group are currently piloting joint care plans and joint RiO entries on the RiO electronic system	**Completed** Dec 2010
4.2	The Trust should take steps to resolve the issue of 'joined up' documentation in the context of New ways of Working for psychiatrists and other professional groups, and determine lines of responsibility in ensuring that documentation by all clinical staff is relevant, appropriate and medico-legally defensible, including the documentation of joint visits					
4.3	***The Trust should identify standards for documentation in electronic records and undertake regular audit of electronic record keeping.***	Standards to be developed and audited	Finance Director		See 4.1. and 4.2 Data quality and clinical supervision policies developed June 2010 Electronic clinical records will be	**Completed** June 2010

Ref No	Recommendations	Action Required/Taken	Lead	Time-scale	Progress/ completion	Completion & comments
					monitored and audited through: • The RiO Data Quality Reports which are produced regularly and reviewed at EMT • Clinical supervision and medical appraisal processes – random review of cases and records	
4.4	***Team managers should be alerted to the importance of maintaining accurate records of team discussions and meetings***	Item to be placed on local Older Peoples Services team brief	Clinical Governance Leads		Item included on local team brief June 2009	**Completed** June 2009
4.5	The Trust should explore whether RiO (electronic clinical information system) is able to highlight any 'unknowns' in the Initial Risk Assessment/ Management plan when this is reviewed later	To take this issue to the Trust RiO group	Clinical Governance Leads		**June 2010 update** This has been explored and clarified that it is not possible to set up the system in this way. However other work in relation to developing and monitoring clinical risk and Care Programme Approach training, monitoring training attendance, and new clinical supervision processes support effective risk management practice and documentation	**Completed** June 2010
4.6	Following the introduction of RiO, in particular the documentation of assessments and progress notes on the system, all staff should be advised that they	1. For Rio Editorial Group to clarify issues related to time/entry on the system – make sure Clinicians are enabled to alter time and date to reflect client contact.	Managers		**June 2010** RiO guidance clearly explains the process for entries on RiO being made against the date of the action, ***not*** the date of entry onto the system.	**Completed** June 2010

Ref No	Recommendations	Action Required/Taken	Lead	Time-scale	Progress/ completion	Completion & comments
	should include the date and time of the material to which they are referring in the body of the text so that there is no confusion as to the chronology of events	2. To be included in RiO version 6 3. The system and process to be clarified with staff			Data quality monitoring and supervision process are in place to monitor the quality of Rio recording Staff have become more competent in use of RiO since the date of the incident, but a reminder and clarification has been included in the staff RiO news bulletin.	

Ref No	Recommendations	Action Required/Taken	Lead	Time-scale	Progress/ completion	Completion & comments
5.0	**Carer's Needs and Assessment:**					
5.1	Staff should be reminded of the importance of assessing the needs of carers both in terms of referrals for such an assessment to Social Services but also in terms of the journey of clinical enquiry so that it is an integral part of clinical practice and that it is gathered in a timely way and monitored on a regular basis	1. Clarify to and remind staff that there are no confidentiality issues relating to listening to what carer's have to say by placing item in SDG team brief 2. new CPA policy document being developed 3. CPA training being developed	Sue Barton		Included in local team brief June 2009 Included in CPA policy (including interim policy document) Annual CPA audit – first audit cycle completed CPA training now being provided and evaluated re both attendance and effectiveness	**Completed** June 2009

6.0 included above as 1.3

Ref No	Recommendations	Action Required/Taken	Lead	Time-scale	Progress/ completion	Completion & comments
7.0	**Securing GP Involvement and Access to Records:**					
7.1	The Trust should work with the PCT to secure a Memorandum of Agreement which facilitates the early involvement of GPs in the investigation of serious untoward incidents and access to essential clinical information	This will be raised with the SHA and Kirklees PCT as part of the process of sharing the findings of this report The issue will also be raised with the PCTs through the new quality boards	Director of Nursing		Discussion and agreement reached between PCT and SWYPFT – future process will be Director of Nursing to Director of Nursing communication re GP involvement in RCA investigation processes.	**Completed** June 2010

8.0 Post Incident Management:						
8.1	The Trust should clarify the Trust's post incident guidance on the photocopying of records, taking account of the situation when the Coroner's Officer or Police may be waiting to remove such records	Review and clarify current process and amend incident management policy and procedures as necessary	Senior Portfolio Manager Risk		Incident management policy updated and approved May 2010	**Completed** June 2010

Overall action plan implementation monitoring					
Any overall resource issues identified		**None**			
Outcome of risk assessment of impact of changes to systems or practice (see risk assessment format)		**None**			
Action plan developed by:	**Senior Portfolio Manager Risk**	**Date action plan Issued:**	Oct 2010	**Action plan review date/s**	
Approved by:	**Director Nursing**			31/12/09	Jan 2010
				April 2010	17 June 2010
				Sept 2010	Nov 2010
Signed off as completed by:	**Associate Director of Nursing**	**Date signed off as completed**	**Dec 2010**		

NB: Please ensure that all identified action leads have agreed to this lead role and have a copy of the action plan

The Independent Investigation Team can confirm that this action plan has been implemented

15. Notable Practice

There were several areas of notable practice identified during the course of the Independent Investigation.

15.1. The Internal Investigation Team found the following:

- *"timely response to a routine referral;*
- *coherent team working and systems and processes in place for generally effective verbal communication and case management;*
- *evidence that the CMHT is committed to and open to learning, including the initiation of their own team review processes to reflect on the care provided to Mr. X prior to the commencement of the Internal Investigation;*
- *flexibility in the CMHT's working practices to accommodate a joint visit - Associate Specialist Psychiatrist and CPN 2 - at short notice;*
- *CPN 2 espoused the principles of the recovery model in drawing up the care plan;*
- *CPN 2 was able to regain the confidence of Mrs. X again after the initial meeting of the 8 December 2008;*
- *the application of clinical supervision, in accordance with Trust policy;*
- *the appropriate application of CPA."*[159]

15.2. The Independent Investigation Team found the following:

The Independent Investigation concurred fully with the findings of the Internal Investigation Team. Additional notable practice relevant to this case was identified in the following areas:

- Trust post incident management;
- Care Programme Approach development.

The Trust management of the post incident arrangements ensured the optimal amount of learning was both identified and put into practice in the form of service development

159 Internal Investigation Report P72

initiatives. These initiatives were set out in a detailed action plan that was worked through and implemented fully.

The Trust was in the process of developing new Care Programme Approach policy and practice at the time Mr. X was receiving his care and treatment form the Trust in December 2008 in line with the new national requirements that came into being in October 2008. This has been accomplished in a manner that is both comprehensive and evidence-based.

Trust Post Incident Review Process

Following the incident the Trust undertook an internal investigation and developed an action plan to address all the recommendations made. This action plan was regularly updated and implementation was monitored by the Lead Director who reported progress to the Clinical Governance and Clinical Safety committee. Some actions were implemented by the local team and service, whilst some required Trust-wide actions and liaison with partner agencies. The fully completed action plan was signed off by the Committee in December 2010. The management of the incident was robust and consequently the Independent Investigation has not been required to make additional recommendations.

Care Programme Approach Policy and Process

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

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

- Those individuals requiring CPA will have been assessed as having complex needs and presented with higher risks. Those individuals identified as requiring secondary mental health services but who do not present as having complex needs or high levels of risk will have their care managed through the Standard Care process. Both CPA and Standard Care have clear and robust processes for assessment, care planning,

review and transitions in care. Both processes have identified professionally qualified clinicians who understand the role required of care coordinators. In the case of CPA this is usually a Community Mental Health Nurse or Social Worker attached to one of the Trust community specialist teams working within the context of a multidisciplinary team and are therefore best placed to undertake this role.

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

All invitations to a review are recorded.

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

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

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

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

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

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

6. Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting agencies, not just the planned occasions where people meet for reviews.

Best practice relating to the delivery of CPA and Standard care process is supported fully by Business Delivery Units (BDUs). CPA training, risk training and systems training supporting CPA is available to all staff. Effective monitoring of CPA includes:

- Monthly reporting on the Trust's Key Performance indicator relating to care plans being offered to service users. The Trust consistently reports figures above the 80% target and is constantly working to maintain and improve this. These monthly figures are reported to service managers and disseminate to teams to alert any significant changes relating to the key Performance Indicator.

- Annual audit of CPA based on good practice standards. The audit includes:
    - Interrogation of clinical recording from a random sample of electronic and paper records covering areas of demographic information, assessment

standards, care plan standards and review standards. CPA registration and standards relating to effective delivery of care coordination.

- Staff survey related to care coordination and training.
- A service user and carer survey based on a random sample.
- Triangulation of standards in relation to what the Trust says it is doing with patient experience.

16. Lessons Learned

There were few 'lessons to be learned' regarding clinical practice as a result of this particular investigation. However it was noted that communication between primary and secondary care may benefit from a more structured protocol. In the case of Mr. X no communication took place on the part of the CMHT back to the GP following the referral, apart from an acknowledgement of the referral having been received. The GP continued to prescribe medication for Mr. X and was also being 'built into' the contingency and crisis plan.

With the advent of *New Ways of Working* in October 2007 significant changes occurred to the ways in which mental health teams across the country functioned. *New Ways of Working* set out the national implementation guide for policy change that had been in development over a period of four years previously. The Department of Health stated that *New Ways of Working "promotes a model where distributed responsibility is shared amongst team members and no longer be delegated by a single professional such as the consultant."*

This has had the result of altering traditional communication pathways. Psychiatrists usually write to GPs following a clinical assessment having taken place. This is still the current practice when a psychiatrist is the nominated lead clinician. However psychiatrists are no longer automatically placed in the lead clinician role. In the case of Mr. X CPN 2 was the lead clinician. She operated in accordance with the CMHT operational policy with regard to communication timeframes with the GP, however this did not allow for the more immediate response that usually takes place between doctors.

Whilst the communication process that occurred in the case of Mr. X between the CMHT and the GP did not breach any policies or protocols, it illustrated well how new workforce processes, in this case *New Ways of Working*, can lead to fractures in traditional communication pathways. There were no contributory issues apparent resulting from this communication 'delay' however it serves to act as an example of how the introduction of new processes can often disrupt older more established ways of working. It would have been better practice to have kept the GP abreast with the assessment and management plan that was being developed for Mr. X, this was of particular relevance as the GP maintained a role

in Mr. X's care and treatment and may have been called upon during the Christmas holiday period had Mr. X reached a crisis.

17. Recommendations

The Executive Directors of South West Yorkshire Partnership NHS Foundation Trust had the opportunity to review the recommendations required for this case at both the preliminary feedback stage and during the factual accuracy checking stage. The Trust should be given recognition for the work that it has put into this process and the progress that it has already put into place. Due to the depth of work carried during the interval between the Internal and Independent Invesitgation a great deal of work has been conducted. As a consequence few recommendations have been identified as requiring further action.

Work Already Completed

Since this incident the Trust developed and implemented an action plan to address the issues identified in the Internal Investigation into the care and treatment of Mr. X. There has also been significant progress in a number of developments within the organisation to improve systems and services. The implementation of change and improvement had addressed the issues identified in both the Internal Investigation process and in this report. These include:

1. **Care Programme Approach (CPA)**

   Development of the new CPA policy and procedure has been completed in agreement with the Trust's three Local Authority partners, and is now implemented. Associated training for staff and effective monitoring and audit processes are in place.

2. **Risk Assessment**

   The Trust has implemented fully the use of the Sainsbury Risk Assessment across both adults of working age and older people's services, and developed a risk assessment and risk training policy incorporating the principles of the Department of Health Good Practice Guidance. A regular training programme is provided together with CPA training.

3. **Electronic Record System**

   The Trust has implemented and rolled out an electronic record system (RiO) across the Trust. This system supports communication in relation to providing care as well as

providing progress and history records. Both CPA and risk assessment are integrated into this system. Electronic record keeping is monitored and audited through RiO data quality reports.

4. Referrals management and Communication with Primary Care

A Single Point of Access (SPA) referral system is now in place in Kirklees with a standardised referral form agreed with GPs throughout the Primary Care Trust. SPA will be provided by a defined team, which includes both clinical and administrative staff with a single base location, using a standardised referral process.

Having a single point of access offers a number of benefits for service users, referrers and the Trust, including:

- equitable access to mental health services for all service users;
- establishing a standardised referral and assessment process;
- a clear, consistent and accessible referral route for all referrers;
- increased service quality, productivity and efficiency;
- improved relationship with referrers.

With the implementation of the new CPA policy, which includes the role of the Care Coordinator, and staff training to support this, communication systems are now working more effectively. Currently this policy is being updated and will include additional emphasis on the importance of communication, which will be reinforced through the link training programme.

In addition there are now standardised CPA communications and a standardised discharge form and discharge letter in place. The RiO implementation and development programme is also developing a system for generating letters, for example, to communicate CPA invitations and outcomes, medical care plans and discharge letters to GPs.

5. Training, Supervision and Appraisal

Implementation of policies and procedures is supported by staff training, supervision and appraisal. Training programmes have been developed using the training needs analysis and attendance is monitored.

An integrated (Trust and Social Services) supervision policy has been developed for staff working in integrated teams, and supervision and appraisal processes are in place.

6. Post Incident Management Including Support for Staff

All relevant policies and procedures have been reviewed and amended to address issues identified in this process.

In relation to supporting staff following a serious incident the Trust's 'Well Being' group is considering this issue, to ensure that the Trust's approach to this reflects best practice.

7. Audit

The Trust has an audit programme to monitor the effectiveness of Trust policies and procedures, which is supported and monitored by the Clinical Audit and Practice Effectiveness Group which is a sub group of the Clinical Governance and clinical Safety Committee.

Recommendations

The Independent Investigation Team acknowledges the work that has been undertaken by the Trust. In order to support this work one recommendation has been made.

Recommendation 1

The Trust in conjunction with its commissioning bodies should conduct as part of its ongoing clinical audit programme an audit to consolidate the implementation of all of its new policies and procedures. The audit should be conducted either one year following the policy implementation changes, or within six months of the publication of this report, whichever comes first. The audit should include:

- the take up of CPA and risk assessment training across all disciplines;
- compliance with the risk assessment policy;
- the effectiveness of referral and discharge processes;
- clinical supervision compliance;

- the quality of clinical supervision processes;
- a compliance and quality review of the new electronic clinical record system;
- a feedback process from all staff who have been involved in serious untoward incident procedures.

Glossary

Anhedonia	The inability to feel pleasure from normally pleasurable experiences.
Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or peoples' own homes.
Fluoxetine	Fluoxetine (Prozac, Sarafem) a drug used in the treatment of depression, obsessive-compulsive disorders.
Mental Health Act (2007)	The Mental Health Act 1983/2007 covers the assessment, treatment and rights of people with a mental health condition.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts.
PRN	The term "PRN" is a shortened form of the Latin phrase *pro re nata*, which translates roughly as "as the thing is needed". PRN, therefore, means a medication that should be taken only as needed.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a persons risk to

	both themselves and to others.
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
Seven-day Cardiac Trace	If a patient is experiencing palpitations or heart rhythm disturbances on a very infrequent basis, or if a 24-hour heart monitor has failed to pick up any abnormalities, a Cardiologist may suggest an extended period of heart monitoring. This increases the chance of documenting the heart rhythm at a time when the patient is experiencing symptoms. The monitor continuously records the heart beat over a seven-day period.
Venlafaxine	Venlafaxine is an anti depressant drug which becomes effective within two-four weeks of commencement.
Zopiclone	Hypnotic used for the short-term treatment of insomnia (difficulty sleeping). It also has the effect of a tranquiliser. Overdose: Zopiclone when taken alone usually is not fatal, however, when mixed with alcohol or other drugs such as opioids, or in patients with respiratory, or hepatic disorders, the risk of a serious and fatal overdose increases.

Appendix One

Timeline for the Independent Investigation of the Care and Treatment of Mr. X

Date and time	Event
24/7/1927	Mr. X was born.
	~~
7/5/**2002**	The GP referred Mr. X to the Trust for initial assessment for treatment.
24/5/02	CPN 1 wrote to the GP after an initial assessment of Mr. X, *"Both the Dewsbury Risk Assessment and the direct questioning proves that he is a threat to himself. ... He will not admit that he will try again but in my opinion should this man not improve or we intervene on a very professional basis then I think it would be inevitable that this man will kill himself."*
27/5/02	Referred to Priestley Day Unit due to *"extreme anxiety and depression".*
22/6/02 onwards	Attended Day Unit Concludes with *"there has been very little real change in his mood and on the whole remains very negative about what the future has in store for him".*
4/9/02	Mr. X was discharged from the Day Unit.
17/9/02	Referred to the Associate Specialist Psychiatrist outpatient clinic.
30/9/02	First recorded entry as outpatient by psychiatrist *"Seen with wife... Changes Zispin to Venlafaxine..."*
2002-2003	Seen as an out-patient every 2-3 months during 2002-3 with wife. Letters were sent from the Associate Specialist Psychiatrist to the GP on progress.
27/4/2004	Seen as an out-patient *"Feeling 100% ... going on cruise"...* A letter was sent from the Associate Specialist Psychiatrist to the GP on progress. Reducing Zopiclone and Venlafaxine.
23/11/2004	Seen as an outpatient *"Very well"? ...has been on two more cruises..."* Venlafaxine was decreased. A letter was sent from the Associate Specialist Psychiatrist to the GP on progress.
12/4/**2005**	Last outpatient appointment. Discharged back to the care of the GP.
	~~

Date and time	Event
1/12/2008	The GP referred Mr. X to the North Kirklees CMHT because *"he was low, depressed, felt life was not worth living".* Mr. X referral papers faxed to CMHT. Previous psychiatric history – **NO.** Medication – Fluoxetine 20mg started 28 November 2008.
2/12/08	**Referral screening form** completed by ***a Community Psychiatric Nurse at the team base***. *"Presenting mental health problem – low mood". No details on risk recorded.* *To be seen "within 14 days."*
2/12/08 08.55	**Communication Record** – *"Referral received. ['Known to services' struck through] ... Urgency not known to gateways to care."*
2/12/08	Referral date recorded on RiO as accepted to (OPS) North Kirklees South CMHT.
3/12/08 13.30	Mr. X was allocated to CPN 2. She telephoned and arranged a visit for 8 December. **Communication Record** (made by CPN 2) – *"Telephone to Mrs. X, he's really down in the dumps, he's been to Huddersfield about voluntary work. He's decided that he can't eat or sleep, watching TV during night. Visit to GP yesterday – he's changed the medication. Spending his time sighing and says there's nothing to live for".*
8/12/08 15.00pm	CPN 2 visited Mr. X at home for the first time. Another appointment was made to visit again on 18 December.
9/12/08 12.05	**Communication Record** – *"Home visit... Mrs. X was present through some of the visit but I felt I had to ask her to let me speak to her husband alone as she was talking over him and I felt he'd be more open without her. ... Felt he went to pot when he stopped working... Feels there is nothing in their life, no point in going on. He has thought about taking his life and has thought about how he'd do it but says he has not got to that point yet…He also promised me he would not do anything before my next visit on Thursday 18 December 2008."* *"Mrs. X feels she is forced to do what her husband wants, feels she's having her arms forced... He has found himself a voluntary job working in a plastics moulding factory which he started yesterday... He says he feels very anxious about being depressed, feels horrible and miserable all the time – is not sleeping... not eating anything".* *"After I'd spoken to Mr. X we went through to the kitchen and his wife was livid saying it was her house and I had no right to*

Date and time	Event
	speak to her husband on his own. I explained it was important to have spoken to Mr. X on his own. She seemed to think he's been talking about her, which I said he hadn't". ... "She'd put up with her husband getting his own way for 50+ years of their married life... There is a clear conflict between Mr. X and Mrs. X and this could exacerbate his depression."
9/12/08	**CPA** Start date 9/12/08 Care Coordinator – CPN 2 "Current CPA level – CPA" Next CPA Review 9 June 2009 **Care Plan** completed with needs, interventions and aim/outcomes identified started and not signed off by CPN 2. **Interventions** *"To support Mr. X by visiting weekly, building a therapeutic relationship, giving him the opportunity to express his thoughts and concerns. Basdec assessment to be undertaken to assess depression and anxiety levels. Therapeutic relationship to be built up with Mr. X to aid in depth questioning about suicidality. Regular involvement of medical staff for assessment and medication review."* *"To support Mr. X in exploring activities which he can look forward to."* *"Suggest referral to Relate counselling and support dialogue between Mr. X and his wife."*
9/12/08	**Contingency and Crisis Plan** started and not signed off by CPN 2. *"Steps to be taken if client fails to attend or meet other commitments"*. Items ticked are: *"Contact GP, Contact Care Manager, Discuss with RMO, telephone."* **Crisis Plan** *"Mr. X or his wife to contact CPN 2 or Associate Specialist Psychiatrist. For Mr. X to contact his GP. In emergency contact emergency services. If Mr. X needs to talk urgently out of hours to contact Samaritans or NHS Direct".*
9/12/08	**HoNOS Plus form** completed. Scoring 3 for suicidal behaviour and 2 for problems with depressed mood.

Date and time	Event
	"Care package selected 01b CMH Health problems (greater need)."
9/12/08 15.17pm	*"Comprehensive health and social care needs assessment"* started and not signed off by CPN 2. *"Depression over past month. Feels there is nothing in their life and no point going on. Has plans to end his life but has not got bad enough to act on this yet. Did not disclose what his plans are. Feels anxious about his depression, is not sleeping or eating properly. Feels horrible all of the time, is miserable. Has been prescribed Venlafaxine 75mg once daily, recently changed from Fluoxetine which was prescribed by the GP on 28 November 2008. Mr. X's wife says she has to put up with his depression for years and went through it all 5 years ago."* *"Volatile relationship between Mr. X and his wife, they want very different things from life."* *"Good eye contact, good posture, attentive, able to concentrate, intelligent and articulate. Slight agitation and restlessness. Speech level, context and content normal. Depressed mood and anxious about his depression but is motivated to find voluntary work and still takes dog out for 2 hours each afternoon and admits this makes him feel better."*
9/12/08	"**Initial Risk Assessment/Management Plan**" started and not signed off by CPN 2. **Risk Indicator - suicide** showing YES to *"D - major psychiatric diagnosis', E - expressing suicidal ideas, F - considered/planned intent, H - expressing high levels of distress, L - unemployed/retired, O - compliant with prescribed medication".* *"Currently feels suicidal, says he has a plan but promised not to act on it. Previous depression in 2002 following unplanned retirement in 2001. Feels there is no point to his life. Mr. X gets angry with his wife who shows lack of understanding of his depression."* **Risk Indicator - Neglect** showing YES to *"C - failing to eat properly, H - lack of positive social contacts".* *"Mr. X currently finds eating difficult…"* **Risk Indicator - Aggression/Violence** showing YES to *"E - known personal trigger factors, K - signs of anger and frustration".*

Date and time	Event
	Risk Indicator - Other showing YES to *"Risks relating to memory problems/relating to cognitive impairment."* **Risk Indicator - Physical-Environmental problems** showing YES to *"E - sensory impairment - sight, F - sensory impairment - hearing, G - elimination - bladder, I - ability to prepare food and drink, J - risk associated with finding way around local environment".* *"Wears glasses and hearing aid, currently having trouble passing urine, intends to visit GP about this".*
9/12/08 15.35	**Communication Record** – *"Message left for Mr. X about possible visit tomorrow to do BASDEC etc".*
9 or 10/12/08 10.00am Copy unclear	**RiO Entry** - CPN 2 made a telephone call from team base, purpose unclear. *"Outcome - other".*
10/12/08 8.10am	**Communication Record** – *"telephone call from Mr. X, he'd rather wait until our appointment on Thursday 18/12/08 as he has plans for today".*
10/12/08 8.30am	**RiO Entry** - CPN 2 made a telephone call from team base, purpose unclear. *"Outcome - other".*
10/12/08	**RiO entry** "Care plan opened - summary text".
10/12/08 12.50	**Communication Record** – *"telephone call from Mr. X who explained his wife felt very put out by me wanting to talk to him alone, he thinks she is very jealous. She feels I am against her. I explained that I am not and on my next visit I plan to spend some time with Mrs. X as I realise she too needs support. Mr. X said he'd found the conversation we'd had very useful and supportive. I offered to talk to my manager about his situation. I suggested the possibility of a male worker and perhaps doing a joint visit on Thursday. I also suggested that Relate counselling could be useful to both of them. He said he was too old to start a new life, I explained that Relate would help them find a way to get along better together".*
11/12/08 09.00am	CPN 2 made a telephone call from team base, purpose unclear.
15/12/08 10.30	**Communication Record** – CPN 2 wrote *"FUTURE COMMUNICTION NOTES ON RIO".*
15/12/08	An appointment in the outpatient clinic. *"Cancelled by service".*

Date and time	Event
15.10pm	
17/12/08 9.45am	CPN 2 makes a phone call from team base. *"Cancel reason - Booked in error"?*
17/12/08 9.45am	CPN 2 makes a phone call from team base. *"Outcome - other".*
17/12/08 13.00pm	A telephone call was made by Mrs. X to check the time of appointment for 18 December. *"Mr. X had gone to Filey to walk the dog ... on Saturday and had got lost on the way, missing the turning off the motorway. He also said he would not mind dying in a car crash if it happened accidentally. I spoke to her about us not hitting it off very well on my initial visit but she said she was looking forward to my visit and the chance to talk to me."*
18/12/08 15.00pm	CPN 2 and the Associate Specialist Psychiatrist visited Mr. X at his home. Mr. X *"... is still very depressed and feels he has nothing to live for*". He said "he was old and decrepit and had no purpose in life". Taking Zopiclone 3.75mg dose, 1 or 2 per night as necessary. Advice given regarding 'sleep hygiene'. Mr. X was waiting results of cardiac monitor test on 29 December. *"Any increase in medication will be dependent on the results and a change in medication may be indicated, the Associate Specialist Psychiatrist a to monitor".* *"The Associate Specialist Psychiatrist asked Mr. X if he would like to come into hospital, he refused but said if he didn't improve he would come in. Mr. X was not sectionable under the mental health act and did have the capacity to make the decision himself".* *"When asked about suicidality Mr. X said he didn't feel life was worth living, he had thought about suicide and thought he would probably drown himself in the canal or river. He said he did not have active plans for this".* CPN 2 discussed the possibility of voluntary work and that Mr. X and his wife were due to be away for a few days over Christmas. The next visit was planned for 23 December 2008.
19/12/08	CPN 2 made a telephone call from team base to Mr. X's home.

Date and time	Event
08.40am	
22/12/08 09.20am	CPN 2 made a telephone call from team base to Mr. X's home.
22/12/08 10.45am	CPN 2 made a telephone call from team base to Mr. X's home.
22/12/08	**"Multi-Disciplinary Risk Assessment"** started by CPN 2. *"**Categories of Risk identified** - Suicide and Self harm, Other".* *"**Historical information** - Depression 2002, expressed suicidal ideation and plan to tie a rope around his neck and drop from the balcony (Balcony no longer exists) did not carry it out…"* *"**Health related**. … problems urinating… recent cardiac trace…"* *"**Risks from other** …Wife no longer wishes to partake in foreign holidays…"* *"**Positive resources** - Walks dog 2 hours each day…seeking voluntary work… wife generally supportive and vigilant… Planned holiday break over Xmas… He is desperate to find activities to keep him busy".* *"Wife initially resistant to me seeing Mr. X alone but now sees therapeutic reason for this. Plan to give her time and support too, support worker to be taken on visits to facilitate this".* *"**Planned intent**. Says he may drown himself in canal or river, no active plans voiced".*
22/12/08	Risk Management Plan following on from above started and not signed off by CPN 2. *"**CPA - Enhanced**".* *"**Opportunities for risk prevention**. Support for Mr. X and his wife in the form of weekly visits by care coordinator to build a therapeutic relationship individually and together. Home visit from Associate Specialist Psychiatrist then follow up in out-*

Date and time	Event
	patients clinic…" *"**Short term crisis management options**. Weekly visits from care coordinator to monitor mood and offer support. Regular out-patients appointments. Basdec to aid mood monitoring, suicide risk factors checklist. Adjust medication as necessary."* ***"Long term management options.** Hospital admission if Mr. X feels he is not getting any better. Support Mr. X to find… work… activities… holidays…"* ***Next Review** - "27/1/09 at CMHT meeting".*
23/12/08 14.05pm	CPN 2 and a Support Worker visited Mr. X and his wife at their home. *"There was no answer when I knocked on the door which was unusual as Mr. X and Mrs. X were usually at the door to meet me. I looked in the dining room window and saw a light on in the bathroom was on and clothes on the floor. I knocked again on the door and window. The Support Worker noticed five full bottles of milk outside the door. We both went round the back of the house to look in the window to see if we could see anyone…. We went back upstairs to get the telephone number to ring the house and alert duty and managers as to my concerns. I rang the number… I could hear the phone ringing in the house then the answer phone clicked in so I rang off. I then rang the office back and spoke to the team manager, who confirmed my thoughts about ringing the Police. I rang the Police at 14.29pm. They arrived at about 15.40pm. The Support Worker and I went into the house after them… The officers came back, I asked if people were dead, one of them said two people were dead. The Support Worker and I were told to wait in our car… Adverse incident and management briefing report to be completed first thing tomorrow. Service Manager has been informed."*
23/12/08 15.40pm	Mr. X and Mrs. X were found dead at their home.