2008

Report of the Independent Investigation into the Care and Treatment of M

SUI 2003/1578

This is a report of an independent investigation into the Care and Treatment of M carried out by Caring Solutions (UK) ltd

Presented to the Board of Yorkshire and the Humber Strategic Health Authority – April 2009

Caring Solutions (UK) ltd

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Executive Summary

On Sunday 14 September 2003 an 82 year old woman was killed by her son (M) who was at that time 43 years of age. They lived together in a small bungalow and had done so for several years

M had a twenty year history of mental illness for which he had been in receipt of regular anti-psychotic medication mainly delivered by depot injection, which he received from his local GP practice. Despite his illness he was able to hold down a regular job at a local factory and was thought of by many as a quiet and friendly man.

M had been referred in October 2001 for a consultant psychiatrist opinion by his GP querying drug induced parkinsonism, due to a hand tremor he was complaining about. Following a series of outpatient appointments he had been placed on a reducing level of depot medication with the intention of ceasing it altogether if his symptoms remained manageable for him.

In the days leading up to his mother's killing he had become very upset about an incident at work. The incident had caused him considerable distress and rapidly led to a loss of confidence in himself and everyone around him. He began to behave strangely and relatives who witnessed this believe this incident triggered the behaviour which was to lead to him killing his mother.

In the hours leading up to the incident the family made two calls to the out of hours GP service; these calls played an important part in the unfolding events.

In February, 2004 he was convicted of manslaughter on the grounds of diminished responsibility and made subject of a hospital order with restrictions

In May 2005 he was transferred from a regional secure unit to a more local purpose built secure centre for forensic psychiatry, where he remains to date.

Causes and Findings

The independent investigation team stresses that the Mental Health Trust now operating and providing services is totally different from that in 2003. Their comments relate to circumstances at that time and that time only.

The independent investigation team found that:

M's illness of paranoid schizophrenia was characterised by paranoid delusional beliefs, auditory and visual hallucinations and disturbances in his thinking processes. These symptoms were often accompanied by deterioration in his

mood and increasing anxiety. As a direct result of his experiences he feels at risk from others and had previously reacted violently as a result.

The root cause of this homicide was:

The rapid reduction of medication and the way this was managed in the absence of a risk assessment determined through the Care Programme Approach.

The contributory factors were:

- The lack of management of the case using the principles of the Care Programme Approach by the team reviewing him at the outpatient clinic.

- M was not seen by a consultant psychiatrist when re-referred in 2001 and thereafter prior to the homicide.

- The Care Coordinator role should have been taken by a consultant psychiatrist considering the position of the junior medical staff.

- There was a static formulation of this patient's illness with insufficient challenge when seen as an outpatient.

- There was elicited opinion that the reduction in medication was inappropriate.

- There was no recorded risk assessment documented and therefore no relapse action plan.

- More effort should have been made to explore additional methods of engagement with his mother even though he was reluctant to involve her.

- M and his family were respectful recipients of services from the medical profession and more attention should have been paid to the effective use of authority and persuasion with M.

- There was no information given to M's mother on what action to take if she needed help.

- The use of a Community Psychiatric Nurse to monitor the change in medication was not explored and after such a long period of receiving a depot injection the possibility of a short hospital admission to manage any change in medication was not considered.

- His missed appointment was not followed up, but he was offered an appointment six months later.

- Notes were not routinely available at outpatient clinics to review history.

- The out of hours service was not rigorous enough in their response to the family's request for help. There was no 'signposting' to services which did exist. The out of hours service failed this family on the week-end in question.

- M's mother did not receive a 'Carer's Assessment'

1. Introduction

1.1 The independent investigation team sincerely hopes that the contents, observations, findings and broad recommendations made in this report offers some resolution and closure to the relatives of their elderly mother who was the victim in this tragic set of circumstances.

1.2 On Sunday 14 September 2003 an 82 year old woman was killed by her son who was at that time 43 years of age. They lived together in a small council owned warden controlled bungalow and had done so for several years. His father had died when M was aged 28.

1.3 M had a twenty year history of mental illness for which he had been in receipt of regular anti-psychotic medication mainly delivered by depot injection, which he received from his local GP practice. Despite his illness he was able to hold down a regular job at a local factory and was thought of by many as a quiet and friendly man. Relatives suggest he was a kind and loving son and a cherished member of a close family.

1.4 The events were that in the days leading up to his mother's killing he had become very upset about an incident at work where he had been shot at by a fellow employee using a pellet type gun causing a minor injury to his shoulder. He made a formal complaint to his employers and was more concerned that nothing would be done because the person responsible was a member of the family who owned the business.

1.5 The incident had caused him considerable distress and rapidly led to a loss of confidence in himself and everyone around him. He began to behave strangely and relatives who witnessed this believe this incident triggered the behaviour which was to lead to him killing his mother.

1.6 During the evening of the 13th September, 2003 family members gathered at his and his mother's home to re-assure M that everything would be all right and that he had their support. He remained unconvinced. He and his mother were last seen together at 01:00 hours on Sunday 14 September 2003 by his younger sister and her husband. They were forcibly asked to leave by her brother who by this time was very distressed.

1.7 About 08:00 hours on the 14th of September he was disturbed by the occupants of an isolated boarding kennels some ten miles from his home as he smashed a glass panel in the front door. He drove off in his car and was seen to be carrying a large knife. The police were contacted and in possession of his car registration began a search for the car. A visit to his home address was made by police officers where they discovered the dead body of his mother. She was lying on the floor of the living room and had been subjected to a frenzied attack and her throat was cut. A serrated knife, later determined as that used to kill his mother, was found in the kitchen of the bungalow.

1.8 At 10:20 hours M was arrested in his car by armed police officers. Despite appearing dazed and confused he resisted arrest. No formal interviews were undertaken in police custody as he was deemed unfit for interview as he was so disturbed, although he did confirm he had killed his mother.

1.9 The family made two calls to the out of hours GP service. One was made at 20:17 hours on the 13th September and the other at 01:14 hours on the 14th September, 2003. These two calls played an important part in the unfolding events.

1.10 Additionally he had been referred in October 2001 for a consultant psychiatrist opinion by his GP querying drug induced parkinsonism, due to a hand tremor he was complaining about. Following a series of outpatient appointments he had been placed on a reducing level of depot medication with the intention of ceasing it altogether if his symptoms remained manageable for him. He was placed on a small dose of oral medication on the 12 September 2002 and was last seen as an outpatient on 29th May 2003 and was to be seen again six months later when, if all was well, he would have been discharged back to his GP's oversight.

1.11 M was transferred to a local prison where his mental state was grossly abnormal. He did not take food or fluids and was admitted to a general hospital for three days to be re-hydrated. He was transferred to a regional secure unit on the 28th of October under Sections 48/49 of the Mental Health Act, 1983 for assessment and treatment of his mental disorder.

1.12 He appeared at Crown Court on the 20th of February, 2004 where he was convicted of manslaughter on the grounds of diminished responsibility and

made subject of a hospital order with restrictions pursuant to Sections 37/41 of the Mental Health Act, 1983. The restriction order is without limit of time.

1.13 On the 4th of May 2005 he was transferred to a more local secure centre for forensic psychiatry, where he remains to date.

2. The Internal Inquiry

2.1 At the time of the offence the Primary Care Trust (PCT) was different to that which operates today and was responsible for commissioning mental health services and the GP out of hours' service. The Community Mental Health Trust providing mental health services at that time has reformed into a Mental Health Trust referred to throughout this report as the MH Trust.

2.2 Following this incident the Community Mental Health NHS Trust (CMHT) operating then established a Stage 1 internal inquiry report which was completed by a single senior operational manager. The final report was dated the 23rd of November 2004. Findings of the internal reports are captured in italics to distinguish them from the findings of this independentl inquiry.

2.3 The brief report contained findings which confirmed views held by the family; in that, "*this (the incident at work) appears to be the stressor which provoked his deterioration and increased paranoid views that others, including his mother, were intending to harm him or have him taken away".*

2.4 It further observes: *"Following re-referral to the CMHT in 2001 by his GP he was seen at three to six monthly intervals by medical staff to continue to review his mental health and review his medication. However, he was not registered on or cared for using the Care Programme Approach."*

2.5 "*Whilst this does not appear to have led to any significant shortcomings in the care and treatment the patient received, and attention was clearly paid to the issue of clinical risk to self and others, it did result in no formal risk and relapse plan being in place."*

2.6 "*However, there is evidence of ongoing communication between the reviewing medical staff, the patient and his GP, which identified that the patient should contact either of them in the event of any problems or deterioration, and the regular medical reviews which were undertaken," and*

subsequent investigation," indicate that it is highly unlikely that the use of a formal risk assessment would have predicted that the patient was a danger to anyone".

2.7 *"In September 2003 nurses were the only professional group required to carry out a recognized risk assessment. However this has since been reviewed and formal risk assessments are required by all practitioners".*

2.8 The report concludes, "*it is arguable as to whether more rigorous arrangements over the period of change would have influenced the outcome in this unfortunate case*".

2.9 The resulting recommendations were:

- *The CMHT should ensure that all existing patients are registered and managed as described in the CPA guidelines.*
- *The CMHT should ensure clearly its policy in relation to the use of formal risk assessments and the frequency of review.*
- *The CMHT should ensure that patients being transferred from depot to oral medication are considered to be at increased risk and their support and frequency of review increased during the transition period.*

2.10 The timescale for implementation of the above recommendations was December 2004 and the quality of this report is commented on later in this report.

2.11 A document dated the 3rd of June 2008 was produced by the current Primary Care Trust. This was completed (when it was known there was to be an independent investigation) to ensure progress against the recommendations with the outcome of confirmed positive action having been taken.

2.12 Of particular note was the production of a general principles document ratified in August 2005 entitled, 'Recommendations for Antipsychotic Medication Switches' to address the third recommendation. This document reflected NICE recommendations, some of which were incorporated into the principles:

- *The choice of antipsychotic drug should be made jointly by the individual and the clinician based on informal discussion on the relative benefits and side effects which is recorded in the notes.*
- *A risk assessment should be performed by the clinician responsible for treatment and the multidisciplinary team regarding compliance with medication. Depot preparations should be prescribed wherever possible.*
- *When full discussion is not possible, for example in an acute psychotic episode, the oral atypical antipsychotics shouls be considered treatment options of choice because of lower risks of extrapyramidal side effects. The individual's carer or advocate should be consulted where possible and appropriate.*

The document identifies issues for consideration. Some of which are:

- *Advise individual that switch of medication is associated with increased risk of relapse.*
- *Additional support and monitoring should be in place for individuals during the switch. Where applicable this should be via the Care Programme Approach.*
- *Where switching is considered while in primary care additional support and monitoring should be in place.*
- *Formulate relapse prevention strategy*
- *Ensure full care plan in place to support and monitor individual during and post switch.*

The above was the only documentary evidence provided to confirm the enactment of the recommendations made in 2004.

2.13 A separate review was also undertaken by the current PCT in 2007, entitled 'Homicide Review' which in part related to the GP Out of Hours Service, although review of this part of the service was not a requirement identified in the Stage 1 report, which concluded that, "*any patient who is already under the care of a psychiatrist is to be referred to the 'Crisis Management Team' if there is any change in their mental health status as they will have access to patient notes and risk/relapse plans*". In May 2008 information was sent to all out of hours Primary Care Centres reminding all staff about the role of the Crisis Management Team and how to access them. The computerised system used has been developed and refined. The investigation team were unable to verify its current efficiency.

3. The 2007 Review by the current Mental Health Trust (MHTrust)

3.1. The final document (the report was undated, however the computer generated file indicates July 2007) entitled, 'Review of the SUI 2003/1578 (Homicide)' was eventually obtained by the independent investigation team mid-October, 2008 when the Team had already reached its conclusions. This report was referred to in the review undertaken by the current PCT in June 2008. We had asked for this report from the PCT. We eventually approached the Medical Director of the MHTrust for his help to locate and supply the report which he promptly and helpfully did.

3.2. There were very limited terms of reference for this report's review and it is unclear from the report who had commissioned it; what methodology was adopted by the reviewers to reach their conclusions; who received the report and what action if any was taken on it. We were informed that this review was an internal document and was completed when the MH Trust knew there was to be an independent external review, was not part of any formal process and was designed to see if any further interventions were needed. The investigation team accepted and concluded from the evidence provided that the current systems for investigations of serious and untoward incidents are more rigorous now than they were in 2003 and are more closely performance managed.

3.3. However, the MH Trust's review underpinned the Team's conclusions. This three page review document mainly focused on the consultant and medical group. The review was conducted by a clinical director and consultant psychiatrist, and a clinical nurse manager.

3.4. The review did however make the following observations had M been subject to the Care Programme Approach:

3.5. "*The risk relapse plan should have picked up that when he relapsed in the past he became rapidly unwell and had exhibited risky behaviour (arming himself with a knife)"*

3.6. "His mother may have been involved in the process and the family would have a point of contact in the event of relapse, (the family were aware of his deteriorating mental health prior to the homicide and had made calls to "doctors" who gave telephone advice to take extra medication. There is no indication that his family contacted medical staff from the Trust)".

3.7. "Care coordinator role would have been taken by the consultant psychiatrist, as the Specialist Registrar was not a permanent medical officer within the Trust".

3.8. The report identifies as one contributory factor that, *"he (M) had not seen a consultant and it is not clear if his case was discussed with the locality consultant either informally or in supervision."*

3.9. It finally notes in this particular section that, "*with the benefit of hindsight any of the above may have made a material difference to the outcome".*

3.10. The Team was left with a confused picture as to how the investigation of this homicide was handled. The homicide occurred in September 2003 with M being dealt with by the Crown Court in February 2004. The Stage 1 report was completed in November 2004 and the Review of Homicide in July 2007, both conducted by the MHTrust. The current PCT also undertook a review of elements pertaining to this homicide in a report dated June 2008. This trail of activity in time alone does not seem to follow a prescribed pattern normally pursued in such matters.

4. The Independent Investigation.

4.2. Introduction

4.2.1. On the 27th June 2008 the Independent Investigation Team (the Team) met with representatives of the Strategic Health Authority, the MHTrust, the Primary Care Trust and other interested parties. Terms of Reference were agreed.

4.2.2. The Team noted they would, as far as was possible, follow the 'Good Practice Guidance' produced by the National Patient Safety Agency (February, 2008) for conducting such investigations. The approach taken is described later although much of it was shaped by the Terms of Reference.

4.2.3. It was noted that prior to the commissioning of this independent investigation there had been an opinion expressed that after such a passage of time it may not be necessary for such an investigation to take place. Without doubt that passage of time did make the initial and ongoing collection

4.2.4. However, under the guidance issued in HSG(94)27, as amended in June 2005 (paragraph 33-36) and August 2007 the Team were commissioned by the Strategic Health Authority, who were obliged to do so, to investigate the care and treatment of a service user of specialist mental health services where, following due process of law, a finding of guilt for the homicide has been determined. Such investigations are required to address:

- The care and treatment the service user was receiving at the time of the incident.
- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs.
- The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.
- The adequacy of the risk assessment and care plan and their use in practice.
- The exercise of professional judgment and clinical decision making.
- The extent of services' engagement with carers and the impact of this.
- The quality of the internal investigation and action.
- Of key importance is that staff who gave evidence, and, as far as is possible, the patient and victim remain anonymous. The key outcome is to develop services based on the outcomes of various investigations.

4.3. The Terms of Reference.

4.3.1. Terms of Reference for Independent Investigation (2005/95) were set by NHS Yorkshire and the Humber Strategic Health Authority (SHA) in consultation with the local Mental Health Trust, PCT and independent investigation team.

4.3.2. The investigation was required to address:

- The care and treatment the service user was receiving at the time of the incident (including that from non-NHS providers e.g. voluntary/private sector if appropriate);

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

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

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

- The exercise of professional judgment and clinical decision making ;

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

- The effectiveness of specialist services utilised in the provision of care, i.e. alcohol services.

- The extent of services' engagement with carers and the impact of this.

- The Quality of internal investigation and Review.

- ***Also to identify***:

- Learning points for improving systems and services;

- Developments in services since the user's engagement with mental health services and action taken since the incident.
- To consider if any omissions or issues identified in the investigation of the incident remain unresolved.

- ***To make***:

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

- To report these findings and recommendations to the Board of Yorkshire and the Humber Strategic Health Authority.

4.4. Guidance to Independent Investigators

4.1.1 The guidance developed by the Strategic Health Authority lays out the procedure for such investigations. The administrative requirements were met. The investigation has no legal status and witnesses are not compelled to attend for interview or provide a statement and agencies are also not compelled to provide documents. Of particular note is the style to be adopted with the main principle of promoting fairness to all involved in this process and in this case the involvement of the service user's family and the sensitivity with which this is dealt.

4.5. The Conduct of the Independent Investigation.

4.5.1. It will be apparent from the above that the terms of reference set out in part the procedure which was to be adopted. We began by obtaining M's consent to the release of documents relating to his care and treatment and also to his subsequent conviction in Crown Court.

4.5.2. M was not interviewed by the Team. This was on the opinion of his current consultant forensic psychiatrist and responsible medical officer which precluded his involvement in the process because of the adverse effects this would have on his mental health. Furthermore it was the RMO's view that M lacked capacity in relation to consent to disclosure of information regarding his index offence and his medical history since he was not able to properly weigh that information with regard to himself.

4.5.3. Accordingly a best interests meeting took place on the 8th August, 2008 in which the clinical team explored the issues of the investigation in both the inappropriateness of his participation but also the benefit that disclosure of information would give indirectly to him and to the wider public.

4.5.4. The outcome was that it was considered appropriate for the Team to access his records and that this considered decision was in his best interests and an appropriate course of action. This was confirmed in a letter dated 11th of August, 2008 and was helpful in obtaining access to his records.

4.5.5. The local police officers who conducted the homicide investigation made themselves available and provided valuable records giving an excellent account of events, including access to the pathologist's report and photographic evidence. Pre-trial assessment records from the regional secure unit were thorough and helpful in giving an insight into his mental state post arrest and events of the index offence.

4.5.6. Other documents provided included his medical records which were made available to us in his current placement and those compiled over the years he was in contact with mental health services. His GP records, including correspondence, were of particular interest.

4.5.7. 17. Using the above documents and with the assistance of another local NHS Teaching Primary Care Trust, who provided the 'Lead Co-ordinator' administrative support and advice to the Team, we listed those whom we considered were likely to be able to give relevant observations to the Team

4.5.8. Staff requested to attend received a letter to which was attached the terms of reference, how the Team were to proceed and its membership. All staff invited agreed to attend and were most helpful and open in their responses.

4.5.9. It was apparent that the history of M's care and the decisions made about his care which were material to the investigation could be ascertained to a significant degree from the documents with which we had discovered and been provided with. We invited the senior clinicians in M's care who could expand upon the information available to us in an attempt to ensure the facts we were told were germane and proportionate to the issues we were asked to consider.

4.5.10. On 7th August, 2008, one of M's two sisters was interviewed in her home.

4.5.11. The Team heard from staff on the 2nd and 3rd of October, 2008. They were; the consultant psychiatrist who had involvement with M as an outpatient up until 2000 and oversight of his junior colleagues thereafter; the GP; the current PCT's Head of Clinical Governance and Risk who was accompanied by a GP who had experience of the Out of Hours Service and M's current Responsible Medical Officer (RMO). On the 24th of October the consultant psychiatrist member of the Team discussed the case with a specialist registrar who dealt with M and his reduction of medication.

4.5.12. Following the above visits, reading the documentation and interviewing staff a draft report was prepared. That draft was provided on a strictly confidential basis to the commissioners of the independent external investigation and other key agencies, and they were invited to make such responses as they considered appropriate. Some amendments were made to the report as a result of the helpful responses which we received and for which we were grateful.

4.5.13. This report concludes with our recommendations. They have been through the same process described above.

5. M's Mother

5.1 M's mother was born in 1921; she was described as the backbone of this devout Christian family, was a good hearted woman and held the family together. She looked after her son and they were very close. His mother spoiled M and did a lot for him. M contributed to household expenses and he endeavoured to see that his mother never went without.

6. The Patient, M.

6.1 The following has been retrieved from the records the team had access to and the interviews with his sister and current consultant forensic psychiatrist.

6.2 M was born in 1959 close to where he was to live his life until the death of his mother. He was born at home, as were his sisters, and there were no reported pre-or post-natal complications. He describes a childhood in which he felt loved.

6.3 He attended school between the ages of five and sixteen. He enjoyed school and had no truancy or difficulties with teachers or other authority figures. He left school with low grade examinations in geography and art..

6.4 On leaving school he worked on a farm for two years with day release to an agricultural college and had to leave at aged eighteen as his employer could not afford to pay him an adult wage. He then worked at a farm produce company as a fork lift truck driver. At this time when he was aged 24 he experienced his first episode of mental illness and was suspended from work for hitting a work colleague. He was seen at home by a local consultant

psychiatrist who noted that M, “denies his symptoms and there may be much more going on under the surface than is immediately admitted to.”

6.5 His employer was understanding of his illness and he continued to work there until the age of about 30.

6.6 For the next two to three years he did casual work consisting of short-lived manual jobs. He finally gained employment in a company packing health products and worked there for some eight years until events leading up to his index offence. It would appear that he had been a reliable employee throughout his working life and had always tried to regain employment after job loses.

6.7 As noted above he first came into contact with psychiatric services in 1983. He had a history of becoming increasingly suspicious at work and was experiencing paranoid ideas and abnormal perceptual experiences including voices making derogatory remarks about him. He then commenced antipsychotic medication and was followed up as an outpatient for the next five years.

6.8 In 1988 he required admission to hospital where he remained informal for one month. His presentation was described as hesitant, retarded, vague and he was reluctant to eat food provided. He was found to be in a severe state of self neglect, and had become increasingly socially withdrawn and paranoid. He believed he was being poisoned and became non compliant with medication.

6.9 There are reports in his notes that document that he hid in a cupboard in his bedroom at home believing he was in danger (this was confirmed by his sister who witnessed this and the calling of the local pastor of the Pentecostal church in an attempt to get him to come out). He was also on a window ledge trying to break a window and would often look out of the window looking for people coming to get him. He would stay in the wardrobe because voices were telling him to jump out of the window, and he was frightened. It had also been reported that prior to this admission he had tried to get a knife and drive off in his car although M denies this and states the possession of a knife was required for his work. His presentation at this time would appear to be congruent with fearfulness secondary to paranoid ideas. He was treated with depot medication and on recovery he was followed up as an outpatient until 1991

6.10 In 1991 his supervision was transferred to a community psychiatric nurse (CPN) who remained involved in his care until 1993. He was then discharged to his GP who continued to administer his depot medication. Throughout M demonstrated good levels of compliance with follow up and treatment.

6.11 In 2001 his GP requested further psychiatric assessment when M presented with troublesome side effects due to his depot medication. When assessed on 20 November 2001 there was little evidence of paranoid ideas at the time and a planned and very slow reduction in his medication was recommended. He was seen by a specialist registrar of the consultant psychiatrist at this appointment.

6.12 At review on the 8th February 2002 he described an improvement in side effects, with his hyper salivation abating. He was living at home with his mother very contentedly. He was seen this time by a SHO to the consultant psychiatrist who was reluctant to suggest further reduction in the frequency or dose of his depot injection.

6.13 He was reviewed again on the 9th of May 2002, again this time by the specialist registrar, when a further reduction in medication was advised with the intention of stopping it altogether and substituting it with oral medication.

6.14 He was next seen on the 15th of August 2002 and on 12th of September for the last times by the specialist registrar when M reported some re-emergence of paranoid thoughts. The GP's letter of the 28th of August stated, "he has been somewhat down with perhaps some worsening of his paranoid ideation. This, if anything, has become worse. He is somewhat depressed and finding it difficult to motivate himself to do anything. I was really wanting your thoughts on whether it would be preferable to start him on an anti-depressant or a newer anti-psychotic at this stage?"

6.15 Nevertheless, his depot was reduced again with a note back to the GP stating, "I would be grateful if he could have one final injection of the Modecate and then we will decease with this". He was started on a small dose of Risperidone at a dose of 1mg at night for two weeks and then 1mg twice a day thereafter.

6.16 On the 18th of October 2002 he was seen for all other appointments by another specialist registrar of the consultant psychiatrist when he presented as reasonably well although described episodes of poor sleep, lack of motivation, vague paranoid ideas and excessive tearfulness. He was advised to increase the oral medication and start on an antidepressant, although he declined this management. The appointment ended where M agreed to continue taking the small dose of medication and any changes would be discussed at his next appointment. He was feeling better at his next review when he was seen on the 28th of November and questioned the need for continuing any antipsychotic medication.

6.17 He was seen again in January 2003 when he was assessed as well and again on the 29th of May 2003 when he reported vague paranoid thoughts once more. The final letter to the GP notes, "I have reviewed his notes and he does have a definite diagnosis of schizophrenia and hence should really continue his medication for an indefinite period".

6.18 He failed to attend an appointment in July and so another appointment was made for December 2003.

7. The Homicide

As the Team were unable to interview M the following has been gleaned from police transcripts and witness statements, custody and clinical records and court reports.

7.1 M described himself as feeling reasonably well up until the Thursday prior to the killing of his mother, which occurred on the Sunday. His sister also stated she was not aware of any additional problems. He had however stopped going to his social club some months previously resulting in social withdrawal.

7.2. On the Thursday when at work he was shot with a type of air pellet gun by the son of the owner of the factory. Initially he made a verbal retort, and when the son later apologised, said that the pellet could have damaged his eyes. At this point the son stated that this had in fact been his intention. From this point M appears to have experienced a rapid and significant deterioration in his mental state. He ruminated over whether and how he should complain over the following days. He believed he would lose his job. He became increasingly agitated about this and reported the belief that

others wished to harm him started soon after. He recalled he did not sleep and also became worried his family wished to harm him. He does not believe he took his oral medication with any consistency at this time. He repeatedly tried to leave his home but was dissuaded by his family.

7.3. Throughout his illness he has described seeing people's faces changing colour to become either markedly red or alternatively white. These experiences had specific significance to him in that people with red faces have demonic powers and intend to cause him harm. He would on occasion say to his mother, "what have you gone red for?" or "why have you gone white?"

7.4. After another night of not sleeping he remembers feeling frightened and believing that his mother was telephoning someone to take him away or harm him. It was at this stage he killed his mother.

7.5. Following this he remembers fleeing the house in panic and had to get away and remembers trying to find "sanctuary" by breaking a window in a house. He believed at that time that crows were evil and attempting to kill him. When arrested by the police he remembers not wanting to leave his car as he felt safer there. He remembers little of his brief time in prison and the various professional who visited and assessed him.

7.6. At the regional secure unit he was treated with 5mgs of Risperidone twice a day and Procyclidine to treat side effects, mainly stiffness. His discharge summary noted that he had consistently shown improvement in his mental state over his 18 month stay and had shown no overt psychotic symptoms. He had undertaken a significant course of bereavement therapy and had visited his mother's grave. He was transferred nearer to his family on the 4th of May, 2005.

7.7. When at the regional secure unit M wrote about his experiences when unwell. This confirmed the observations made by the consultant psychiatrist who first saw him at home in that there was indeed, "more going on under the surface than is immediately admitted to." From this letter it was apparent that he was constantly troubled by his paranoid thoughts especially of people making what he believed were derogatory remarks about him. He also wrote to the Crown Court Judge a poignant letter about his mother expressing his remorse.

8. Calls to the Out of Hours Service

8.1 The family made two phone calls to the GP 'Out of Hours Service' prior to the index offence. The witness statements made by the family to the police investigation have been referred to concerning these calls and the actions taken by the family were reconfirmed by M's sister when she was interviewed by members of the Team.

8.2. When reading the clinical notes at the regional secure unit two single pages were discovered which are a brief computerised record of the calls and the responses and advice given. We were not given, nor were we able to locate, further in depth information relating to these calls recorded by the out of hours' service. On a Saturday at 11:00 hrs the local doctors transfer to the out of hours' service.

8.3. The first call was made by M's sister at 20:17 on the Saturday evening of 13th September, 2003. Statements record that his mother believed that they should, "get the doctor". M did not want this to happen, but when he went outside his sister telephoned the out of hours's service. At 20:20 a GP telephoned the house and M answered the phone and said that he was alright. His sister asked him if she could speak with the doctor which she did. Between them they established he had medication for a mental disorder. The doctor advised a doubling of the dose to 4mgs twice a day and then asked if she had anything else in the house. The sister said she had some KALMS (a herbal recipe over the counter medication). She was advised to give him two of those and to call back if he gets worse, "but she didn't come out – we wanted her to come out". This statement was determined on interview with M's sister and reconfirmed the police witness statements.

8.4. The record on the database recorded under: Condition – poss. nervous breakdown, injury at work preying on mind – call back if not improving.' His sister witnessed him taking the tablets (KALMS and prescribed medication).

8.5. Indeed the situation did not improve and M's sister on arrival at her home called the service again at 01:14 on Sunday 14 September 2003.

8.6. When M had returned home from an abortive trip to ask his niece in a neighbouring town if he could stay with her because she was always happy

and he wanted some of that to rub off on him. He was told he could not stay and when he returned home he had turned particularly nasty and his sister feared for her safety. She clearly told the call centre routing the call her home telephone number and specifically requested the return call should come to her and not her mother and M's home. She was informed she would receive a ring back. "They never did". This statement from police witness statements was reconfirmed at interview with M's sister.

8.7. In the 'Condition' record it notes, "please call sister back – patient no better and told to call back earlier if symptoms hadn't improved".

8.8. No return call was received because the doctor returning the call, who was different to the doctor spoken to during the first call, telephoned M's home at 01:20 hours. The phone was answered by M who, "demanded to know why I was ringing him; I told him I'd had a message he was feeling unwell; he denied this and insisted he did not need a doctor". It then goes on to note, "NB - apparently sister not actually with him – called OOH from different address. Follow up message (fax to surgery)."

8.9. At 02:20 am his sister received a telephone call from her other sister to, "ask if the doctor had been out". She said, "there had been no contact from the doctor."

8.10. His sister was clear that she said, "please come and see him" to the first doctor and remains unhappy how the second call was handled.

9. Community Psychiatric Nurse Input.

9.1 The CPN saw M from February 1991 until his discharge from his case load from 14 October 1993. There was a stated rationale for nursing intervention which was that, "a home visit is necessary in order to obtain views of other members of the household on M's progress. Being a very reserved gentleman it is necessary to observe him in his natural surroundings."

9.2. In 1993, during a period of unemployment, he acted as a voluntary driver, a task he coped with exceptionally well being punctual and very competent. His management of stress was tested to the full at a residential home where he did some work in a voluntary capacity when he constantly had to ask for reimbursement of expenses which resulted in an altercation between him and

the officer-in-charge. Through brokered discussion and compromise a solution was found.

9.3. The CPN wrote to M's GP on the 25th of October 1993 to inform him he was to discharge M from his caseload as he was now more positive in his outlook and showed no evidence of florid thought disorder.

9.4. On viewing the records fully there is no record of any engagement with his mother or other family members despite the initial stated intention to obtain views of other members of the household.

10. Interviews with staff.

10.1 The Consultant Psychiatrist

10.1.1 He pointed out to the Team that he had not interviewed M or seen him in a clinical setting between 2000 and 2003. However, he was able to give a good account of M's history and the work of his junior medical staff from 2001 when the change of medication was being managed.

10.1.2 Following the homicide on the following day of the 15th of September 2003 his secretary called the GP's surgery twice. The first time was to enquire if M had collected his medication (which he had done on the 9th) and the second time to query if the patient's sister lived in the same village.

10.1.3 He indicated that in 2003 there was available an on call psychiatrist with three junior doctors on rotation between the local psychiatric hospital and A&E. There was access to the crisis resolution team which was commissioned from a bordering city. These services were accessible to the out of hours' service. There are he told us concerns pertinent to the threshold for visiting by this service as there are geographical constraints.

10.1.4 The independent investigation team specifically asked about use of the Care Programme Approach (CPA) in practice in 2003. We were told that in outpatient clinics it was not used. This was clearly noticeable in the correspondence to the GP in M's case. As a group of consultants operating at the time it appears it was decided that it was not deliverable in that setting. There were however elements of CPA which could have been incorporated into practice. M's sister confirmed to us that the family had no idea who to

contact in an emergency, especially in metal health services, except the GP surgery. The family had certainly not heard of a risk and relapse plan.

10.1.5 Finally we asked if there would have been any difficulty asking a CPN to keep an eye on M at home considering this significant change in his long standing medication regime. He confirmed there would have been no difficulty in engaging the services of a CPN at that time.

10.1.6 On reflection he finally told us that he may not have changed M's medication. If this was the case it left us questioning the level of supervision and consultation available to this trainee grade member of staff.

10.2 The Specialist Registrar

10.2.1 The consultant psychiatrist member of the Team discussed M with the Specialist Registrar (who now practices as a consultant psychiatrist) on 24th October, 2008.

10.2.2 She was able to recall him particularly as she had spoken to the then Specialist Registrar after the incident who had recently taken over M's case from her. She was at the time in the early stages of her higher specialist training and felt well supported and supervised. At the time she thought M to be a straightforward case.

10.2.3 Her recollection was that the GP was not just asking for medication review but was also questioning the original diagnosis as he had seemed so stable for so long. Correspondence from the GP contains no questioning of the diagnosis.

10.2.4 Her memory is that he did not want to involve his family and that he was very keen to come off his medication as soon as possible and was not willing to be more closely monitored by a CPN and that this service would have been available.

10.2.5 She did not recall him admitting to any symptoms other than a vague noise he heard and as she also doubted the diagnosis she saw no problem in acquiescing to his request to stop treatment.

10.2.6 In hindsight she realises that she set about the reduction far too quickly and this is not the way she would do things now. She would have also

10.2.7 She believes that he would have been given information about how to contact services if he felt the need to, but this was obviously not given to his family as he did not want them contacted.

10.2.8 At the time it was not practice to have access to previous notes about history at outpatient appointments. This has subsequently changed.

10.3 M's GP

10.3.1 We found him to be most helpful and he gave a useful description of his work as a GP in a predominately rural location and the mental health issues he encounters. He had a good knowledge of M's presentation and impressed us with his knowledge of mental health and approaches to treatment.

10.4 GP with experience of out of hours' service

10.4.1 The current PCT's Head of Clinical Governance and Risk accompanied this GP. He too was helpful and gave us insights into how the service operated in 2003. Calls were routed via the regional ambulance service. Much of the work of this service we were told encompassed palliative care, and the cover at the week-end concerned was being mainly provided from the north of the county. As the final call was received and responded to in the early hours of the Sunday then the GP's surgery would receive a fax for the Monday morning. Calls are now recorded.

10.4.2 We were told that better 'signposting' was now practiced as there is now a greater awareness of services to utilise and information concerning them. There is an increased awareness of listening and more in depth questioning coupled with access to the Mental Health Register via enhanced computerised facilities.

10.5 M's current Responsible Medical Officer (RMO)

10.5.1 We were reassured that M has been told that he needed to accept that his life would be much as it is now into the future. It is difficult to see him living in a less secure structured environment. When well he has escorted leave endorsed by the Home Office. He uses this privilege responsibly.

10.5.2 We asked the RMO's opinion regarding the referral for the management of his medication side-effects and he was of the same view as the consultant psychiatrist on the independent investigation team that he would not have reduced M's medication at all. He would have pointed out to him that he had remained reasonably well for the past twenty years and that although the tremor was an unfortunate long term problem it could be relieved by interventions other then stopping his depot medication.

11 Risk Assessment

11.1 At the outset of the external investigation the Team indicated that they would refer to the Report of the Royal College of Psychiatrists 'Rethinking risk to others in mental health services' (March 2008).

11.2 The areas from the report we feel required noting are the following: "*All psychiatrists are conscious of the immeasurable impact of homicides and violence on victims, perpetrators and families and recognize their responsibility to their patients and the wider public to use their professional skills to reduce risk*".

11.3 Key findings of this report note that, "*risk management is a core function of all medical practitioners and that some negative outcomes can be avoided or reduced by sensible contingency planning. Risk, however, cannot be eliminated and accurate prediction is never possible for individual patients. The risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour*".

11.4 The limitations and value of risk assessment instruments must be understood. "*Risk assessment should be seen as an assessment of a current situation, not as a predictor of a particular event. Its critical function is to stratify people into a group (low, medium or high risk), which will help dictate the appropriate care and treatment and risk management strategy*".

In considering the case of M the above led the independent investigation team to conclude that improvements are needed in the existing arrangements for training and continuing professional development in risk assessment and management throughout the MH Trust.

11.5 The Department of Health, (2007) issued, 'Best Practice in Managing Risk' highlighting some general principles of risk assessment. These are:

11.6 "*Accurate risk prediction is never possible at an individual level. Nevertheless the use of structured risk assessment when systematically applied by a clinical team within a tiered approach to risk assessment can enhance clinical judgement. This will contribute to effective and safe service delivery*". In the case of M there was no risk assessment and therefore little to aid the enhancement of clinical judgement.

11.7 "*Positive risk assessment is part of a carefully constructed plan and is a required competence for all mental health practitioners".* In M's case there was poor planning for risk and exposed the competence of the practitioners involved.

11.8 "*Risk management requires an organizational strategy as well as competent efforts by individual practitioners*". Finally in M's case at the time of the events there was a failure to follow the requirements of the Care Programme Approach and there appears to have been little monitoring of this by the wider organization.

11.9 Current approach to Risk Assessment

11.9.1 In 2007 the Mental Health Trust undertook a pilot to consider the use of the 'Galatean Risk Screening Tool' (GRiST) by the adult mental health services. This online decision support system for mental health professionals has been developed by the Universities of Warwick and Aston the development of which was funded by the Department of Health. The tool was recommended within the document mentioned above.

11.9.2 Following the pilot the Trust's Safer Services Committee endorsed and adopted the GRiST model throughout the adult mental health service in 2008.

11.9.3 Of particular note is that one of the standards requires, "*that assessments will be completed following any significant change to the client's presentation or situation*". Should similar situations presented by M's case now be considered then there would be an expectation that the standard would be followed.

11.9.4 Much of the above reflects that which is the current thinking surrounding risk assessment, however the content is not particularly new and the Care Programme Approach and clinical knowledge and practice in 2003 could and should have been applied in this case.

12 Relatives and Carers

12.1 We do not intend to spell out all of the rights of relatives and carers to be involved in the decisions in planning the mental health treatment of those they care for, love and support. Much of the process of involvement can be based on mutual interest and concern, respect and a willingness to communicate with each other

13 'Refocusing the Care Programme Approach – Policy and Positive Guidance', Department of Health, March 2008.

13.1 We considered this document, which is to be implemented from October 2008, and set this against what it states concerning the involvement of relatives and carers. We did the same for the revised Code of Practice. As a background we describe some of the policy directions indicated by Government. We were required to undertake this in the Terms of Reference.

13.2 The Care Programme Approach (CPA) was introduced in 1990 as a framework of care for people with mental health needs and was at that time to run in parallel with the local authority Care Management system. The CPA was revised and integrated with Care Management in 1999 to be used by health and social care staff in all settings, including inpatient care. Two tiers of CPA were established: standard and enhanced. Standard was described as being for those people whose needs could be met by one agency or professional. People on enhanced CPA had multiple needs which are more likely to be met by inter-agency coordination and cooperation. There is likely to be a higher element of risk and disengagement from services. (M was a patient not registered at all on CPA. If he had it would in all probability have been 'standard').

13.3 The key elements of this approach were the systematic assessment of individuals' health and social care needs. A Care Plan was to be developed to address those needs. A Care Coordinator was to be appointed and regular review was to take place making changes to the plan to reflect changing need. Close working relationships between health and social services were stressed, as was the need to involve the service user and their carers. This did not take place for M.

14 'The National Services Framework for Mental Health: Modern Standards and Service Models' Department of Health Sept 1999.

14.1 The rationale behind this guidance is that, "carers play a vital role in helping to look after service users of mental health services, particularly those with severe mental illness. Providing help, advice and service to carers can be one of the best ways of helping people with mental health problems. While caring can be rewarding, the strains and responsibilities of caring can also have an impact on carers' own mental and physical health. These needs must be addressed."

14.2 **Standard 4** states that: "All mental health service users on the Care Programme Approach should:

- Receive care which optimizes engagement, prevents or anticipates crisis and reduces risk.
- Have a copy of a care plan which:
  - includes the action to be taken in a crisis by the service user, their carers and their care coordinators,
  - advises the GP how they should respond if the service user needs additional help,
  - is regularly reviewed by the care coordinator'
  - be able to access services 24 hours per day and 365 days per year".

14.3 Standard 6 states that: "All individuals who provide regular and substantial care for a person on CPA should:

- Have an assessment of their caring, physical and mental health needs, repeated at least on an annual basis.

- Have their own written care plan, which is given to them and implemented in discussion with them".

14.4 We have commented on this as M's 82 year old mother had him living with just her in a warden controlled bungalow. She was not approached and offered the service of a 'Carers Assessment' and had no information as per Standard 4.. Non of the above applied to M as it had been decided that the guidance was not to be followed in particular if the patient was seen at outpatient facilities.

15 The Stage 1 Report

15.1 One of our Terms of Reference was to comment on the quality of reports undertaken in the initial stages of the responses to this homicide.

15.1 We make the following observations including those previously highlighted areas of the Stage 1 Inquiry report completed in November 2004:

15.2 The report makes generalized statements not backed up with determinable facts and gives opinions when the initial task is to quickly ensure that policy and procedural issues are urgently changed as required and that clinical or managerial action is taken to ensure safety and that all relevant records are secured. There is no recorded contact with relatives or action taken to support them. The report appears to be dated some 14 months after the event.

15.3 The most illogical statement which reads so is, "*it is evident that information contained in witness statements (particularly the patient's relatives), the patient's prison inmate medical record and psychiatric notes compiled whilst awaiting trial in the regional secure unit was not all available to the Trust's mental health service during his most recent episode of treatment*." The reason for this that it was produced after M had killed his mother and the Trust at that time had no more involvement with him.

15.4 Other examples are:

- *"attention was clearly paid to the issue of clinical risk to self and others."* We could find no documentary evidence to sustain this comment

- o *" that it is highly unlikely that the use of a formal risk assessment would have predicted that the patient was a danger to anyone."* As there was no assessment this can not be a reasoned conclusion.

- o *"it is arguable as to whether more rigorous arrangements over the period of change would have influenced the outcome in this unfortunate case".* We disagree with this conclusion.

15.5 The report was poorly constructed.

16 Causes and Findings

16.1 We need to stress that the Trust now operating and providing services is organisationaly and structurally different from that in 2003. Our comments relate to that time and that time only.

16.2 Consequent upon his illness of paranoid schizophrenia M experiences a cluster of symptoms characterized by paranoid delusional beliefs, auditory and visual hallucinations and disturbances in his thinking processes. These symptoms are often accompanied by deterioration in his mood and increasing anxiety. As a direct result of his experiences he feels at risk from others and had previously reacted violently as a result.

16.3 The root cause of this was: **The rapid reduction of medication and the way this was managed in the absence of a risk assessment determined through the Care Programme Approach.**

16.4 The contributory factors were:

- The total lack of management of this case using the principles of the Care Programme Approach by the team reviewing him at the outpatient clinic.

- M was not seen by a consultant psychiatrist.

- The Care Coordinator role should have been taken by a consultant psychiatrist considering the position of the junior medical staff.

- There was a static formulation of this patient's illness with insufficient challenge when seen as an outpatient.

- There was elicited opinion that the reduction in medication was inappropriate.

- There was no recorded risk assessment documented and therefore no relapse action plan.

- More effort should have been made to explore additional methods of engagement with his mother even though he was reluctant to involve her.

- M and his family were respectful recipients of services from the medical profession and more attention should have been paid to the effective use of authority and persuasion with M.

- There was no information given to his mother on what action to take if she needed help.

- The use of a Community Psychiatric Nurse to monitor the change in medication was not vigorously explored and after such a long period of receiving a depot injection the possibility of a short hospital admission to manage any change in medication was not considered.

- His missed appointment was not followed up but he was offered a six month appointment for December.

- Notes were not routinely available at outpatient clinics to review history.

- The out of hours service was not rigorous enough in their response to the family's request for help. There was no 'signposting' to services which did exist. The out of hours service failed this family at the week-end in question.

- M's mother did not receive a 'Carer's Assessment'

17. Recommendations.

The independent external investigation team believes there is other documentation which existed but we were unable to locate although the evidence available to us was sufficient to draw our conclusions. The passage of time in this case made this

particular aspect of discovery less easy than a case involving a shorter period of time after a homicide. What is clear in this case is there did not appear to be a sense of urgency or rigorous and accurate analysis of this particular homicide, despite there being a requirement to do so. We had no documentary evidence presented to us to dissuade us of this view. We were also left with a feeling of organizational complacency at that time about the death of this elderly woman.

Recommendations

17.1. The MHTrust should develop and describe a broad based action plan to ensure it has explored additional methods of engagement with carers particularly where service users are reluctant to involve them.

17.2. The use of the Care Progamme Approach in out patient clinics should be the subject of audit and reported to the MH Trust Board.

17.3. The 'issues for consideration' contained in the document, 'Recommendations for Antipsychotic Medication Switches' should form the basis of a clinical audit.

17.4 The newly adopted GRiST risk assessment tool should be subject to audit in outpatient clinics and the outcome reported to the Board. Tick box mentality should be avoided and the audit should focus on the quality of the clinical input, observations and interpretation, contingency plans and the flexibility of the process and that the format in use are validated for each specific patient group.

17.5 There should be production of information packs for service users and their relatives and carers concerning areas identified in the revised Mental Health Act Code of Practice and the Care Programme Approach. The documentation should reflect all rights and responsibilities afforded to them and what to do in emergencies.

17.6. The assessment of carers and the progress the Trust makes in this area should form an annual report to the Board on the impact future engagement and assessment of need has.

17.7 The PCT should construct and conduct an audit of the Out of Hours Service showing particular attention to how specific mental health calls have been

dealt with and the effectiveness of this service. How calls regarding mental health issues are routed at point of contact to appropriate emergency mental health services, thus avoiding the out of hours GP service, should be subject to audit.

The Investigation Team

This investigation was chaired by Dr. Colin Dale and was supported by Dr. Michael Rosenberg and Mr. Peter Green.

Colin Dale has been an Executive Nurse in three NHS Trusts; has worked as a professional adviser to the Royal College of Nursing (RCN), National Institute for Mental Health in England (NIME), National Patient Safety Agency (NPSA) and the Dept of Health and has a track record of research publications and international conference presentations. He has successfully worked on a large number of projects in recent years including: Caring for Prisoners (an evaluation of the role and responsibilities of the Prison nurse); The RCN Primary Care Education project literature review on inter-disciplinary education; work for the Nursing and Midwifery Council, the Dept of Health, the Prison service for England and Wales and a number of local and regional projects for individual Trusts and organisations. He is currently a National Project Manager for the National Institute for Mental Health in England and a Senior Policy Adviser for the Offender Health Services at the Department of Health. He has worked on several previous mental health inquiries.

Dr Michael Rosenberg is the Consultant Psychiatrist, Inpatient Triage, South Downs Health NHS Trust (a new post involving the assessment and care of newly admitted patients for the first seven days of their care episode). Between 2003 – 2006 Michael was the Chief Executive and Honorary Consultant Psychiatrist South Downs Health NHS Trust; a Trust where he had previously been the Medical Director between 1998 – 2003. Michael was responsible for the Psychiatric Intensive Care Unit at Mill View Hospital from 1999 to 2005 (a modern 10-bedded unit caring for acutely mentally ill patients, requiring short-term intensive treatment). He is approved under Section 12(2) of the Mental Health Act 1983. Michael has extensive experience of the investigation of critical incidents and advised on the management of complaints in his Trust. He was the lead director for the Trust Patients' Advisory Forum and responsible for developing the Trust Strategy for Patient and Public Involvement.

Peter Green is a qualified psychiatric social worker and general manager with significant experience as a senior executive in local government, the National Health Service, the Mental Health Act Commission and latterly independent psychiatric hospital provision and consultancy. Peter was the principal social worker at St. James's University Teaching Hospital, Leeds, and has worked in all three high security hospitals, as a

senior practitioner at Rampton Hospital, the head of social work services at Broadmoor Hospital and the Director of Rehabilitation at Ashworth Hospital. He has considerable expertise in the assessment of mentally disordered offenders and evaluation of service delivery. He has significantly aided the administration of two public inquiries.

Colin Dale and Peter Green have recently completed a review of 40 homicide cases for NHS London committed by recipients of mental health services between 2002 and 2006 and are managing a similar process for 39 cases for NHS North West.

All three members of the investigation team are independent of any of the Yorkshire organisations involved with the incident and have had no involvement in any of the investigations to date.