Independent Investigation into SUI 2005/2579

June 2009

Consequence UK Ltd
Lydes House
392 Pickersleigh Road
Malvern
Worcester
WR14 2QH

Yorkshire and the Humber Strategic Health Authority
Blenheim House
Duncombe Street
Leeds
North Yorkshire
LS1 4PL

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

The Investigation Team members were:

- Ms Maria Dineen, Director, Consequence UK Ltd
- Dr Maureen Devlin, Independent Healthcare Consultant and Associate, Consequence UK Ltd
- Mr Mike Foster, Assistant Director of Nursing, Oxfordshire and Buckinghamshire Mental Health NHS Trust
- Dr Mark Potter, Consultant Psychiatrist South West London Mental Health NHS Trust

Acknowledgements:
The Investigation Team wish to thank the deceased's wife, (who is also the mother of the mental health service user), and his brother and sister for sharing with them their recollections of the weeks leading to his death.

The Investigation Team also wishes to thank:

- all of the staff at Leeds Partnerships NHS Foundation Trust who gave willingly of their time to assist us in understanding the full context of the care and management of the mental health service user involved in the homicide on 10 July 2005;
- the general practitioners in Leeds who participated in our on-line survey; and
- the independent investigation team appointed by Leeds Mental Health Teaching Trust in 2005 for their cooperation with this investigation.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Intention

On 10 July 2005 a patient of Leeds Mental Health Trust stabbed his father to death in his bed where he lay next to his mother. He was remanded to HMP Leeds on 12 July and subsequently transferred to a high secure hospital for urgent treatment under Section 48 of the mental health act on 17January 2006. He remains an in-patient at this hospital.

This report sets out the findings of the independent Investigation Team, following its analysis of the internal investigation report written by the independent investigators appointed by Leeds Mental Health Teaching Trust to assess the care and management of mental health service user MHSU 2579 (the MHSU), meetings with the family of the MHSU, and exploration of key issues relevant to the care and management of the MHSU with staff currently working for Leeds Partnerships NHS Foundation Trust.

Purpose

The terms of reference for the work commissioned were to:

- Undertake an analysis of the MHSU's mental health clinical records and to identify any significant care management concerns that would require investigating as part of this independent investigation.
- Undertake an assessment of the internal investigation undertaken by Leeds Mental Health Teaching Trust to determine the extent to which it provides reasonable analysis and explanation of the care management concerns identified by the independent Investigation Team.
- Undertake further analysis of the care management concerns in the MHSU's case where appropriate and necessary.
- To ascertain, if at all possible, the validity of the LMHTT internal investigation finding that the attack on the service user's father was not foreseeable or preventable by the mental health services at that time.

Outline of the review process

To deliver the above the following activities occurred:

- A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- A critical appraisal of the Trust's internal investigation report
- A meeting with the mother of the MHSU (wife of the deceased), and an aunt and uncle of the MHSU (brother and sister of the deceased).
- The use of a semi-structured survey instrument.

- A survey of GPs via the Leeds Local Medical Committee (LLMC)

Main conclusions

Before addressing the specific conclusions arising from this investigation the Investigation Team wishes to make clear that the systems and processes underpinning the delivery of safe and effective care to mental health service users in Leeds have developed and improved considerably since 2005. It is the view of the Investigation Team leader that the system failures that occurred in relation to the care and management of this MHSU would not occur today.

With regards to this MHSU it is clear that there were a number of missed opportunities to assess him following his referral by his GP in February 2005. The preventability of this incident will therefore always remain a possibility even though the act itself was not foreseeable. The Investigation Team draws this conclusion on the basis of information obtained from an analysis of the MHSU's medical record, the Trust's own internal investigation report, discussion with the independent investigation team leader appointed by Leeds Mental Health Teaching Trust in 2006 and from information provided by the MHSU's family about how he was in the weeks and days leading to the incident.

The factors that might have made the difference are:

- A full assessment of the MHSU by an experienced member of the Sector 1 community mental health team (CMHT), (including a consultant psychiatrist), who was cognisant of the MHSU's past history and relapse behaviours, followed by regular community follow up and a reinstatement of enhanced Care Programme Approach (CPA) status. This would have provided the opportunity for a mental health professional to assess the MHSU, to determine whether or not he was relapsing and to institute an appropriate care plan.
- Although the MHSU's mother and father are reported to have become increasingly concerned about their son they did not feel able, at the time, to ask the GP to initiate an assessment under the Mental Health Act 1983. A whole range of complex family factors underpinned this which are completely understandable.
- The wider family being aware that they could have approached the GP about their concerns and asked this person to consider whether or not assessment under the MHA was possible.

In stating the above the Investigation Team attributes no blame to the family of the MHSU for what happened. Caring for someone with a severe mental illness can be traumatic and difficult. The impact of the experiences the MHSU's parents had with their son between 1994 and 2005 cannot be underestimated. It is very understandable that they

would not have wanted to have put at further risk, or further worsened, the fragile nature of the relationship between father and son.

The family members of the deceased, who met with the investigation team leader on 18 April 2009, accept the findings and conclusions of the Investigation Team. They do however believe that LMHTT let their nephew down regardless of whether or not the death of their brother was preventable. The Investigation Team agrees with this.

Main recommendations
The Investigation Team has a number of recommendations for Leeds Partnerships NHS Foundation Trust.

Recommendation 1
The operational policy for the community mental health teams is more structured that that in place in 2004 – 2005, and now sets out the process for reviewing referrals and the timescales within which a response must be made. When its content is reviewed, it is suggested that the following are considered for inclusion:

- A clear definition of the roles of clinical and managerial leaders.
- A clear definition of the roles and responsibilities of individual team members (to include clarity of differentiation between the bands of community psychiatric nurses (CPNs)).
- Case load allocation and case mix.
- Collective CMHT caseload size and the maximum case load for each team member.
- CMHTs' relationships with general practitioners (e.g. at least twice a year one or more of the CMHT members will meet with the GP practice to look at issues of concern, referral patterns etc, meeting more frequently if required).
- Systems for preceptorship and induction of new staff (to include how different grades of staff are managed and supported).
- Handover arrangements when a care coordinator leaves, or where care coordination responsibility is transferred between services.

Recommendation 2
Although the response rate from GPs to the survey questionnaire circulated to all GP practices in Leeds (150 practices approximately 300 GPs) was very disappointing (13%), a number of key issues emerged from the responses that were received. These were:

- That 50% of respondents to the survey said that they 'sometimes' felt that their concerns were respected when an urgent referral is made to mental health services.

- 50% of respondents had concerns about the usefulness of information sent to GPs from the specialist mental health service in Leeds following initial assessment and at the point of discharge.
- 32% of respondents had concerns about the overall quality of information sent to GPs from specialist mental health services.

The Investigation Team does not believe it is appropriate to make substantive recommendations on the basis of the above information i) because of the low response rate and ii) because variables such as the geographical placement of a GP practice, or interpersonal relationships between CMHT members and staff at a GP practice /health centre could alter the results of the survey considerably.

However, neither is it appropriate to ignore the messages collated as a result of the survey. Therefore the Investigation Team suggests that the Directorate of Adult Services considers how it can further explore these issues on a sector by sector basis. In addition to aiding effective communications between primary care and specialist mental health services, further exploration of the stated concerns should inform the development and design of current and future electronic documentation.

Recommendation 3
It is recommended that the Trust ensures that its regular audits of record keeping incorporate audit of the quality and clinical usefulness of the documentation and do not focus solely on whether or not particular sections of a documentation tool are populated.

With regards to the audit of documents such as letters to GPs following an assessment of a service user, or after discharge back into the community, clearly GPs will need to have an active stake in this process.

1.0 INTRODUCTION

On 10 July 2005 the MHSU stabbed his father to death in his bed where he lay next to the MHSU's mother. The attack was frenzied. Although the relationship between father and son had been tense, his mother never believed that her son would harm his father. The MHSU's aunt and uncle however were deeply concerned that the MHSU would harm his father. This concern was heightened in the weeks leading up to the patricide where they observed the MHSU's behaviour to have deteriorated significantly. Because neither of his parents wanted to initiate an assessment under the Mental Health Act, the wider family felt that they had no choice but to respect the parents' wishes. They did not know that they could independently have raised a legitimate concern about their nephew's mental state.

This, and the fact that their nephew did not appear to have any active involvement from the specialist mental health services in the months leading to their brother's death, remains a cause of concern for them.

Overview of the MHSU's contacts with specialist mental health services

June 1994 – June 2003

The MHSU was first assessed by specialist mental health services in June 1994. A history of low mood and thoughts of suicide precipitated this. A diagnosis of anxiety and insecurity was made.

In July 1994 an attempt of serious self harm was made and in September 1994, following a domiciliary assessment, he was readmitted to hospital on an informal basis. The precipitating factors were increasing agitation and talking of having evil thoughts related to killing his parents. The records note that he was fearful of 'going crazy'. It is also noted that he was also frightened of going into hospital because he thought he might harm someone. He eventually took his own discharge on 5 October.

A clear diagnosis was not made at this time although the possibility of schizophrenia was raised.

On 17 October 1994 the MHSU was readmitted to hospital on a compulsory basis under Section 2 of the Mental Health Act (1983). Thoughts of killing his parents prevailed at this time.

In 1996 the MHSU's diagnosis of schizophrenia was formalised.

Following his discharge from hospital in November 1994 and until March 1999, the MHSU was successfully managed in the community, on enhanced CPA, with the support of a community psychiatric nurse

and outpatient follow up by the medical team. He did however continue to display self neglect and aggression.

Between 2000 and 2001 the MHSU was noted to be much improved and between November 2000 and March 2001 he was weaned off his anti-psychotic medication.

Sometime after May 2001 the MHSU was moved to Standard CPA following the departure of his care coordinator who did not believe that further CMHT input would be of benefit given the static nature of the MHSU's situation and his seeming lack of impetus to engage in beneficial activities.

Between May 2001 and June 2003 the MHSU was managed entirely via six monthly outpatient appointments and in June 2003 he was discharged back to the care of primary care services.

February – July 2005
Between June 2003 and February 2005 the MHSU had no contact with the specialist mental health service. His family report that during this time he was very well, only showing signs of deteriorating mental health towards the end of 2004.

On 28 February 2005 his then GP made a routine referral to the specialist mental health service as she was concerned about his behaviours. This was upgraded to an urgent referral in March 2005.

The MHSU was assessed in outpatients by a Locum Consultant Psychiatrist on 28 April 2005 and again on 26 May 2005. On both of these occasions his appointments were for 10 minutes only.

On 10 July the MHSU attacked and killed his father.

PLEASE SEE APPENDIX 2 (page 74) FOR A MORE DETAILED CHRONOLOGY OF THE MHSU'S CONTACTS WITH SPECIALIST MENTAL HEALTH and PROBATION SERVICES

2.0 TERMS OF REFERENCE

The terms of reference for this independent investigation set by Yorkshire and the Humber Strategic Health Authority (the SHA), in consultation with Leeds Partnerships NHS Foundation Trust, NHS Leeds and Consequence UK were:

To:-

- Undertake an analysis of the MHSU's mental health clinical records and to identify any significant care management concerns that would require investigating as part of independent review.
- Undertake an assessment of the internal investigation undertaken by Leeds Mental Health Teaching Trust to determine the extent to which it provides reasonable analysis and explanation of the care management concerns identified by the independent Investigation Team.
- Undertake further analysis of the care management concerns where appropriate and necessary.
- In undertaking the above it is expected that the independent Investigation Team will be mindful of:
  - The Care Programme Approach.
  - Risk assessment of the MHSU, including risk relapse planning and risk containment plans.
  - The clarity of and evidence of appropriate care planning.
  - The effectiveness of communications between LMHTT staff and staff from other statutory and voluntary agencies that may have been involved in the MHSU's care.
  - Evidence of contact with carers and/or other family members
- To ascertain, if at all possible, the validity of the LMHTT internal investigation finding that the attack on the service user's father was not foreseeable or preventable by the mental health services at that time.

In addition, Consequence UK Ltd will undertake:

- A more systematic assessment of the current approach to and quality of service user focused risk assessments.
- An assessment of the Trust's systems and processes for the employment of, assessment of, and supervision of locum doctors.
- An assessment of the quality of communications between LMHTT and General Practitioners who work within the boundaries of Leeds Primary Care Trust.

Consequence UK will identify:-

- Learning points for improving systems and services.
- Developments in services since the user's engagement with mental health services and action taken since the incident.

Consequence UK will make:-

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

3.0 METHODOLOGY

The methodology for this investigation differed from the approach we often find valuable for HSG(94)27 investigations. The reason for this was that overall the Trust's own internal investigation was sufficiently searching to make a repeat of the investigation unnecessary in terms of learning potential and value for money.

It was therefore agreed between Consequence UK, Yorkshire and the Humber SHA and Leeds Partnerships NHS Foundation Trust that a more contemporary approach would be taken.

This approach was discussed in full with the family of the MHSU and the family of his deceased father. They were supportive of a different approach and accepted that the independent Investigation Team was unlikely to identify any significant weaknesses in the MHSU's care and management over and above those already identified by the Trust itself. They were agreeable to this approach because the Investigation Team assured them that:

- a detailed critique of the original investigation would be conducted and the findings of this included in the investigation report; and
- if any area was considered to require re-investigation or further exploration and consideration then the Investigation Team would undertake this.

The specific investigation and analysis tools utilised were:

- the *Consequence UK Ltd Structured Timeline*;
- simple gap analysis;
- round-the-table discussion (open and structured);
- semi-structured survey; and
- interviews and telephone conference with LPFT staff with responsibility for specific aspects of service delivery and clinical practice.

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

- The MHSU's mental health records held by Leeds Partnerships NHS Foundation Trust.
- The *Report into the Care and Management of the MHSU* by Leeds Mental Health Teaching Trust March 2006.
- Information collected via questionnaire analysis.
- Interviews and meetings.

Note: The community mental health records for the MHSU were requested on numerous occasions from Leeds Partnerships NHS Foundation Trust. The Trust advised the Investigation Team that they were unable to locate these records in spite of having undertaken an extensive search for them.

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

At the commencement of the investigation the Investigation Team wrote to the MHSU advising him of the investigation, offering him the opportunity to meet with the Investigation Team and seeking his permission to have access to his medical and police records.

The MHSU expressed no wish to meet with the Investigation team and withheld his consent to access his records. This refusal to provide consent was overridden by the public interest aspect of this investigation.

Contact was made with the mother of the MHSU, and she was advised of her son's withholding of consent. It was explained to her that this did not mean that she could not meet with the Investigation Team. Her wish was to meet with the Investigation Team leader, in the company of her brother and sister in law (the brother and sister of the deceased). She informed her son that we would be meeting.

The meeting took place on 17 May 2008.

A further meeting to take the family through the findings and recommendations of the investigation was held on 18 April 2009. At this meeting was:

- The mother of the MHSU
- Two of the deceased brother's
- One of the deceased sisters

5.0 FINDINGS OF THE INVESTIGATION

This section of the report sets out the main findings of the independent Investigation Team in relation to:

- 5.1 The completeness and quality of the internal investigation commissioned by the then Leeds Mental Health Teaching Trust. (page 14).
- 5.2 The current approach to and quality of clinically focused risk assessments undertaken in Adult Services. (page 18).
- 5.3 Carers (Page 26).
- 5.4 General Practitioner experiences of working with specialist mental health services. (page 30).

5.1 The independent Investigation Team's analysis of Leeds Mental Health Teaching Trust's internal investigation into the care and management of the MHSU (March 2006)

Leeds Mental Health Teaching Trust commissioned three individuals external to the Trust to undertake an investigation on its behalf.

These individuals were:

- A former chief executive of the Northern Centre for Mental Health.
- A consultant psychiatrist.
- A director of nursing from another mental health trust.

The Trust should be complimented on the seriousness with which it took the incident and the need for independent input into the investigation.

Even though the investigation was undertaken on an 'external' basis it was assessed against the key questions Consequence UK would normally benchmark an internally conducted investigation against. Consequence has used this benchmarking criterion since 2006, and initially devised its outline when critiquing root cause analysis investigations undertaken by the National Patient Safety Agency pilot sites in 2002 and 2003[1]. The standards applied pre-date the Trust's investigation report and reflect the standards expected of serious untoward investigations in the NHS since 2003/2004, including the application of root cause analysis.

The questions applied to the Trust's report were:

[1] Consequence led the delivery of the NPSA's RCA pilot learning set programme and contributed to the development of the NPSA's e-learning tool kit. The evaluation of the quality of investigations undertaken by pilot participants was a key component of how participants' understanding of the RCA investigation was assessed. The NPSA began its roll out of RCA investigation training to the NHS in 2004.

- 5.1.1 Were the terms of reference for the investigation reasonable and does the investigation report show evidence that these have been addressed?
- 5.1.2 Have all key facts been identified, based on our analysis of the clinical records?
- 5.1.3 Have the diagnosis and adequacy of care of the MHSU, including key issues of concern, been appropriately explored?
- 5.1.4 Have issues such as
  - risk assessment (including risk management and relapse planning);
  - care planning;
  - Care Programme Approach;
  - clinical supervision;
  - interagency communications;
  - inter-team communications;
  - housing;
  - support for carers/families including Carer's Assessment;
  - team performance and leadership; and
  - service culture

  been adequately explored?
- 5.1.5 Are the conclusions of the Trust's investigation report congruent with the facts as the independent Investigation Team understands them? Are they reasonable for the case investigated?
- 5.1.6 Did the recommendations made appear to be appropriate based on the findings of the Trust's own investigation? Furthermore, will they, if implemented, reduce the risk of a) the incident occurring in the future and b) the occurrence of similar care management concerns to those identified in this case?
- 5.1.7 Was there evidence of a systems-based approach to the investigation?
- 5.1.8 Where the LMHTT investigation identified care concerns how satisfied was the independent Investigation Team with the quality of the analysis of these based on the information documented within the report ?

In addition to presenting our perspective on the completeness and quality of the Trust's investigation report, where appropriate this Investigation Team has provided its reflections on some aspects of the MHSU's care and management.

The overall conclusion of the Investigation Team's critique of the LMHTT investigation team is that the key issues relating to:

- the ineffective processing of the GP referral in February 2005, which led to the GP making an urgent referral; and

- the lack of appropriate assessment of the MHSU in April and May 2005

were highlighted by the LMHTT independent investigation team. However, the reasons for these lapses in service and care delivery were not explored as fully as one would have expected.

In spite of the lack of systems analysis undertaken during the original investigation, it is the opinion of the independent Investigation Team that the LMHTT report was sufficiently comprehensive to make the possibility of further beneficial learning from a re-investigation remote.

The full detail of the Investigation Team's critique of the original LMHTT investigation report is presented at Appendix 1 (page 48).

SECTIONS 5.2 – 5.4

5.2 The approach to and quality of client-focused risk assessments undertaken in the Adult Services Directorate

As the Trust's report highlights, there is nothing in the clinical records to suggest that any meaningful risk assessment was carried out with the MHSU.

As a result the independent Investigation Team believed it essential to gain a better insight into the client-focused risk assessment in Leeds Partnerships NHS Foundation Trust.

Three key activities were undertaken to gain an insight to this:

- A meeting with the professional identified as the lead for risk assessment in the Trust in 2008.
- The physical review of 18 randomly selected completed risk assessments from three wards and three CMHTs.
- Information gathered via a semi-structured survey issued to all ward managers and CMHT team leaders in the Adult Services Directorate at Leeds Partnerships NHS Foundation Trust.

Information provided by the trust risk assessment lead.

The lead for clinical focused risk assessments in Adult Services advised that:

- The formal training provided to date focused mainly on how to use the risk tool known as "FACE[2]" rather than how to do a good risk assessment. However, there have been some practice based elements included. These are:
  - The use of vignettes. These are provided by FACE and workshop attendees use these to work through a FACE risk assessment.
  - Some contextual information from the findings of independent investigations following homicides, and data from the suicide and homicide confidential inquiry report.
  - An emphasis that it is not OK to just identify risk and then not to identify how it is to be managed.
  - Highlighting that past history is an important indicator of potential future risk behaviour.
- The training provided to date has not been as in-depth as the current risk lead would have wished. It is only a one-day programme and therefore has time limitations.

[2] FACE is a dedicated risk assessment product that is used by a range of mental health trusts.

- There is a separate training programme for safeguarding children and vulnerable adults.
- The training department holds records of all staff who have attended the FACE training since its inception.
- In addition to the formal training, the risk lead has provided informal training to staff on request. The content of this has always been responsive to the team's needs, but would often include working with the FACE vignettes.
- Staff, in the opinion of the risk lead, do need clearer guidance on how to complete a risk assessment and a better understanding of how to use FACE.

In addition to the above the risk lead advised that Leeds Partnerships NHS Foundation Trust has embarked on a complete overhaul of how it delivers risk assessment training and the content of the programme. This is in recognition of the need for more in-depth practice focused training.

A number of trainers for each directorate have been identified and they are being trained by the consultant nurse for forensic services and the risk lead. Once trained, the consultant nurse will shadow the trainers until both he and they are satisfied that the trainer is delivering the new programme to the desired standard.

It is expected that each trainer whilst delivering the core programme content will be responsive to the needs and experience of the persons attending a workshop. It is also expected that the trainer will be responsive to the needs of the directorate in terms of getting key risk assessment messages across (for example following an incident review).

The new programme is based on the DH document "Best Practice on the management of risk" and recent Royal College of Psychiatrists reports.

The initial aim of the Trust is to get all qualified staff through the core training programme and then to review and expand the programme as necessary. Ideally, the Trust's risk lead revealed, they would like a two-day programme to be developed. **Note:** If the training is delivered on a team basis all team members can attend – qualified or unqualified. However, qualified members cannot opt out.

Finally, and reassuringly, a full audit of FACE is also planned.

Information elicited from staff via the semi-structured survey

The number of respondents to the survey was disappointing (29 out of 80 questionnaires circulated – 36%). This was particularly so as the questionnaires were sent to each care location by recorded delivery. The recipients were the:

- clinical team leaders on Wards 1,3, 4 and 5;
- clinical service manager for inpatient services;
- clinical team leaders for the North-East, South, East, North-West, and Central Community Mental Health Teams;
- the clinical team leader and clinical services manager for the crisis team; and
- the medical director of LPFT for circulation to a random group of consultant psychiatrists and other appropriate members of the medical staff.

Each bundle of questionnaires (5-7 in a bundle) to the clinical team leaders was accompanied by a letter of instruction and explanation about the importance of the survey. Pre-addressed envelopes were also provided to facilitate the return of the completed questionnaires.

Although the response rate is not statistically significant from a 'research paper' perspective there were sufficient responses to make the data meaningful and of relevance to this investigation.

In relation to risk assessment a number of questions were posed to staff in the survey. These were:

- When did you last attend the Trust's training work shop on client focused risk assessment?
- How valuable was the training in relation to your practice in the risk assessment of service users?
- How confident are you in your knowledge and skill base in undertaking a full risk assessment with someone presenting with apparent complex needs?

The responses to these questions revealed that:

- 50% of respondents had attended risk assessment training within the last three years, in keeping with the recommendation of the 1999 Confidential Inquiry into Homicides and Suicides in England.
- 30% of respondents had not attended any Trust risk assessment training at all. Although a small number of these professionals may have attended training elsewhere, the Trust needs to ensure that all staff attend appropriate update training at least every three years.
- Of the 15 staff who had attended the Trust's risk assessment training programme, 90% reported that they found it to be helpful.

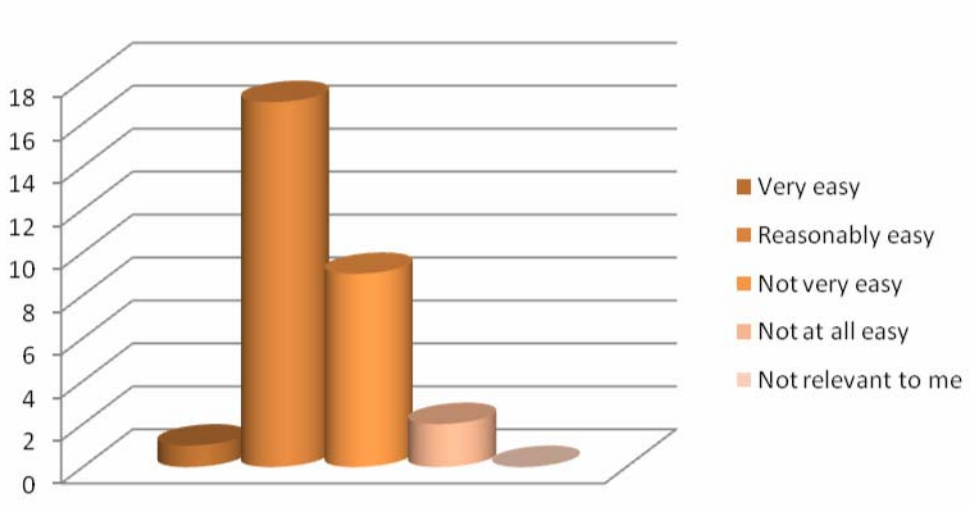
- 90% of respondents reported being confident in their knowledge and skill base in undertaking client focused risk assessments.

With regards to the question “How easy is it in Leeds to gain a comprehensive understanding of the risk history of a Service User who is known to the mental health service but is a new client for you?” The following graph (graph 1) depicts the responses:

Graph 1

Number of respondents: 29

Very easy	1
Reasonably easy	17
Not very easy	9
Not at all easy	2
Not relevant to me	0



With regards to the quality of documentation only 30% of respondents rated the current quality as good. No respondent rated it as excellent. 40% said the quality of documentation was reasonable/OK and 20% said it was poor.

Other questions asked of Trust staff were:

- Based on your personal experience how would you rate the quality of crisis and relapse prevention plans?
- What have been the most significant changes in the Trust’s approach to risk assessment over the past five years?

Only 4 respondents rated the quality of crisis and relapse prevention plans as good, with 14 rating them as reasonable/ok. However 12 respondents also rated these plans as patchy or poor. Given that the Trust now puts an emphasis on relapse signature planning, one would have hoped for a higher level of perceived quality of these documents from staff. This is something that the Trust needs to consider including in any audit of the success of its revised approach to risk assessment training.

With regards to the changes staff have experienced in the last five years the list below represents what staff collectively said. Individual comments are presented as well as those where more than one person reported a similar view point (x2, x3 etc). The rationale for presenting singular comments as well as grouped comments is that collectively they create a profile of staff perspectives. Clearly one can see that the overriding response from the respondents is positive and that there are few 'less positive' comments and no strong theme within these. Nevertheless the less positive comments should be noted and reflected on by the lead for client focused clinical risk assessments and the governance council for adult services.

Positive Comments

- All mental health professionals complete the risk assessment compared with only CPNs, ward nurses and other nurses previously.
- Everyone assessed will have an up to date face risk assessment.
- Crisis resolution involvement - central point for information (x5).
- Big focus on 'suicide prevention'.
- Networkable (i.e. now electronic).
- New and revised observation policy (x2).
- This has been done regularly (i.e. risk assessment).
- The importance placed on FACE and RA(x3).
- Appointment of a risk trainer (x2).
- Requirement that every Service User has an up to date FACE risk assessment, and more stringent controls to ensure that this happens (x4).
- Acknowledge that it should be used as a live document.
- Audits (ward level) to ensure up to date RA's are in place.
- Change of culture - at times was a degree of belief no matter what that things sometimes went wrong - now there is a more analytical approach.
- Requirement for there to be a management plan.
- Compulsory provision of risk assessment between tiers of CPA
- Face risk assessments are reviewed following SUIs.
- Staff are having training (x3).
- The implementation of CPA.
- FACE Format for adult services has been updated - minor changes only.
- Risk profiles disseminated to other teams. E.g. Crisis team.
- Relapse prevention.
- Care Co-ordination has improved- all patients now have a CC within 72 hours of admission has involvement with in-patients (x3).
- The style of document (FACE).

- 7 day follow up of all service users following discharge from a mental health in-patient facility. (National requirement).
- Ward Managers regularly audit risk assessments.
- Increased emphasis on the service user and the carers views of Risk - Excellent!
- Use of word (i.e. I.T.) to complete RA and update.
- Regular CPA reviews.
- Face risk assessments - focus people to confront risk issues.
- I.T. has made information more easily available.
- Review and monitoring of mental health.
- Discharge CPA.
- Reviewing and updating risk profile.

Less Positive Comments

- The Trust has become fixated with the quality of the paperwork rather the quality of the assessment.
- Not aware of changes (x2).
- Risk assessments for new admissions should be on the ward prior to the service user being admitted – i.e. available from the Crisis Resolution and Home Treatment Team who are the gate keepers of admissions.
- Various methods taken to complete historical/current indicators of risk. Not always useful for clarity of accessibility.
- Not enough support/encouragement given to therapeutic risk taking.
- More risk averse.

The assessment of risk assessment documentation by the Investigation Team

It is the experience of Consequence UK that staff tend to be honest, if not a little harsh, in their questionnaire responses. However, because the issue of risk assessment, and the quality of risk assessments, had arisen in three different incidents involving mental health service users that Consequence UK was asked to review, we considered it essential that we independently assess the quality of risk assessment documentation for ourselves across the in-patient and community services.

The Investigation Team visited three in-patient wards, the Crisis Resolution and Home Treatment Team (CHRT) and three community mental health teams in the Adult Services Directorate at Leeds Partnerships NHS Foundation Trust.

The key findings from the site visits are that:

- Overall the Investigation Team found the standard of risk documentation to be of a good standard with reasonable qualitative information provided where risk indicators were identified.

- The Investigation Team is satisfied that FACE risk profiling is embedded within the Trust, although the quality of record-keeping varies.
- Training and updating of staff in risk assessment has until now been neglected. The training provided on FACE has focused more on the completion of the FACE documentation tool rather than the practice of risk assessment. However, this is to be remedied by the newly-appointed risk assessment lead. A key objective for the post holder is to delivery risk assessment training on a team by team basis across the Adult Services Directorate
- There appears to be no standardised approach to updating of individual service user FACE profiles. This needs to be rectified in the current revision of the Trust's risk assessment guidelines. One suggestion would be to 'score through' any previous document and to mark it as 'updated', along with the date and the name of the 'assessor'. One would anticipate that the tracking of updated/revised profiles will be immeasurably easier once electronic record keeping is the norm.
- There is currently no process in place to validate individual staff competence in client-focused risk assessment. The independent Investigation team appreciates that designing a standalone validation tool may not be easy, but it should be possible for an assessment package to be agreed. Key elements of such a package might include assessment via peer supervision, management supervision, randomised audits of the documented risk profiles, and the use of role play or scenario analysis. Randomised assessment of the quality of risk assessment will also be undertaken by the clinical risk assessment lead.
- CPA documentation was generally good, but there was little evidence of Carer involvement. In the community health teams visited in only two out of nine sets of records was evidence of Carer involvement in the CPA process apparent. Furthermore in some instances, the Investigation Team observed that service user agreement was not obtained for their CPA plan, but the plan was circulated to those on the distribution list anyway.
- Of the CMHT records assessed, all were where they should have been and all of good quality.
- The CRHT only employs staff with post qualification experience and therefore assumes that its staff are competent in risk assessment. There is currently no validation process for this.
- Historical client assessment information, held electronically by the CRHT, is not automatically accessed by staff when a

known service user is referred to them. However the CRHT team leader asserts that his staff do seem more alert to the need to access historical information as a result of previous incidents involving service users.

- Overall the CRHT notes are of better quality than ward notes.
- There were CPA plans in all CMHT files. This gave confidence that the CPA process is working.
- The CMHT CPA documentation consistently showed who had been invited to planning meetings, who attended and who had copies of plans circulated to them.
- At this time Trust electronic record systems are not synchronised - this means that if there are records held on the outpatients system the CRHT cannot access this. This is problematic when this is the only place where there are records about the service user.

5.3 CARERS

Families and carers are an important component in the delivery of an effective mental health service, and they are often well placed to alert mental health service when the family member with mental illness is showing signs of relapse. This is especially so where the service user lives with his/her family.

Although it is appreciated that there are confidentiality issues when it comes to discussing the precise details of a service user's care and management with a carer, or family member, the concerns staff often have around these do not mean that carers and families should not be well informed about 'a diagnosis' and the types of relapse behaviours commonly associated with such a diagnosis.

At the very least all carers/families should be offered an appointment with the Carer's Support Service so that there is opportunity for them to raise any concerns or anxieties they have. This is also an opportunity to make sure that the family understand their vital role in alerting either the GP or the mental health service if they think the service user is relapsing and how they can do this, including the initiation of a mental health act assessment.

To gain a sense of how mental health professionals relate to carers a range of questions specific to carers were posed in the questionnaire issues to staff.

How often do you offer the carer (or significant other) in a service user's life a 'Carer Assessment'?

Respondents: 28	
For all new assessments	3
Always if I feel that the individual has a carer role	15
Sometimes	4
More often than not	1
Rarely	2
N/A	3

That 15 respondents (54%) of staff, make their own judgements about whether someone meets their criteria of having a 'carer' role could be concerning. The service specification for LPFT Carers Team states that a carer is defined as "a friend, partner or relative of someone with mental health difficulties". The manager of the Carers Team advised "We have tried to be inclusive rather than the 'so many hours a week'". This suggests that there be perceptual differences between front line staff and the staff working in the Carers Team.

To gain a better insight as to what informs a mental health professional's perspective, respondents were asked what criteria they used to determine whether or not a person was a carer.

The following represents the range of responses received. The number in brackets indicates the number of similar comments.

- If they request support (x5).
- If they believe they are a carer and validates in someway the relationship/ involvement with patients (x3).
- If mental health needs of individual impact on another (x4).
- Unpaid.
- If the carer is observed to be struggling with the needs of the service user (x2).
- If patient considers the person a carer (x2).
- Level of time, support, contact whether this be physical, emotional, psychological, monetary given by carer to SU (x9).
- Stress and pressure on family members.
- Carer may be relative or friend of SU who has a significant role in care or responsibility (x6).
- The interest in SU's treatment.
- If contact with SU is regular.
- If I am informed someone performs a carers role.
- Relative, friend, neighbour who provides support/ help to someone who would find it difficult to manage without help.
- If the carer is also a service user.
- Carers - paid/ unpaid.
- Does the SU describe individual as the carer?
- Carer needs respite care.
- If they are a family member or have a close relationship (x11).
- Impact of client's illness on their (carer's) life.
- Live with or have regular contact with next of kin - even in a different city (x2).
- I offer carers assessments/ support referral for people involved with service users I work directly with or if I happen to discuss issues with other service users carers.
- Other family members who support.
- Take on responsibility for SU when unwell.
- Needs of carer - most carers decline.
- Consider the support network of carer (x3).

Overall these responses are reassuring, that the respondents to the questionnaire take a broad perspective when considering whether or not to offer a Carer's Assessment.

Another area of concern raised by this investigation was the fact that the mother and father of this MHSU did not feel able to alert their GP, or the mental health team, or the Jewish Welfare officer that they believed their son to be very ill and in need of a mental health assessment. This Investigation Team has come across this scenario

on a number of occasions when meeting with families of service users involved in similar incidents.

We therefore felt it essential to explore this area with staff working in adult services at Leeds Partnerships NHS Foundation NHS Trust. The following conceptual information and question was posed:

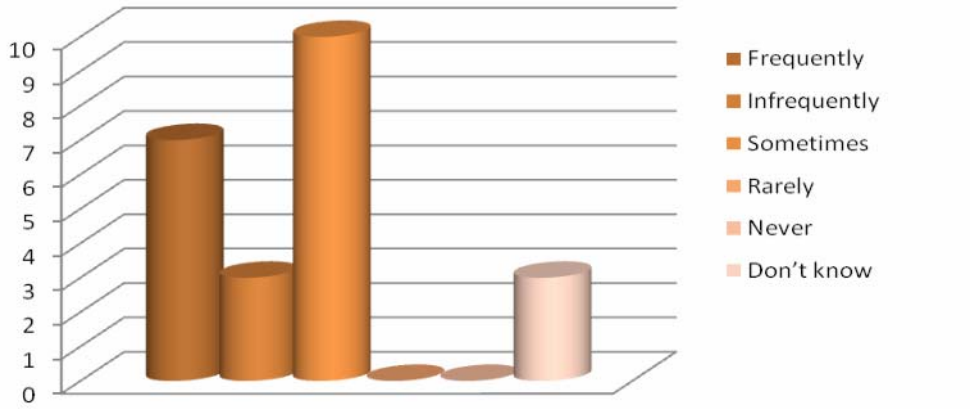
"Sometimes families do not tell the mental health team important information about behaviours or changes of behaviour in the service user out of

- Misplaced loyalty to their loved one.
- Because they fear their loved one will be detained.
- Because they are so worn out by coping with the stress of living with their loved one's mental illness +/- addiction that they do not have the inner strength or energy to do so. Essentially they have become co-dependent.

As a care coordinator how often do you provide opportunity for significant family/carers to share information with you in private?"

Graph 2
Twenty three staff responded to this question. Their responses were:

Frequently	7
Infrequently	3
Sometimes	10
Rarely	0
Never	0
Don't know	3



The importance of providing a significant family member, partner or carer with opportunities to share any concerns about the behaviours of the service user cannot be underestimated. One might have hoped for a higher percentage of staff who always offer private time to the family or carer of the service user, however time and concerns about conflicts in relation to confidentiality issues may well act as barriers to this. Families/carers themselves may feel inhibited in sharing openly with a care coordinator especially where the service user is known to have

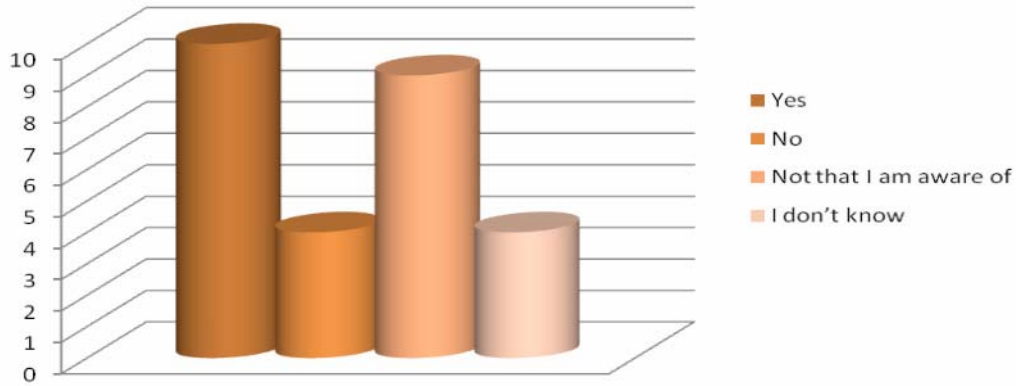
objections to there being communications between the two parties. These challenges make it all the more important that all families of mental health service users are aware of whom they can safely make contact with if they are very concerned about the service user's mental well being, and there are noticeable signs of relapse. The lead for this investigation has yet to speak to a service user's immediate and wider family who is aware that they can, if very concerned, approach the service user's GP and ask for a Mental Health Act assessment. In the case of this MHSU, had the aunt and uncle been aware of this, they would have acted out of concern for the safety of their brother despite the inability of his mother and father to do so. Had they been aware and acted, their nephew may have received a detailed assessment in the days prior to the incident (see section 6.0 page 38 for contemporary information on Carer Support at LPFT.)

The final question posed to the staff who completed the questionnaire was contributed by the family of the MHSU. It was:

If a service user is given a formal diagnosis of schizophrenia is it usual practice to suggest a family meeting so that there can be a common understanding of what the diagnosis means?

Graph 3

Respondents:	27
Yes	10
No	4
Not that I am aware of	9
I don't know	4



5.4 General practitioner experiences of working with specialist mental health services

There were issues highlighted by the Trust's own investigation in relation to the correspondence with the MHSU's GP between 2003 and 2005, and in the response made to her initial letter of referral in February 2005, and then to the urgent referral in March 2005. Consequently it was agreed with the Trust and Yorkshire and Humber SHA that as part of this investigation we would seek input from a selection of GPs working in Leeds to gain feedback from them about their experiences of working with specialist mental health services and the quality and usefulness of the information provided to them.

To achieve this the Investigation Team sought the support of the Leeds Local Medical Committee (LLMC). The chair of this committee and its members agreed as representatives of GPs in Leeds to support the survey.

Consequently an on-line survey was distributed by the LLMC to all 150 GP practices represented on the LLMC (approximately 300 GPs). Instructions were provided to each practice about what was required. It was also made clear in the introduction to the survey that a 'practice based' response was preferable but responses from individual GPs were acceptable.

This generated 39 responses:

- 8 of these were practice based.
- 31 were from individuals.

The spread of individual respondents was as follows:

- 21 respondents were GPs.
- 14 were practice managers.
- 1 was a "business partner".
- 1 was a GP registrar.
- 1 was "not individual practice based".

The Investigation Team was assured that where practice managers completed the survey this would be following consultation with the GP partners.

The anomaly in the figures prompted a re-examination of the responses elicited. Consequently the Investigation Team is confident that 16 responses were practice based with 23 responses coming from individuals.

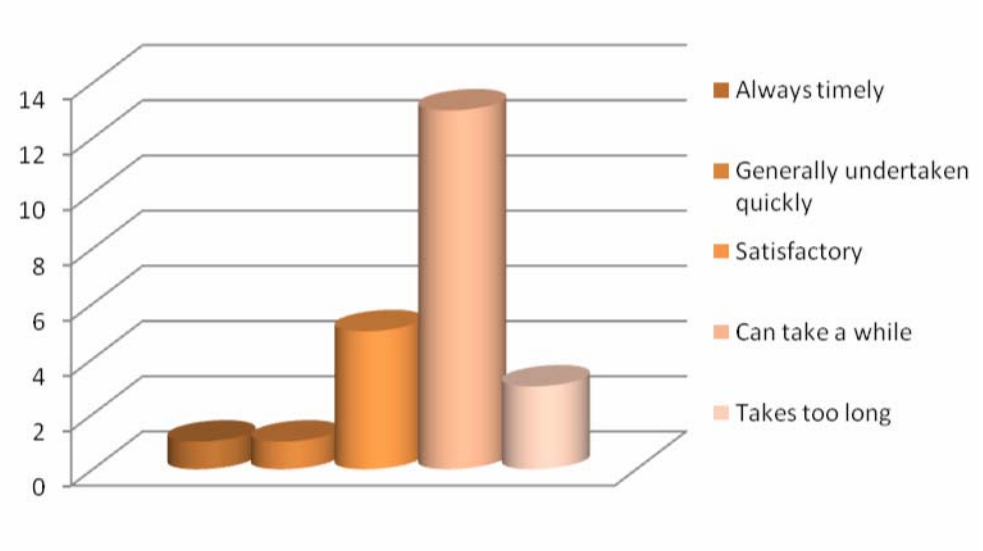
In percentage terms this equates to a 10% response rate from GP practices. This response rate was very disappointing and does place a limitation on the extent to which the information contributed by respondents can be utilised without further exploration of issues by

LPFT. However because of the severity of the incident that occurred, and since a total of 16 GP practices and 23 individuals have provided information to the Investigation Team, it is important that the key messages communicated are presented within this report.

The questions posed and the responses are detailed on the following pages:

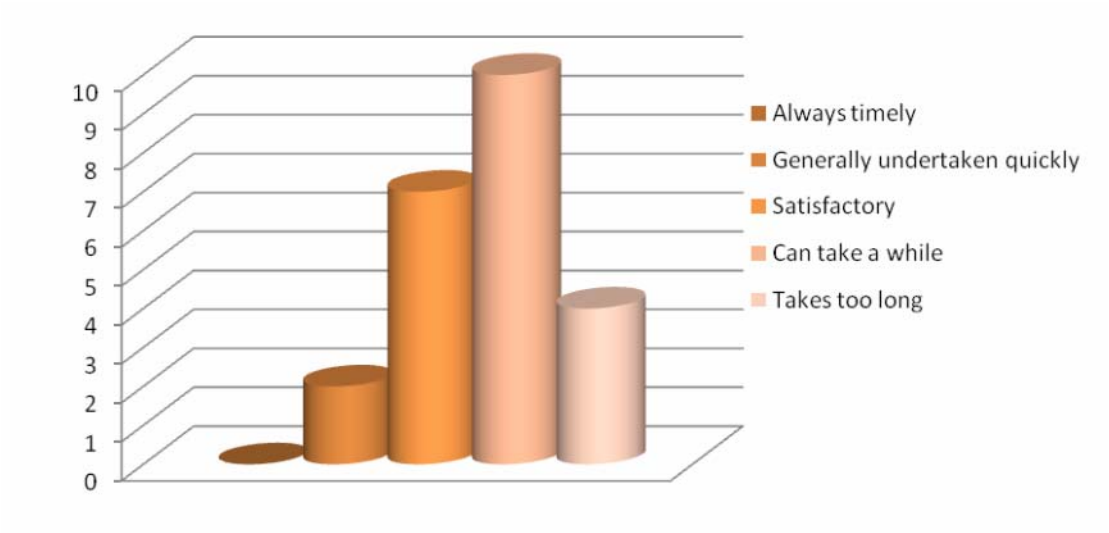
Q1: When you refer a patient for psychiatric opinion, what is your experience of how the assessment is managed?

Respondents: 23	
Always timely	1
Generally undertaken quickly	1
Satisfactory	5
Can take a while	13
Takes too long	3



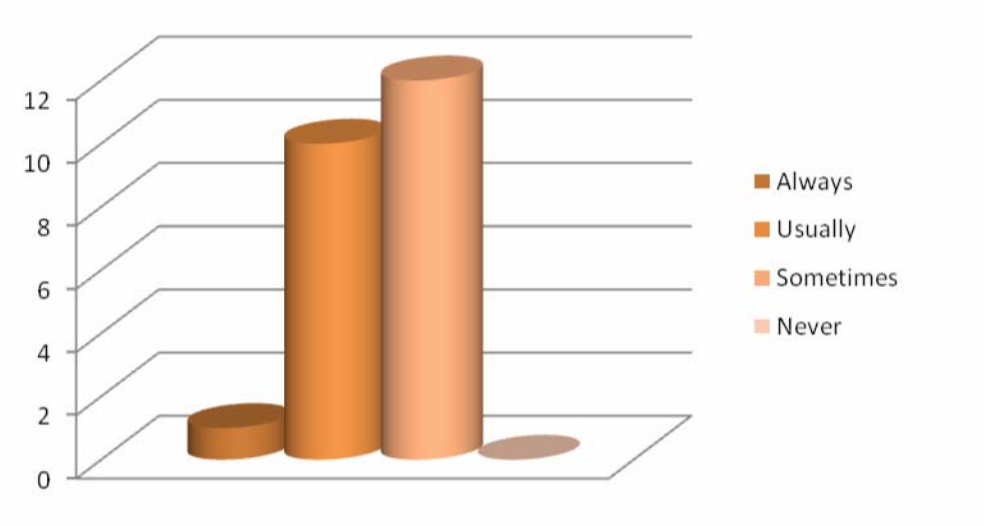
Q2: What is your experience when you refer a patient for assessment by the community mental health team?

Respondents: 23	
Always timely	0
Generally undertaken quickly	2
Satisfactory	7
Can take a while	10
Takes too long	4



Q3: Do you feel that your concerns are respected when you make an urgent referral to mental health services?

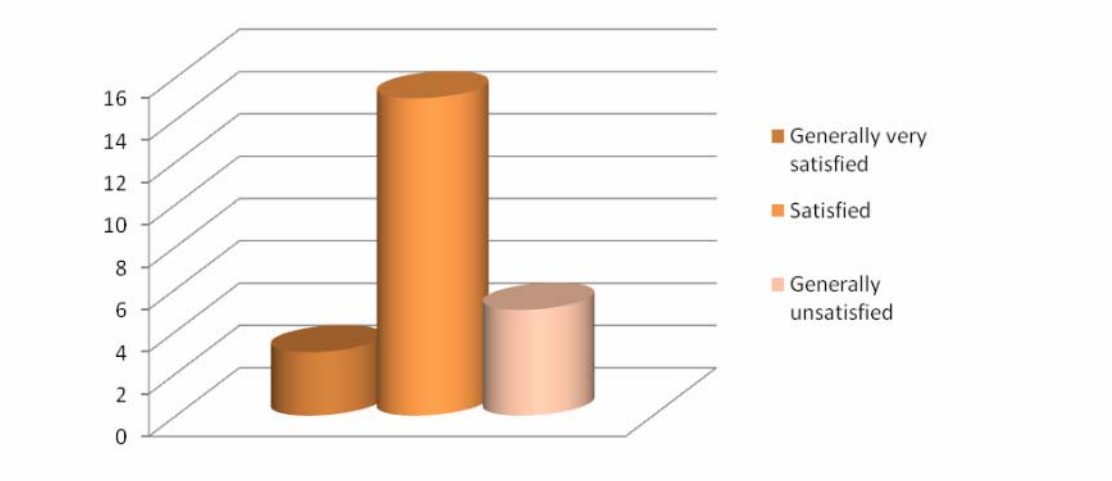
Respondents:	23
Always	1
Usually	10
Sometimes	12
Never	0



The response to this question does give cause for concern and suggests that Leeds Partnerships NHS Foundation Trust needs find out why GPs do not always feel that their concerns are taken seriously and what, if anything can be done, to improve this.

Q4: How satisfied are you with the response to urgent referrals?

Respondents: 23	
Generally very satisfied	3
Satisfied	15
Generally unsatisfied	5



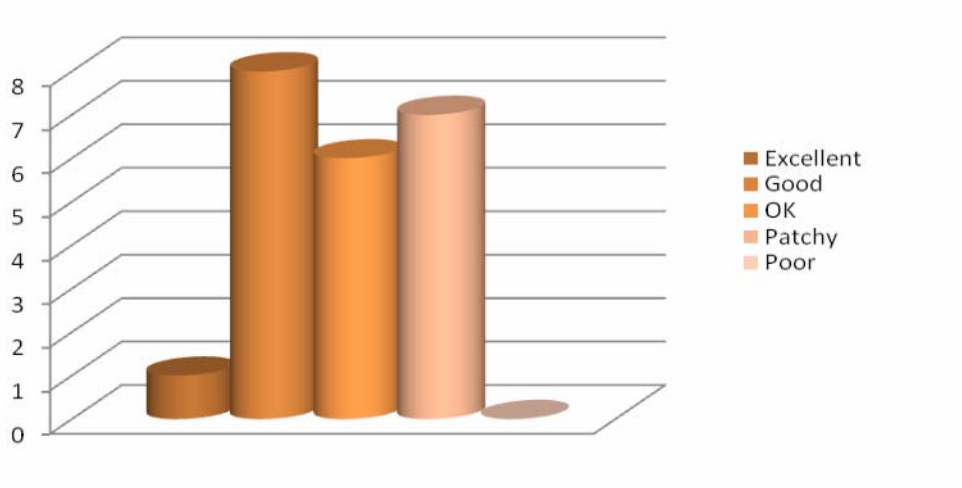
The following three questions specifically target the perceived quality and usefulness of information sent by the specialist mental health service in Leeds to service users' GPs. The effective management of a service user in the community relies on there being a unified and well understood management plan amongst all agencies engaged with the individual, and often their family. The GP is a central figure in the provision of care in the community and often the first point of contact if a service user is becoming unwell. It is therefore essential that the information they are provided with is of good quality, and of practical use to them in the delivery of their clinical responsibilities to the service user and the family/carer.

Q5: How would you rate the overall quality of information sent to GPs from mental health services?

Respondents: 22

Excellent	1
Good	8
OK	6
Patchy	7
Poor	0

68% of respondents reported that the information is at least OK and sometimes excellent.



Q6: Specifically, how useful clinically is the information provided to GPs after the INITIAL ASSESSMENT of an individual?

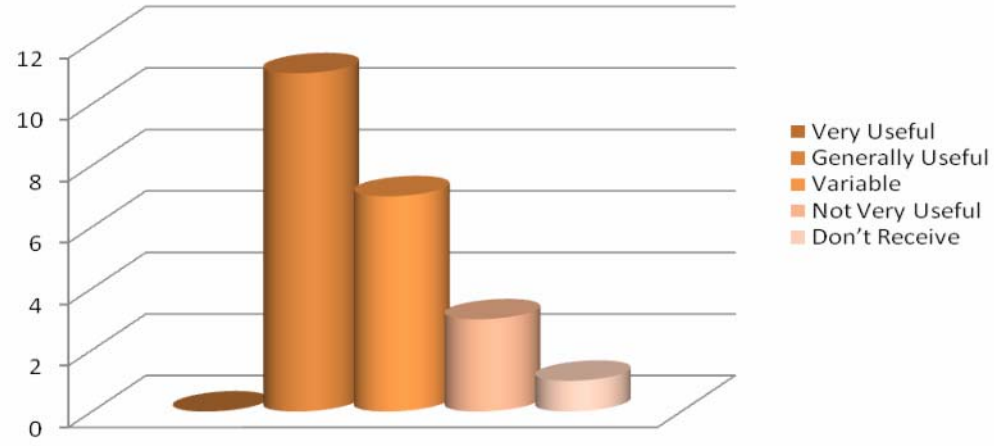
Respondents:	22
Very useful	1
Generally useful	10
Variable	10
Not very useful	1
Don't receive	0

Although it is encouraging that 50% of respondents find the information useful, the fact that 50% say that the information is variable suggests that consistency in the quality of information provided to GPs needs to be improved across all sectors and in-patient services.

Q7: Specifically, how useful clinically is the information provided to GPs FOLLOWING AN INDIVIDUAL'S DISHARGE from inpatient mental health services?

Respondents: 22

Very useful	0
Generally useful	11
Variable	7
Not very useful	3
Don't receive	1

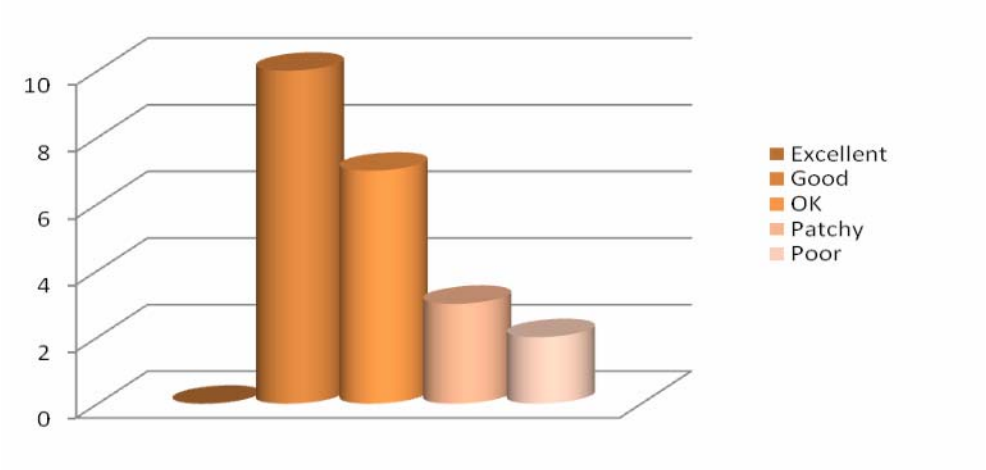


Again there is an almost 50% split in the number of respondents who are satisfied with the quality and usefulness of the information they receive and those who find it variable, or simply not useful. As highlighted above the Trust needs to look more carefully at how, and what, information it provides to GPs.

Q7: How would you rate the quality of information provided by mental health services relating to the management plan for an individual?

Respondents: 22

Excellent	0
Good	10
OK	7
Patchy	3
Poor	2


10
8
6
4
2
0
Excellent
Good
OK
Patchy
Poor

This last question about the information provided to GPs from the mental health service in Leeds, is perhaps the most important as it provides an insight as to why some GPs are not satisfied with the quality of information they receive.

Q8: Does the information you receive from mental health services generally help you/your practice to manage the individual within the community?

Respondents: 21
Only 13 respondents said yes to this question. Respondents who answered no were asked to say what would have helped.

Eight respondents contributed the following information:

- "Sometimes there is not full enough information and the Patient is not always aware where to get help quickly other than via A+E which they are reluctant to go to."
- "Most acute letters with risk information etc are too long (often tick box discharge sheets of up to 11 pages). A lot of the information in this type of format is of little use to clinicians in general practice. A more concise document with the salient important facts would be useful, and appreciated. ..... The problem with the document being so long is that there is the temptation not to read it in detail." (*Investigation Team comment – although individual GPs may take this risk, the suitability of format, and content of information being sent to GPs needs to be a consideration for Leeds Partnerships NHS Foundation Trust. GPs have busy clinics with 10 minute patient appointments plus domiciliary and emergency callouts. They may not have enough time to work through lengthy documents that may contain information that is not useful to them from the perspective of primary care management, and risk awareness).*
- "More information and better follow up with CPNs."
- "Not always specific advice for what is to happen in a crisis."

An area of concern to the family of the MHSU was the awareness about the risks associated with their son / nephew. In the case of this particular MHSU, the GP recognised he was becoming unwell at an early stage and took appropriate action to ensure that he was assessed by the specialist mental health service, changing the referral to 'urgent' when after a month following her initial referral no assessment had occurred.

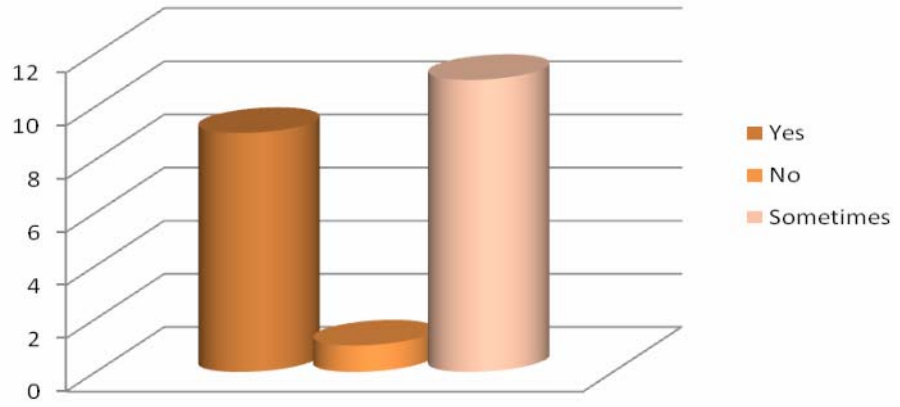
Awareness about the risk signature for service users is therefore critical for GPs.

The following question sought to gain an insight to GPs' confidence in this area.

Q9: **Does the information you receive from mental health services provide a clear picture of the individual's risks – including any warning signs?**

Respondents: 21

Yes	9
No	1
Sometimes	11



The variability in the response here should be of concern to Leeds Partnerships NHS Foundation Trust. The Trust needs to aim for a consistently positive 'yes' response to this question.

6.0 ACTIONS TAKEN BY LEEDS PARTNERSHIPS NHS FOUNDATION TRUST SINCE THE INCIDENT

The specialist mental health Trust in Leeds has worked tremendously hard since 2005 to improve its adult services. In fact plans were already underway to implement a service wide improvement plan in advance of the incident involving this MHSU.

The following provides outline information of some of the work undertaken that addresses the key concerns raised by the LMHTT investigation team.

Carers Assessment

LPFT, like many mental health trusts, established a Carers Team in response to Standard Six of the National Service Framework for Mental Health first published in 1999. The current Carers Team evolved from the Carers Team Service. A number of factors influenced its evolution this:

- the findings of Leeds Metropolitan University's evaluation of South Leeds Carers Service;
- stakeholder discussions; and
- the establishment of a Standard 6 Implementation Group and Standard 6 Project Group.

The current Carers Team underwent a service review between March 2006 and January 2007. This process resulted in the present model. The revised approach has resulted in a centralised service with clear links to community mental health teams. There are a total of 11 individuals employed within the team.

The Carers Team provides a range of services including:

- Assessment of carers' needs.
- Development of a carers' action plan.
- Provision of one to one support.
- Development and facilitation of local carer support groups.
- Information and advice to mental health workers on carers' issues.
- Provision of information and education sessions on a range of subjects to mental health workers and carers.

Of particular note is the Carers Handbook that has been produced. This is a very good publication which is well presented and contains essential information a carer needs to be aware of in an easily digestible format.

It is also encouraging that the Carers Team has instituted a range of performance measures including the provision of an evaluation questionnaire to all identified carers. Furthermore the information provided does not go to the Carers Team direct but is analysed by an independent third party within the Trust.

The Carers Team is in the process of finalising a referral procedure for use within LPFT's CMHTs. It will be helpful if the final document sets out clearly for CMHT staff the Trust's working definition of 'a carer', so that the offer of a Carers Assessment can be consistently applied across all sectors.

Finally, the Investigation Team Leader was impressed by the commitment and enthusiasm displayed by the current Team Leader for the Carers Team and also the broad perspective the team have decided to take in relation to who can be considered to have 'carers' needs'.

Discharge Letters
The analysis of the MHSU's clinical records revealed a variable standard of discharge summary. Now LPFT utilises a standardised format which requires clinicians to record:

- Date of admission.
- Date of discharge.
- MHA status.
- CPA levels.
- CPA co-ordinator.
- CPA meeting.
- Diagnosis (and ICD code).
- Medication on discharge. (x days supplied)
- Allergies.
- Follow-up plan.
- Crisis plan.
- Circumstances of admission.
- Risks on admission.
- Past psychiatric history.
- Past medical history.
- Family history.
- Personal history.
- Forensic history.
- Drug and alcohol history.
- Social history.
- Pre-morbid personality.
- Mental state examination on admission.
- Physical examination on admission.
- Pathological investigations.
- Progress on the ward.

This means a full discharge summary should provide other agencies, including GPs, with all the important information they require to effectively support the community management of the service user.

With regards to audit, there have been two formal audits of the discharge summaries undertaken since April 2007 which have looked

at completion of discharge summaries and a further audit which was undertaken in April 2008 although this was not a formal Trust audit. The latter audit looked at both completion of the templated discharge summary and the timeliness of the completion of the discharge summaries. Consultant medical staff also confirmed that they review discharge summaries produced by their trainee medical staff to ensure that these are to a high standard.

Allied to these audits the medical secretaries at the Becklin Centre undertake a monthly audit of when discharge summaries are dictated, produced in draft format, checked by medical staff and sent to community teams and general practitioners. The standard for completion of the final discharge summary is 14 days from discharge.

The Adult Services Directorate has agreed that the development of the PARIS[3] integrated clinical information system should include discharge summaries from in patient wards, acute community services and home treatment. Using the existing templates a form will be developed on PARIS which will allow for better auditing of both the content of the discharge summaries and timeliness of completion. Correct development of the summaries will allow for variance tracking and further help to understand the causes of this.

The results of all audits are presented at the directorate's clinical governance council meetings, and actions agreed to ensure that there is continuing improvement in the quality of the discharge letters and the timeliness with which they are dictated and typed.

Risk assessment

The Adult Services Directorate has implemented a team based risk assessment training programme for all clinical teams with a clear commitment to the auditing of practice both formally and informally via supervision arrangements. With regards to the training the CRHT and inpatient teams have been prioritised within this and training is due to complete by the end of summer 2009 for these teams. The training comprises a one day team training event with a half day follow up session held to review changes in practice following the training.

The training is mandatory for all clinical staff and this is documented in the directorate training needs analysis. Responsibility for attendance of team members lies with the clinical team manager and clinical services manager. At the time of writing the lead for clinical risk assessment reports that with the exception of sickness all staff are attending for the training as booked. This represents a marked improvement in practice. From 2005 up until 2007 the training records showed significant non-attendance and workshops that had to be cancelled as under subscribed. The Trust has done well to effect a culture change here.

[3] PARIS is the electronic documentation system being implemented at LPFT.

Risk assessment training is also discussed monthly at the directorate risk forum.

As already highlighted in this report, the Investigation Team's assessment of a randomised sample of FACE profiles revealed good quality of information provided across the sample.

Locum and staff induction

LPFT currently enjoys very low usage of short term locum contracts. However it has developed a structured approach and logging system for the induction of locum and all staff.

7.0 CONCLUSIONS OF THE INVESTIGATION TEAM

Before addressing the specific conclusions arising from this investigation the Investigation Team wishes to make clear that the systems and processes underpinning the delivery of safe and effective care to mental health service users in Leeds have developed and improved considerably since 2005. It is the view of the Investigation Team leader that the system failures that occurred in 2005 would not occur today. The system for the receipt of and assessment of GP referrals bears no resemblance to that in place in 2005, and there are now clear and auditable standards around this process.

With regards to human error, one cannot say that the error of judgment that occurred in this case will not occur again, it is impossible to do so. However Leeds Partnership NHS Foundation Trust has enjoyed a sustained period of not having to employ short term agency locum doctors. This means that it can ensure that all members of its medical team are properly inducted, supervised and monitored, enabling any clinical practice concerns to be quickly identified and acted upon for the benefit of the clinician and the service users receiving care.

In addition to significant improvements in the clinical supervision of medical staff the Trust has also improved its commitment to and practice of supervision of its nursing staff. Again the contemporary approach to clinical supervision in LPFT bears little resemblance to the situation in 2005.

The Adult Services Directorate of LPFT is now also able to evidence a strong commitment to good governance and continual reflection on its key systems and processes.

The LPFT has made considerable investment in the development of its Adult Services Directorate, and consequently the quality and consistency of the service available to those requiring care from this specialist mental health service in Leeds.

All of the above being said the Investigation Team has reflected on what happened in 2005, and the body of information gathered by the original independent investigation team as well as our own research. As a result of this work we have the following conclusions that are specific to the care and management of this MHSU.

In relation to the care and management of the MHSU

Both the LMHTT and independent investigation teams agree that opportunities to have assessed this MHSU were missed and therefore it will always remain a possibility that had the lapses in care not occurred, the MHSU's relapse may have been identified and an appropriate management/care plan instituted.

However, there are no guarantees that had the MHSU's care and management been optimal that the incident would have been prevented. This is partially due to the circumstances of the incident. The behaviour of the MHSU in the minutes preceded the attack were unremarkable, and his manner and demeanour as far as his mother could tell were the same as on other occasions when he had returned home in the early hours of the morning having been out for most of the night. The MHSU whilst previously demonstrating violent behaviour had not caused material harm to either of his parents before.

The factors that might have made a difference in this case are:

- A full assessment of the MHSU by an experienced member of the Sector 1 CMHT, (including a consultant psychiatrist), who was cognisant of the MHSU's past history and relapse behaviours, followed by regular community follow up and a reinstatement of enhanced Care Programme Approach (CPA)[4] status. This would have provided the opportunity for a mental health professional to assess the MHSU, to determine whether or not he was relapsing, and to institute an appropriate care plan.

- Although the MHSU's mother and father are reported to have become increasingly concerned about their son they did not feel able, at the time, to ask the GP to initiate an assessment under the Mental Health act 1983. A whole range of complex family factors underpinned this which are completely understandable.

- The wider family being aware that they could have approached the GP about their concerns and asked this person to consider whether or not assessment under the MHA was possible.

In stating the above the Investigation Team attributes no blame to the family of the MHSU for what happened. Caring for, and living with, someone with a severe mental illness can be traumatic and difficult. The impact of the experiences the MHSU's parents had with their son between 1994 and 2005 cannot be under-estimated. It is very understandable that they would not have wanted to have put at further risk, or further worsened the fragile nature of the relationship between father and son. Furthermore, initiating a Mental Health Act Assessment is very stressful for the family.

It is also very understandable that the sister and brother of the deceased would not have felt empowered to override his decision, and that of his wife, not to seek a Mental Health Act assessment.

[4] For an explanation of CPA please go to the glossary.

The specialist mental health service in Leeds is responsible for the lack of opportunity provided for the identification of the seriousness of this MHSU's relapse. Its system of receiving, screening, and acting on a referral for a known paranoid schizophrenic, who had a clear risk history when unwell in relation to harm to self and harm to his parents, failed when an inappropriate response was made with the sending of an 'opt in' letter.

There was then further system failure in the booking of a 10 minute follow up appointment in outpatients rather than a 45 minute full assessment appointment. It is not possible to conduct a full assessment in this timeframe.

The final safety mechanism relied on the assessing consultant psychiatrist to recognise that a young man with paranoid schizophrenia, who the GP believed was relapsing and who had now been urgently referred by the GP, needed a full assessment, and most probably a home assessment. That no such assessment occurred speaks for itself.

Had there been a change in any of these factors, then the opportunity to identify the deterioration in the mental health of this MHSU could have occurred. Therefore, different and more assertive management was possible. This is why one cannot discount the potential preventability of the incident.

The family members of the deceased, who met with the investigation team leader on 18 May 2009, accept the above findings and conclusions of the Investigation Team. They do however believe that LMHTT let their nephew down regardless of whether or not the death of their brother was preventable. The Investigation Team can only agree with this.

8.0 RECOMMENDATIONS

There are four recommendations for Leeds Partnerships NHS Foundation Trust.

Recommendation 1:
The operational policy for the community mental health teams is more structured that that in place in 2004 – 2005, and now sets out the process for reviewing referrals and the timescales within which a response must be made. When its content is reviewed it is suggested that the following are considered for inclusion:

- A clear definition of the roles of clinical and managerial leaders.
- A clear definition of the roles and responsibilities of individual team members (to include clarity of differentiation between the bands of CMHT workers).
- Case load allocation and case mix.
- Collective CMHT caseload size, and the maximum case load for each team member.
- CMHTs' relationship with general practitioners (e.g. at least twice a year one or more of the CMHT members will meet with the GP practice to look at issues of concern, referral patterns etc, meeting more frequently if required) .
- Systems for preceptorship and induction of new staff (to include how different bands of staff are managed and supported).
- Handover arrangements when a care coordinator leaves, or where care coordination responsibility is transferred between services.

Recommendation 2
Although the response rate from GPs to the survey questionnaire circulated to all GP practices in Leeds (150 practices approximately 300 GPs) was very disappointing (13%), a number of key issues emerged from the responses that were received. These were:

- That 50% of respondents to the survey said that they 'sometimes' felt that their concerns were respected when an urgent referral is made to mental health services.
- 50% of respondents had concerns about the usefulness of information sent to GPs from the specialist mental health service in Leeds following initial assessment and at the point of discharge.
- 32% of respondents had concerns about the overall quality of information sent to GPs from specialist mental health services.

The Investigation Team does not believe it is appropriate to make substantive recommendations on the basis of the above information i) because of the low response rate and ii) because variables such as the geographical placement of a GP practice, and interpersonal relationships between CMHT members and staff at a GP practice or health centre could alter the results of the survey considerably.

However, neither is it appropriate to ignore the messages collated as a result of the survey. Therefore the Investigation Team suggests that the Directorate of Adult Services considers how it can further explore these issues on a sector by sector basis. In addition to aiding effective communications between primary care and specialist mental health services, further exploration of the stated concerns should inform the development and design of current and future electronic documentation.

Recommendation 3
It is recommended that the Trust ensures that its regular audits of record keeping incorporate audit of the quality and clinical usefulness of the documentation and do not focus solely whether or not particular sections of a documentation tool are populated.

With regards to the audit of documents such as letters to GP following an assessment of a service user, or after discharge back into the community, clearly GPs will need to have an active stake in this process.

Activities that are known to make a beneficial contribution to assessing the quality of record keeping are:

- Peer review audits.
- Clinical audit tools that seek qualitative as well as quantitative data (for this to have credibility the auditors would need to establish their baseline so all are working to the same criteria of quality assessment).
- Clinical and management supervision.

Advisory Note Only
The Executive Management Team at LPFT, and in particular those responsible for the commissioning and quality assurance of serious untoward incident investigations and the accompanying investigation reports are strongly advised to refer to Appendix 1 and to note the comments made about the strengths and weaknesses in the 2579 investigation previously commissioned. It would be prudent for LPFT to bear in mind these observations when quality assessing future internal investigation reports.

APPENDIX 1 – THE FULL DETAIL OF SECTION 5.1 "THE INDEPENDENT INVESTIGATION TEAM'S ANALYSIS OF LEEDS MENTAL HEALTH TEACHING TRUST'S INTERNAL INVESTIGATION INTO THE CARE AND MANAGEMENT OF THE MHSU (MARCH 2006)"

5.1.1 Were the terms of reference the Investigation reasonable and has does the Investigation Report evidence that these have been addressed?

The Trust's investigation team were appropriately asked to "*review the care and treatment of the MHSU.....taking into account past care and treatment, and any other factors that seem relevant; to provide a report and to make such recommendations as seem appropriate".*

Given the growing emphasis on undertaking 'root cause analysis' investigations since 2002, and the national expectation for this in national risk management standards since 2004 one might have expected a more directive terms of reference.

For example:

- To establish the full details of the MHSU's care and treatment within Leeds Mental Health Teaching Trust, and where possible other NHS, voluntary or statutory agencies.
- To identify the aspects of the MHSU's care and treatment that were reasonable.
- To identify and clarify any areas where the MHSU's care and management fell below the standard expected.
- Where care fell below the required / expected standards to explore and understand the reasons for this.
- To identify the 'root causes' or most significant influencing factors as to why care fell below the expected standard.
- To make recommendations to address the 'root causes' of the problems identified.
- To write and present an investigation report to 'XX' which sets out the investigation team's findings in relation to the above.

It is the experience of Consequence UK that it is generally helpful to NHS staff asked to lead investigations if the terms of reference agreed guides them through a structured investigation process. This does, in the experience of Consequence UK Ltd, lead to greater consistency in achieving an appropriate analysis of any identified slips in care or service and can facilitate the delivery of a clearly structured investigation report.

5.1.2 Have all key facts been identified?

Our analysis of the MHSU's clinical records was hampered by the lack of access to his community mental health records. However, based on our assessment of information contained within his medical records, and our discussions with the MHSU's family, it does appear that the key facts in relation to the MHSU's contacts with the specialist mental health service were identified in the Trust's investigation report.

Information relating to the MHSU's contacts with his GP practice, and the Jewish Housing Association (JHA) are not presented in the Trust's investigation report. Although, where an investigation is conducted on an 'internal' basis we would not necessarily expect this, it is something that an external investigation team should have tried to achieve, (or at least it should have set out its rationale for not accessing these records).

The consent of the MHSU would have been required and also all agencies would need to have agreed to jointly support the investigation process.

In relation to current investigation practice, Consequence UK Ltd encourages Leeds Partnerships NHS Foundation NHS Trust to proactively seek the active engagement of all agencies in future serious incident reviews, and the consent of the service user regarding access to any relevant records other agencies may hold.

The Trust's Investigation Team did meet with the welfare officer, from the Jewish Housing Association assigned to the MHSU, and also the MHSU's general practitioner. This represents good practice.

5.1.3 Have the diagnosis and adequacy of care of the MHSU, including key issues of concern, been appropriately explored?

The external team commissioned by the then Leeds Mental Health Teaching Trust took a proportionate approach to its investigation, focusing its detailed analysis on the care provided between February 2005 and July 2005. There was therefore limited commentary regarding the care and management of the MHSU between June 1994 and June 2003.

The Investigation Team understands, from the family of the MHSU, that he enjoyed a number of years of good health prior to his re-referral to specialist mental health services, and our analysis of the MHSU's records confirms that the period of care of most significant to questions of preventability was February 2005 to July 2005. We therefore support the decision of the Trust's investigation team not to undertake a detailed analysis of the totality of the MHSU's care and management from specialist mental health services in Leeds.

There are however two issues that emerged from the limited assessment of the MHSU's care (1994 – 2003) that should have been more fully explored, or at least commented on in relation to practice in 2006 (when the Trust report was written). These issues are:

- The MHSU's diagnosis and the communication of this and its implications to him and his family.

  In early October 1994 the MHSU's diagnosis was unclarified, and noted as "? Depression ? Schizophrenia". On 26 October 1994, during his period of compulsory detention and assessment under Section 2 of the Mental Health Act, Consultant Psychiatrist 2 notes his diagnosis as Schizophreniform Disorder (using DSM IIIR). However there is no diagnosis noted on the discharge summary sent to the MHSU's GP on 22 November 1994. The first time schizophrenia as a diagnosis is stated in his medical records is in a letter from his GP to Consultant Psychiatrist 3 on 22 March 1999. Correspondence from the MHSU's GP to Consultant Psychiatrist 3 also states that schizophrenia was diagnosed in 1996, there is however nothing in the medical records provided to the independent Investigation Team to support this.

- The non-provision of ongoing CMHT or Compass Team support for the MHSU following the departure of his care coordinator in May 2001. The outgoing Care Coordinator made a referral to the Compass Team in June 2001, however, following assessment the MHSU was not taken on as he preferred to remain with his existing community mental health team. The assessment took place almost one month after the care coordinator wrote to Consultant Psychiatrist 2, advising that she was leaving the Sector 1 team, and that she did not think it appropriate for another member of the team to take the MHSU onto their case load. The subsequent Compass assessment form states: "Doesn't want to change teams and have to get to know new people". The CPA review documentation of May 2001 does state that Consultant Psychiatrist 3 would be the care coordinator but he was not present at this meeting, and there is nothing to say what the alternative plan was to be if the Compass team could not accept the MHSU onto its caseload.

The Trust analysis of the MHSU's care in 2005

The Trust Investigation Report looks in reasonable depth at the MHSU's care pathway during 2005 and critically examines the quality of care he received. The independent Investigation Team is satisfied

that the Trust Investigation Team highlighted the most pertinent issues. These were:

- The inappropriate response to the MHSU's initial referral in February 2005.
- The lack of assessment of the MHSU when he was seen in out patient's on 28 April 2005.
- The lack of any identifiable risk assessment of the MHSU or reference to his past risk history, where the issues relating to his dislike towards his father are clearly documented.
- The lack of detail in the contemporaneous clinical records and in the correspondence from Consultant Psychiatrist 3 to the MHSU's GP.

Given that the Trust had commissioned an external investigation team, the report does not communicate the rigour of exploration one would have expected. The report does not set out the usual standard of practice for the locum consultant involved (Consultant Psychiatrist 4), or set out in detail the precise detail of his assessments, to the best of his recollections, on 28 April and 26 May 2005.

Furthermore a cursory glance through the MHSU's clinical records would have alerted any moderately seasoned clinician to the fact that more time was required and that a detailed assessment for this MHSU would be necessary. The Trust's investigation team did interview the Consultant Psychiatrist 4 and explored with him his usual practice and how he conducted his assessment of this MHSU. The investigation lead advised that Consultant Psychiatrist 4 did not interview well, was not consistent in the information he gave and even though he reported undertaking a thorough risk assessment neither the investigation lead, or his team, were satisfied that a comprehensive assessment had been conducted. The investigation lead confirmed that the investigation team viewed the quality of the outpatient assessments conducted as insufficient.

With regard to the inappropriate response to the original letter of referral by the MHSU's GP, that is the sending of an opt-in letter to the MHSU. The independent Investigation Team does not consider the Trust's explanation of this to have been adequate.

Reflections by independent Investigation Team

The sequence of events following the MHSU's referral back to specialist mental health services in February 2005 was as follows:

- 28 February 2005 - GP makes a 'routine' referral to the mental health service.
- 3 March 2005 - the referral letter is received by Sector 1 CMHT.
- (Unknown date) - referral went to CMHT meeting.
- 17 March 2005 - referral sent to medical records by medical secretary.

- 21 March 2005 - opt in[5] letter sent to the MHSU by medical records officer.
- 21 March - GP refers the MHSU on an urgent basis.
- 30 March - the GP letter is received by Sector 1.
- (Unknown date) - a note is made on the original referral letter for 'out patient' appointment please'.
- 28 April - the MHSU is seen in outpatients by Consultant Psychiatrist 4.

Our review of the MHSU's records revealed that although the referral of 28 February has written on it 'CMHT referral meeting' it also has written on it "out/pts appt-arrange please". Neither note is dated. The only date identified is 17 March 'Medical Records'. This ties in with the subsequent pro forma letter sent from the medical records officer to the MHSU on 21 March.

Why it took so long for this letter to be sent to the MHSU has not been explained within the Trust investigation report. Our exploration of this issue with a current clinical team manager, who was working with the Sector 1 team in 2005, revealed that the original letter was sent to the Becklin Centre direct to the doctor. It should then have gone to the team meeting for allocation at the Ashwell Centre, as is indicated on the referral letter itself. There were no minutes of team meetings kept at the time and the agenda lists were only kept for a short period. It is therefore not possible to determine whether or not the MHSU's referral was discussed at the meeting.

A review of the calendar for March 2005 shows that if the referral had been discussed this should have been accomplished by Friday 12 March (i.e. within a week of referral). It however, took almost three weeks from the referral being received by the mental health service for the 'opt-in' letter to be sent to the MHSU. This is too long a time frame.

Although it is clear that the LMHTT investigation team did consider the system failure in relation to the management of the initial referral letter, this consideration was not as comprehensive as it could have been.

With regards to the appointment eventually offered for 28 April this occurred following receipt of the second letter of referral from the MHSU's GP on 21 March.

As noted above it is the independent Investigation Team's assertion that the MHSU's referral should have been discussed by the Sector 1 team within a week of it being received and, on the basis of his history alone, proactive telephone follow up within this time should also have occurred.

[5] An opt in letter is one that acknowledges the referral to the patient and requires them to proactively contact the CMHT to confirm that they want an appointment.

To ensure that we (the independent Investigation Team) are not suggesting an unreasonable standard of response the perspectives of five mental health professionals (two consultant psychiatrists, one approved social worker, and two senior mental health nurses) were sought. All of these professionals were presented with the following synopsis:

"A CMHT is sent a routine referral from a GP about the potential relapse of a paranoid schizophrenic. What period of time would you expect the service user to be assessed in, and would the sending of an opt in letter be appropriate?

In the case in question there was time delay of three weeks before sending an 'opt in letter', and an eight week delay between first referral and first face-to-face assessment"

The responses received were as follows:

Response 1, consultant psychiatrist:

"Would think that it (*the assessment)* should be done within a week."

Response 2, consultant psychiatrist:

"A responsive CMHT would read all incoming letters on the day of receipt and keep anything non-urgent for the next referral meeting, or respond immediately if the clinical scenario warranted such a response. The timing of the appointment would once again be judged on the clinical situation as described by GP.

A patient with a history of psychosis should be seen within the week of receipt of letter, unless the clinical scenario seemed to be non-urgent and no safety factors were present."

Response 3, approved social worker:

"When an opt in letter is sent part of the rationale is to test out an individual's commitment to treatment/counselling. When you have someone with a psychosis history, and the inherent dangers possibly of non engagement, an opt in letter would seem questionable. Far better would be to make direct contact and assess the need in situ.....
In terms of how long this process should take, there are often unexpected issues, team staffing, sickness, admin delays, etc that compounds matters regarding expected turn around. Did the team have standards on response times?"

Response 4: senior nurse and associate director of risk management:

"Assuming that there are no risk issues that mean the patient needs to be seen urgently, I would expect the patient to be allocated at the next team meeting and given an appointment within

the next few weeks. 'Opting in' is a bit of a problem where a patient lacks insight/motivation etc - a more assertive approach may be more appropriate in those instances."

Response 5: senior nurse and commissioner of mental health services:

"In my view Opt-in letters should not be used in psychosis as the risk of non engagement is well documented... so yes it (3 weeks) is too long but I would question the practice anyway."

Response 6: clinical team leader of a CMHT at Leeds Partnerships NHS Foundation Trust:

"From memory at the time (2005) we were attempting to discuss all referrals in a weekly multi disciplinary meeting to pick up on issues such as the ones you describe. If there was any evidence of engagement issues risk or serious mental illness contact would not rely on partial booking. .....
"Currently (2009) we do not have a partial booking system, though I can only speak for my teams in the north east Leeds. All referrals come to the duty desk run by senior team members who read and action the referrals on a daily basis. A service user with a diagnosis of schizophrenia or risk history would be contacted direct (mostly on the phone) to negotiate when and where to see.

If a medic were to assess an appointment letter would be sent (with a specific time) but again it is likely that a telephone call would be given in the first instance.

The decision making would be done by the duty worker if necessary following discussion with myself or/and the consultant who share the same base as the rest of the team.

Certainly if paranoid ideas were noted on the referral or a major part of patient history then this should be considered by the duty worker and direct contact made to negotiate assessment. It would be the case that if the referral noted risk issues then the community worker would see the service user either prior to or alongside a medic.

The duty workers work in twos one 'band 6 and one band 5'. There are two 'hand over' type meetings in the week which are multi disciplinary including the consultant and clinical team manager. Assessments/ongoing/duty issues can be discussed at these meetings however, all referrals are actioned on the day of referral to avoid unnecessary delays.

We have three time scales:

1. Emergency referrals – to be seen within one day if the service user is currently on case load.
2. Urgent referrals – to be seen within 3 days. This is also for all new clients. If a new client needs more urgent or same day the referral goes to the crisis team for A 4 hour response.
3. Routine referrals – to be contacted within 10 days and seen within the month."

The lack of thorough exploration of the management of the initial referral in February 2005, and the decision to send an 'opt in' letter, is a significant weakness in the Trust's investigation report. Had this referral been more appropriately managed the MHSU may well have received a more detailed assessment at an earlier stage, and an assessment at his home, with or without communication with his mother or father.

Although there are no guarantees that a more assertive approach would have averted the tragedy that subsequently occurred, without a doubt the MHSU would have had a better quality of assessment, and there would have been the opportunity to address his medication more assertively if the assessments highlighted a need for this.

What definitely would not have happened would have been the 'follow up' appointments booked for the MHSU in the outpatient clinic.

The focus of attention by the Trust's Investigation Team is on the practice of the Consultant Psychiatrist 4. Although he was responsible for his own practice, it is the assertion of the Consequence UK team that the Trust's investigation should have taken a broader perspective and looked at the robustness of the whole system. It is only by taking a whole systems approach that the most reliable lessons can be learnt and therefore recommendations can be made. Consultant Psychiatrist 4's actions were not the only reasons why the MHSU did not receive the full and thorough assessment he required.

We do not know, and will not know, what the absolute root cause was, however it is clearly apparent that the chain of events commenced with the initial assessment and response to the GP referral made on 28 February 2005.

This observation does not excuse the reported poor practice of Consultant Psychiatrist 4, which fell far short of expected standards, but it does mean that the ineffective working of the appointment and allocation system contributed significantly to the lack of appropriate assessment of the MHSU.

It is notable that the current appointment and allocations system in the adult services is markedly different to those in place in 2005 and there are clearly defined timeframes for responding to referrals.

5.1.4 Have issues such as

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

been adequately explored within the Trust's report?

Risk assessment

The Trust report identifies the lack of an easily accessible risk assessment developed during the MHSU's first period of care, and that upon discharge in June 2003 the locum consultant did not provide the MHSU's GP with any advice on possible signs of relapse or what action to take in response.

The Trust Investigation Report reveals that although Consultant Psychiatrist 4, who assessed the MHSU on 28 April and 26 May 2005, said that he did undertake a risk assessment on the MHSU, there was no documentary evidence to support this. Furthermore the length of outpatient appointment offered to the MHSU was insufficient to make claims of having undertaken a risk assessment credible.

Coupled with the above was Consultant Psychiatrist 4's assertion that he was unfamiliar with the FACE risk assessment model[6]. He was however in his third week of his second period of time as a locum consultant for the then LMHTT. This detracts from his assertion. However, the lack of familiarity with the Trust's standardised approach, which had been in place since 2003, calls into question the induction process the Locum received and the mentoring/supervision he was afforded. There is no evidence that these issues were explored with this individual, or with the clinical and managerial leaders of the Adult Services – Mental Health at the time. They should have been.

It is the view of the Consequence UK Investigation Team that the reported history from the MHSU's GP, coupled with his presentations in 1994 and 1995, should have raised significant risk concern about the MHSU. The lack of exploration and/or the initiating of a community based assessment was a significant slip in the service offered to this MHSU by the specialist mental health service in Leeds.

[6] FACE is a particular model of risk assessment that was used by Leeds Mental Health Teaching Trust.

Because the lack of risk assessment was such a significant concern in the months preceding the incident, section 5.2 (page 18) pays particular attention to this area of clinical practice from a contemporary perspective.

Care planning

The report says little of the care planning for the MHSU between 1994 and 2003 other than his care is routine. Our analysis of the MHSU's records shows that his in-patient episodes were confined to 1994 and thereafter he received community based care. There is sufficient information in the correspondence section of the clinical notes to show that the nursing and medical staff engaged in his community management were well aware of the MHSU's needs and did try and engage with him.

Care Programme Approach

The first reference to the CPA is in 1996. Thereafter meetings are noted to have been held on:

- 8 March 2000;
- 12 July 2000; and
- 2 May 2001.

There were only two CPA review documents in the medical records. The latter of these, 2 May 2001, notes the MHSU to be on standard CPA. There is nothing in the records provided to Consequence UK to say he was ever on enhanced CPA, however it is likely that he was given the number of professionals and agencies involved in his support package (that is, consultant psychiatrist, the Jewish Housing Association, GP and CPN). There is no documented rationale for why he was placed on standard CPA. The only change in the number of persons and agencies providing the MHSU with support in 2001 was the departure of his CPN. All other professionals remained engaged with his care package.

Comment

Although the course of the MHSU's clinical care and reported well being between 2001 and June 2003 suggests that standard CPA was an appropriate level of CPA for him, it is an area of practice that one would have expected the Trust's investigation team to have commented on.

The level of CPA for an individual client relates to capacity within the CMHT as well as the standardised criteria. For example if you have six key workers/ care coordinators who all have a caseload of 25 then the capacity of the team for enhanced CPA cases is 150. Therefore the 150 'most needy' clients will be on enhanced CPA. If a service user is the 151st client who meets enhanced CPA criteria, then an assessment will need to be made of the caseload of whomever is nominated to be their key worker so that a decision can be made about who can safely

be stepped down to standard CPA. This is part of good CMHT management.

Clinical supervision
There is no mention of clinical supervision. Recommendations are made concerning the management of the performance of locum consultants but not their clinical supervision.

Inter-agency communications
The internal report makes very clear that there was a welfare worker from the Jewish Housing Association who was actively involved with the MHSU.

The report's content also shows that the MHSU's GP was engaged with the MHSU and his family.

However the report does not comment of the quality of engagement by the Trust staff with either the Jewish Housing Association and the MHSU's welfare officer, or the GP. The only comment made is in relation to the inadequate discharge information provided to the GP in 2003. However we (the independent Investigation Team) do know that the family of the MHSU were very satisfied with the support they received from the welfare officer and their GP. Indeed they spoke very highly of their GP and the support she gave them over the years following the inception of their son's illness.

Because effective inter-agency working is a key feature of an effective specialist mental health service, this independent Investigation Team has undertaken a series of focus groups with a number of voluntary organisations in Leeds who work closely with mental health service users and Leeds Partnerships NHS Foundation Trusts. The aggregated data from this work suggests that although working relationships have improved considerably, third sector agency staff believe further development is required for optimal working relationships to be achieved.

The independent Investigation Team also sought feedback from a number of GPs currently working within Leeds. Because effective response to GP referrals is a key feature of this case, the information elicited is presented in Section 5.4 (page 30) of this report.

Inter-team communications
Although the internal report highlights misdirection of the MHSU to the out-patient clinic on his re-referral in 2005, it does not comment on inter-team communications.

There is no exploration of how the CMHT was managing its referrals at the time, or how team meetings were managed. The Trust's

investigation team says that it 'assumed' that the problems occurred because of the changes recently made to how referrals were received and screened by community teams. It did not test out its assumption.

Comment
Although this issue is not explored by the Trust's investigation team there is sufficient information in the MHSU's clinical records prior to his discharge in 2003 to suggest that inter-team relationships were good and that there were good levels of communications between the nursing and medical staff involved with the MHSU up to and including June 2001. The quality of the correspondence between the MHSU's care coordinator and the then consultant psychiatrist in April 1996 was of an excellent standard.

Housing
The MHSU lived at home with his parents. There is no indication in the health records, or in the investigation report, that the appropriateness and/or risks of this were explored with the MHSU or his family. However it is clear that the MHSU received close contact with the community mental health team and that both of his main care coordinators, up to and including June 2001, did visit the family home. In addition to the support provided by the specialist mental health services, the MHSU and his family were supported by the Jewish Housing Association and a welfare officer from the JHA worked closely with the family.

The independent Investigation Team also knows from meeting with the family of the MHSU that there was no question of him not living with his parents, or another family member. The MHSU had tried independent living before and it did not suit him. Furthermore, the MHSU's mother told the Investigation Team that she never felt at risk as a result of her son's behaviours and nothing would have induced her to ask him to leave the family home.

Furthermore having met with the family of the MHSU, it is doubtful whether a meeting with his parents would have revealed the extent of the risks they lived with on a daily basis. Following the MHSU's detention under the Mental Health Act in October 1994 and the exacerbation in ill feeling between father and son that this caused neither parent wanted to create more turmoil. Both parents we believe felt curtailed by the express wish by their son that they did not 'speak to anyone' about him.

Support for carers:
This area is insufficiently addressed within the Trust's investigation report. However the triggers for exploring this further were contained in the MHSU's pre-2003 care and management which was not the focus of the Trust's investigation team.

The records analysis revealed sufficient information in the MHSU's clinical records between 1994 and May 2001 to suggest that there was regular contact between the visiting CPNs 1 and 2 and the parents of the MHSU. However in May 2001 it is noted in a letter from CPN 2 to Consultant Psychiatrist 2 that the MHSU's mother is not satisfied with the explanation they have been given about her son's diagnosis. The CPN suggests that 'perhaps she *and the MHSU* could be seen at the Ashwell Centre by a medic so this matter could be discussed".

There is nothing in the records provided to the independent Investigation Team that any such discussion occurred.
Because the engagement of, and support for, carers is such an important issue, information about the current perspectives and practice of staff is presented in Section 5.3 (page 26) of this report.

Team performance and leadership
This is not commented on in the report. However, our review of the MHSU's clinical records suggests that the communications between the specialist mental health service and primary care were of a reasonable to good standard between 1994 and June 2001. Furthermore the correspondence between the mental health professionals suggests good levels of team performance, especially in relation to inter-team communications and awareness of key issues of importance in effective client management.

Service culture
This is not commented on in the report. There is nothing in the analysis of the MHSU's clinical records that suggests that a wider review of service culture would have been required in this case.

5.1.5 Are the conclusions of the Trust's investigation report congruent with the facts and are they reasonable for the case investigated?

The Trust's report concluded that the attack by the MHSU on his father was neither foreseeable nor preventable. The Trust's Investigation Team does however state its conclusion cautiously. This is because it did not know why the MHSU attacked his father and whether it was the consequence of an untreated psychotic episode. The Trust Investigation Team states that:

"Whilst there are several administrative failings in the management of the referral on the part of the Trust, we do not consider that these have any bearing on the subsequent events".

However, the Trust's Investigation Team also says that had a more thorough assessment of the MHSU's mental state and risk been undertaken, that revealed untreated psychosis or significant risk issues this may have resulted in a different package of treatment with more support provided.

Independent Investigation Team comment
Knowing the circumstances of an incident, and its antecedents, is important in making a judgment on its potential preventability and also its forseeability.

In this particular case the family of the MHSU had become increasingly concerned about his deteriorating behaviour in the weeks leading to the death of his father.

The following extract from our meeting with them highlights this:

"O[7] told me that E was at his house approximately two weeks before the incident. The MHSU was becoming more and more ill at this time. E told O that he was concerned that *the MHSU* would harm him but what could he do? It was his son and he didn't want to see him locked up.

O recalls that E was completely ground down – worn out and powerless.

A:
A told me that she tried to explore with E what services *the MHSU* was getting. A works on one of the adult inpatient Units in a support capacity. It was and remains her impression that her nephew was receiving very little input from specialist mental health services. It

[7] O is the MHSU's Uncle. E is the MHSU's Father, A is the MHSU's aunt. The initials of all three have been changed to maximise their anonymity.

seemed that only the chap from the Jewish Housing Association was in touch with him and this was an unqualified worker. "A befriender".

A told me that she spoke with the charge nurse on her ward about her concerns. She reports that this individual told her to try and persuade the MHSU's mother and his father to initiate a Mental Health Act assessment. A corroborates what O and the MHSU's mother have said – namely- that this was not an option for the MHSU's parents as they saw it at the time.

A also revealed that at this time *the MHSU* was following his Dad around all of the time. O revealed that E was a 'hate figure' for *the MHSU*. It had always been so since he became ill.

Three weeks before the incident (Father's Day) A tried to speak with E but she couldn't as *the MHSU* wouldn't allow it. He wouldn't allow anyone to speak about him.

A recalls her nephew saying "Don't say it's lovely to see him". E, she recalls said "It's always a bad time in this house" in response to her enquiry as to whether her visit was timely.

A could see her nephew was very unwell – he was sweating profusely, and agitated. She was, she recalled, anxious for her children who were with her, and for their safety.

The MHSU, A stated, was continually calling her father a bully. He kept repeating himself. She felt he was not taking his medication – when challenged he said it didn't matter about his medication."

In addition to the above the aunt of the MHSU told the Investigation Team that the MHSU had held her daughter up against the wall by her throat in the winter of 2004.

Although one cannot suggest that the incident involving the MHSU and his father was predictable, there was sufficient information available in the MHSU's clinical history, especially his first presentations in 1994 and 1995, and the recollections of the family in the period leading up to the incident, to suggest that the MHSU did pose a risk of potential harm to his mother and father. The extent to which he posed a risk is however not clear. Although the MHSU's past behaviours suggested the capacity for violence, and he had previously placed his hands around the throat of his mother, he had not previously carried out any act that resulted in serious harm to either parent.

However because the MHSU did not receive an appropriate assessment between March and June 2005 means that there was a loss of opportunity to identify the extent of his relapse, the degree of medication compliance, and the degree of risk he posed to himself or others.

Both the independent Investigation Team and the original independent investigation team commissioned by LMHTT agree that opportunities to have assessed this MHSU were missed.

Therefore, for the family of the MHSU, and of his deceased father, it will always remain a possibility that had the MHSU received timely and appropriate assessment then a more comprehensive management plan may have been instituted for him.

However, because of the circumstances of the incident, i.e. that the MHSU had returned home from a night out immediately prior to the attack, there are no guarantees that even if this had occurred that the incident was preventable by virtue of better mental health management.

5.1.6 Did the recommendations made appear to be appropriate based on the findings of the Trust's own investigation? Furthermore, will they, if implemented, reduce the risk of a) the incident occurring in the future and b) the occurrence of similar care management concerns to those identified in this case?

The report makes seven recommendations.

Recommendation 1: " We recommend that during periods of service reorganisation extra attention is taken to ensure continuity of care for clients."

We are a little unclear as to whom this recommendation has been made. Between February and July 2005 there was no lack of continuity of care - simply a lack of care. The system that appears not to have worked was the screening and assessment of a GP referral via the newly implemented 'partial booking system'. The GP letter asking for an urgent appointment was addressed directly to the consultant psychiatrist in Sector 1. This was written one month after the original letter of referral.

The recommendation here should have targeted the system that failed and impressed upon the Trust the need to ensure that the new process was properly implemented in all of its CMHTs. Furthermore a requirement for the Adult Services Directorate in the then Leeds Mental Health Teaching Trust to establish an audit process, to test the effectiveness of the new system and whether it was working, should also have been stated integral to the recommendation.

Recommendation 2: "We recommend that the Trust ensures through regular audit that discharge letters for service users with serious mental health problems contain a case summary, including risk factors and

relapse signature, and what to do in the event that such signatures become apparent."

This is essentially a good recommendation and if it has been acted on by the Trust then GPs should be receiving a more consistent standard of discharge letter whether the discharge relates to inpatient or outpatient services.

The only addition we would have made to this recommendation is the development of a standardised discharge pro forma for use regardless of the point of discharge of a service user.

Recommendation 3: "We recommend that the Trust review its pathways into care and assessment to ensure that clients are seen in a timely and efficient manner. In particular we recommend that the Trust develop protocols which ensure that the partial booking system is sensitive to the needs of clients with mental health needs."

This recommendation is not very clear.
At the time of the incident in which the MHSU was involved, Leeds Mental Health Teaching Trust already had a process for reviewing referrals in Sector 1. This took the form of discussing all referrals in a weekly multi disciplinary meeting to pick up on issues such as those presented by the MHSU. If there was any evidence of engagement issues, risk or serious mental illness, contact would not, it has been reported, rely on partial booking. Unfortunately for reasons not explored at the time, and which will not be recalled now, this MHSU slipped through the net.
The key message that needed to be picked up by the Trust was the need for clear guidelines on how referrals should be assessed and issues to be considered in coming to a decision about how to follow up the referral.
This Investigation Team also draws the Trust's attention to the need for the audit of compliance with the guidelines by the clinical team manager for each sector.

Recommendation 4: "We recommend that the Trust undertake a regular audit of assessments of new clients to ensure that proper recording and risk assessment [is] taking place."

The undertaking of regular audits of the quality of record keeping is an essential patient safety activity. Unfortunately many record keeping and process audits only look at quantifiable information, for example with record keeping audits - is an entry dated and is the author's name clearly legible?

The intention of the Trust's investigation team is encapsulated by the words "to ensure that proper recording and risk assessment taking place".

Some additional direction as to how this recommendation could be delivered may have been helpful, such as the regular use of peer review audit of clinical records.

Recommendation 5: "We recommend that the Trust makes locum Consultants record the fact that they have read, understood and will comply with the expectations placed upon them by the Trust's policies, particularly those that relate to clinical practice."

This recommendation although well intentioned falls short of the mark in relation to locum consultants. A more powerful recommendation would have been something along the lines of:

"The Trust needs to ensure that it has a clear and auditable process for ensuring that locum consultants:

- Have an identified mentor.
- Are introduced to key clinical policies and procedures, including the local operational policies.
- Have an induction to their immediate place of work including the MDT.
- Are familiarised with key documentation tools.
- Are advised about any baseline expectations in relation to how clients are assessed and followed up 'in Leeds'."

To ensure that all services induct their locums appropriately the assistant medical directors for each service should be responsible for ensuring that all locums are practicing to an acceptable standard. Furthermore each service should be able to evidence the induction process for each and every new consultant and locum doctor employed on a short to long–term contract.

Note: It is accepted that for practical reasons the induction for short-term agency locums may not achieve the above. Nevertheless LPFT should have clearly defined standards and expectations of what essential information is provided to these individuals on the occasions when they have to make use of agency locum services.

Recommendation 6: "We recommend that the Trust regularly audits letters from locum doctors to referrers to ensure that the information given is consistent with Trust quality standards in this area."

This recommendation is a little woolly and is unlikely to make any valuable contribution to the overall consistency of information being sent to GPs.

The recommendation would have been far more effective had it said something like:

"The Trust must ensure that all directorates have a standardised 'post assessment' pro forma for sharing information with general practitioners and other referrers. The headings used for the current discharge pro forma would make a useful starting point for this."

In addition the Trust might consider surveying GPs on an annual basis to obtain information on the usefulness of the letters sent.

Recommendation 7: There is a whole paragraph that relates to Consultant Psychiatrist 4 who, in the opinion of the Trust's Investigation Team let his standards drop in relation to his management of the MHSU.

The paragraph contains wording such as: "For this reason the Trust would decline to employ the doctor again. For this doctor it is fair to say that the Trust had no other concerns about his practice. .....Also we think this report should be drawn to the attention of other mental health Trusts in the interests of patient safety."

The way the perspective of the Trust's investigation team is presented could have been improved.

From the Consequence UK Investigation Team's discussions with the team leader for the Trust's investigation, it is clear that careful consideration was given to how the non-actions of the locum consultant could be addressed. The then team leader did not consider that he had authority to write directly to the medical director at the Trust where the Locum was employed at the time of the investigation. Neither was the error of sufficient magnitude to involve the General Medical Council or National Clinical Assessment Authority. A decision was therefore made to recommend that the matter be brought to the attention of the director of public health with a view to issuing a practice alert letter.

Discussion with the current medical director revealed that the range of options open to the investigation team and the trust were limited at the time because Consultant Psychiatrist 4 (the locum) had left the employ of the Trust. It is the perspective of the current medical director that had the consultant psychiatrist been a substantive employee, or on a longer contract, then the recommendation may have been quite different.

It is the perspective of this Investigation Team that a formal letter could have been sent from the then investigation team to the SHA, the chief executive of LMHTT and the medical director and chief executive of the Trust employing the locum consultant in 2006, highlighting the concern about his/her performance in relation to the management of the MHSU.

5.1.7 Was there evidence of a systems-based approach to the investigation?

The Trust's investigation report presents a limited systems analysis in relation to the care concerns it identifies. In light of the severity of the incident a more detailed exploration of the systems and processes and clinical decision making should have been conducted as this report has highlighted.

Although the Trust commissioned individuals external to the Trust to conduct the investigation it does need to remember that the final investigation report is the public face of the investigation and its content must properly reflect the rigour, depth and breadth of investigation undertaken. If it does not then, the report does the investigation team and the Trust a disservice.

5.1.8 Where the LMHTT Investigation identified care concerns how satisfied was the independent Investigation Team with the quality of the analysis of these based on the information documented within the report?

The independent Investigation Team has provided detailed comment in relation to this under Appendix 1, section 5.1.3, pages 48 – 54. "Have the diagnosis and adequacy of care of the MHSU, including key issues of concern, been appropriately explored?"

However, if this incident were to be investigated for the first time today we would expect to see clear evidence of the following having been addressed by the Trust's investigation team:

- An exploration of the way referrals were received and reviewed by the sector 1 community mental health service in order to gain a fuller understanding why the MHSU was not provided with an assessment in a timely manner, and why the referral was dealt with as a review rather than a new assessment. (The internal report touches on this but does not present what precisely happened in this MHSU's case).
- How the weekly CMHT team meeting was managed, how new referrals are discussed and how decisions made are recorded, and reviewed.
- How the consultant psychiatrist(s) interfaced with the CMHTs and how they participated in the decision making process regarding assessment.
- The use of CPA and how embedded it was in the culture of the community services (including what training was given and to whom, what the standards were for transfer of care between care coordinators within the same CMHT, and how it was evaluated and audited).

- The assessment and management of clinical risk (including the Clinical Risk Assessment and Management policy, use of clinical risk assessment tools and how it was evaluated and monitored).
- The involvement of carers and relatives in the assessment of patients and the care planning and delivery subsequently (including support to carers through the carers' assessments and psycho-education about the patient's illness and treatment).
- The links between primary care and the community mental health services (including liaison over new referrals and shared cases).
- The recruitment and induction of temporary staff, including locum consultants, and the arrangements for supervising their practice and managing their performance.
- The management of health records (including whether they were integrated or not and how they ensured the quality of record keeping i.e. through audit).
- The contribution of other agencies to the MHSU's care (i.e. primary care and the Jewish Housing Association).
- The care and rehabilitation of patients with severe and enduring mental health problems (including what services were available, and how closely they followed the NICE guidance on schizophrenia). How typical was the MHSU's care in this Trust?

5.1.9 Reflection Points for Leeds Partnerships NHS Foundation Trust

Although the investigation commissioned by the Trust in 2005/2006 was reasonable, it did not meet the expected standards in relation to root cause analysis at the time. This was largely due to the lack of detail in the terms of reference provided to the LMHTT independent investigation team. The following detail is intended therefore to assist the Trust in delivering high quality serious untoward event investigations in the future, along with investigation reports that evidence the quality of the investigations undertaken and that a root cause analysis approach has been applied where appropriate.

The Trust needs to:

- critique its current investigation guidance to staff, (not its adverse incident management guidance) and check to ensure that this is clear and unambiguous, including ideas and suggestions on the different approaches one can take to the investigation process. These include:
  - Traditional style investigation with face to face interviews with staff members.
  - Round-the-table clinical review meetings with an independent[8] facilitator and independent clinical advisor.
  - A blended approach – face to face interviews and round-the-table review.

  The guidance should also provide staff with an outline of the available investigative techniques that the Trust supports and direct them where to learn more about their application. For example:
  - Structured and simple timelining.
  - Control/barrier analysis.
  - Failure modes and effects analysis.
  - Investigative/cognitative interviewing.
  - 'Brain Writing'.
  - Affinity mapping and content analysis.

- ensure that it has standing terms of reference for serious untoward incident investigations that are applied to all high impact (code red) investigations[9] commissioned by the Trust's executive directors or by the associate medical directors and associate directors for each directorate (see page 48 of this report).

[8] By independent we mean independent to the Team and locality involved in the incident.
[9] Clearly such terms of reference can be amended if particular investigations requires this. Having core terms of reference will support the attainment of consistency in the standard of investigations undertaken in the Trust.

With regards to investigation reports, the National Patient Safety Agency issued guidance for NHS trusts in 2008. The following simplifies this.

Use of person-identifiable information
As a matter of principle neither the initials of staff members, nor that of the service user, or their family should be used. In this respect the report should be completely anonymous.

Coded terms such as;

- "Consultant Psychiatrist 1 (Cons P1)";
- "Consultant Psychiatrist 2 (Cons P2)";
- "CPN1";
- "CPN2";
- "SHO1;"
- "SHO2" or
- "Service User (2005/2579) (SU2579)"

are much safer and more appropriate if the focus of the investigation is to learn lessons for improvement rather than to 'name and shame'.

In the investigation management file however there does need to be a list that identified the individuals to whom the codes refers.

Formatting
The original LMHTT report would have benefited from:

- An executive summary.
- More precise terms of reference. Note: the terms of reference should provide an investigation framework for the appointed investigators.
- A more detailed investigation methodology.
- Robust proof reading.
- A structure that ensured that the 'main findings' are stated with clarity and before the full and detailed chronology is presented. The full detail of a service user's history can be placed in an appendix providing that it is clearly signposted within the report. This enables the report to feel less text heavy and brings to the fore the most important information in the report, i.e. the investigation team's findings.
- A clear front facing page and index.

Investigation report structure
The Investigation Team suggests that at minimum the following sections need to be included in any investigation report:

- Facing front cover.
- The names and professional status of the investigation team members.
- Acknowledgements.

- Index.
- Executive summary.
- Introduction (why the investigation was commissioned and an outline of the service user's contact with the specialist mental health service, any key issues, the service user's forensic history, and the incident and post incident management).
- Terms of reference.
- Outline methodology (this could go in an appendix).
- Contact with the service user, the service user's family, and the family of the victim.
- Findings of the investigation, including:
  - Positive feedback – what was managed well;
  - Main care delivery/management concerns and service delivery concerns (each should be clearly articulated.)
  - The most significant contributory factors to the main care delivery/management concerns. This information comes from undertaking a systems focused (root cause analysis) investigation.

  Note i: Where the analysis of the care concerns generates a lot of data and repetition of data, placing this information in a signposted appendix is sensible.
  Note ii: Sometimes there are no care delivery or service delivery concerns that relate directly to the case under investigation. In such instances 'critical questions' can be used instead of care delivery or service delivery concerns.
- Additional learning opportunities arising from having done the investigation. (This section contains the 'added value learning' that should emerge from the investigation process, but which is not directly linked to direct care management concerns identified).
- Conclusion – this should address the terms of reference and/or predictability and preventability of the incident. It should also acknowledge any significant improvements implemented prior to the completion of the investigation.
- Recommendations. (These should address the main contributory factors to the main care concerns before all else).
- Appendices, including:
  - Detailed chronology for the service user.
  - Sources of information used to underpin the investigation team's findings and recommendations.
  - Detail of the systems analysis of each main care management concern using the NPSA's human factors framework or similar if the data is too voluminous for the main body of the report.
  - Glossary.

APPENDIX 2 – CHRONOLOGY OF THE MHSU'S CONTACTS WITH LMHTT

This chronology gives a comprehensive picture of the MHSU's contacts with LMHTT between June 1994 and July 2005.

Date	Contact
15 June 1994	An urgent referral was made to the psychiatric unit by the MHSU's GP. The referral letter states that the MHSU has 'had ideas of self harm over the past few weeks and went to a friend's flat with the intention of hanging himself – he decided against it." There were scars on both of his forearms evidencing recent acts of self harm. Both of his parents were also noted to suffer from depression.
17 June 1994:	The MHSU was seen in the outpatient clinic at Meanwood Health Centre. His father accompanied him. The assessment revealed that the MHSU had been self harming since the age of 15. These instances were precipitated by the breakup with girlfriends and jealousy. It is also noted that the MHSU had called off his wedding to his then girlfriend at five days notice. They were however still 'together'. The letter to the GP notes that the MHSU has no previous psychiatric history and he passed all his milestones at the appropriate ages. The assessing Consultant Psychiatrist, Consultant Psychiatrist 1, did not find the MHSU to be depressed. He was anxious and cognitive function was intact. Overall the consultant's opinion was the MHSU had an anxiety state. He was prescribed dothiepin 50mg at night. He was also given the contact details for the Westminster Pastoral Foundation and his father had the telephone number for MIND. The consultant suggested that the MHSU engage with one of the organisations for counselling. He was booked for a follow up appointment on 12 August.

Date	Contact
31 July 1994	The MHSU was admitted to Ward 37 via the St James University Hospital A&E department having tried to hang himself with an electric flex. His parents were away on a two week holiday. His brother and a friend accompanied him. The MHSU reported wishing he was dead and regrets the failure of his attempt. The precipitating event was his girlfriend telling him that she was 'leaving him'. The MHSU discharged himself from hospital the same day. Follow up was kept for 12 August as planned.
12 August 1994	The MHSU did not attend for his follow up appointment. In view of this Consultant Psychiatrist 1 advised the MHSU's GP that he will not plan further follow up unless she specifically requests this.
29 September 1994	The MHSU was assessed at home by Consultant Psychiatrist 2 at the request of the MHSU's GP. This assessment notes that over the period of a fortnight the MHSU had become more agitated and was having evil thoughts which were related to killing his parents. "He would frequently get up in the middle of the night and come into the room, saying he was upset and distressed and the father and mother were both feeling somewhat threatened by him". When hospitalisation was discussed, the MHSU said he was frightened by this but did agree. But then he jumped up, suddenly pushed past his father and ran out of the house. Arrangements were made for his admission and he subsequently arrived on Ward 40.
29 September – 4 October 1994	The MHSU was initially on level II observations. These were subsequently reduced to general observations. Weekend leave was given with return agreed for 4 October. The MHSU's phoned Ward 40 and advised that he felt better and did not want to return. He was persuaded to come and see the medical staff in the afternoon, however it was his father who attended on his behalf. The MHSU's father was advised to ask his son to call the ward on the 5th and to arrange a time to see one of the medical team. The MHSU did not call the ward and was therefore discharged.

Date	Contact
24 October 1994	Consultant Psychiatrist 2 was again asked to assess the MHSU at home. He was noted to be very much the same as he had been on 29 September. The MHSU did tell the consultant that he had not felt any better in hospital and had lied to be discharged. He agreed to re-admission but was noted to be ambivalent about this. On assessment the MHSU said he was "plagued by evil thoughts to do with killing his mother and father. He had in fact placed his hands around his mother's neck but had not continued with the act when she told him to let go of her."
25 October 1994	The MHSU absconded from the in-patient unit and was subsequently assessed under the Mental Health Act and sectioned under Section 2 of this act. On readmission the MHSU was placed on oral anti-psychotic medication and this did result in an improvement of his symptoms within 72hrs. He became more relaxed and the thoughts of being possessed by the devil receded.
31 October 1994	The MHSU was noted to report being compliant with his medication when on home leave. He admits to no thoughts of self harm or of harm to others. He reports feeling compelled to move and blames this on his medication. He cannot lie still. The impression is of drug-induced akathisia. Overnight leave agreed and a two day supply of zuclopenthixol is provided (25mb BD).
1 November 1994	Mental Health Act Appeal: Outcome was that the MHSU was to remain on Section 2 of the Mental Health Act for further assessment and treatment.

Date	Contact
16 November 1994	The MHSU's section expired at midnight on this day. The clinical records show that he spent long periods on home leave but attended for all of his ward rounds on time. No reports of thoughts of self harm or harm to others. The MHSU was not entirely happy. He was bored, wanted a job and to be doing more. The plan is for discharge. Medications: ▪ Zuclopenthixol 25mb BD ▪ Procyclidine 5mg BD ▪ Lofepramine 70mg Arrangements are also made for the MHSU to see someone about employment. Follow up in outpatients is planned for one week's time. **Note:** The discharge summary does not state any diagnosis.
16 November 1994 -March 1995	Three unremarkable outpatient follow up appointments.
2 May 1995	Consultant Psychiatrist 2 wrote to the MHSU's GP. His letter notes that although the MHSU has been free of 'unpleasant thoughts for a considerable length of time', he continues to complain of feeling low in himself and wanting to do anything. His medications were changed as the MHSU reported that the lofepramine has not helped. His new medication was ▪ Sertraline 50mg. He remained on zuclopenthixol and procyclidine.
9 June 1995	Did not attend for outpatient follow up. However the MHSU's father did ring Consultant 2.

Date	Contact
16 June 1995	Consultant Psychiatrist 2 undertook a domiciliary assessment at the request of the MHSU's GP. Correspondence following this assessment notes: ▪ That for 6 weeks the MHSU had not bathed. ▪ He had been spending most of the day in bed. ▪ He had been eating intermittently. ▪ He had been closing all the windows in the house and has been concerned about air coming into the house, and refusing to go out of the house. ▪ He swore at his parents when they asked him to have a bath. ▪ He showed none of the original signs of psychosis for which he was originally referred in 1994. ▪ The MHSU denied abnormal thoughts on interview. ▪ He refused to have a bath even when requested to do so by Consultant Psychiatrist 2. ▪ Consultant Psychiatrist 2 did not consider the MHSU to be suffering from negative symptoms of schizophrenia but that he might have positive symptoms that he is trying to cover up. The MHSU's zuclopenthixol was increased to 25mg in the morning and 50mgs in the evening. His procyclidine was increased to 5mg tds. He was also on 100mg once a day of sertraline. The letter notes: 'I will see him again in the near future'.
30 August 1995	The mental After Care Association (MACA) is a charitable group providing a range of services to individuals with mental health problems. It also provides support to carers. The MHSU's mother had contacted the service regarding her son, who is noted to be being treated for 'psychotic depression'. The MACA requests a short assessment from Consultant Psychiatrist 2 setting out whether he feels the MHSU would benefit from the MACA service. Consultant Psychiatrist 2 does provide his support for this.
17 October 1995	CPN input was requested by Consultant Psychiatrist 2. The MHSU was asleep when she (the CPN0 attended at the MHSU's home and his mother out. It is noted that the mother specifically wanted the appointment when she was home. It is also noted that the CPN was able to establish that the MHSU has no insight into his illness.

Date	Contact
17 April 1996	There is a good quality letter from CPN 2 to the MHSU's Consultant Psychiatrist (Consultant 2). This CPN was taking over the care coordination responsibility from CPN1. His correspondence notes: ▪ That the MHSU was spending all day in bed. ▪ His personal hygiene was very poor. ▪ He was binging on food and drink and being violently sick. ▪ He was aware that he was not well but didn't know what was wrong. ▪ The MHSU reported existing on a day to day basis. The letter also notes that: ▪ The MHSU showered when he knows the CPN is visiting ▪ With persuasion from the CPN the MHSU's mother agreed to provide less care for the MHSU, for example he had to make his own breakfast. ▪ By 14 April the MHSU was more spontaneous and started a conversation without prompting. The CPN also raised a concern about how much insight the family have into the MHSU's illness. His mother is noted to refer to the 'depressive' illness and the 'odd behaviours'. The CPN suggested an increase in the MHSU's medication. His side effects to date were very minor. The plan was for the CPN to monitor the MHSU and to try and initiate some rehabilitation activities as well as providing support to the MHSU's parents.
11 June 1996	**CPA meeting at Jewish Welfare Board** This record notes that a care need is specific support for the MHSU's mother and a named individual is noted to be delivering this.

Date	Contact
February 1998	Change in care coordinator following re-sectorisation (CPN3). Between this time and March 1999 the CPN observed no florid positive signs of schizophrenia. However she notes that his life was severely affected by the negative symptoms of lack of volition and anxiety leading to the avoidance of many situations. At this time his treatment had not been reviewed by a psychiatrist or GP for two years. The new Care Coordinator therefore requested a full medical review.
18 March 1999	The MHSU's GP referred the MHSU for routine follow up. The referral was made at the suggestion of the care coordinator as the change in sector boundaries meant that his consultant psychiatrist would change and there had been no formal handover of the MHSU's case from Consultant Psychiatrist 2 to Consultant Psychiatrist 3. The referral was to effect this handover. This letter notes that schizophrenia was diagnosed in 1996, and that his medications were: ▪ Zuclopenthixol 500mg every other week, procyclidine 5mg tds, lansoprazole and cisapride.
11 August 1999	The MHSU was assessed by Consultant Psychiatrist 3. The letter to the GP notes that he is socially isolated and lonely and that he has poverty of thought plus involuntary movement most likely associated with his depot injections. A decision was therefore made at this time to reduce the frequency of his injections to three weekly, and when the consultant was happy that the MHSU can cope with this to further reduce the frequency to four weekly injections.
6 October 1999	The MHSU reported that he could cope with his injections on a three weekly basis. He had no more shakes. His zuclopenthixol was to be administered once a month from this date. His other medications continued.

Date	Contact
October 1999	The MHSU continued to be followed up in outpatients. Motivation was his biggest challenge. He continued to live at home, watching TV mostly. There were no thoughts of self harm or harm to others. He did however remain aggressive (verbally) towards his parents. On the 22 October his medications were: ▪ Injection zuclopenthixol 500mg IM every four weeks ▪ Procyclidine 5mb bd ▪ Lansoprazole 30mg daily, cisapride 20mg bd
8 March 2000	**CPA Review** This notes that the MHSU, his parents, Consultant Psychiatrist 3, a SHO, a ASW, and the Care Coordinator were present. It is also noted that it had been six years since positive symptoms of schizophrenia. It is also noted that the MHSU continued to be 'very poorly motivated to do anything despite encouragement". The CPA plan does cite the parents as individuals to be involved in encouraging their son to do more along with the Welfare officer/Outreach support worker from the JHA. Ongoing support for the MHSU's parents is also noted as a feature of the CPA plan. The MHSU's depot injections are reduced to 300mg every five weeks. Note: The MHSU missed his outpatient appointment (OPA) on 16 March.
10 May 2000	OPA follow up. Nil of note.
June 2000	A letter from Consultant Psychiatrist 3 to Leeds City Council confirms that the MHSU has a diagnosis of depression and schizophrenia, and that the severity of each fluctuates from time to time.

Date	Contact
October 2000	A letter from Consultant 3 to the MHSU's GP notes no significant change in his condition. His medications were: ▪ Injection Zuclopenthixol 300mg every five weeks ▪ Quetiapine 200mg bd. Correspondence from the care coordinator confirmed that there had been no change in the MHSU's mental state following the reduction in his depot medication. The CPN, in her correspondence, asked Consultant 3, if he would consider stopping the depot altogether as there had been no ill effects from the reduction.
19 March 2001	The MHSI attended for outpatient follow up with his welfare/outreach officer. He is noted to be well kempt. His speech was spontaneous. There was no evidence of formal thought disorder. The SHO on discussion with the MHSU's care coordinator, notes that there may be issues of negative symptoms of psychotic illness, or other reasons for his poor motivation. There were however no noted psychotic symptoms of evidence of suicidal ideation. Medication at this time is quetiapine 200mg, being reduced with the aim of stopping it completely. The plan regarding the MHSU's medication management is to be discussed at the multi-disciplinary team meeting. Follow up was planned for six weeks' time.

Date	Contact
2 May 2001	**CPA REVIEW** The record is not clear regarding who attended this meeting as attenders and apologies are noted in the same physical space. It is noted at this CPA that care coordination responsibility is passed from the CPN to Consultant Psychiatrist 3. However there is nothing to suggest that Consultant Psychiatrist 3 was present at the meeting. The Crisis plan is noted to be: Contact GP, Contact Jewish Welfare Board, or Consultant 3. **Note:** The CPN wrote to Consultant 3 about the CPA meeting, and set out clearly what emerged from the meeting and enclosed the CPA documentation. This was read by the consultant on 25 May and a note written on it 'please file'.
21 May 2001	The MHSU was discussed at the Compass Rehabilitation Service Team meeting regarding his assessment and referral from the sector 1 CPN. The outcome of this, following assessment on the 21 June, was that the MHSU was not accepted onto the Compass Team caseload. The primary reason for this was the MHSU's unwillingness to work with the team.
20 December 2001	The MHSU was assessed in outpatients by an SHO. It is noted that he previously had a diagnosis of schizophrenia and depression. At this time it is noted that the MHSU described 'absolutely no problems'. He reported his mood as fine. It is noted in the clinical record that he no longer had a CPN. His home and social situation remained stable. The MHSU reported that his motivation was increased and that he was filling his day much more productively. No thoughts of suicide. No signs of psychosis. The plan was to see him again in six months and no changes were made to his medication.

Date	Contact
20 June 2002	The MHSU was seen in outpatients with his Welfare Officer. He is noted to be finding life worth living. His appetite and sleep were good. Medication is quetiapine 200mg in the morning. The plan is to see him in six months
December 2002	There is no out patient record for this month.
3 June 2003	The MHSU was seen in outpatients with his support worker from the JHA. He is noted to be socially active. He had lost weight (5 stone). He was fit and had run a marathon. He was hearing no voices. He was not depressed. He is noted to be very well. No further follow up in outpatients is necessary as no psychiatric interventions are required. He was therefore discharged back to primary care services.
June 2003 – April 2005	There are no assessments of the MHSU by the specialist mental health services.
28 February 2005	A routine letter of referral was received by Sector 1 from the MHSU's GP. The referral letter was computer generated and is marked as a routine referral. It asked for a 'psychiatric appointment' at the Sector 1 Adult Psychiatry Clinic. The letter is addressed to 'Dear Doctor'. It notes: ▪ That the MHSU is 32 years and has a history of schizophrenia. ▪ That he has been well on quetiapine for the last five years. ▪ He has regular GP follow up. ▪ He has regular support from the JHA. ▪ He has experienced paranoid ideas in recent months – he believes people are talking about him and that his father is always watching him. ▪ He has sometimes acted on the feelings of anger towards his father. ▪ He has no auditory or visual hallucinations. ▪ He is aware that his paranoid symptoms may be related to his illness.

Date	Contact
21 March 2005	An ‘opt in’ letter was sent to the MHSU from the medical records department.
21 March 2005	A second letter of referral was received from the MHSU’s GP. On this occasion it was marked as urgent. The referral notes that he was increasingly low in mood and that life was not worth living. His alcohol intake had also significantly increased and he had taken an overdose of his quetiapine several months previously.
7 April 2005	The MHSU had an outpatient appointment. However he was late for this having attended at the wrong venue initially. He is not prepared to wait to be seen and requests an alternative appointment.
28 April 2005	The MHSU was seen in outpatients. He is noted to be depressed. He is not drinking any alcohol at the weekend. The record notes he is having a lot of arguments with his father. He was commenced on venlafaxine 37.5 mg daily and advised to continue with his quetiapine 200mg daily. The letter from Consultant Psychiatrist 3 to the GP notes that the MHSU advised that he does get paranoid easily, but that there were no psychotic symptoms. The letter also states that the MHSU no longer hears voices. Follow up was arranged for four weeks.
26 May 2005	The MHSU was seen again in outpatients. The written record of this visit is paltry. It does however note that the MHSU was not suicidal or depressed. The letter to the GP is slightly more detailed. It states that the MHSU is not ‘depressed or paranoid anymore’. His medications were: venlafaxine 37.5mgs in the morning and quetiapine 200mg at night. The letter notes that the MHSU has been advised that he could also take his venlafaxine at night in two weeks’ time if he continue to feel drowsy in the mornings. Follow up was planned for two months’ time (8 weeks). The letter to the MHSU GP notes the appointment time as 3.45 on 8 September 2005 (four months later).
12 July 2005	The MHSU was assessed following his arrest for the murder of his father at Chapeltown police station. He was assessed on three occasions for fitness for formal interview. Following discussion with the on call clinical services manager and the clinical team manager, admission to the hospital wing of HMP Leeds was advised due to risk of self harm and for further assessment of psychosis.

APPENDIX 3 - SOURCES OF INFORMATION USED TO INFORM THE INVESTIGATION'S FINDINGS

The sources of information used to inform the investigations findings were:

- The MHSU's clinical records.
- The original investigation report commissioned by LMHTT completed in 2006.
- Telephone conference with the Trust's independent lead investigator.
- Meeting with and telephone conference LPFT's current lead for client-focused clinical risk assessment.
- A survey of a randomised sample of record keeping across three in-patient wards, three CMHTs and the CRHT.
- Liaison with five mental health professionals unrelated to the then LMHTT or the current LPFT to explore the parameters of practice in relation to the management of GP referrals.
- A semi-structured survey instrument sent to
  - in-patient clinical team managers (CTMs) on wards 1,3, 4 and 5 of the adult inpatient services;
  - the CTM and clinical services manager for the CRHT;
  - the CTMs for CMHTs in central, north-east, east, south, and north-west Leeds; and
  - the clinical services manager for the acute in-patient wards.
- A 'round-the-table' meeting with 12 members of staff working in adult inpatient services bands 5-7.
- Verbal and written information and evidence of change provided by LPFT staff.
- A meeting with the MHSU's mother, aunt and uncle.
- LMHTT policy documents:
  - CMHT operational policy document 2004 – 2005.
  - Admission process for in-patient services (last updated October 2008).
  - Clinical risk management policy and guidance for staff (2007).
- LMHTT CPA policy 2003.
- CMHT operational policy (2004 / 05).
- Operational policy community sector (2005 / 06).

Note: Because the principal issues were identified in LMHTT's original investigation report the Investigation Team did not consider it appropriate to re-interview staff involved in the MHSU's care. The investigation did however take information from the team leader for Sector 1 in February 2005 so that a clear understanding of the referral systems and processes then and now could be achieved. It was this system that was of most interest to the Investigation Team in this case.

APPENDIX 4: GLOSSARY AND FURTHER INFORMATION

CARE PROGRAMME APPROACH (1995 – 30 September 2008)

The Care Programme Approach has four main elements as defined in 'Building Bridges: A guide to arrangements for inter–agency working for the care and protection of severely mentally ill people'. DH (1995) London HMSO.

These are:

- Assessment: Systematic arrangements for assessing the health and social needs of people accepted by the specialist mental health services;
- A care plan: The formation of a care plan which addresses the identified health and social care needs;
- A key worker: The appointment of a key worker (now care co–ordinator) to keep in close touch with the patient and monitor care; and
- Regular review: Regular review, and if need be, agreed changes to the care plan.

The cornerstones of the CPA

These four principles, of assessment, care plan, care co–ordination and review are the cornerstones of the Care Programme Approach. Implicit in all of them is involvement of the person using the service, and where appropriate, their carer.

Modernising the CPA

In 1999, the Government undertook a review of the CPA which was considered timely for a number of reasons including:

- the introduction of the National Service Framework for Mental Health, published in September 1999;
- the lessons learnt through research, reviews and inspections; and
- the need to listen to professionals' views about the CPA. The review resulted in the publication of 'Effective Care Coordination in Mental Health Services, Modernising the CPA', published in October 1999.

Key changes

This confirmed the Government's commitment to the CPA for working age adults in contact with secondary mental health services and introduced changes to the CPA. The key changes are:

- Integration of the CPA and care management — the CPA is care management for people of working age in contact with specialist mental health services.
- Appointment of a lead officer — Each health and social services provider is required to jointly identify a lead officer to work across both agencies.

- Levels of the CPA — two levels of the CPA must be introduced — Standard and Enhanced.
- Abolition of the supervision register — from April 2001, supervision registers can be abolished providing the Strategic Health Authority is satisfied that robust CPA arrangements are in place.
- Change of name — key worker to be referred to as care co–ordinator.
- Reviews of care plans — the requirement to review care plans six-monthly is removed. Review and evaluation should be ongoing. At each review the date of the next meeting must be set.
- Audit — regular audit is required looking at qualitative implementation of the CPA.
- Risk assessment/risk management — risk assessment is an ongoing part of the CPA. Care plans for people on enhanced CPA are required to have a crisis plan and contingency plan.

Standard CPA
Standard CPA is for people who require the support of only one agency. People on standard level will pose no danger to themselves or to others and will not be at high risk if they lose contact with services. The input of the full multidisciplinary community health team will not be required – service users on standard CPA will generally require the support of one or two members of the team.

Enhanced CPA
Enhanced CPA is for people with complex mental health needs who need the input of both health and social services. People on enhanced CPA generally need a range of community care services. This group of people may include those who have more than one clinical condition and also those who are hard to link with services and/or with whom it is difficult to maintain contact. Some people on enhanced CPA are thought to pose a risk if they lose contact with the services. Generally speaking, enhanced CPA tends to apply to people with more severe mental health problems such as schizophrenia or manic depression. In some cases, enhanced CPA can gain you better access to services.

From 1st October 2008, the term CPA will describe the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex needs.

From October 2008 the term CPA will no longer apply to individuals in contact with a single professional.

SCHIZOPHRENIFORM DISORDER

Ref:
http://www.psychnetuk.com/dsm_iv/schizophreniform_disorder.htm

Schizophreniform Disorder is characterised by the presence of the symptoms of schizophrenia, including delusions, hallucinations, disorganised speech, disorganised or catatonic behaviour, and negative symptoms. The disorder, including its prodromal, active, and residual phases, lasts longer than 1 month but less than 6 months. For a material part of at least one month (or less, if effectively treated) the patient has had 2 or more of:

- Delusions (only one symptom is required if a delusion is bizarre, such as being abducted in a space ship from the sun).
- Hallucinations (only one symptom is required if hallucinations are of at least two voices talking to one another or of a voice that keeps up a running commentary on the patient's thoughts or actions).
- Speech that shows incoherence, derailment or other disorganisation.
- Severely disorganised or catatonic behaviour.
- Any negative symptom such as flat affect, muteness, lack of volition.

This disorder is not the direct physiological result of a general medical condition or the use of substances, including prescription medications. A statement of prognosis should be added to the diagnosis.

With good prognostic features (2 or more of the following):

- Actual psychotic features begin within 4 weeks of the first noticeable change in the patient's functioning or behaviour.
- The patient is confused or perplexed when most psychotic.
- Premorbid social and job functioning are good.
- Affect is neither blunt nor flattened.

Associated features:

- Learning problem
- Hypoactivity
- Psychosis
- Euphoric mood
- Depressed mood
- Somatic or sexual dysfunction
- Hyperactivity

- Guilt or obsession
- Sexually deviant behaviour
- Odd/eccentric or suspicious personality
- Anxious or fearful or dependent personality
- Dramatic or erratic or antisocial personality.

Differential Diagnosis:
Some disorders have similar or even the same symptoms. The clinician, therefore, in his diagnostic attempt has to differentiate against the following disorders which he needs to rule out to establish a precise diagnosis;

- Schizophrenia
- Brief psychotic disorder
- Schizoaffective disorder
- Mood disorders.

Cause:
Schizophreniform disorder appears to be related to abnormalities in the structure and chemistry of the brain, and appears to have strong genetic links, but its course and severity can be altered by social factors such as stress or a lack of support within the family. The cause of schizoaffective disorder is less clear cut, but biological factors are also suspected

Treatment:
Medication is the most important part of treatment as it can reduce and sometimes eliminate the psychotic symptoms. Case management is often needed to assist with daily living skills, financial matters, and housing, and therapy can help the individual learn better coping skills and improve social and occupational skills.