Independent Investigation

into

SUI 2008/1621

Commissioned by

NHS Yorkshire and the Humber

Strategic Health Authority

September 2011

Independent Investigation: HASCAS, Health and Social Care Advisory Service

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1. Preface to the Independent Investigation Report

The Independent Investigation into the care and treatment of Mr. Y was commissioned by the NHS Yorkshire and the Humber Strategic Health Authority (the SHA) pursuant to *HSG (94)27*[1]. The Investigation was asked to examine the circumstances associated with the death of Mr. Y's father on the 21 February 2008.

Mr. Y received care and treatment for his mental health condition from the South West Yorkshire Partnership NHS Foundation Trust (the Trust) between 21 June 2004 and the date of the incident. It is the care and treatment that Mr. Y received from this organisation that is the subject of this Investigation.

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

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations.

We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's senior management who have granted access to facilities and individuals throughout this process. The Trust Senior Management Team has acted at all times in a professional manner during the course of this Investigation and has engaged fully with the root cause analysis ethos of this Investigation.

We are particularly grateful to Mr. Y's mother, who was also the wife of the victim, for her co-operation at a very distressing time for her.

This cooperation and support has allowed the Investigation to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

2. Condolences

The Independent Investigation Team would like to extend its condolences to the family and friends of the victim.

Mr. Y died in January 2011. The Independent Investigation Team would like to extend its condolences to his family and friends.

3. Incident Description and Consequences

Mr. Y was born on 15 March 1982, the third of four children. On 28 May 2004, at the age of 22, he was referred to the South West Yorkshire Mental Health Services by his General Practitioner who described him as being severely depressed with suicidal thoughts and suffering with extreme anxiety. Mr. Y was assessed in the psychiatric out-patients department in June 2004 and subsequently referred to the Early Intervention Service.

By August 2004 Mr. Y was reporting a number of symptoms which suggested that he was suffering from a psychotic illness. He had three in-patient admissions between September 2004 and February 2005.

From October 2004 until he was arrested in February 2008 Mr. Y's accommodation was provided by a Housing Association whose staff provided him with on-going support. He had regular psychiatric out-patients appointments. Care and support were initially provided by the Early Intervention Service and subsequently by the North Kirklees Community Mental Health Team (CMHT).

Mr. Y was discharged from psychiatric follow up in November 2007 but continued to be seen by the CMHT. He was last seen by the CMHT on 18 February 2008 and by the staff of the supported housing project on 19 February 2008 when he reported that he was feeling better, although it was noted that he was ruminating on his past.

Mr. Y's mother reported that she felt that her son's mental state had been deteriorating for perhaps two months prior to the events of 21 February 2008, possibly since the time that his anti-psychotic medication had been stopped. On 31 January she had contact Mr. Y's Housing Support Worker to express her concern about her son's mental health and informed the Worker that "*a few weeks ago*" he had sent her a text saying that he was having thoughts of wanting to hurt people. Around the 20 February 2008 Mr. Y's mother had sent him a text message telling him that a young girl was missing in the local area. Mr. Y later reported that this information had made him think of his own childhood. He reported that he had been feeling unwell for some days and was dwelling on what he believed had happened to him in

his childhood. He experienced flashbacks of his childhood and became convinced that his father had abused him. According to his own report Mr. Y did not sleep on the night of 20 February 2008. He drank four cans of lager and became determined to confront his father.

Early on the morning of 21 February 2008 Mr. Y made his way to his father's home. He is reported to have said something like *"Who is the paedophile you or me?"*[1] to his father. Mr. Y had taken a plumbing tool with him and, according to his account, "*lost it"*. He hit his father, killing him. Mr. Y was arrested and taken to the local police station. He was assessed by a Section 12 doctor who concluded that Mr. Y's beliefs were delusional but deemed him fit to be questioned. He was accompanied by an Appropriate Adult during his interview with the police.

Mr. Y was initially remanded to prison but as his mental health deteriorated, he was transferred to a secure unit under section 48 of the Mental Health Act (1983). He was convicted of manslaughter on the grounds of diminished responsibility at Leeds Crown Court in November 2008 and detained under the Mental Health Act (1983) at a medium secure facility with the South West Yorkshire Partnership NHS Foundation Trust.

Mr. Y died on 4 January 2011.

[1] Case notes p.614

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

The HASCAS Health and Social Care Advisory Service was commissioned by Yorkshire and the Humber Strategic Health Authority (SHA) NHS to conduct this Investigation under the auspices of Department of Health Guidance (94)27, LASSL(94) 4, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:
"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

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

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

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

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

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

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

The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what would have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been fully investigated by an impartial and Independent Investigation Team.

5. Terms of Reference for the Independent Investigation

The Terms of Reference for the Independent Investigation were set by Yorkshire and the Humber Strategic Health Authority (the SHA) in consultation with South West Yorkshire Partnership NHS Foundation Trust and NHS Kirklees. They are as follows:

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

In particular, to take account of and comment on:

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

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

- The quality of the internal action plan.

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

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

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

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

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

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

- The extent to which care and treatment was interrupted as a result of CPN staff changes.

- The extent of services' engagement with family carers and the impact of this (both before the incident and subsequently).

To identify:

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

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

- Any additional learning points for improving systems and services.

To make:

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

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

To report:

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

6. The Independent Investigation Team

Selection of the Independent Investigation Team

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

Investigation Team Leader and Chair

Dr. L.A. Rowland	Director of Research, HASCAS Health and Social Care Advisory Service. Clinical Psychologist Member.

Investigation Team Members

Dr. A. Johnstone .	Chief Executive Officer, HASCAS Health and Social Care Advisory Service. Nurse Member.
Mr. Alan Watson	National Development Consultant, HASCAS Health and Social Care Advisory Service, Social Worker Member.

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, HASCAS Health and Social Care Advisory Service.
Dr. David Somehk	Consultant Psychiatrist Peer Reviewer.
Mrs Tina Coldham	National Development Consultant, HASCAS Health and Social Care Advisory Service, Service User.

Mrs. Louise Chenery	Stenography Services.

Independent Legal Advice

Mr. Ashley Irons	Capsticks Solicitors

7. Investigation Methodology

7.1. Classifications of Independent Investigations

Three types of Independent Investigation are commonly commissioned, these are:

- Type A – a wide-ranging investigation carried out by a team examining a single case;
- Type B – a narrowly focused investigation by a team examining a single case or a group of themed cases;
- Type C – a single investigator with a peer reviewer examining a single case.

Each of these categories has its own strengths which make it best suited to examining certain cases. This Investigation was commissioned by Yorkshire and the Humber Strategic Health Authority as a Type C Independent Investigation.

A 'C' type review is principally a documentary analysis review which utilises:

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

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

The Independent Investigation Team concluded that that the work of the Internal Investigation was sound. However, given the complexities of Mr. Y's presentation, the outstanding issues relating to the care he received and the observations of the Internal Investigation, the Independent Investigation Team decided to interview the key clinical witnesses who provided care and treatment to Mr. Y whilst under the care of South West

Yorkshire Partnership NHS Foundation Trust. The Trust Corporate Team was also interviewed. In effect this case was investigated as a Type 'B' review with the full agreement of the Strategic Health Authority.

7.2. Communication and Liaison

7.2.1 Communication with the Family of the Victim and of Mr. Y.

The Chair of the Independent Investigation Team met with Mr. Y's mother on 18 May 2011 to discuss her view of her son's problems, the care and treatment he had received, her involvement in the Internal Investigation and the support she had received from the Trust.

7.2.2 Communication with the South West Yorkshire Partnership NHS Foundation Trust

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

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

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

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

On the 6 December 2008 the Chief Executive Officer of HASCAS/Nurse Member of the Independent Investigation Team and the Social Worker Member of the Independent

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

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

On the 8 February 2011 a meeting was held between the CEO of HASCAS/Nurse Member of the Independent Investigation Team and the Trust Corporate Team in order to discuss the findings and to invite the Trust to contribute to the development of recommendations.

At the time of writing this report a 'Learning the Lessons' workshop was being planned between HASCAS/The Independent Investigation Team and the Trust in order to provide witnesses to the Investigation, and other members of the North Kirklees CMHT, an opportunity to reflect upon the findings and the lessons learned as a consequence of this Investigation.

7.2.3 Communication with NHS Kirklees (Primary Care Trust)

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

The PCT provided GP clinical records and performance management data to the Independent Investigation Team.

Senior Members of the HASCAS Independent Investigation Team met with the NHS Kirklees Director of Nursing and Associate Director of Clinical Governance on the 27

September 2010. On the 12 January 2011 another meeting was held with the Associate Director of Governance to discuss progress and additional process requirements.

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

7.3. Witnesses Called by the Independent Investigation

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

Table 1: Witnesses Interviewed by the Independent Investigation Team

Date	**Witnesses**	**Interviewers**
12 January 2011	**South West Yorkshire Partnership NHS Foundation Trust** • Trust Acting Chief Executive; • Trust Acting Director of Nursing; • Trust Medical Director; • Trust Service Director. • Trust Risk Manager	**Investigation Team,** • Investigation Team Chair, Clinical Psychologist; • Investigation Team, Nurse; • Investigation Team, Social Worker; • In attendance: Stenographer.
13 January 2011	**South West Yorkshire Partnership NHS Foundation Trust** • Early Intervention Nurse; • Psychiatrist 1; • Social Worker 1; • Manager 1.	**Investigation Team,** • Investigation Team Chair, Clinical Psychologist; • Investigation Team, Nurse; • Investigation Team, Social Worker;

	Connect Housing Association • Supported Housing Worker 1; • Supported Housing Worker 2;	• In attendance: Stenographer.
14 January 2011	**South West Yorkshire Partnership NHS Foundation Trust** • CPN 1; • Senior Community Care Officer 1; • Manager 2; • CPA Manager.	**Investigation Team,** • Investigation Team, Nurse; • Investigation Team, Social Worker; • In attendance: Stenographer.

The Chair of the Independent Investigating Team spoke to Mr Y's GP by telephone on 8 June 2011 to discuss the care and treatment of Mr Y.

7.4. Salmon Compliant Procedures

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

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

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

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

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

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

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

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

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

(h) that they will be able to access copies of the clinical records both before and during their interviews to refresh their memory.

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

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

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

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

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

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

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

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

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

7.5. Independent Investigation Team Meetings and Communication

7.5.1 Initial Team Processes

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

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

7.5.2 The Team met on the following occasions:

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

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

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

7.5.3 Other Meetings and Communications

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

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

7.6. Root Cause Analysis (RCA)

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

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

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix 1). From this, causal factors or critical issues can be identified.

3. **Root Cause Identification.** The National Patient Safety Agency advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This investigation utilised the Decision Tree and the Fish Bone.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

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

7.7. Anonymity

All staff of the South West Yorkshire Partnership NHS Foundation Trust and Connect Housing Association have been referred to in this Investigation report by reference to their role titles and on occasion a suffix e.g. CPN 2, CCO 1, Psychiatrist 1, to preserve their anonymity.

The individual whose care and treatment is the subject of this report has been referred to throughout as Mr. Y.

8. Information and Evidence Gathered (Documents)

During the course of this investigation the following documents were actively used by the Independent Investigation to collect evidence and to formulate conclusions.

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

In addition questions relevant to the Investigation were put to an Elder of the Jehovah's Witness Community and general expert advice on the beliefs of the Jehovah's Witness Community was sought. Confidentially was preserved during this process.

9. Profile of South West Yorkshire Partnership NHS Foundation Trust

9.1 The South West Yorkshire Partnership NHS Foundation Trust

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

Figure 1: Geographical Location of South West Yorkshire Partnership NHS Foundation Trust

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

[2] Trust Presentation to the Independent Investigation

South West Yorkshire Partnership NHS Foundation Trust: Vision, values and goals.

The Trust vision is to be:

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

The Trust's values are:

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

The Trust goals are to:

- *"develop a robust service strategy based on a sound understanding of stakeholder expectation and market opportunities;*
- *ensure that organisational systems are working to best effect to support effective service strategy;*
- *maintain and develop an organisational culture that reflects the Trust's values and promotes effective delivery of services for the diverse population served by the Trust, including challenging stigma and discrimination in mental health and learning disability services;*
- *develop a clear organisational structure which promotes accountability and responsibility at all levels;*

- *seek out opportunities to develop new services and approaches which support the Trust's strategy and its core business and help maintain a strong market position;*
- *ensure partnerships are developed which support the core business of the Trust and bring benefits for the communities served."*[3]

Table 2: Staff in Post by Occupational Group

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

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

9.2 Kirklees Community Mental Health Team.

9.2.1. Background

The North Kirklees Community Mental Health Service was reconfigured into sector teams in 2002. The service consisted of three generic sector teams covering the Batley, Spenborough and Dewsbury areas of North Kirklees.

The sector teams provided services for two identified groups of working age adults:

- Those with common mental health issues who were typically seen for 3 to 6 sessions and then referred back to their GP;
- Those requiring ongoing and specialist care.

[3] Annual Report and Accounts 1 May 2009 - 31 March 2010 PP 21-25
[4] Annual Report and Accounts 1 May 2009 - 31 March 2010 P31

9.2.2. The service provided

The teams:

- Provided support and advice to primary care services;
- Undertook assessments of mental health problems;
- Provided interventions to reduce and shorten distress and suffering;
- Established a detailed understanding of all local resources relevant to supporting individuals with mental health problems and promoted effective interagency working;
- Assisted service users and carers in accessing support;
- Made available psychological interventions including: Cognitive Behavioural Therapy (CBT), stress management, Solution Focused Brief Therapy, social skills training, Anxiety Management, and a series of sessions follow a formulation of the problem;
- Did not provide an out of hours crisis service.

- Conducted all initial assessments by completing a Health of the Nation Outcome Scale (HoNOS Plus) assessment and then a Sainsbury Centre initial risk assessment if required.

Each service user was assigned a care co-coordinator with responsibility for ensuring appropriate assessment, care and review was carried out.

9.2.3 Referrals

Sector teams accepted referrals for assessment from GPs, Social Services and all other components of the mental health services, as well as self-referrals and carers' referrals.

9.2.4. Teams and Staffing

The community mental health teams each consisted of: one Team Manger, Community Mental Health nurses, Approved Social Workers, Social Workers, Principal Community Care Officers and Community Care Officers. Medical staff were integrated into, but are not full time members of, the community teams.

There was no psychology or occupational therapy resource as part of the community teams.

9.2.5 Current CMHT Service provision

The specifications for the community services were updated in the 2010-2011 Service Plan.

The aims of the community service were identified in this plan as follows:

- *"Support primary care services by seeing referred service users for specialist assessment, advice and short term treatment. Includes clusters 1 to 3 that have been screened by IAPT but not accepted due to degree of risk posed.*
- *CPA care coordination for those service users presenting with more complex needs.*
- *Localised service to play part in multiagency action seeking to prevent mental health difficulties developing."*

The client group served was described as follows:

"Clusters 4 - None urgent (urgent would be seen by crisis services) Assessments /time limited work with those presenting with risk……

Clusters 5-8 and 11-13 ongoing reviewable CPA care coordination work, it is anticipated will be bulk of teams' caseload.

Increasing responsibilities for administrating self direct support (SDS) for citizens meeting Kirklees eligibility criteria as part of a 'universal offer'"

9.2.6 Referral

Referrals are accepted from: GPs, Crisis Teams, Improving Access to Psychological Therapy services (IAPT) and inpatient teams. If appropriate an assessment is undertaken and clinical recommendations are made to the service management which decides on the priority of the service user's case and the allocation of staff.

The services are working towards responding to non-urgent referrals within 14 days. Prior to April 2010 the target time for responding was 4 weeks to undertake an assessment.

9.2.7 Staffing of Community services

The staffing of the community services is reported below.

Table 3: Staffing of the Community Services

Staffing	**Designation**	**Band**	**WTE**
Numbers reflect total of six teams	Consultants		5.5
	Associate specialist		0.5

	Trust grade Staff grade SHO		4 4 3
	Admin		14
	Team managers	Band 7/ social service team manager	3+2
	Social workers	Senior practitioner	5
	Social workers CPNs CPNs Community care officers Support workers Housing support worker	Grade 10 Band 6 Band 5 Band 3	11 29 10.5 8 3 1

[5]

9.3 Early Intervention for Psychosis Service

9.3.1 Background

In 2000 an embryonic Early Intervention in Psychosis service was established. This was made up of two CPNs, two occupational therapists and a technician. However, as this service was not funded it was subsequently disbanded. At the time that Mr. Y was receiving services from the Trust the Early Intervention service was provided by two CPNs. This service covered the three CMHTs in North Kirklees.

The two CPNs acted as care co-ordinators for individuals aged between 18 and 25 who were thought to be experiencing their first episode of psychosis. They accessed the multi-disciplinary resources of the CMHTs in the provision of the services for their clients.

[5] South West Yorkshire Partnership NHs Trust CMHT Service Plan 2010-2011

The Early Intervention service did not have an operational policy at this time but worked to the relevant parts of the CMHT policies and the Trust CPA policy. Management of the service was provided by the manager of one of the CMHTs. This manager provided management and case supervision. The two CPNs maintained their caseloads at around 15 cases each. They provided cover for each other during periods of leave or sickness.

The normal route for referrals into the Early Intervention service was for the referral to be screened by the CMHT. If the referral was found to meet the criteria for secondary mental health care and thought to be appropriate for the Early Intervention service it was passed to the two CPNs. Having assessed the referral they responded in writing to the CMHT manager or the referrer informing him/her of their decision to accept the person into the Early Intervention or not.

There was no fixed duration of attachment to the Early Intervention service but at this time this was seldom more than three years.

9.3.2 Current Early Intervention Services

South West Yorkshire Partnership NHS Foundation Trust has now established a more comprehensive Early Intervention in Psychosis service. This works with people aged between 14 and 35 who are experiencing their first episode of psychosis.

The aim of the service is to identify and treat symptoms early to promote recovery. It has been shown that if psychosis is identified and treated in a timely manner and with the right support, individuals can recover, maintain relationships and achieve their aspirations. The service offers help and support to enable people to recover and continue to have a good quality life.

The Trust has three Early Intervention services covering Calderdale, Kirklees and Wakefield. They were set up in response to Government guidance and in line with local and national need. Each service works with young people who are experiencing, or are at risk of experiencing, a first episode of psychosis and aims to support individuals and their carers on the road to recovery. The young people who are supported by these services often have a complex range of problems, for example substance abuse and/or offending behaviour. The

teams work with diagnostic uncertainty, and offer extended periods of assessment, working intensively with young people for up to three years.

Each team has a manager, Community Psychiatric Nurses (CPNs), social workers, Approved Mental Health Professionals (AMHPs), Support Time Recovery (STR) Workers, secretaries and also input from Clinical Psychologists, Doctors and Pharmacists.

The Teams provide support and treatment through talking therapies and medication; helping people resolve family or personal problems and assisting people to access training, education or employment.

People can be referred to the Early Intervention service by any NHS or social service staff member including GPs, health visitors, school nurses, youth offending teams or substance misuse services. Self-referrals are also accepted.

9.4 Services for people with Complex Presentations and Personality Disorders

There are currently no dedicated resources for individuals with a diagnosis of Personality Disorder in the Trust. These individuals are currently managed within the general adult mental health services. However, the Trust is in the process of recruiting a medical consultant psychotherapist to be based in the Kirklees district. It has consulted widely on the job description for this post.

The post holder will have the lead for developing a service for people with complex presentations and/or personality disorders. S/he will be expected to collaborate with colleagues from other districts and from the psychology department in developing the service.

The post holder will provide consultation to colleagues as well as providing a clinical service to the identified population.

10. Chronology of Events

10.1. First Stage of the RCA

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

10.2. Chronology

Mr. Y was born on **15 March 1982**, the third of four children. He had an older brother and sister and a younger brother.

After school Mr. Y went to a local college where he studied Health Studies for approximately five months, catering for approximately seven months and then plumbing

On **28 May 2004** Mr. Y's General Practitioner (GP) made an urgent referral to Psychiatrist 1 of the South West Yorkshire Partnership NHS Foundation Trust (the Trust) Mental Health NHS Trust (SWYMHT)**.** In his referral letter the GP identified that Mr. Y had been suffering from "*severe depressive illness"* for about four months. He was reporting "*mood changes, sleep disturbance and suicidal thought."* Mr. Y had quit his training course as a plumber "*because of anxieties over the responsibilities involved. His anxiousness was profound*" The GP's primary concern was Mr. Y's continuing suicidal thoughts.[6]

[6] Case notes p. 347

The referral letter reported that Mr. Y was a devout Jehovah's Witness *"I believe that some elements of their Christian teaching are making his situation worse. He feels guilt in that he has brought this illness upon himself."*[7]

Mr. Y had been prescribed Fluoxetine to which he appeared to respond well initially but he did not like the sense of lethargy he experienced with this medication. Mr. Y's medication was therefore changed to the anti-depressant Zispin (Mirtazapine). Again Mr. Y appeared to respond well but he did not like this medication because he experienced muscle aches and pains.[8]

Mr. Y's GP concluded that Mr. Y's depression "*has been poorly responsive to treatment partly because of poor compliance."*[9]

This referral was received on **8 June 2004** and marked "*Urgent*".

On **21 June 2004** Mr. Y was assessed by a Staff Grade Psychiatrist. She reported that Mr. Y had been depressed since the age of 11. He had thoughts of committing suicide and was anxious about upsetting people. No perceptual abnormalities were noted.

Describing his family background Mr. Y reported that his father was strict in his interpretation of the Jehovah's Witness teachings. Mr. Y reported that if he did something his father disliked he would shout and read from the Bible. When asked if he had experienced any kind of abuse Mr. Y responded that "*Being in Kingdom Hall is a kind of abuse of the mind*."[10]

Mr. Y reported that he did not have a good relationship with his siblings.

The Staff Grade Psychiatrist concluded that Mr. Y was "*very depressed but I believe it is as a result of the situation he is living in. He feels extremely under pressure from his dad and wants to please him all the time and it is mainly to do with his dad's religious beliefs.*

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[7] Ibid
8 Case notes p. 347
9 Case notes p. 347
10 Case notes p.26, 345

I have the impression that [Mr. Y] wants to get out of it but he is afraid to upset his dad. There is low self-esteem, no assertiveness and he appears quite anxious."[11]

Mr. Y was prescribed the anti-depressant Venlafaxine XL 75 mg. In addition assertiveness training, anxiety management and a self-help for depression group were discussed with Mr. Y. He said that he did not feel he could cope with a group situation. Referral to the CMHT was also considered. Mr. Y said that he would like to think about this option.

On **2 July 2004** Mr. Y was seen by the Staff Grade Psychiatrist and Psychiatrist 1. He appeared to be anxious during this interview and again reported that he had been depressed for a long time. When asked about his relationship with his father Mr. Y reported that there was a distance between them. The Consultant Psychiatrist concluded that it was difficult for Mr. Y to express his feelings. His assessment, at this stage, was that Mr. Y had a number of emotional problems. He advised Mr. Y that he should not label himself as someone suffering from a psychiatric illness.

Psychiatrist 1, who was also a psychotherapist, arranged to see Mr. Y, for four sessions, to assess his suitability for psychotherapy.[12]

On **19 July 2004** Mr. Y's parents rang the mental health services to report their concerns about his behaviour. He was arguing with his brother and using abusive language which was unusual.

Mr. Y's father contacted the police who took Mr. Y to the local Accident & Emergency Department where he was assessed by the Crisis Resolution and Home Treatment Team (CRHTT).

During this assessment Mr. Y reported feeling low but denied any thoughts of self harm. He displayed no perceptual abnormalities. Mr. Y described the impact of his religious beliefs on family life and reported his conflict with members of his family. He said that he did not want

11 Case notes p.345
[12] Case notes p. 267, 344

to return home because he did not feel safe there and did not want another confrontation with his brother. Mr. Y was placed in emergency temporary accommodation.[13]

A Health of the Nation Outcome Scale (HoNOS) assessment was completed on which Mr. Y was given a rating of 0 on the suicide, self harm scales, hallucination and strong beliefs scales and a rating of 2 on the depression and overactive/aggressive/disruptive scales. The HoNOS uses a rating scale running from 0 to 4. When Psychiatrist 1 spoke to a representative of Kirklees Council later that day he reported that the risks associated with Mr. Y were low.[14]

On the same day Mr. Y's mother contacted Psychiatrist 1 to discuss her son. However he told her that as he was assessing Mr. Y for psychotherapy he did not feel it would be useful for him to hear her version of events. He advised her to speak to one of the other doctors in the team and gave her the contact number for the Carer's Support Service. [15]

Following his appointment with Mr. Y on **22 July 2004** Psychiatrist 1 sent a fax to the Early Intervention CPN**.** He had seen Mr. Y on six occasions and although Mr. Y had not disclosed any evidence of psychosis, Psychiatrist 1 asked the Early Intervention CPN to assess Mr. Y to exclude this possibility.[16] He copied the CRHTT assessment to her and informed her that Mr. Y had returned to his parents' home and had agreed to see her.[17] The Early Intervention CPN sent an appointment letter to Mr. Y on 28 July 2004.[18]

On **25 August 2004** the Early Intervention CPN made a home visit to Mr. Y. He had, however, had an argument with his family the previous Saturday, the police had been called and Mr. Y had been placed in temporary accommodation.[19]

On **27 August 2004 the** Early Intervention CPN met with Mr. Y. The previous evening he had been arrested, charged with "*Behaviour which might cause distress to others".* He had spent the night in the police cells and had been find £80.[20] Mr. Y reported that he had got into an argument in a local pub. He was arrested and spent the night in the police cells. On

[13] Case notes p.253, 332
[14] Case notes p.269
[15] Case notes p.268
[16] Case notes p.12
[17] Case notes p. 334
[18] Case notes p. 178
[19] Case notes p. 183
[20] Case notes p. 183

returning home he had argued with his parents and had been asked to leave. He was subsequently placed in temporary accommodation.[21]

The Early Intervention CPN recorded that Mr. Y was describing ideas of reference, delusional thinking, and suspiciousness. He was also reporting that he had *"a mission to complete although he is vague about how and when this will happen.*" The Early Intervention CPN noted that *"[Mr. Y] is possibly experiencing psychosis*". Mr. Y was also reporting suicidal ideation, low mood, low self esteem and low confidence. Mr. Y disclosed that he was struggling with his faith.[22]

Given Mr. Y's mental state the Early Intervention CPN concluded that the temporary accommodation in which he was staying was "*totally unsuitable*". She planned to contact Psychiatrist 1 urgently to arrange an in-patient admission for Mr. Y.[23]

On **09 August 2004** Mr. Y failed to keep his appointment with Psychiatrist 1.[24]

On **1 September 2004** the Early Intervention CPN received a phone call from Mr. Y's mother informing her that Mr. Y had tried to hang himself with a belt the previous day. When the Early Intervention CPN assessed Mr. Y he was reporting suicidal ideas, ideas of reference and hallucinations. He was also reporting that he believed that he might have some influence over events taking place in Russia at the time.

A HoNOS assessment was completed at this time. Mr. Y was given a rating of 4 on the suicide and depression scales, 3 on the Overactive/Aggressive scale and 3 on the hallucinations, unreasonable beliefs and drinking scales. He was also rated as 4 on a five point scale for vulnerability at this time.

Mr. Y was admitted as an in-patient to Ward 18 of the Priestly Unit [25]. When the Early Intervention CPN visited Mr. Y on the in-patient ward on the **3** and **6 September 2004** he continued to report hearing muffled voices and having an influence on what was happening in

[21] Case notes p.184 , 438
[22] Case notes p.184
[23] Case notes p.13
[24] Case notes p.334
[25] Case notes p. 8,184, 438

Russia. In his letter of **7 September 2004** Psychiatrist 1 described Mr. Y as possibly being in the prodromal phase of a "*psychiatric illness"*[26]

At the ward round on **7 September 2004** Mr. Y was diagnosed as suffering from a psychosis.[27] His anti-depressant medication was stopped and an anti-psychotic medication, Quetiapine, was introduced.

On **9 September 2004** Mr. Y was offered a place at a supported housing scheme.[28]

On the same day Mr. Y was late returning to the ward. He smelt of alcohol and after being questioned about his drinking became angry, banged his head on the wall and said he felt suicidal. The nursing notes recorded: *"Aimed his anger verbally towards [the nursing assistant] as she was the one who pointed out that he was late back. Stated that she was a 'bitch' and if he came across her and her partner whist out he would 'give him a good kicking.'"*[29]

On **10 September 2004** Mr. Y was *"making impulsive dashes to run off the ward."*[30] On **11 September 2004** he again tried to leave the ward. *"He spoke about his escaping from the unit. He is adamant that he would do so as being here is doing him no good.*"[31] The Senior House Officer was called to speak to Mr. Y and he agreed to remain on the ward.[32]

On the same day Mr. Y's parents reported to the nursing staff on the ward that he had been abusive to them during their visit for no apparent reason.[33]

On **13 September 2004** Mr. Y continued to report symptoms consistent with him experiencing a psychotic illness and was talking of having to deliver a message to the world about happiness. However he disclosed that he was not taking his medication.[34]

[26] Case notes p. 311
[27] Case notes p. 273
[28] Case notes p.186
[29] Case notes p.448
[30] Case notes p.453
[31] Case notes p.456
[32] bid
[33] Case notes p. 454
[34] Case notes p.187

At the ward round on **14 September 2004** it was reported that Mr. Y continued to experience paranoid ideas. His medication was changed to Olanzapine. However on **17 September 2004** Mr. Y again informed the Early Intervention CPN that he was not taking his medication.
On **17 September 2004** Mr. Y was informed by his mother that she and his father were separating**.** The nursing notes record that Mr. Y did not appear to be "unduly upset" by this news.[35]

At the ward round on **20 September 2004** Mr. Y reported that he was continuing to hear voices and felt that the staff *"knew about him*". A diagnosis of paranoid psychosis was recorded at this time.[36]

On **23 September 2004** Mr. Y's mother reported to the ward nursing staff that Mr. Y was upset. He felt guilty because he felt he was a source of worry to his mother and this was making her ill.[37]

On **24 September 2004** Mr. Y spoke to the Early Intervention CPN about life being a living hell and being tortured by the fires of hell.[38]

At the ward round on **28 September 2004** the Early Intervention CPN reported that Mr. Y's home leave had not gone well. He had been telling his parents that his life was not worth living.[39]

On **1 October 2004** Mr. Y was assessed by the CRHTT in preparation for discharge. The opinion of the CRHTT was that "*It [would] not be therapeutically beneficial to detain him [Mr. Y] on the ward if he wants to leave."* The CRHTT offered to support Mr Y either while he was on leave or on his discharge. They tried to contact the Early Intervention CPN but she was not at work at that time.[40]

Mr. Y was discharged from in-patient care on Friday **1 October 2004.**

[35] Case notes p. 18, 460
[36] Case notes p.276
[37] Case notes p. 466
[38] Case notes p. 188, 468
[39] Case notes p.188 , 470
[40] Case notes p. 474

There was some confusion surrounding this discharge. The nursing notes recorded:
16.00 "For discharge to-day…following ward round. {Mr. Y] will come to the ward to collect his medication at 6.30."[41]

However when the Early Intervention CPN heard of his discharge on Monday **4 October 2004** she immediately went to see Mr. Y and re-assessed him. She found him to be depressed, suicidal, agitated and anxious.[42] Mr. Y was readmitted.

On admission to the ward it was noted that Mr. Y had been drinking "*excessively*" over the week-end, was behaving bizarrely and expressing ideas of self harm. A HoNOS assessment was completed at this stage. Mr. Y was given a rating of 2 on the suicide scale and 0 on the self harm and depression scales; and 0 on the hallucinations scale and 2 on the unreasonable belief scales.[43].

On **5 October 2004** the Early Intervention CPN brought the issue of Mr. Y's unplanned discharge to the attention of the Nursing Manager of the mental health unit.[44] She was concerned that Mr. Y had been discharged late on a Friday evening without any discussion with either the Supported Housing Project, to which he was going, or herself. Mr. Y had spent the weekend without staff support from the housing scheme. She informed the nursing manager that prior to his discharge Mr. Y had been expressing suicidal thoughts and drinking alcohol.[45]

Housing Support Worker 1 also contacted the manager of the in-patient services and the ward manager concerning the lack of consultation surrounding Mr. Y's discharge. She was assured that a plan was being put in place to hold weekly meetings/discharge meetings to which a representative of the Supported Housing project would be invited.[46]

At the ward round on **5 October 2004** Mr. Y denied any psychotic experiences. When reminded that he had said that he would jump in front of a train he said that he did not recall

[41] Case notes p.473
[42] Case notes p.277
[43] Case notes p. 508
[44] Case notes p. 194
[45] Case notes p. 194
[46] Housing notes p.1, 5

this and that it was probably a slip of the tongue. He said that he wanted to be discharged from the in-patient unit and promised to take his medication.[47]

On **22 October 2004** Mr. Y's mother contacted the Early Intervention CPN to ask her opinion about Mr. Y coming to live with her as he was homesick. The Early Intervention CPN advised that this might be detrimental to both Mr. Y and his mother.[48]

At the ward round on **26 October 2004** Mr. Y reported that he was not experiencing any psychotic symptomatology but that he did feel depressed and did not feel ready for discharge.[49]

On **5 November 2004** the CRHTT were asked to carry out a pre-discharge assessment. On **7 November 2004** they contacted the ward to say that they were concerned about Mr. Y's presentation. He was expressing suicidal ideas and his mood was depressed. [50]

Mr. Y was discharged from the in-patient unit **on 19 November 2004** with a diagnosis of paranoid psychosis. He was assessed as posing no threat to others and minimal threat to himself. During his time in hospital Mr. Y had been having overnight leave at the supported hostel, Crakenedge, and this is where he went on discharge.[51]

Throughout **November and early December 2004,** despite repeated offers of support and encouragement from both the Early Intervention team and the supported housing staff, Mr. Y failed to attend the daytime activities that had been organised for him on a regular basis. During this period there was contact with Mr. Y on most days by either the mental health staff or supported housing staff.

By **7 December 2004** Mr. Y was reported to be drinking heavily and asking to go back into hospital. The Early Intervention CPN did not feel that this was justified as Mr. Y was not obviously depressed.[52]

[47] Case notes p. 278, 477
[48] Case notes p.197
[49] Case notes p. 279
[50] Case notes p.498
[51] Case notes p, 198,229, 283, 330
[52] Case notes p. 200

On **15 December 2004** the Early Intervention CPN spoke to Mr. Y about him lending money to fellow tenants. She recorded that Mr. Y was "adamant" that he was going to continue doing this.[53]

On **18 December 2004** Mr. Y presented at the local Accident & Emergency Department where he was assessed by the CRHTT. He was expressing concerns about the safety of work he had done approximately 13 months earlier when he was working as a plumber. He reported that he had thought of hanging himself but said that he had no plans to act on this idea. He was offered admission to hospital but declined this.[54]

Later the same day the Supported Housing Staff at Crakenedge contacted the CRHTT to inquire about the assessment of Mr. Y. They asked if he was detainable under the Mental Health Act. The CRHTT felt that he was not.

Mr. Y contacted the CRHTT again on **20 December 2004** expressing the same pre-occupations. He again declined the offer of admission.[55] The CRHTT informed the Early Intervention CPN that Mr. Y had again been in contact with them. When she assessed Mr. Y he again expressed his concern that he had not connected a gas fitting properly and that someone would be injured. He had contacted his ex-employer and the manufacturer of the gas fitting to inform them of the danger that he believed to exist.[56] When the Early Intervention CPN discussed Mr. Y's behaviour with the Supported Housing Staff she speculated that Mr. Y might be "*causing chaos and mayhem to get attention…… [Mr. Y] could be showing signs of Personality Disorder*".[57]

Mr. Y spent Christmas alone in his room at the hostel.

On **7 January 2005** the Early Intervention CPN was informed by a member of Supported Housing Staff that Mr. Y had been phoning his mother and the CRHTT saying that he was going to hang himself. He had been saying similar things to other tenants at the Supported

[53] Case notes p.204
[54] Case notes p.269
[55] Ibid p. 204
[56] Case notes p. 204
[57] Housing notes p. 7

Housing project. She suggested that this behaviour might be related to Mr. Y's financial situation.[58] [59]

On **21 January 2005** Mr. Y had presented at the Accident & Emergency Department saying he wanted to hang himself. He was accompanied by his mother. Mr. Y's father had rung earlier to report that Mr. Y had put a belt round his neck and attached this to the handle of a door in his parents' home, while his father was present.

Mr. Y reported that he was *"in pain"*; that he was unhappy; he experienced no sense on enjoyment; he was angry and frustrated and felt that he might explode at any time. When asked if he wanted to die he replied: *"No I want to live a normal life."*

During the assessment Mr. Y again put his belt around his neck and banged his head against the door.

He denied that he had any current problems with alcohol.[60]

Mr. Y was admitted as an in-patient. A HoNOS assessment was completed. Mr. Y was given a rating of 2 on the overactive/aggressive, suicidal, self harm and unreasonable beliefs scales and 3 on the depression scale. He was given a rating of 0 on the hallucinations scale.[61]

On **23 January 2005** Mr. Y told one of the ward nursing staff that that he put a belt around his neck at his parents' home *"so that the hospital staff would take him seriously as he did not think he could relay this verbally."*[62]

On the same day he completed a Beck Depression Inventory on which he obtained a score of 18, placing him in the mild depression category.[63]

On **24 January 2005** a member of the Supported Housing staff contacted the mental health services to inform them that Mr. Y was not engaging with the staff at the project. They had

[58] Case Notesp.208
[59] Housing notes p. 8
[60] Case notes p. 1811, 244
[61] Case notes p. 401
[62] Case notes p. 381
[63] Case notes p. 405

not been informed that Mr. Y had been admitted to hospital.[64] They were subsequently invited to attend the ward round on 26 January 2005.

.On **25 January 2005** Mr. Y asked for some Lorazepam during a visit by his parents. The nursing staff felt that Mr. Y already appeared over sedated and refused his request. He then began to bang his head against the wall. [65]

At the ward round on **26 January 2005** it was reported that Mr. Y was displaying no symptoms of psychosis but was reporting that he felt low. He showed no motivation and did not want to move on with his life.

The Early Intervention CPN reported that each time she discussed employment with Mr. Y he threatened to kill himself. Possible diagnoses of Borderline Personality Disorder, psychosis and depression were discussed. It was decided at this ward round to reduce and then stop Mr. Y's anti-psychotic medication.[66]

On the **27 January 2005** a risk assessment was completed and Mr. Y was rated as a low risk.[67]

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A Professionals meeting was held on **31 January 2005.** It was decided that Mr. Y's diagnosis was no longer one of depression.[68] It was noted that there was "*some confusion surrounding diagnosis and management. It was felt that involvement with services may not be beneficial…..It was felt that promoting an independent 'normal' life style would be most beneficial."*[69] Psychiatrist 1 suggested a diagnosis of *"psychological problems with an element of depression rather than psychotic illness."*

It was recommended that Mr. Y should resume psychotherapy with Psychiatrist 1.

[64] Case notes p. 211/Housing notes p.11
[65] Case notes p.384
[66] Case notes p.285-6/385
[67] Case notes p.413
[68] Case notes p.211
[69] Case notes p.357

Mr. Y was expressing some uncertainty about where he should live. The view of the meeting was that he should be encouraged to continue to live at the supported hostel while he decided his longer term future as this would promote his independence.

Prior to this meeting Mr. Y had told the Early Intervention CPN that he was feeling better and together with the CPN had filled in an application form for a job at McDonalds. However the nursing notes recorded that Mr. Y "sabotages" attempts to help him return him to work and he was not attending the day centre as planned.[70]

The contingency plan following this review recorded:
"Inform: [Early Intervention CPN]; Contact [Consultant Psychiatrist]; Contact CHTT. Aim to maintain in the community"[71]

On **31 January 2005** Mr. Y's father contacted the ward to inform them that his son had been drinking all day. He had drunk approximately seven cans of beer. Mr. Y had been urinating in public and throwing himself on the ground outside. His mother had thrown a jug of water over him because he refused to get up. He had also exposed himself to his 24 year old sister. Mr. Y's father was seeking the advice of the staff on whether he should contact the police. He was advised that he must make the decision.[72] Mr. Y returned to the ward smelling of alcohol and later left to sleep at his parents' home.[73]

At the ward round on **1 February 2005** Mr. Y denied any recollection of these events.[74]

On **1 February 2005** Mr. Y was discharged from the in-patient service.[75] The ward staff liaised with the Early Intervention CPN who agreed that Mr. Y should be discharged and undertook to do the seven day follow-up assessment.[76] The discharge summary recorded a diagnosis of depression. Mr. Y was prescribed Olanzapine, an anti-psychotic medication, and Citalopram, an anti-depressant medication on discharge. The discharge summary noted that Mr. Y was not drinking and his home leave had gone well.[77]

[70] Case notes p. 211/389
[71] Case notes p.360
[72] Case notes p. 212/293
[73] Case notes p.393
[74] Case notes p. 287/312
[75] Ibid
[76] Case notes p.395
[77] Case notes p.370

On **5 February 2005** the Early Intervention CPN received a copy of a letter giving notice to Mr. Y that his tenancy was to end. She noted that the letter was sent before the professionals meeting on 31.01.2005. She confronted the Housing Association as this information had not been shared at the meeting. It was later explained by the Housing Association that this was a standard procedure as Mr. Y was on a time limited tenancy and the process had been explained to Mr. Y.[78]

On **7 February 2005** the Early Intervention CPN discussed Mr. Y with Psychiatrist 1. He informed her that he would be seeing Mr. Y on his return from leave and would be organising a brain scan for Mr. Y at the request of his mother.[79]

On **11 February 2005** the Early Intervention CPN carried out a Carer's Assessment with Mr. Y's father. However no support plan was recorded. [80]

On **15 February 2005** Mr. Y was seen by SHO 1 for an out-patient appointment. His diagnosis was recorded as psychosis under remission and mild depression. Mr. Y reported that he was not experiencing any hallucinations or delusions but he did report that he occasionally felt as if someone was pulling his arm and he could hear muffled music. Mr. Y suggested that these symptoms might be caused by anxiety. He reported that he was attending the day centre and wanted to return to work. Mr. Y was prescribed Olanzapine 5mg and Citalopram 20mg but the focus of the intervention with Mr. Y was to engage him in day time activities. [81]

On **22 February 2005,** while out with Early Intervention Worker 1, Mr. Y was noted to be laughing and smiling inappropriately and *"looking at a chef's gun and sharp knives"*. This worker had the impression that Mr. Y wanted her to respond to this behaviour, which she felt was not appropriate or helpful to do. Mr. Y informed her that he had not eaten for some days but that he was drinking alcohol.[82] Early Intervention Worker 1 contacted Crakenedge Hostel to ask the staff to monitor Mr. Y's eating. While talking to the Crakenedge staff they reported that Mr. Y was displaying what they described as "*attention seeking behaviour*", for example

[78] Case notes p. 216
[79] Case notes p.216
[80] Carer's notes p. 3
[81] Case notes p.310
[82] Case notes p.217

he was lining up all his cans of beer on the wall outside the hostel *"no matter what the weather."* They reported that they were *"not making an issue of this."*[83]
A HoNOS assessment on **23 February 2005** identified depression and drinking as Mr. Y's main problems.[84]

A CPA review meeting was held on **1 March 2005** when it was noted that Mr. Y was at risk of social isolation, abusing alcohol and financial exploitation. The plan was for Mr. Y to continue to be seen in the out-patients department, to attend the day centre groups for depression and assertiveness skills and for the Early Intervention CPN and a member of the supported housing staff to monitor Mr. Y's drinking and his vulnerability to exploitation by fellow tenants. This CPA plan was not signed by Mr. Y.[85]
.
Mr. Y appears to have been seen at least twice a week by the Early Intervention team during this period in addition to the ongoing contact he had with the Supported Housing workers.

On **15 March 2005** Mr. Y attended his out-patient appointment smelling strongly of alcohol. He informed the Senior House Officer that he was drinking a bottle of cider a day.[86] On this same day the Early Intervention CPN met Mr. Y's parents and they reported that they were distressed by his drinking and his "*interest in pornography."*[87]

Mr. Y's level of drinking had been discussed with him by both the Early Intervention CPN and a Housing Support Worker but Mr. Y had insisted that he did not need specialist help to moderate his drinking. On those occasions where he acknowledged that it would be beneficial to moderate his drinking Mr. Y insisted that he could achieve this himself, without specialist help.

On **15 March 2005** Mr. Y was seen in the psychiatric out-patients department by Senior House Officer 2. He described himself as "O.K." and denied any abnormal experiences. He admitted that he was drinking a bottle of cider a day. He also informed the Senior House Officer that he was not taking his medication regularly.[88]

[83] Case notes p.218
[84] Case notes p.41
[85] Case notes p.83
[86] Case notes p.167
[87] Case notes p. 222
[88] Case Notes p.289

On the same day the supported housing staff heard shouting coming from Mr. Y's room. When they checked on him he was found to be *"extremely drunk."* He explained that he had been shouting at the ghosts who pulled him out of bed. However he added that he did not expect anyone to believe him as this only happened when he had been drinking.[89]

On **21 March 2005** in a telephone conversation with Mr. Y's mother the Early Intervention CPN discussed the possibility of Mr. Y being prescribed Antabuse, a medication to help an individual stop drinking, and referral to the alcohol services.[90]

Mr. Y's mother subsequently contacted his GP who prescribed Antabuse on **24 March 2005**, However on **12 April 2005** Housing Support Worker 1 contacted the Early Intervention service to inform them that Mr. Y had stopped taking his Antabuse as, he reported, it made him feel sick.[91]

On **19 April 2005** Mr. Y reported to the Early Intervention CPN that another tenant was regularly taking money from him. Mr. Y was afraid of this man and tried to avoid him. It was for this reason that he sometimes failed to respond when she called. The Early Intervention CPN spoke to the Supported Housing Staff about this.[92]

On **21 April 2005** the Early Intervention CPN carried out a Carer's Assessment with Mr. Y's mother. The carer's support plan was not completed.[93]

At his out-patient appointment on **10 May 2005** Mr. Y reported that he believed that the Olanzapine was making him have strange thoughts. His mood was low but he denied any thoughts of self harm. His medication at this time was Olanzapine 5mg and Citalopram which was increased to 40mg.[94]

[89] Housing notes p.16
[90] Case notes p.222
[91] Case notes p.225
[92] Case notes p.222
[93] Carer's notes p. 15
[94] Case notes p. 163

A HoNOS assessment was completed on **31 May 2005.** Mr. Y was given a rating of 3 for depressed mood and drinking, a rating of 2 for hallucinations, unreasonable beliefs and being overactive/aggressive. He was given a rating of 0 for being suicidal and self harming.[95]

On **3 June 2005** Psychiatrist 1 reported that he had completed an eight session assessment of Mr. Y's suitability for psychodynamic psychotherapy. He concluded that Mr. Y was not suitable for this type of intervention but that he might benefit from Cognitive Behaviour Therapy (CBT) at some point in the future.[96]

On **5 June 2005** Mr. Y's mother wrote to the supported housing scheme to inform them that Mr. Y was being exploited by another tenant.[97]

On **7 June 2005** Mr. Y's mother telephoned the Early Intervention CPN to inform her that Mr. Y was drinking heavily. The Early Intervention CPN informed Mr. Y's mother that she had employed motivational interviewing techniques in an effort to persuade Mr. Y to address his drinking problem but he was determined to continue drinking.[98]

On **10 June 2005** Mr. Y was arrested for being drunk and disorderly.[99]

On **14 June 2005** an HoNOS assessment was completed. Mr. Y was given a rating of 4 (out of a possible 4) for being overact/aggressive and for drinking and 3 for depressed mood but 0 for risk of suicide and self harm.[100]

On **15 June 2005** a support planning meeting was convened by the housing association providing Mr. Y's supported accommodation. Mr. Y, his mother and the Early Intervention CPN attended the meeting. It was noted that Mr. Y was being exploited by other tenants, that he was misusing alcohol and that he became verbally aggressive and posed a threat to himself when he had been drinking and that he was at risk of becoming socially isolated. He was not deemed to be ready to live independently.[101]

[95] Case notes p.41
[96] Case notes p. 162 & 305
[97] Case notes p.160
[98] Case notes p.227
[99] Case notes p.228
[100] Case notes p.41
[101] Case notes p.136, 229

There are brief notes in Mr. Y's clinical records indicating that a CPA meeting was held on **27 June 2005.** Again concern was expressed about the level of Mr. Y's alcohol consumption. At the meeting Mr. Y agreed to moderate his drinking. However after the meeting he informed the Early Intervention CPN that he intended to get drunk.[102]

Later the same day loud noises were heard from Mr. Y's room. When the Supported Housing Staff checked on Mr. Y they found him to be very drunk, banging his head on the wall. They called the CRHTT to inform them of the situation. They then called the police who in turn called for an ambulance. Mr. Y was charged with a breach of the peace.[103] The following day, **28 June 2005,** Mr. Y appeared to be very distressed. He told the Supported Housing Staff that he felt he had let his parents down and asked for reassurance. He told the staff that he felt happy only when he drank.[104]

On **12 July 2005** Mr. Y appeared in Court. He was bound over to keep the peace for six months and fined £50.[105]

On **26 July 2005** Mr. Y made a statement to the police reporting that another tenant was taking money from him. This tenant was later arrested.[106]

On **11 August 2005** Mr. Y told the Early Intervention CPN that he had not had any alcohol for two weeks. He also reported that he felt that he was benefiting from a change in his medication.[107]

However, on **22 August 2005,** following a family holiday, Mr. Y's mother reported to the Early Intervention CPN that Mr. Y would spend all day in bed if he was allowed to. She also reported that she was "*upset by [Mr. Y's] attitude to his Mum and Dad's separation."*[108]

[102] Case notes p.230,290
[103] Case notes p. 231, 236. Housing notes p.20
[104] Housing notes p.20/21
[105] Case notes p. 231
[106] Case notes p. 232
[107] Case notes p.236/237
[108] Case notes p. 236

Between **1** and **13 September 2005** Mr. Y refused to see the Early Intervention CPN when she called on him.[109]

However a care plan was completed for Mr. Y dated **2 September 2005.** This was signed by Mr. Y.

It covered the impact of alcohol on Mr. Y's behaviour, housing, social activity, medication for depression and psychotherapy with Psychiatrist 1.[110]

On **1 September 2005** Mr. Y's mother contacted the Early Intervention CPN to tell her that Mr. Y was angry with her, the Early Intervention CPN. He had told his mother that he felt like hitting the Early Intervention CPN. Mr. Y's mother suggested that the Early Intervention CPN should be accompanied when she saw Mr. Y. The Early Intervention CPN felt that Mr. Y was saying these things to provoke a reaction and that he did not pose a threat to her. However she informed Mr. Y's mother that she would be making no further visits to Mr. Y unless he made contact with her. She received a message the next day from Mr. Y saying that he had been trying to contact her.[111]

On the same day a HoNOS assessment was completed for Mr. Y. He was given a rating of 2 for being overactive/aggressive, 3 for depressed mood and 0 for risk of suicide, self harm and drinking.[112]

The Early Intervention CPN saw Mr. Y on **14 September 2005** when she informed him that if he continued to sabotage the plans for his care he would be discharged. She also discussed his inappropriate sexual behaviour with him. Mr. Y was interviewed on the same day for alternative, move-on accommodation.[113]

On **19 September 2005** Mr. Y's mother again contacted the Early Intervention CPN and discussed her concerns about Mr. Y's behaviour towards her. The Early Intervention CPN

[109] Case notes p. 239-240
[110] Case notes p.43
[111] Case notes p.240
[112] Case notes p. 39
[113] Case notes p.241

told Mr. Y's mother that she thought his behaviour was an expression of his desire to be needed.[114]

On **10 October 2005** Mr. Y was seen by Psychiatrist 1 for an out-patient appointment. He was accompanied by his mother. It was reported that Mr. Y was sleeping most of the day, that he had little interest in life, was low in mood and felt he would be better off dead. Mr. Y reported that he had not had any alcohol since June 2005. Mr. Y's mother said that she was worn out. Psychiatrist 1 suggested that that she saw someone from the Carers Support Service.

Mr. Y's diagnosis was recorded at this time as: psychological problems, personality issues, low mood and anxiety and misuse of alcohol. His medication was changed to Venlafaxine XL 150mg and Aripiprazole 10mg.[115]

Later the same day, Mr. Y was informed that he was in arrears with his rent. Mr. Y's mother contacted the Early Intervention CPN to discuss the situation. Mr. Y was thinking of donating all his money to his Church. It was suggested that Mr. Y's mother looked after Mr. Y's money for him, with his permission. She put his money into a bank account and kept a written record of all subsequent transactions. Mr. Y's mother suggested that she would return to the family home if her son was also allowed to return. The family were not in favour of this. Mr. Y's sister telephoned the Early Intervention CPN later that day to inform her that she was very upset at the idea of Mr. Y returning home.[116]

On **19 October 2005** Mr. Y's mother wrote to the Early Intervention CPN saying that she feared that she might discharge Mr. Y if he did not make progress. She found this possibility distressing as both she and Mr. Y relied on the help and support the Early Intervention CPN provided.[117]

On **25 November 2005** Mr. Y's mother reported that Mr. Y had spent £2000 in the previous few weeks. She was concerned that he was vulnerable and was being exploited.[118]

[114] Case notes p. 242
[115] Case notes p.129
[116] Case notes p.73
[117] Case notes p.135
[118] Case notes p.75

The Early Intervention CPN was on sick leave for approximately five weeks from this point.

Mr. Y was seen as an out-patient by Psychiatrist 1 on **5 December 2005.** Again Mr. Y reported that he had had no alcohol since June. Mr. Y reported that he heard voices which he interpreted as God saying critical things. Psychiatrist 1 discussed interpreting these experiences in a more psychological manner. Mr. Y's diagnosis and medication remained unchanged.[119]

On **19 December 2005** Mr. Y's father contacted the Supported Housing Staff to report that a fellow tenant had "borrowed" £1100 from his son. He was angry and had contacted the police but they had informed him they could do nothing. Mr. Y's father felt that this incident proved his son was vulnerable and could not manage his money.[120].

On **3 January 2006** the Supported Housing Staff informed the Early Intervention CPN that Mr. Y was reluctant to engage with them. They were concerned that he was giving his money to other tenants but when they had tried to discuss this with him Mr. Y had insisted that he had given his money voluntarily. [121]

On **4 January 2006** Mr. Y's mother wrote to the Early Intervention CPN informing her that Mr. Y was continuing to be exploited financially. She also reported that Mr. Y was receiving religious instruction from his father. She commented "*He tells me that he has had his head messed with yet he is allowing himself to be indoctrinated again"*[122]

The next day Mr. Y, himself, told the Early Intervention CPN that he wanted to "*become a brother*" and was receiving instruction from his father.[123]

On **10 January 2006** a HoNOS assessment was completed. Mr. Y was given a of 2 for depressed mood and 0 for self harm, risk of suicide, over activity/aggression, drinking, hallucinations and unreasonable beliefs,[124]

[119] Case notes p. 134, 559
[120] Housing notes p. 25
[121] Case notes p. 76
[122] Case notes p.145
[123] Case notes p.77
[124] Case notes p. 39

On **11 January 2006** The Early Intervention CPN accompanied Mr. Y to the careers office. However by **13 January 2006** he was saying that he was not ready for work.[125]

On **20 January 2006** a review meeting was held at the Housing Association providing Mr. Y's supported accommodation, it was decided that his tenancy would not be renewed and that he would, therefore, require move-on accommodation in April 2006. Mr. Y's risks were recorded as being: Vulnerability – high, relapse of Mr. Y's mental health – low. [126]

On **24 January 2006** the Early Intervention CPN noted that Mr. Y was anxious about having to move. He was also making inappropriate sexual comments to her and to his Housing Support Worker both of whom were females.[127]

On **14 January 2006** the Early Intervention CPN visited Mr. Y at his request. He appeared bright and communicative and informed her that he intended to isolate himself, to start drinking, start smoking and that he did not want a job. The Early Intervention CPN discussed Mr. Y with her supervisor. She concluded that Mr. Y was able to make an informed decision and as a result she discharged him from her case load. [128] She wrote to Psychiatrist 1, to Mr. Y's GP and to Mr. Y's Housing Support Worker informing them of his discharge. She noted in her letter that Mr. Y would, at least initially, be receiving support from the Housing Association when he changed his accommodation.[129]

When the Early Intervention CPN wrote to key people to inform them of her decision, she sent a copy to GP 1 in the belief that he was still Mr. Y's GP. However, Mr. Y had de-registered with GP 1 on 29 September 2005 and did not return to his care until 11 August 2006.

Mr. Y failed to attend his out-patient appointment on **7 March 2006.**[130]

[125] Case notes p.77/8
[H] Case notes p.78
[127] Case notes p.79
[128] Case notes p. 80, 130
[129] Ibid p.130
[130] Case notes p. 559, 599

On **17 March 2006** Mr. Y told the Staff at the Supported Housing project that he was *"feeling bad"* because he had told his Housing Support Worker that that he "*had a crush*" on her. However the nature of professional relationships was explained to Mr. Y and he said that he understood this.[131]

On **24 April 2006** Mr. Y received an abusive letter from his brother which greatly upset him.[132]

On the **27 April 2006,** during his key worker session with Supported Housing Worker 1, Mr. Y discussed this letter. He was still upset by it but felt that it reflected his brother's mental state at the time. Mr. Y's management of his finances were also discussed during the session. Mr. Y's key worker pointed out to him that he had given away all his savings, around £10,000, in two years. Mr. Y felt that he could cope and that if staff intervened on his behalf then those asking him for money might become angry with them.

Mr. Y disclosed that he was thinking of returning to Kingdom Hall "*as he could not cope with the hassle from his family."*[133]

Around **3 May 2006** Mr. Y's father tried to contact the Early Intervention Service to inform them that he was concerned about Mr. Y's behaviour and had banned him from the family home. Early Intervention Worker 2 tried to contact Mr. Y's father by telephone on **3** and **11 May 2006** without success.

On **19 May 2006**Early Intervention Worker 2 wrote to Mr. Y's father telling him that Mr. Y had been discharged from the Early Intervention Service but the staff at the Supported Housing project continued to work with him. She advised Mr. Y's father that as his son did not know that he had contacted the service they *"could not act on [his] concerns."* She advised Mr. Y to contact the staff at the Supported Housing project who could talk to Mr. Y and if necessary liaise with the CMHT. [134]

[131] Housing notes p. 27
[132] Housing notes p. 29
[133] Housing notes p. 46
[134] Case notes p. 126

On **5 June 2006** Mr. Y's parents wrote to the Housing Association expressing their concern that other tenants were intimidating and financially exploiting their son.[135]

On **26 June 2006** Mr. Y was reviewed by Psychiatrist 1 at a psychiatric out-patient appointment. Mr. Y was reporting a range of symptoms compatible with psychosis. Psychiatrist 1's diagnoses at this time were: psychological problems, personality issues, low mood and anxiety, alcohol misuse and *"? Psychotic illness."* Mr. Y was prescribed Aripiprazole 10mg and Venlafaxine 150mg. He was also referred to the CMHT with the request that a CPA review should be arranged after Mr. Y had been assessed.[136]

Mr. Y called the CMHT on **7 July 2006** inquiring about the progress of his referral. He was informed that he was to be seen by CPN 2 and an appointment was made.[137]

Mr. Y had a psychiatric out-patient appointment on **10 July 2006**. At this appointment Psychiatrist 1's impression of Mr. Y was that he was confused, had a poor sense of self identity, suffered with overwhelming emotions and intense neediness, he had difficulty with relationships, feared abandonment and misused alcohol. He suggested a diagnosis of Borderline Personality Disorder. Mr. Y's medication remained unchanged.[138]

By this time Mr. Y had moved to less supported accommodation. When CPN 2 visited later the same day he found Mr. Y drunk on the floor of a neighbour's flat.[139]

CPN 2 made his initial assessment on **17 July 2006.** He identified that Mr. Y was experiencing distressing thoughts related to his religious beliefs. Mr. Y's self esteem was poor; he had no friends or social network. Mr. Y was spending a significant amount of money on alcohol, and although he was not addicted he did become preoccupied when he drank. Mr. Y was not reporting any suicide plans and CPN 2's impression was that he did not pose a risk of violence. He was managing his self care.

[135] Housing notes p.33
[136] Case notes p.125 & 560
[137] Ibid p.46
[138] Case notes p. 561
[139] Case notes p. 48

CPN 2's plan was to address Mr. Y's self esteem, challenge his thought processes and work with Mr. Y on his self care skill and his social-confidence.[140]

Although CPN 2 noted on **1 September 2006** that there would be fortnightly visits from the CMHT staff, from the case notes it would appear that he was only seen on **3 August 2006, 1 September 2006** and **29 September 2006.** There was then a gap until **23 November 2006.**

Mr. Y appeared to be showing some improvement and was engaged with a day service which he attended several times a week during **August and September 2006**.[141]

Mr. Y was seen by Psychiatrist 1 on **4 September 2006** when he recorded that Mr. Y was more optimistic and had not heard any voices for the previous month. His diagnosis was again: psychological problems, personality issues, low mood and anxiety, and alcohol misuse. Mr. Y's medication remained unchanged. Again Psychiatrist 1 requested a CPA review following assessment by the CMHT. His letter to Mr. Y's GP was copied to CPN 2.[142]

CPN 2 visited Mr. Y on **23 November 2006.** Mr. Y reported that he was making considerable progress with respect to his self esteem. He rated himself at point 5 on a 10 point scale of "wellness". However he did report that he continued to struggle with ideas of and beliefs about God.[143]

Mr. Y's outpatient appointment for **27 November 2006** was cancelled. He was next seen by Psychiatrist 1 on **5 December 2006.** Mr. Y was distressed and tearful throughout this appointment. He reported that he had started attending Kingdom Hall again to please his father. He observed that he felt "*judged and persecuted by this religious group."* He reported a negative view of himself and was experiencing a sense of guilt and shame. Mr. Y's diagnosis and medication remained unchanged. However he noted in his letter to Mr. Y's GP that: "*I feel it would be appropriate soon that we arrange another case conference to discuss [Mr. Y's] on going progress".* Psychiatrist 1's letter to the GP was copied to CPN 2.*[144]*

[140] Case notes p.30
[141] Case notes p.50
[142] Case notes p.123
[143] Case notes p. 50
[144] Case notes p.121

Mr. Y cancelled his appointment with CPN 2 on **14 December 2006.** However, CPN 2 phoned Mr. Y who reported that he was continuing to make progress and had been attending a 'Back to Work' course. He planned to spend Christmas at his mother's home. CPN 2 agreed to see Mr. Y in the New Year.[145]

Mr. Y was seen by Psychiatrist 1 on **30 January 2007.** He was accompanied by his mother who was angry that Mr. Y was again being financially exploited. However Psychiatrist 1 felt that while Mr. Y was vulnerable it was important that he learned what is appropriate and inappropriate in his relationships with other people and that he would have to make some mistakes in order to learn. He also noted that Mr. Y was attending a sports group and Worklink. Mr. Y's mother was receiving support from the carers support service. [146].

CPN 2 saw Mr. Y on **2 February 2007.** He found Mr. Y to be positive; he reported that he was attending the MIND day services two to three times a week and a 'Back to Work' course. CPN 2 informed Mr. Y that he would be leaving and a new member of staff would be identified to work with him.[147]

On **12 February 2007** Mr. Y's mother contacted the CMHT to express her concerns about Mr. Y being financially exploited again. CPN 2 made contact with Housing Support Worker 1 who had known Mr. Y for some time. She explained that this was a long standing problem. She had tried to teach Mr. Y assertiveness skills in the past but he continued to find it difficult to say "No" to people.[148]

CPN 2 visited Mr. Y on **16 February 2007** to introduce him to his new CMHT worker, Community Care Officer 1 (CCO 1). He also produced a new care plan. This addressed his self esteem, the distressing thoughts which affected Mr. Y's ability to function socially and manage his self care activities, and Mr. Y's vulnerability to exploitation. It was planned that Mr. Y would be seen on a fortnightly basis. This care plan was not signed[149]

[145] Case notes p. 51
[146] Case notes p.592
[147] Case notes p. 51
[148] Case notes p.52
[149] Case notes 42, 52

On the **23 February 2007** Mr. Y reported that his neighbour had kicked his door on the previous evening. The police were called and they advised both parties to stay away from each other. The housing association sent a warning letter to Mr. Y's neighbour as he had breached his tenancy agreement. [150]

On the **24 February 2007**, Mr. Y retaliated and smashed his neighbour's door with a hammer. Mr. Y was arrested by the police and cautioned for an offence of criminal damage.

CCO 1 visited Mr. Y on **5 March 2007.** He reported that he was trying to control his drinking; he was attending a 'Back to Work' course and awaiting a work placement. He reported that his relationship with his parents was good. He told CCO 1 that he was not getting on with his neighbour. Mr. Y was not reporting any thoughts of self harm.[151]

CCO 1 saw Mr. Y again on **20 March 2007** and identified no issues of concern.

Mr. Y was seen by Psychiatrist 1 on **30 April 2007**. Mr. Y reported that he was feeling a little better, that he had a place on a work placement scheme and that he had reduced his alcohol intake to four cans of larger a day. Psychiatrist 1 wrote to Mr Y's GP advising him that his diagnosis for Mr. Y was: Psychological problems (related to being very judgemental about himself related to his religious beliefs and family dynamics) and low mood and anxiety. He also advised that Mr. Y's anti-psychotic medication be reduced from Aripiprazole 10 mg to 5 mg. His anti-depressant medication, Venlafaxine 150mg, was to remain unchanged.[152]

CCO 1 saw Mr. Y at home on **14 May 2007.** He reported that his neighbour, with whom he had some conflict, had moved but Mr. Y visited him at his new address. Mr. Y was continuing to control his drinking and was attending a computer course. CCO 1 referred Mr. Y to an anxiety management course. He identified no concerns.[153] Mr. Y had been allocated a befriender from the St Anne's Befriending Service.

CCO 1 completed a HoNOS assessment at this point. He gave Mr. Y a rating of 2 for depressed mood and 0 for risk of suicide and self harm. Disruptive and aggressive behaviour

[150] Housing p. 50
[151] Case notes p.53
[152] Case notes p.587
[153] Case notes p. 54

was given a rating of 1. Hallucinations was given a rating of 1 and unreasonable beliefs a rating of 2.

On the same day CCO 1 wrote to Mr. Y to inform him that he would be on sick leave from the **15 May 2007**. Mr. Y was advised to contact the CMHT manager if he needed help, or the CRHTT team out of hours.[154]

On **19 June 2007** Supported Housing Worker 1 contacted the CMHT to inform them of her continuing concerns regarding Mr. Y's vulnerability to exploitation. She also inquired if there was someone who might help Mr. Y in CCO 1's absence.[155]

On **26 June 2007** Mr. Y's Housing Support Worker contacted the CMHT to inform them that Mr. Y had been deteriorating over the previous six weeks; he had allowed two people to stay in his flat, was lending them money and was, in consequence in rent arrears. Mr. Y had admitted taking crack cocaine on several occasions with his two visitors. He had been questioned by the police about a burglary of a neighbouring, empty flat and removing pipe work.[156]

The housing support worker e-mailed this information to the manager of the CMHT. In her e-mail she pointed out that CCO 1 was on sick leave and asked for someone to be identified to support Mr. Y.[157] The manager of the CMHT asked Social Worker 1 to re-assess Mr. Y.[158]

On **27 June 2007** Social Worker 1 contacted the Housing Support Worker**.** The plan recorded at this time was for the Housing Support Worker to continue to support Mr. Y, to provide information about the advocacy service, to monitor Mr. Y's mental health and contact Social Worker 1 "if *and when necessary*". Social Worker 1 was to contact the CMHT housing liaison worker to help Mr. Y secure alternative accommodation.[159]

Mr. Y was seen by Psychiatrist 1 on **9 July 2007.** At this appointment he told Psychiatrist 1 that he felt well, and was not experiencing any symptoms of anxiety or psychosis. However

[154] Case notes p.119
[155] Housing notes p. 56
[156] Case notes p.113
[157] Case notes p.113
[158] Case notes p. 56
[159] Case notes p. 57

he had shaved off his hair and eyebrows. Mr. Y informed Psychiatrist 1 of the recent events including being charged with burglary. There is no record that he informed Psychiatrist 1 that he took crack cocaine. Mr. Y's Venlafaxine was reduced to 75 mg, his Aripiprazole remained at 5 mg.[160]

On **10 July 2007** Mr. Y's mother informed the carer support worker that Mr. Y had been visiting her and pleading with her to give him money. When she had refused he had become verbally aggressive. This happened while he had the two visitors staying in his flat. Mr. Y asked his mother to contact the police to have his visitors removed. She did this. She reported that he was not welcome in his father's house and his bother and sister did not want anything to do with him.[161]

On **13 July 2007** Social Worker 1 visited Mr. Y with the housing liaison worker. He had been to Court and had been bailed to appear again on 24 July 2007. Social Worker 1 clarified the roles of the different agencies involved in caring for and supporting Mr. Y. She offered to visit him fortnightly if he needed extra support with his mental health.[162]

On **20 July 2007** Mr. Y received a letter from the Housing Association to inform him that he would not be evicted but that his tenancy had been downgraded to an assured short hold tenancy.[163]

On the same day Mr. Y reported that he was taking his medication as prescribed when asked by the Housing Support Worker. [164] The discrepancy in relation to the reduced dose of Aripiprazole was not detected. Housing Support Worker 1 had not been informed of the change in medication, and it was not her responsibility to monitor this.

On **1 August 2007**, Mr. Y telephoned the CMHT asking for the telephone number of the Samaritans. He said that he was in a financial mess and that he did not know what to do. He was advised to speak to the Housing Support Worker for practical advice. [165]

[160] Case notes p. 116/567
[161] Carer's notes p.30
[162] Case notes p. 57Housing notes p.62
[163] Case notes p.113
[164] Housing notes p. 62
[165] Case notes p. 58

Later he called Housing Support Worker 1. He asked for the number of the Samaritans and told her that he was feeling low and had thoughts of suicide. She gave Mr. Y the number of the Samaritans and checked that he was seeing Social Worker 1 the next day and arranged to see him herself the following day. [166]

Housing Support Worker 1 contacted Social Worker 1 the next day to check that she was seeing Mr. Y that day and to pass on her concerns regarding Mr. Y.[167]

CCO 1 returned from sick leave on **6 August 2007** and contacted the various agencies involved with Mr. Y for an update as to what had been happening in his absence and Mr. Y's current state of well being.. He visited Mr. Y on **8 August 2007** when Mr. Y reported feeling "*better*" and "*more settled*" and having "*learned a lesson*". Mr. Y reported that he was looking forward to attending the anxiety management group.[168]

CCO 1 saw Mr. Y on approximately 13 occasions throughout the rest of 2007, initially at weekly intervals.

Mr. Y attended the first day of the anxiety management course on **20 August 2007** but failed to attend subsequent sessions. He called the organisers of the group to tell them he could not attend because he had a "*stress headache*".[169]

Mr. Y was seen by Psychiatrist 1 in the out-patients department on **24 September 2007.** Psychiatrist 1 wrote to Mr. Y's GP informing him that Mr. Y described himself as feeling well, not having drunk alcohol for two weeks, attending a sports group and looking to join a job club. He was, however, concerned that he was spending too much time alone. He reported that members of the Jehovah's Witnesses community were visiting him. He also reported that he was getting on better with his mother. Mr. Y told Psychiatrist 1 he was experiencing some spasms which woke him. Psychiatrist 1 felt that this might be related to his medication and suggested that Mr. Y stop his Aripiprazole but continue with his Venlafaxine.[170]

[166] Housing notes p.63
[167] Housing notes p. 64
[168] Case notes p. 58
[169] Case notes p,105
[170] Case notes p. 102

When CCO 1 met Mr. Y on **22 October 2007** he noted no obvious deterioration in his mental health, he was going shopping with Housing Support Worker 1 and he was interested in being referred to the Pathways day services**.**[171]

On **6 November 2007** Mr. Y was offered a place on the anxiety management group which was due to start on 12 December 2007.[172].

On **9 November 2007** Housing Support Worker 1, who had been asking Mr. Y to keep a mood diary and completed a depression inventory to monitor his mood, noted that his mood was lower that it had been. He speculated that was because he was less active and his mood diary seemed to confirm that his mood was lower when he was in his flat on his own. He looked at the types of mood he was experiencing and the thoughts that were associated with them with this worker.[173]

Mr. Y was seen by Psychiatrist 1 on **12 November 2007.** Mr. Y told Psychiatrist 1 that he was feeling well and that the anti-depressant medication was making him feel less anxious. He was feeling more motivated. He was attending a course at the day centre aimed at helping him get back to work, attending a cookery course and occasionally a sports group. He felt well supported by CCO 1 who he was seeing fortnightly. Mr. Y reported that he had not experienced any psychotic-like symptoms since he had stopped his Aripiprazole. Given this presentation Psychiatrist 1 discharged Mr. Y back to the care of his GP. His diagnosis at this time was: "*Psychological problems (linked to judgemental issues re Jehovah's witness and family dynamics), low mood and anxiety."* His medication remained Venlafaxine 75 mg.[174]

On **21 November 2007**, the staff from the cookery course that Mr. Y had been attending contacted the Housing Support Worker to inform her that Mr. Y had appeared to be low in mood on the previous day and had left the course early.[175]

On **23 November 2007** Mr. Y was seen by CCO 1 who recorded that Mr. Y was continuing to do well and he identified no concerns with Mr. Y's mental health or behaviour.[176] A

[171] Case notes p.60
[172] Case notes p.98
[173] Housing notes p. 66
[174] Case notes p.100/568
[175] Housing notes p.67
[176] Case notes p. 60

HoNOS assessment was completed with Mr. Y being given a rating of 2 for depressed mood, 1 for overactive/aggressive and 0 for risk of suicide, self harm, hallucinations and unreasonable beliefs.[177]

On **7** and **10 December 2007** CCO 1 tried to contact Mr. Y on a number of occasions without success.[178] He eventually made contact on **11 December 2007** when Mr. Y told him that he had lost his telephone charger and so could not take any telephone calls. Mr. Y reported that he was continuing to attend his various day time activities and CCO 1 accompanied Mr. Y to his cookery course noting that his displayed some "*low level*" anxiety.[179]

On **12** and **13 December 2007** CCO 1 accompanied Mr. Y to his anxiety management group where he again showed some initial anxiety but later felt calmer. On **13 December 2007** CCO 1 informed Mr. Y that he was about to go on sick leave and agreed that Mr. Y should contact the CMHT if he felt he needed help.[180].

On **17 January 2008** Mr. Y was seen by Housing Support Worker 1 for his regular key worker support sessions. During this session she informed him that she would no longer be his key worker and that he would be seeing someone else. This change of key workers was part of the housing association's standard procedure.

On **29 January 2008,** when he returned to work after his sick leave, CCO 1 tried on a number of occasions to contact Mr. Y by phone. He then contacted Housing Support Worker 1 asking her to ask Mr. Y to make contact with him. The Housing Support Worker informed CCO 1 that she had seen Mr. Y over recent weeks and had no particular concerns about him but she had noticed that his drinking had increased.[181]

CCO 1 made a home visit to Mr. Y on **31 January 2008** but received no reply.

On **31 January 2008** Mr. Y's mother telephoned Housing Support Worker 1 to relay her concern over Mr. Y's mental health. He had sent a text message to her some weeks earlier

[177] Case notes p. 40
[178] Case notes p.61
[179] Case notes p. 61
[180] Case notes p.62
[181] Case notes p. 62

expressing thoughts of wanting to hurt people, though no-one in particular was identified. Mr. Y had not sent her a text message or visited her recently and this was unusual. Housing Support Worker 1 gave Mr. Y's mother CCO 1's telephone number and told her that the housing association would increase Mr. Y's support. [182]

The Housing Association notes for the same day record that Mr. Y was displaying no motivation; he was sitting in the chair smoking; his flat was dirty and messy with beer cans and cigarette butts scattered around it. Mr. Y described himself as feeling very negative. He was talking about himself in the third person and asking whether people were talking about him. Housing Support Worker 2 noted that there were a number of medication packets on his table, some opened some not. When asked if he had been taking his medication Mr. Y at first he said that he was and then changed his answer to "*No*".[183] It was planned that this information should be passed on to CCO 1.[184]

On **4 February 2008** Housing Support Worker 2 contacted CCO 1. He informed CCO 1 that he was concerned about Mr. Y. When he had visited Mr. Y there were beer cans littering his flat, Mr. Y was not eating and he looked depressed.[185] CCO 1 arranged to see Mr. Y immediately with the Housing Support Worker. When he arrived at Mr. Y's flat Mr. Y appeared to be in a low mood and was talking about how his father had treated him in the past. He also disclosed that he had stopped taking his anti-depressant medication as he felt that he had been taking it for too long. Mr. Y's last prescription had been dispensed on 27 December 2007. After some discussion Mr. Y agreed to recommence his anti-depressant. CCO 1 contacted the GP surgery and arranged for a new prescription to be ready for the next day.

Mr. Y reported that he had stopped attending his day activities as he felt low in confidence and self esteem. He agreed to go to the next sports groups on 6 February.2008 with CCO 1 accompanying him. He also agreed to go shopping for food with the Housing Support Worker. Mr. Y said that he had not had a drink since "last week". CCO 1 accompanied Mr. Y

[182] Housing notes p. 71
[183] Housing notes p. 70
[184] Housing notes p. 73
[185] Housing notes p.71/81

for gas and electricity tokens. At the end of this session Mr. Y said that he felt better for talking and that he had no thoughts of self harm.[186]

On **6 February 2008** Mr. Y's mother contacted CCO 1 to inform him that she had seen her son the day before. He had been drinking and had wanted to continue drinking at her house. She had asked him to leave. She was concerned about the amount Mr. Y was drinking. CCO 1 agreed with Mr. Y's mother that Mr. Y's mood and functioning deteriorated when his drinking increased. CCO 1 suggested that she should encourage Mr. Y to seek help via Lifeline, which up to that time he had been reluctant to do. Mr. Y's mother reported that she was seeing her son more frequently and had been buying him household items.[187]

When CCO 1 visited Mr. Y later that day to take him to the sports group Mr. Y said that he was *"not up to"* going to the group. There were empty beer cans around the flat and Mr. Y had not picked up his prescription from his GP. CCO 1 accompanied Mr. Y to pick up his prescription. Mr. Y assured CCO 1 that he would take his medication. They spoke about the detrimental effects of alcohol on mental health and functioning and CCO 1 encouraged Mr. Y to "*seek appropriate help*". Mr. Y, however, told CCO 1 that he did not think he had a problem with alcohol. [188]

CCO 1 completed a HoNOS assessment on the same day. Mr. Y was given a rating of 2 for depressed mood, unreasonable beliefs and drinking; a rating of 1 for disruptive and aggressive behaviour and ratings of 0 for hallucinations, risk of suicide and self harm. [189]

On **8 February 2008** CCO 1 contacted Supported Housing Worker 2 who informed him that he had seen Mr. Y the day before. He felt that there was an improvement in Mr. Y's mood and he was talking more positively about the future.[190]

On **13 February 2008** CCO 1 called to see Mr. Y however he received no answer. He then contacted the Support Housing Staff and was told that Housing Support Worker 2 was due to see Mr. Y the next day. CCO 1 asked that Mr. Y be reminded that he would be calling to take

[186] Case notes p. 62
[187] Case notes p. 64
[188] Case notes p.65
[189] Case notes p. 10
[190] Case notes p. 66

him to his visit to Pathways on 18 February 2008. He also sent a letter to Mr. Y to confirm this appointment.[191]

On **14 February 2008** Housing Support Worker 2 called to see Mr. Y**.** He received no reply. He contacted CCO 1 and informed him that he would instigate the Housing Association's Missing Persons procedure the next day as Mr. Y had not been seen for a week.[192]

On **15 February 2008** CCO 1 contacted Mr. Y's mother. She reported that she had last spoken on the telephone to Mr. Y on Monday evening. She expressed concern over Mr. Y's drinking and isolation. CCO 1 said that he would try to engage Mr. Y but he had to agree to receive a service. He asked Mr. Y's mother to remind him of his appointment on 18 February 2008. CCO 1 recorded the following plans: accompany Mr. Y to Pathways, try to re-engage Mr. Y with support services, and to reiterate the negative effects of alcohol on his mental health.[193]

On **17 February 2008** Mr. Y went for a walk with his mother. He told CCO 1 that he had enjoyed this. She reminded him of his appointment on 18 February 2008. On **18 February 2008** CCO 1 accompanied Mr. Y to Pathways. CCO 1 recorded that Mr. Y was brighter in mood and appearance.

Mr. Y was shown around Pathways and expressed an interest in the singing group. CCO 1 agreed to facilitate his attendance at this for the first two weeks of the seven week course. The plan was as follows: continue to take medication, moderate drinking, keep appointments, and attend the singing group at Pathways.[194]

On **19 February 2008**, Mr. Y was visited by Housing Support Worker 2. Mr. Y reported that he was feeling better than the last time he was seen. However it was noted that he continued to sit at home and ruminate, dwelling on things which people had said to him in the past.[195]

[191] Case notes p. 66
[192] Case notes p. 66/Housing notes p. 92
[193] Case notes p.67
[194] Case notes p. 68
[195] Housing notes p.87

On the 19 February 2008, Mr. Y's mother sent Mr. Y a text message to inform him that a little girl had gone missing from the locality. [196]

At some point, the exact date of which is unclear, Mr. Y made repeated telephone calls to his mother at work. When she spoke with Mr. Y, he told her that his father had sexually abused him. She asked him what proof he had and he had none.

On **21 February 2008** CCO 1 called at Mr. Y's flat to accompany him to the singing group at Pathways. He received no reply. He left a message on Mr. Y's answer phone and sent a letter to him asking him to make contact. [197]

On **21 February 2008** Mr. Y was arrested for the murder of his father**.**

When Mr. Y was assessed at Dewsbury police station he reported that he had been unwell for two or three days. He had been having "*bad thoughts*" about having been physically and sexually abused by his father as a child. He felt 99% certain that these beliefs were true. He said that his mother had sent him a text message about a missing child in Dewsbury and as a result he had not been able "*to hold it together".*[198]

The psychiatrist assessing Mr. Y following his arrest was of the opinion that Mr. Y's beliefs were delusional but that he was fit to be detained and interviewed in the presence of an appropriate adult.[199]

[196] Case notes p.570
[197] Case notes p.68
[198] Case notes p. 570
[199] Case notes p. 570

11. Timeline and Identification of the Critical Issues

11.1. Thematic issues

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

11.1.1 The Care Programme Approach: Assessing Needs and Planning Care

The Independent Investigation found that best practice, as reflected in the Trust's 2007 Care Programme Approach (CPA) policy, was not reflected in the care and treatment provided to Mr. Y. Mr. Y was placed on the standard level of CPA throughout the time he was under the care of the Trust. This was not reviewed as his circumstances changed. Mr. Y's needs were not assessed, nor was his care planned in a systematic manner or in response to his changing life circumstances, as would have been expected by best practice.

There is no evidence that Mr. Y, his mother or the supported housing staff, who provided a significant amount of Mr. Y's support, were consistently involved in identifying Mr. Y's needs or in planning his care.

11.1.2. Risk Assessment and Management

There was no overall formulation to provide an understanding of the factors that might have influenced the level of risk Mr. Y posed. There were a number of occasions when the risk he posed both to himself and to others, should have been assessed and risk managment and crisis management plans put in place. However this was not done.

The Health of the Nation Outcome Scales were employed to assess the risk Mr. Y posed. This is too imprecise a device to be used for this purpose. In 2006 the Trust introduced a revised risk management policy which approved the use of the Sainsbury Risk Assessment Tool. This revised policy was not implemented in Mr. Y's case. The risk management plans that were

drawn up were of a basic standard and did not indicate what needed to be done to manage any risk Mr. Y posed or what the goals of the interventions might be.

Best practice would indicate risk assesssments and the consequent development of management plans should have been done in co-operation with the service user, his carers and those professionals involved in his or her care. There is no evidence that this best practice guidance was followed in Mr. Y's case.

11.1.3. Diagnosis

Mr. Y had a number of diagnostic labels applied to him while under the care of the Trust. His initial presentation was one of an affective disorder. Later, symptoms suggestive of a psychosis emerged. Over time these appeared to subside and other problems came into prominence: his misuse of alcohol, his vulnerability, his chronic low self esteem and poor survival skills. However, there was no agreed formulation or diagnosis of Mr. Y's problems. Members of the team caring for him adopted different models to inform their clinical practice. This lack of a clear and agreed formulation reduced the likelihood of Mr. Y receiving the most effective care in a consistent manner.

From early in his contact with the mental health services clinicians identified that there were "*personality issues*" associated with Mr. Y's presentation. Unfortunately, at this time, there were no dedicated services for individuals suffering from personality disorders within the Trust, to which staff might have referred Mr. Y. This aspect of Mr. Y's presentation therefore went unaddressed.

11.1.4 Treatment

11.1.4.1. Medication

Throughout the time Mr. Y was under the care of the South West Yorkshire Partnership NHS Foundation Trust he was on either anti-depressant medication or a combination of anti-depressant and anti-psychotic medication. Appropriate medications were employed at recommended dosages. Mr. Y's medications were regularly reviewed and changed in response to both the symptomatology he was reporting and his report of the side effects he was experiencing.

It was suggested during Mr. Y's in-patient admission in January 2005 that the anti-psychotic medication might be stopped. However Mr. Y continued to be prescribed this medication until September 2007. This was a not an unreasonable treatment regimen given that Mr. Y reported symptoms which might have been indicative of an underlying psychosis when he became distressed.

When Psychiatrist 1 reduced and then stopped Mr. Y's anti-psychotic medication in 2007 he did this in accordance with good practice. He recommended reducing the Aripiprazole from 10 mg to 5 mg in May 2007, monitored Mr. Y's mental state until September 2007 then recommended that the medication be discontinued. Mr. Y's medication was not reduced until August but this was not known to Psychiatrist 1 when he made his decision to recommend that Mr. Y's anti-psychotic medication be stopped. That this information was not available to Psychiatrist 1 was a serious weakness. However, the decision by Psychiatrist 1 to discontinue Mr. Y's anti-psychotic medication was a reasonable one given the information available to him at that time.

11.1.4.2 Psychological Therapies

Psychiatrist 1 identified that Mr. Y might benefit from individual psychological therapy and assessed his suitability for psychodynamic psychotherapy. He concluded that Mr. Y was not suitable for this form of intervention but that he would benefit from a more structured approach, such as CBT. There is no evidence that this recommendation was pursued or that Mr. Y was referred for CBT or any other form of psychological therapy.

Best Practice Guidelines for both psychosis and depression recommend that service users with these types of problems should have access to psychological therapies. These were not made available to Mr. Y. There were no psychological resources allocated to the community team at this time. This may have made it difficult to access psychological therapies. It may also have reduced the importance accorded to these interventions.

The dynamics of Mr. Y's family life played an important role in his presentation. Psychological interventions to explore and address these issues might well have been beneficially provided, however there is no evidence that such a course of action was considered.

11.1.4.3 Alcohol

Mr. Y had a significant alcohol misuse problem for most of the time he was in contact with the Trust's mental heath service. The detrimental effects of alcohol on his behaviour, his mental state and even on his ability to benefit from the services made available to him were well recognised. Mr. Y's family and those providing care and support repeatedly encouraged Mr. Y to address his alcohol problem. Mr. Y's mother accompanied him to his GP who prescribed the medication Antabuse to help Mr. Y stop drinking. However Mr. Y showed no consistent motivation to reduce his alcohol intake and on a number of occasions reported that he used it to ameliorate the distress he experienced associated with his mental health problems.

Given the services available there was little the staff of the Trust could do to affect Mr. Y's drinking without his willing co-operation. This was not forthcoming. They consistently provided him with information about the alcohol service but had no authority to compel him to engage with this service. This was a source of frustration for Mr. Y's family, the staff of the Trust and the staff of the Housing Association.

11.1.5. Cultural Diversity

Religion played an important role in Mr. Y's life. There appears to have been an assumption that religion was a cause of distress to Mr. Y, but the possibility that his problems with religion might be a manifestation of his mental health problems does not appear to have been explored. Had this been done the monitoring of his mental state may have been more sensitive and reliable.

Despite the acknowledgement of the importance of religion in Mr. Y's life, no advice was sought on the beliefs of the Jehovah's Witnesses nor was any attempt made to forge a co-operative relationship with the local Jehovah's Witness community. Such a relationship might have informed the assessment of his mental state and facilitated or potentiated interventions.

11.1.6. Vulnerable Adults and Safeguarding

Mr. Y's vulnerability to exploitation was recognised by his family and those caring for him. This vulnerability was understood to be a product of Mr. Y's upbringing, beliefs and his personality. Several members of staff tried to help Mr. Y by explaining to him the consequences of his actions, by working with him on his self esteem and assertiveness skills,

by referring him to therapeutic and skills groups and by offering to look after his money. What they did not do was to trigger the Adult Safeguarding Procedures.

Mr. Y's family were frustrated that nothing was done which protected their son. However, staff felt that they were limited in the extent to which they could intervene because Mr. Y usually withheld his consent for them to confront those exploiting him. They felt bound to comply with his wishes.

While there is no guarantee that following the Adult Safeguarding procedures would have offered Mr. Y significantly more protection, with a consequent improvement in his mental health, not triggering the Safeguarding Procedures was a missed opportunity to explore, in a structured and formal way, what might have been done to help Mr. Y.

The fact that abuse resulting from Mr. Y's vulnerability was not prevented, significantly financially disadvantaged him. It also, at least episodically, harmed his mental health and well-being.

11.1.7. Service User Involvement in Care Planning

It is the conclusion of the Independent Investigation Team that the care and treatment offered to Mr. Y aimed at promoting his independence, self confidence and assertiveness. To this extent the care provided was user centred. However, in part because of the lack of formal care planning and in part because of Mr. Y's personal characteristic, those caring for Mr. Y found it difficult to engage him in planning his care and establishing his goals.

11.1.8. The Family

Involving the families and carers of service users in the assessment of needs and the planning of care is well established good practice. Mr. Y's family were not involved, formally or systematically, in the assessment of his needs or planning of his care.

Having identified the importance of the dynamics of Mr. Y's family on his mental health and well-being this should have been explored and included in the formulation of his problems. This was not done. Similarly, having identified this issue, consideration should have been given to the provision of some form of family intervention. Again this was not done.

Mr. Y's parents' need for support was identified and resources were put in place to meet this need. This was good practice. However, it would have been better practice if an agreed plan, to meet the identified needs, had been put in place.

11.1.9. Communication and Care Co-ordination

Communication failed on a number of important occasions in Mr. Y's case, for example when he was discharged from in-patient care, when the psychiatrist caring for him advised that his anti-psychotic medication should be reduced, when he changed his GP, and when his mental state began to deteriorate in 2008. Some of these breakdowns represented serious weaknesses in the system of communication and could have resulted in serious incidents occurring at those times.

At the time when Mr. Y was under the care of the Trust there was no mechanism in place to ensure the staff of the Supported Housing Association were systematically involved in the assessment of his needs or in the planning of his care. There was no joint working policy in place between the Housing Association and the mental health services.

At times the responsibilities of the mental health services and the Housing Association appear to have been blurred. Blurring boundaries and responsibilities is not good practice as it places both service users and staff at risk.

11.1.10. Management of Mr. Y's care

A number of weaknesses in the overall management of Mr. Y's care were noted.

- *Continuity of care*

There was no mechanism in place to ensure that Mr. Y remained in contact with the mental health services when he was transferred between elements of the service.

- *Continuity and the provision of appropriate care*

While under the care of the CMHT there were significant periods when Mr. Y had no contact with the mental health services.

- *Leaning and reflective practice*

Perhaps because Mr. Y's care was not formally reviewed on a regular basis, there is no evidence of any reflection on, or learning from, previous experiences by those providing care and treatment for Mr. Y. This is of particular note for those episodes when Mr. Y's care co-

ordinator was absent and his mental state or behaviour deteriorated. Such reflective practice would have informed Mr. Y's care planning.

- *Clarity of roles*

At times there appears to have been a lack of clarity about roles and responsibilities of members of the multi-disciplinary team. Psychiatrist 1 initially tried to fulfil the roles of both Psychotherapist and Consultant Psychiatrist. On reflection with the Independent Investigation Team he acknowledged that this way of working created an unhelpful tension and he has subsequently changed his way of working.

- *Understanding the role of the care co-ordinator*

Despite the emphasis placed on the co-ordinating role of the care co-ordinator in the Trust's CPA policy, Mr. Y's care co-ordinators appear to have focused on the delivery of care rather than on assessment, planning and co-ordinating the delivery of care. There is no evidence that Mr. Y's requirement for care co-ordination was formally reviewed each time his circumstances changed. Perhaps because of this and the emphasis placed on the delivery of care, there is little evidence that the skills needed to act as a care co-ordinator for Mr. Y were reflected on.

One consequence of the lack of overall case management was that when Mr. Y's mental state began to deteriorate, the safety net that should have been available to monitor his needs and risk was not in place for prolonged periods and not robust when it was. The lack of assessment and consequent care planning contributed to the deterioration of Mr. Y's mental state.

11.1.11. Adherence to Local and National Policy and Procedure, and Clinical Guidelines.

The Trust had in place relevant clinical policies and procedures. These were informed by best practice guidance, updated during the period that Mr. Y was under the care of the Trust and were fit for purpose. However Trust staff did not implement these in a consistent manner.

11.1.12. Clinical Governance and Performance.

The Trust has a fit for purpose set of governance arrangements which are overseen by the Trust Board. However failures to adhere to Trust policies do not appear to have been

identified and addressed by the governance structures in place during the time Mr. Y was under the care of the Trust.

11.1.13. Internal Investigation.

The internal investigation was competently prepared and produced a relevant set of recommendations which the Trust has responded to appropriately. The Independent Investigation Team concurs largely with the findings of the Internal Investigation.

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

12.1. RCA Third Stage

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

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

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

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal relationship with the events of 21 February 2008. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user received and any subsequent homicide perpetrated by them.

Contributory Factor. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Mr Y's mental health and/or the failure to manage it effectively.

Service Issue. The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 21 February 2008, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made.

12.2. The Care Programme Approach: Assessing Needs and Planning Care

12.2.1. Context.

The Care Programme Approach (CPA) became the main vehicle for delivering high quality mental health care following the NHS and Community Care Act (1990). From April 1991 Health Authorities, in collaboration with Social Services Departments, were required to put in place CPA arrangements for the care and treatment of people with mental health problems.
In *Building Bridges (1995)*[200] the Department of Health identified the four main elements of the CPA:

- a comprehensive assessment of health and social needs;
- a (CPA) Care Plan which addresses the identified needs;
- a care co-ordinator whose responsibility it is to maintain close contact with the service user, to ensure that the care plan is delivered and to monitor the service user's need for care; and
- regular reviews of the individual's needs for care and support with appropriate revisions of the CPA care plan.

Prior to 2008, when the Department of Health issued its revised guidance on the CPA,[201] there were two levels of CPA identified: Standard CPA and Enhanced CPA. This, at times, led to a lack of clarity as to the level of service an individual was entitled to. The 2008 guidance sought to clarify the situation:
"All individuals receiving treatment, care and support from secondary mental health services are entitled to receive high quality care based on an individual assessment of the range of

[200] Dept of Health (1995) *Building Bridges: A guide to arrangements for inter–agency working for the care and protection of severely mentally ill people.*
[201] Dept of Health (2008) *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*

their needs and choices. The needs and involvement of people receiving services (service users) and their carers should be central to service delivery." [202]

"It is clear that all service users should have access to high quality, evidence-based mental health services. For those requiring standard CPA it has never been the intention that complicated systems of support should surround this as they are unnecessary. The rights that service users have to an assessment of their needs, the development of a care plan and a review of that care by a professional involved, will continue to be good practice for all."[203]

12.2.2. Local Context

Reflecting the national guidance, the 2007 Trust CPA policy identified the following as the key elements of the Care Programme Approach:

> *"• Service user and carer involvement*
>
> *• Comprehensive assessment of health and social care needs and risks*
>
> *• The development of a care plan to address identified needs and risks*
>
> *• The appointment of a care coordinator to oversee the implementation of the care plan and keep in touch with the service user and carer.*
>
> *• Regular review of the care plan."*[204]

12.2.3. Findings of the Internal Investigation

"Care Programme Approach (CPA), Care Planning and Discharge from In-patient services:

Evidence which the Inquiry Team has been in receipt of suggests that individual practitioners may not be working to the Trust wide Policy and, in some respects, may be following locally agreed standards which were in place prior to the establishment of the SWYMH Trust. Some of those who gave evidence appeared confused as to what policy/procedure they were following.

The Inquiry Team, as a result of this Inquiry, is concerned about what appears to be a lack of governance in respect of CPA practice.

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[202] Ibid p. *2*
[203] Ibid p. 11
[204] SWYMHT (02.02.2007) "*The journey" (CPA Framework)* p.3

The CPA documentation in relation to [Mr. Y's] care is of a poor standard with only one set of CPA notes having been dated and signed.

Most of the practitioners whom the Inquiry Team spoke with said that on reflection they felt that [Mr. Y's] CPA level should have been at the enhanced level given that there were multiple agencies involved, behaviours which brought [Mr. Y] in to conflict with the police, his level of vulnerability, his poor concordance with treatment, his excessive bouts of alcohol misuse and, on occasions, illicit drug taking…….

From the evidence which was taken the Inquiry Team is of the opinion that the poor practice in relation to care planning practice in North Kirklees, was borne out of there not being a culture of best practice in the application of CPA This seems to be much (possibly more) a systems failure as it is a criticism of individual staff…….

Although [Mr. Y] was allocated a Care Co-ordinator throughout the period of his involvement with services, Care Co-ordinators tended to act as 'individual' practitioners rather as an individual who had responsibility for 'co-ordinating' the care provided to [Mr. Y]…….

Throughout the period under review, there was no systematic evidence of written transfer summaries when [Mr. Y's] care was transferred from one person to another, other than letters to [Mr. Y's] GP. The method which was used to 'update' a new worker when a case was transferred from one person to another was through an informal discussion between the workers involved."

12.2.4. Findings

Under the general heading of the Care Programme Approach four issues can be identified:

1. The appropriateness of the level of CPA;
2. Assessment and Care Planning;
3. CPA review meetings;
4. Care Co-ordination.

12.2.4.1. Level of CPA: Standard or Enhanced.

Throughout the time Mr. Y was cared for by the Trust he was classified as being on the standard level of CPA.

The trust guidelines in place in 2007 stated that:

"Enhanced CPA will apply to those individuals who

- *Have complex multiple needs which involve a number of agencies e.g. housing, employment, criminal justice system, etc*
- *Present difficulty with engagement, compliance, and cooperation*
- *May have co-existing difficulties with drug and/or alcohol misuse*
- *Have a disorganised or chaotic lifestyle*
- *Present a serious risk to themselves or others*
- *History of violence and/or persistent offending*
- *Fail to respond to care/treatment from general psychiatric services.*

Standard CPA will apply to all those individuals who

- *Are in contact with specialist mental health services*
- *Have support from one or more discipline but who's support needs are low key or minimal*
- *Are more than able to manage their own mental health difficulties*
- *Have an active informal support network*
- *Pose little danger to themselves or others*
- *Are more likely to maintain appropriate contact with services.*[205]

Given the level of care and support Mr. Y received over a substantial period of time, from both mental health and supported housing staff, his support needs must be regarded as more than "*low key or minimal".* During this period he did not display an ability to manage his mental health difficulties, indeed throughout much of the time he was cared for by the Trust the issue of his vulnerability exercised the mental health services, the supported housing staff and his family. For much of this period Mr. Y was also abusing alcohol. He reported that he did this to manage his mental health and psychological problems. Mr. Y reported on a number of occasions that he wanted to kill himself.

[205]SWYMHT (02.02.2007) "*The Journey" (CPA Framework)* p.10

For much of the time he was in contact with the Trust Mr. Y appeared to meet the criteria set out in the Trust's policy for enhanced CPA.

The Trust's policy is clear about the level of CPA an individual should be accorded when they are discharged from in-patient care:
"All those admitted [to in-patient care] should be subject to Enhanced CPA on discharge – this can be reviewed with the care plan. Any exceptions to this need to be recorded with rationales."[206]

Mr. Y had three admissions and discharges between September 2004 and February 2005.On each occasion he was placed on the standard level of CPA on his discharge from hospital. No explanation for placing him on this level of CPA was provided in Mr. Y's clinical notes.[207] While it must be acknowledged that this Trust CPA policy was introduced in 2007, even in 2004/5 placing an individual on standard CPA on discharge from hospital did not reflect best practice.

The level of CPA on which an individual was placed was not an academic exercise. It reflected, amongst other things, the need for the co-ordination of care across agencies. The need for care co-ordination is illustrated well by Mr. Y's discharge from hospital on 1 October 2004. On this occasion neither the staff of the supported housing project, where he was taking up residence, nor the Early Intervention CPN, the clinician who was most familiar with Mr. Y, were informed of his discharge. In consequence no arrangements to support him over his first week-end out of hospital had been put in place. This was a new environment to Mr. Y and the first time he had lived away from his family. Mr. Y did not fare well and had to be re-admitted to hospital three days after being discharged.

There is no evidence in Mr. Y's notes that the level of his CPA was reviewed during his contact with the Trust, even though his clinical picture fluctuated markedly. One might have expected his CPA status to be reviewed in June 2007 when he admitted to taking part in a burglary, taking cocaine and being exploited by his two 'visitors', or in December 2007 when he was discharged from psychiatric out-patients.

[206] Ibid p.16
[207] Case notes p. 312 & 324

The Independent Investigation found that best practice, as reflected in the Trust's 2007 CPA policy, with respect to the allocation of a service user to the standard or enhanced levels of CPA was not followed in Mr. Y's case.

12.2.4.2. Assessment and Care Planning

Assessment

The guidance issued by the Department of Health in 2008, *Refocusing the CPA,* identifies the scope expected of an assessment under the Care Programme Approach in secondary mental health care.

"The MHNSF [The National Service Framework for Mental Health] sets out the range of issues and needs a multi-disciplinary health and social care assessment and care plan may cover depending on need. These including: psychiatric, psychological and social functioning, including impact of education; risk to the individual and others, including contingency and crisis planning; needs arising from co-morbidity; personal circumstances including family and carers; housing needs; financial circumstances and capability; employment, education and training needs; physical health needs; equality and diversity issues; and social inclusion and social contact and independence."[208]

There are a number of examples of Mr. Y's immediate needs being assessed while under the care of the Trust. For example, when he was first seen following his referral to the mental health services in June 2004[209], when he was first seen by the Early Intervention CPN in August 2004[210], when he was assessed by the CRHTT in January 2005[211] and when he was referred to the CMHT in July 2006.[212] These assessments tended to focus on the immediate issues confronting Mr. Y. The point of a CPA assessment is to ensure that an individual's needs, both health and social care needs, are assessed in a comprehensive fashion to enable a robust, co-ordinated care plan to be drawn up.

During the time Mr. Y was under the care of the Trust a range of needs and issues were identified: Mr. Y's vulnerability, his conflicts with his family, his struggle with his religion,

[208] Department of Health, (2008) *Refocusing the CPA* p.17
[209] Case notes p. 265
[210] Case notes p. 13
[211] Case notes p. 244
[212] Case notes p.30

his problems with alcohol, his need to develop the skills to live independently and develop the skills needed to return to work, his lack of self esteem and low mood, his equivocal motivation and symptomatology suggestive of psychosis. However these issues were not explored in a comprehensive and systematic manner as part of a regular review of Mr. Y's on-going needs. Information was not available in a consistent manner to inform Mr. Y's care plan. Indeed the most comprehensive review of Mr. Y's needs was made by the Supported Housing Association in June 2005 as part of their own review and planning system.[213]

The Health of the Nation Outcome Scales (HoNOS) were completed on at least 22 occasions. While these provided some level of monitoring of Mr. Y's mental state these assessments cannot be regarded as comprehensive or detailed assessments of Mr. Y's health and social care needs.

During his time under the care of the Trust Mr. Y's health and social needs do not appear to have been assessed in a comprehensive, structured and regular fashion. In the absence of regular, structured assessments of his health and care needs, it was difficult for those caring for Mr. Y to put in place a robust, coherent and comprehensive (CPA) care plan.

Care Planning

The Trust CPA policy provides clear guidance on both the purpose of care planning and what the Trust expected a plan to contain. The policy states:

"A care plan is a record of needs, actions, intended outcomes and responsibilities written in an accessible and jargon free way. Care plans exist for the benefit of the person using the service and should be based around their needs, not the ability of the service to provide.

Devising a care plan is part of the process of understanding a person's situation and deciding a way forward which should reflect the person's strengths and role in the recovery process….

Principles of Care Planning

- *Care planning meets the requirements of CPA and Care Management*
- *Where appropriate it is a multi agency endeavour*

[213] Case notes p. 136

• The care plan is coordinated by the Care Coordinator who should make sure all those who need to know about the care plan get a copy
• The care plan is based on a thorough assessment of a person's health and social care needs and risks
• The care plan should focus on a person's strengths and seek to promote recovery
• The care plan should recognise the diverse needs and preferences of the person, reflecting their cultural and ethnic background as well as gender and sexuality
• Care planning should be done in the most appropriate forum…The most important thing is to get everyone's views and agreement, and other methods of care planning should be considered……..
• The care plan must take account of any risk to the person, their carer, any worker involved in delivering the care plan and the wider community.

As a minimum all care plans must include:

• A description of the person's needs and risks
• The action to be taken to meet needs and address risks and who is taking this action
• The aim/intended outcome of the action
• Contact details to access support 24 hours a day/7 days a week
• Signs and symptoms of relapse…
• Steps to be taken in the event of a relapse
• A contingency plan to outline steps to be taken if any elements of the care plan cannot be carried out or there is a failure to attend agreed appointments or the Care Coordinator or other key individuals are unavailable…
• A crisis plan"[214]

There are a limited number of care plans covering the almost four years that Mr. Y was under the care of SWYMT.

Two Trust "Care Plan and Review Forms" are available in Mr. Y's notes. The first, dated 31 January 2005, the day before Mr. Y was discharged from hospital, identifies the following actions: resume psychotherapy, review medication, review Mr. Y's accommodation situation,

[214] SWYMHT (02.02.2007) *"The Journey*" (CPA Framework) p.12

plan for discharge, continue to be seen by Early Intervention CPN and to attend psychiatric out-patients.[215]

The second Care Plan and Review Form is undated but appears to date from the time Mr. Y was under the care of the Early Intervention Team. The actions identified were: to review Mr. Y's medication, Mr. Y to attend depression and assertiveness skills groups at the local day centre, address the issue of Mr. Y gaining employment, monitor Mr. Y's vulnerability to exploitation and address Mr. Y's use of alcohol.[216]

Both these reviews contained brief contingency plans but neither was signed by Mr. Y.

A care plan, completed on the Trust's care plan form, covering the period 2 September 2005 to 1 June 2006,[217] identified six areas of need: alcohol intake, psychological issues, accommodation needs, medication, social skills and awareness of relapse signatures. The aims of the plan were to reduce the impact of Mr. Y's drinking, enable him to make informed choices, find suitable housing, reduce depression, alleviate social isolation, reduce risk of relapse and hospitalisation. The interventions included: motivational interventions, psychotherapy, exploring options for accommodation, concordance therapy, to engaging Mr. Y is structured day activities and helping Mr. Y to recognise his symptoms. This care plan is signed by Mr. Y.[218]

Following Mr. Y's assessment on 17 July 2006 a plan was recorded in Mr. Y's notes.[219] This was just three lines long and recorded that Mr. Y had agreed to work with CPN 2 on: self esteem building, challenging the distressing thought processes and improving his daily activities including the development of social confidence. This plan was drafted following an initial assessment of Mr. Y and in the context of Psychiatrist 1 reporting, in his referral letter, that Mr. Y experienced paranoid thoughts and heard voices, that he believed that people could read his thoughts, that he was preoccupied by religion, that he was distressed and praying to be released from his suffering, that he was dependent on his mother, that he could not look after himself and that he spent much of his time pacing.[220] This care plan does not

[215] Case notes 180, 356
[216] Case notes p. 349
[217] Case notes p. 42
[218] Case notes p.43
[219] Case notes p.30
[220] Case notes p.125 &560

appear to have been either formalised or reviewed until the care plan of 16 February 2007 was drawn up. This latter care plan was described as "provisional" and appears to have been drafted in preparation for the handover of care to CCO 1.

A second care plan completed on the Trust's care plan form, covering the period February 2007 to May 2007 identified the following issues: distressing thoughts, social confidence, the skills to return to work and the need to be more assertive. The intervention identified was that the care co-ordinator would visit Mr. Y every two to three weeks to: review the development of structured daily activities and confidence, review strategies for gaining employment, review strategies for addressing distressing thought, review Mr. Y's assertiveness skills and consider referring him to an assertiveness group and to liaise with Mr. Y's GP, Psychiatrist 1, Supported Housing Worker and mother.[221]

CCO 1, who was responsible for co-ordinating Mr. Y's care between February 2007 and the time of the incident in February 2008, does not appear to have completed a formal care plan. He did, however, regularly record in Mr. Y's clinical notes his action plans in relation to Mr. Y.[222]

The question arises as to whether the care plans drawn up for Mr. Y were of an acceptable quality and whether they were drawn up and reviewed with sufficient regularity to promote a high quality of care.

The standard of care planning was poor. Some plans attempt to relate needs to goals and to actions, while others do not. Some of the care plans are more comprehensive addressing medical, psychological and social needs, others are more limited in the scope of what they address. This variability in quality does not reflect good practice and should not be acceptable either to the Trust, as the organisation responsible for providing and monitoring the quality of Mr. Y's care, or to the professionals involved in delivering that care.

A more fundamental criterion of the quality of a care plan is whether it realises the aims of care planning set out in the Trust's policy document. To quote this again:

[221] Case notes p.42
[222] Case notes e.g. p. 62,65,67

"A care plan is a record of needs, actions, intended outcomes and responsibilities written in an accessible and jargon free way. Care plans exist for the benefit of the person using the service and should be based around their needs, not the ability of the service to provide.

Devising a care plan is part of the process of understanding a person's situation and deciding a way forward which should reflect the person's strengths and role in the recovery process."

The Independent Investigation Team conclude that the care plans drawn up for Mr. Y did not meet these standards. They did not always identify needs, actions, intended outcomes and responsibilities. At a broader level it would be difficult to argue that any of Mr. Y's care plans realised the goal of promoting an "*understanding [of] a person's situation and deciding a way forward which reflect the person's strengths*."

User Involvement

A further quality standard is the degree to which an individual is involved in identifying his/her needs and devising a plan to address these. The individual who is the subject of the care plan should always be actively involved in the identification of needs, goals and the most acceptable forms of intervention. One mechanism widely employed to ensure that the individual has been involved in the planning of his/her care is to ask the service user to sign the care plan. Only one of the identified care plans is signed by Mr. Y.

Similarly all those involved in the care of an individual should, wherever possible and with the consent of the service user, be involved in the planning of the care of the individual. Mr. Y's mother was very involved in supporting and caring for her son; the staff of the supported housing scheme also provided a great deal of his support. However, although there were on-going and informal discussions with both Mr. Y's mother and the staff of the supported housing project, neither was involved in identifying his needs or planning his care in any systematic fashion. This was not in accord with best practice.

12.2.4.3 Frequency and regularity of CPA reviews.

One other issue relating to care planning within the CPA framework needs to be identified: the frequency of the reviews of Mr. Y's needs and care plans.

Mr. Y was under the care of the Trust between June 2004 and February 2008. During this time there were a number of occasions when a review of his care would have seemed appropriate, for example:

- when he was first accepted into the service in June 2006 and accepted by the Early Intervention service in August 2004;
- when he was discharged from in-patient care on 1 October 2004;
- when he was discharged from in-patient care on 19 November 2004;
- when his mental state appeared to be deteriorating and he was assessed by the CRHTT in December 2004;
- when Mr. Y's drinking became more problematic, there was increasing evidence that he was being exploited, and Psychiatrist 1 concluded that Mr. Y would not benefit from psychotherapy in May/June 2005;
- prior to his discharge from the Early Intervention service in February 2006;
- following Mr. Y's referral to and assessment by the CMHT in July 2006;
- at the point of the hand over from CPN 2 to CCO 1 in February 2007;
- when CCO 1went on sick leave in May 2007;
- when Mr. Y took in two visitors, took cocaine, and was involved in a burglary;
- when CCO 1 returned from his sick leave in August 2007;
- when Mr. Y was discharged from psychiatric out-patients in November 2007.

On three of these occasions, in particular, good practice suggests that there should have been a CPA review and an assessment of Mr. Y's needs.

The first of these was in February 2006. The Early Intervention CPN had been Mr. Y's main contact and source of support since he had been accepted by the Mental Health services in June 2004. Mr. Y's mother had written to the Early Intervention CPN in October 2005 expressing her concern that she might discharge her son and assuring her that her support was

of great value to both her son and herself.[223] In February 2006 the Early Intervention CPN discharged Mr. Y from her care. Before this support was withdrawn it would have been good practice to have reviewed Mr. Y's care. Given the degree of support the Early Intervention CPN had given to Mr. Y's mother as well as to Mr. Y, it would have been good practice to involve both Mr. Y and his mother in the discussion regarding discharge and in ensuring that an appropriate care plan was in place, informed by how Mr. Y's needs were understood at the time. Psychiatrist 1 and the Early Intervention CPN may have discussed Mr. Y's care and her decision to discharge him, but such a discussion is not recorded in Mr. Y's clinical notes, and such informal discussions do not constitute a CPA review.

Mr. Y's care was not planned at this point. He missed his out-patient's appointment with Psychiatrist 1 in March 2006 and when he was next seen in the psychiatric out-patient department in June 2006, his mental state had deteriorated and he was referred to the CMHT. Psychiatrist 1 requested that a CPA meeting be arranged at this time, however this was not done.

The second occasion when a CPA review should have taken place was in June 2007. Mr. Y had taken two guests into his flat. These individuals exploited Mr. Y, he took cocaine with them and they involved him in a burglary which put his tenancy, and the support that came with it, in jeopardy. The Supported Housing staff reported that Mr. Y had been disengaging from the support being offered by them for the previous six weeks. Mr. Y's Care Co-ordinator had been on sick leave for several weeks. At the request of the housing support staff, an experienced member of the CMHT was allocated to become involved in Mr. Y's care. However, despite all that was happening in Mr. Y's life at this point, no assessment was made of Mr. Y's mental health or social care needs, no CPA review was held and his care plan was not revised. The standard guidance is that when significant events occur in the life of a service user then his/her needs should be re-assessed and his/her care plan revised. It is remarkable that this did not occur at this point in Mr. Y's care.

The third occasion when a CPA review should have taken place was in November 2007. Psychiatrist 1 had known Mr. Y for almost three and a half years when he discharged him in November 2007. Mr. Y's mental health care was now solely in the hands of the CMHT. In

[223] Case notes p.135

these circumstances it would have been good practice to hold a review meeting to identify what care, if any, Mr. Y needed and the goals of this care. Indeed at this point, given the level and type of care that Mr. Y was being offered, some discussion should have been had as to whether Mr. Y continued to meet the eligibility criteria for secondary mental health services.

CPA review meetings are designed to allow those providing care to reflect on the best way of addressing the service user's identified needs. The views of all those involved, most especially the service user, should be taken into account and explicitly used to inform decisions about care and support. There is no evidence in Mr. Y's clinical notes that such reflection took place before important decisions were made, nor that Mr. Y or those intimately involved in his care were involved in the decision making.

12.2.4 .4 Care Co-ordination

During the time Mr. Y was under the care of the Trust he had three care co-ordinators. Despite the clear guidance in both local policies and national guidance, the emphasis of the care co-ordinators was on the delivery of care rather than its co-ordination. This issue is discussed in more detail in the section of the report addressing the management of Mr. Y's care.

12.2.5. Conclusion

The Independent Investigation Team concluded that the findings of the Internal Investigation were largely in accord with those of the Independent Investigation.

The Independent Investigation found that best practice, as reflected in the Trust's 2007 CPA policy with respect to the allocation of a service user to the standard or enhanced levels of CPA, was not followed in Mr. Y's case. Perhaps because of this, Mr. Y's needs were not assessed in a systematic and comprehensive manner on a regular and planned basis or in response to his changing life circumstances.

During the time Mr. Y was cared for by the Trust, several care plans were recorded but these were of variable quality and a number of them did not reflect either the comprehensiveness recommended by best practice or the range of needs Mr. Y was known to have. Mr. Y's care plans were not reviewed with a prescribed regularity, or in response to his changing circumstances, as would have been expected by best practice.

There is no evidence that Mr. Y, his mother or the supported housing staff who provided a significant amount of Mr. Y's support were consistently involved in identifying Mr. Y's needs or planning his care.

Perhaps because of some of the factors identified above Mr. Y's care co-ordination was often confused with the provision of care.

Taking these factors together it must be concluded that Mr. Y's care did not reflect best practice or the Trust's 2007 CPA policy.

- ***Contributory Factor 1: The assessment of Mr. Y's needs and the planning and co-ordination of his care did not meet best practice standards as identified in the Care Programme Approach. While it cannot be concluded that this had a causal relationship with the events of 21 February 2008, the lack of such systematic and comprehensive care contributed to Mr. Y's mental health needs not being identified in a timely fashion and addressed in the most effective manner. This had a deleterious impact on his mental health and well-being.***

- ***Service Issue 1: During the time Mr. Y was under the care of the Trust there did not appear to be an effective mechanism in place to ensure that either best practice or Trust policies, with respect to the Care Programme Approach, were followed at the individual practitioner or team level.***

12.3. Risk Assessment and Management

12.3.1 Context

Risk assessment and planning should not be seen as free standing activities. They are integral elements of the overall Care Programme Approach to assessing and meeting a service user's health and social care needs.

In his forward to *Best Practice in Managing Risk (2007)* Louis Appleby commented:

"*Safety is at the centre of all good healthcare. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk.*"[224]

The guidance goes on to list 16 principles which should characterise the assessment and management of risk. These are listed below:

"*Best practice*

1. *Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience and clinical judgement.*

Fundamentals

2. *Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.*

3. *Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.*

4. *Risk management must be built on a recognition of the service user's strengths and should emphasise recovery.*

5. *Risk management requires an organisational strategy as well as efforts by the individual practitioner.*

Basic ideas in risk management

6. *Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.*

7. *Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.*

[224] DoH (2007), *Best Practice in Managing Risk*

8. *Knowledge and understanding of mental health legislation is an important component of risk management.*

9. *The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.*

10. *Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.*

11. *Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.*

Working with service users and carers

12. *All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.*

13. *Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.*

Individual practice and team working

14. *Risk management plans should be developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.*

15. *All staff involved in risk management should receive relevant training, which should be updated at least every three years.*

16. *A risk management plan is only as good as the time and effort put into communicating its findings to others". (P5-6)*[225]

[225] DoH (2007), *Best Practice in Managing Risk*

12.3.2. Local Context

The Trust in its February 2006 Risk Assessment policy,[226] anticipating the Best Practice guidance, noted: *"Risk assessment is an essential and on-going element of good mental health practice. All members of the team, when in contact with service users, have a responsibility to consider risk assessment and risk management as a vital part of their involvement, and to record those considerations*."

This policy approved the use of HoNOS and/or HoNOS plus and the Sainsbury Risk Assessment tool for assessing risk in working age adults. However, completing an assessment tool does not, on its own, constitute an assessment. As the Best Practice Principles quoted above observe:

"10. *Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach."*

The Trust's Risk Assessment policy of 2008 elaborated this point:

"Risk formulation is the process of analysing and evaluating the risk assessment information and evidence base to inform the risk management plan. It involves developing an understanding of the risk profile of the individual service user and the level of risk presented."

Assessment and formulation are not ends in themselves but, if conducted well, are a way of informing a plan to reduce harm and risk and promote the well-being of the individual. Good practice would indicate that a risk management plan should be put in place as a natural consequence of the assessment and formulation. The Trust's 2006 policy notes:

"Management of Risk:

The Care Programme Approach includes, as part of a systematic approach to risk management, the following key principles:

- *Action to meet/manage identified needs and risks.*
- *Steps to take in a crisis.*
- *Contingency arrangements if the agreed plan cannot be implemented.*
- *Signs and symptoms of relapse and steps to be taken to manage this.*

[226] SWYMHT (February 2006) *Risk Assessment, Management and Training Policy* p. 20

- *Action to take if there is a failure to attend agreed appointments.*
- *Arrangement for follow up within seven days of discharge from hospital for those on enhanced CPA.*
- *Decision making wherever possible should be made within a multi-disciplinary setting. Within this setting it is important that all of the professionals involved in the decision making process have access to the relevant risk information. Where this is not possible, individual professionals should assure themselves that the information on which they base their decisions is as up to date, accurate and complete as possible. Ideally individuals and teams should not make decisions based on incomplete, inaccurate or out of date information. Any and all decisions made, especially in areas where specific risk has been identified, must be clearly identified in the service user's clinical notes."*

The Trust's 2006 policy did not indicate how frequently risk assessments were expected to be undertaken or risk management plans reviewed. However, the 2008 policy recommended that:

"Reviews will be undertaken regularly and a review date identified. Clinical judgment will dictate when additional review is necessary, such as:

- *Deteriorating or improving symptoms.*
- *A serious untoward incident.*
- *A change in circumstances (e.g. non availability of usual support mechanisms).*
- *Transfer or discharge.*
- *CPA review.)*[227]

The policy identified the need for training and required that all clinical staff should have training in risk management including:

- *"Basic Introduction to Risk (identified in staff appraisal)*
- *Awareness of the Trust's Risk Strategy (Optional)*
- *Training specific to approved assessment tools."*

12.3.3 Findings of the Internal Investigation

"Risk Assessment and Risk Management:

[227] SWYMHT (February 2006) *Risk Assessment, Management and Training Policy* p. 20

Risk assessment and risk management were carried out on a 'pragmatic' day to day basis. There was a lack of a formal, structured, multi agency approach to risk assessment and the management of risk…

The SWYMH Trust's Risk Assessment and Management Training Policy was approved in 2006. This policy advocated that HoNOS and HoNOS Plus, Sainsbury Risk Assessment Tool and the FACE Risk Assessment (Calderdale locality only) should be used in respect of managing risk in adult services. The policy emphasised the importance of multidisciplinary decision making and access to relevant risk information for all professionals involved.

There is no evidence that the Sainsbury Initial Risk Assessment/Management Plan or the multidisciplinary risk assessment were routinely used in practice.

The Inquiry Team believes that the Sainsbury Risk Assessment tool should have been used in respect of [Mr. Y]'s clinical risk. However, during the course of this Inquiry it has emerged that there was confusion over the use of the Sainsbury tool within the locality."

12.3.4. Findings

Risk to self

At various times, whilst he was under the care of the Trust, Mr. Y was identified as presenting a risk either to himself or to others. Perhaps the most obvious risk identified was the risk of Mr. Y attempting to commit suicide. This risk was identified by both his family and health professionals on a number of occasions.

When Mr. Y's GP referred him to secondary mental health services on 28 May 2004, one of the main and most concerning symptoms was that Mr. Y was experiencing suicidal thoughts.[228] When he was assessed by the Early Intervention CPN on 28 August 2004 he was again reporting that he had thoughts of killing himself and his mother reported that he had put a belt around his neck and tried to hang himself.[229] The response on this occasion was to admit Mr. Y to hospital.

[228] Case notes 347
[229] Case notes p.13, 184, 438

While in hospital Mr. Y episodically reported that he wanted to kill himself. For example, on 10 and 11 September 2004 it was recorded in the nursing notes that he was making "*impulsive dashes to leave the ward and saying he wished to commit suicide*."[230] The staff were concerned that Mr. Y might cause harm to himself and or to others.[231]

Mr. Y was discharged from hospital in mid November 2004, however by mid December his mental state was deteriorating.[232] On 21 January 2005 he was taken to the Accident & Emergency Department by his family following an episode at home when he had put a belt around his neck. He was re-admitted to hospital.[233] From this time concern about Mr. Y attempting to kill himself features less frequently in his clinical notes. He was consistently rated as being at low risk of suicide when assessed using the HoNOS from this point.

The misuse of alcohol, while less dramatic, was a more persistent and potent source of harm to Mr. Y's mental health and general well-being for much of the time that he was under the care of the Trust.

On a number of occasions Mr. Y's drinking brought him into contact with the police. For example, soon after he had been referred to the secondary mental health services and before his first admission to hospital, Mr. Y was involved in an argument in a local pub and spent the night in the police cells charged with "Behaviour that might cause distress to others."[234] In June 2005 Mr. Y was arrested for being drunk and disorderly in a supermarket.[235] Later the same month he was so drunk at the hostel where he was living that staff called the police. They, in their turn, called an ambulance. Mr. Y was subsequently charged with a breach of the peace.[236]

Mr. Y's drinking was identified by his family and the staff providing him with care and support as being detrimental to his mental health. For example, following his discharge from hospital on Friday 1 October 2004, Mr. Y drank excessively over the week-end and had to be re-admitted to hospital on the following Monday.

[230] Case notes p. 274, 453,
[231] Case Notes 74, 453-455
[232] Case notes p. 269
[233] Case notes p. 244
[234] Case notes p. 183
[235] Case notes 136, 229
[236] Case notes p.231

On 31 January 2005, the in-patient ward was contacted by Mr. Y's family to inform them that he was drunk, lying in the garden and refusing to get up.[237] He had exposed himself to his sister. [238]

Mr. Y's misuse of alcohol also hindered him receiving the care and support that was available to him. On a number of occasions staff from the mental health services called on Mr. Y but he had drunk too much alcohol for them to do any work with him, take him to planned activities or, on occasion, even to talk to him. [239] At times staff were concerned about the harm Mr. Y's drinking was doing to his physical as well as his mental health.[240]

Those caring for Mr. Y persistently tried to encourage him to address his alcohol problem but he either denied than he had a problem or said that he used alcohol as a way of coping and gained relief by drinking. Mr. Y was repeatedly provided with information about local alcohol services but he was not prepared to engage with these. However, in March 2005, following a conversation with the Early Intervention CPN, Mr. Y's mother took him to his GP and he was prescribed Antabuse.[241] By 12 April 2005 the supported housing staff reported that he had stopped taking this.[242]

Mr. Y's vulnerability to exploitation was also an area of serious risk. This is dealt with separately below.

Harm to others

Although Mr. Y was not generally regarded as being a risk to others there were a number of occasions on which he displayed violence or aggression. For example, on 19 July 2004, just two months after he was accepted by the secondary mental health services, Mr. Y was taken by the police to the local Accident and Emergency Department where he was assessed by the CRHTT. This followed a fight between Mr. Y and his brother. On this occasion, Mr. Y was placed in temporary accommodation. Psychiatrist 1, having received the assessment report of the CRHTT and seen Mr. Y's HoNOS scores, felt that he was at low risk of causing harm to himself or others at this time.[243]

[237] Case notes p.393
[238] Case notes p. 212, 393
[239] Case notes p.30, 221, 222, 226
[240] Case Notes p. 218
[241] Case Notes p.222
[242] Case Notes p.225
[243] Case notes p. 269

In September 2004, when he was an in-patient, Mr. Y returned to the ward smelling of alcohol. When questioned about this he was verbally aggressive towards a nursing assistant and threatened that if he came across her and her partner he would "*give him a good kicking*".[244]

In September 2005 Mr. Y's mother telephoned the Early Intervention CPN to inform her that Mr. Y was angry with her, the CPN. Mr. Y had told his mother that he felt like hitting the Early Intervention CPN. The Early Intervention CPN told Mr. Y's mother that she believed that Mr. Y was saying these things to provoke a reaction and he posed no real threat to her.[245]

However, a week later Mr. Y's mother contacted the Early Intervention CPN again to discuss her fear of her son. On this occasion the Early Intervention CPN said that she believed Mr. Y's behaviour was an expression of his desire to be needed.[246]

In September 2007 Mr. Y had an altercation with his neighbour during which both individuals appear to have attacked and damaged the other's door; both were interviewed by the police.[247]

On 31 January 2008 Mr. Y's mother called Housing Support Worker 1 to inform her that Mr. Y had sent her a text message a "few weeks" earlier expressing thoughts of wanting to hurt people, though he identified no-one in particular. [248] Although the plan was to pass this information on to CCO 1 it is not clear that this was done.

On the basis of the incidents recorded above, it would be reasonable to conclude that, at least on some occasions, Mr. Y did appear to pose a threat to himself and to others. In line with the Best Practice Guidance this risk should have been assessed and an appropriate plan put in place to manage the identified risk.

Mental health staff completed the Health of the Nation Outcome Scale for Mr. Y on 22 occasions. The distribution of these assessments was somewhat skewed, with seven assessments being completed between July and December 2004, when Mr. Y was first in

[244] Case notes p.448
[245] Case notes p.240
[246] Case notes p. 242
[247] Housing notes p. 50
[248] Housing notes p.71

contact with the mental health services. Nine HoNOS ratings were made in 2005, two in 2006, three in 2007 and one in 2008.

Mr. Y was given a rating of 2 or more, for risk of suicide, on 8 of the 10 occasions on which he was assessed between July 2004 and January 2005. After this, however, he was consistently given a rating of 0 on the five point scale (0 to 4), indicating that he posed a low risk of harming himself.

On the scale rating "Overactive, Aggressive, Disruptive or Agitated Behaviour" Mr. Y's scores showed a greater fluctuation and a less obvious pattern. In the last year that he was under the care of the Trust HoNOS scales were completed on four occasions, three times between October 2007 and February 2008. On each occasion Mr. Y was given a rating of 1 on the five point scale (0-4) indicating low risk.

Mental health staff, then, used the HoNOS to rate the risk Mr. Y posed with some frequency, and at most of the times when concerns about his mental state were identified. However, the HoNOS is a very broad, non specific tool. It was not designed to act as the primary assessor of risk and is not well suited to this purpose. The Trust introduced the Sainsbury Risk Assessment Tool, which is a more appropriate device for this purpose, with its revised Clinical Risk Management policy in 2006. However, this was not employed to assess the risk Mr. Y posed, although he remained under the care of the Trust until February 2008.

The function of an assessment tool is to provide structured information. However, completing even the most psychometrically reliable and valid tool would not, by itself, constitute an assessment. The Best Practice Guidance talks of "*using the structured clinical judgement approach",* identifying that assessment is not merely the collection of facts but an attempt to understand the relationships between these in determining the individual's behaviour. The reflection and analysis needed to arrive at such an understanding is not evident in Mr. Y's clinical notes. Whatever devices were employed, good practice suggests that this reflection and formulation should have been present.

Having arrived at a formulation that allows an understanding of the individual's behaviour, a risk management plan should then be drawn up. The Trust policy identifies what would be expected to be included in such a plan. It should aim to reduce deleterious risk and provide a

context for taking appropriate positive risks. It should identify the actions to be taken, by whom and when. Importantly, the plan should identify why these actions need to be taken so that any clinician involved in the care of the service user can make informed and consistent decisions.

As noted above, there are few care plans contained in Mr. Y's notes and there are few risk management, crisis or contingency plans. Those that do exist tend to be of the form: inform CPN, contact Psychiatrist, and contact CRHTT.

One, undated, care plan does identify Mr. Y's 'relapse signature'. This was described as: expressing suicidal ideation/low mood, lacking insight and failure to discuss goals. [249] The related plan is to contact various members of staff. No indication is provided as to what these individuals might do, what the goals of their involvement might be or how any interventions might be related to the indicators of relapse. If the individuals, identified in the plan, are not available no guidance is provided as to what those who are available might do.

12.3.5. Conclusion

The Independent Investigation Team found that the findings of the Internal Investigation were largely in accord with those of the Independent Investigation.

Mr. Y reported experiencing suicidal thoughts and, on occasions, tied a belt around his neck saying that he wanted to kill himself. He frequently drank to excess which proved to be deliterious to his mental health and, at times, made it impossible for those trying to provide care and support to him to be able to do so. His drinking brought him into conflict with the criminal justice system and placed him in danger in the community.

At times Mr. Y expressed the idea that he might harm others. He fought with his brother and, on at least one occasion, his mother reported that she was fearful of her son. There were, therefore, a number of occasions on which the risk Mr. Y posed to himself and to others should have been assessed and risk managment and crisis management plans put in place.

[249] Case notes p. 44

The Health of the Nation Outcome Scales were employed by the mental health staff to assess the level of risk Mr. Y posed. This is too imprecise a device to be used to assess risk. In 2006 the Trust introduced the Sainsbury Risk Assessment Tool. This is a more appropiate tool but the revised risk management policy was not implemented and the Sainsbury Risk Assessment Tool was never employed to assess the risk Mr. Y posed.

Accompanying any data provided by assessment tools should be a formulation explaining how various identified factors might influence or determine an individual's behaviour. There is no evidence of such analysis, reflection or formulation in Mr. Y's notes.

Having assessed the risk an individual poses a care plan should be drawn up. This should be done in co-operation with the service user, his carers and those professionals involved in his or her care. There appear to be only two risk management plans in Mr. Y's notes. These are of a basic standard and do not indicate what needed to be done to mangage any risk Mr. Y posed or what the goals of the interventions had been.. There is no evidence that Mr. Y or his family were involved in the assessment and development of these plans.

It is not possible to conclude that this lack of adherance to best practice in assessing and managing risk had a direct causal relationship with the events of 21 February 2008. However, the absence of a robust assessment of the risk posed by Mr. Y detracted from a sound understanding of the factors influencing his behaviour and, in consequence, reduced the ability of those caring for him to identify and respond to his needs in a timely and effective manner.

- ***Contributory Factor 2: The HoNOS scales were used, on a number of occasions, to asssess the risk Mr. Y posed to himself or to others. This was not an appropriate device to be used for the pupose of assessing risk. The Sainsbury Risk Assessment Tool, which was approved by the Trust for assessing risk, was not employed to assess the risk that Mr. Y posed. No formulation or care plans, informed by such formulations, were drawn up to manage any risk that Mr. Y might have presented. Mr. Y and his carers were not involved in asessing Mr. Y's risk or in planning how this might be managed.***

- ***Service Issue 2: Although the Trust introduced a revised policy for the assessment and management of risk this was not implemented in the case of Mr. Y. There did not appear to be an effcetive mechanism in place to ensure that the Trust's policy was implemented or that members of staff had appropriate supervision to ensure that risk was appropriately addressed in line with the Trust procedures.***

12.4. Diagnosis

An often critical element in the assessment of need and the planning of care within the general framework of the CPA is the diagnostic process.

12.4.1 Context:

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

12.4.2. Findings of the Internal Investigation

"Diagnosis:

It can be argued that there was an underestimation of [Mr. Y's] psychotic illness and clinical risk. This may, in part, be the result of practitioners using HoNOS to assess risk …... an emphasis on the recovery model approach which formed the basis of the interventions which [Mr. Y] received or simply that the clinical team did not see that [Mr. Y] presented with anything out of the ordinary, given the overall circumstances. Indeed, this was conveyed to the Inquiry Team by many of the witnesses who gave evidence and that when they became aware of the fatal incident they were shocked.

Throughout this investigation questions have arisen concerning [Mr. Y's] diagnosis. Whilst in contact with MH services, [Mr. Y] received several diagnoses, one of these being psychotic disorder. Although the staff who were interviewed expressed an understanding of the need to

monitor [[Mr. Y]'s mental health for possible recurrence of psychosis, there is no evidence to support that the whole team had a shared understanding of [Mr. Y]'s relapse signature.

Although [Mr. Y]'s 'relapse signature' was noted in 2004…., there is no documentary evidence to indicate that his relapse signature was reviewed, updated or incorporated into a whole-team care plan. The significance of [Mr. Y]'s deterioration at various points was not subjected to a level of rigour that one would reasonably have expected.

[Mr. Y]'s mental illness, as summarised by [Psychiatrist 1] in his evidence to the Inquiry was that [Mr. Y] suffered "(occasional) transient psychosis in the context of very low mood and a lot of distress". This assessment and diagnosis appears to have been supported by staff working with [Mr. Y].

The staff who gave evidence expressed an understanding of the importance of monitoring the possible re-occurrence of psychotic symptoms. Episodes of possible psychotic symptoms were intermittent and often very short term and there were occasions when one party did not always make the other party aware of such features.

Recovery Model:

The care [Mr. Y] received centred on the 'recovery model' (NIMHE, 2005). This approach, which is at the forefront of government policy for the care of mentally ill people, provides a holistic view of mental illness that focuses on the person and not just their symptoms and believes recovery from severe mental illness is possible……

All witness showed a commitment to working with the principles of the Recovery Model. In principle this has to be applauded because this approach is founded on working with the service user's strengths, facilitating growth, change and hope. This emphasis may have had a paradoxical effect in that it may have clouded clinical judgement in respect of [Mr. Y's] mental illness, and the associated risks. Having said that, staff were aware that early in [Mr. Y's] contact with mental health services that psychotic disorder should be considered as one possible diagnosis and was treated along the way."

12.4.3. Findings

Mr. Y was referred to the mental health services by his GP with a diagnosis of severe depression and the symptoms of anxiety. When he was assessed by the Staff Grade Psychiatrist, she also concluded that Mr. Y was depressed and displaying the symptoms of anxiety which she related to his home situation.

When Mr. Y was seen by Psychiatrist 1 in July 2004 he felt that Mr. Y should not, at that stage, be labelling himself as someone with a mental illness. He felt that Mr. Y's difficulties might be better understood and addressed by adopting a broader, more psychological formulation. Psychiatrist 1 assessed Mr. Y for dynamic psychotherapy. Although Mr. Y did not report any symptoms that would justify a diagnosis of psychosis during this assessment, Psychiatrist 1 felt that there was sufficient uncertainty to ask the Early Intervention Team to assess Mr. Y.

By the time he was seen by the Early Intervention CPN at the end of August 2004 Mr. Y was reporting a number of symptoms consistent with a diagnosis of psychosis: ideas of reference, hallucinations, a belief that he had a special mission and that he could influence events occurring in Russia. The Early Intervention CPN felt that Mr. Y was "*probably experiencing a psychosis."*[250] Mr. Y was subsequently admitted to hospital. While in hospital he reported hearing voices, being suspicious and having paranoid ideas. He was given a diagnosis of "psychosis" on 7 September 2004 and prescribed psychotropic medication. Mr. Y was discharged from hospital in 19 November 2005 with a diagnosis of paranoid psychosis.[251]

However, by late December 2004 the possibility that Mr. Y might be suffering from a personality disorder was being mooted.[252] Mr. Y was re-admitted to hospital in January 2005 and at the ward round of 26 January 2005 it was recorded that Mr. Y was not showing any evidence of psychosis. However the following note was made: "*Diagnosis discussed. BPD [Borderline Personality Disorder]. Any psychosis or depression."* On the day of Mr. Y's discharge from hospital, 1 February 2005, a case conference was held. It was concluded that Mr. Y's diagnosis was no longer one of depression. Psychiatrist 1 suggested a diagnosis of *"psychological problems with an element of depression rather than psychotic illness".*[253] The

[250] Case notes p. 13, 184, 438
[251] Case notes p. 330
[252] Housing notes p. 7
[253] Case notes p.212, 389

discharge plan noted that there "*was some confusion over [Mr. Y's] diagnosis and management."*[254]

In the discharge summary for this admission Mr. Y was diagnosed as suffering from depression. On discharge he was being prescribed the anti-psychotic medication Olanzapine and the anti-depressant Citalopram.[255]

When Mr. Y was reviewed by SHO 1 in February 2005 he was give the diagnoses of "*psychosis (under remission)"* and *"depression - mild*". His medication was not changed.

By October 2005 Psychiatrist 1 had revised Mr. Y's diagnosis to: *"Psychological problems, personality issues, low mood and anxiety and alcohol misuse".* His medication had been changed to the anti-psychotic Aripiprazole and the anti-depressant Venlafaxine.[256]

In June 2006 Psychiatrist 1 noted that Mr. Y was reporting paranoid thoughts and hearing voices; he believed that people could read his thoughts; he was preoccupied by God and religion; he was emotionally dependent on his mother and was distressed and tearful. Psychiatrist 1 added *"? Psychotic illness*" to Mr. Y's list of diagnoses. He referred Mr. Y to the CMHT. No change was made in Mr. Y's medication.[257]

In July 2006 Psychiatrist 1 noted that Mr. Y had a poor sense of identity and recorded in his out-patients notes a diagnosis of Personality Disorder. He also noted that Mr. Y was using alcohol to make himself feel better.[258]

In May 2007 Psychiatrist 1, in his letter to Mr. Y's GP, described Mr. Y as suffering from "*Psychological problems (Related to Jehovah's Witnesses - judgements and family dynamics) and low mood."* Mr. Y reported that he was feeling better and had reduced his alcohol intake somewhat. However he also reported feeling sedated by his medication. Psychiatrist 1 wrote to Mr. Y's GP recommending that his anti-psychotic medication, Aripiprazole, be reduced from 10mg to 5 mg a day. However this was not reduced until 8 August 2007.

[254] Case notes p. 180, 356
[255] Case notes p. 312
[256] Case notes p. 129
[257] Case notes p.125
[258] Case notes p. 561

In July 2007 Mr. Y was reviewed by Psychiatrist 1. Although Mr. Y informed Psychiatrist 1 about his two guests, his involvement in a burglary and the possibility that he might be evicted, there is no evidence that he told Psychiatrist 1 about his use of cocaine. Nor is there any evidence recorded in the notes that Psychiatrist 1 was informed of this by any members of the multi-disciplinary team.

Mr. Y attended this out-patient appointment with his hair and eyebrows shaved off. At his interview with the Independent Investigation Team, Psychiatrist 1 said that he saw this behaviour as related to Mr. Y's development and maturation rather than as a symptom of psychosis.[259] Psychiatrist 1 reduced Mr. Y's anti-depressant medication.

In his letter to Mr. Y's GP in October 2007 Psychiatrist 1 recorded that Mr. Y was *"describing himself as feeling well, more optimistic and brighter about the future."* Given this apparently stable improvement and the fact that Mr. Y was complaining of spasms which woke him up at night, which Psychiatrist 1 thought might be a side effect of his medication, he advised Mr. Y's GP to discontinue the anti-psychotic medication in the belief that it had been reduced in May 2007.

Mr. Y was discharged by Psychiatrist 1 on 15 November 2007.

12.4.4. Conclusion

The Independent Investigation Team concluded that while the findings of the Internal Investigation were largely in accord with those of the Independent Investigation. There were, however, a number of issues, which have implications beyond this particular case, which would have benefited from further reflection and analysis. In particular: the role of multi-disciplinary formulation of Mr. Y's problems, the importance of exploring Mr. Y's "personality issues"/personality disorder and the implementation of the Recovery Model.

Mr. Y had a number of diagnostic labels applied to him while under the care of the Trust. As individuals change over time, different issues become more or less prominent in their lives, co-morbidities emerge, transient symptomatology subsides and more enduring difficulties

[259] Interview MR p. 13

become evident. In this context changing diagnostic labels is not bad thing, if it demonstrates reflective practice.

In Mr. Y's case his initial presentation was one of an affective disorder. Later, symptoms suggestive of a psychosis emerged. Over time, perhaps in response to medication, these appeared to subside and other problems came into prominence: his misuse of alcohol, his vulnerability, his chronic low self esteem and poor survival skills.

12.4.4.1 Personality Disorder

From early in his contact with Mr. Y Psychiatrist 1 identified that there were, what he labelled, 'personality issues' associated with Mr. Y's presentation. He felt that Mr. Y displayed many of the traits associated with a diagnosis of personality disorder but was also mindful that Mr. Y was a young man with limited experience of life who was experiencing a great deal of stress and consequent distress. In these circumstances he did not feel it appropriate to give Mr. Y a firm diagnosis of a personality disorder.[260] Unfortunately, at this time, there were no dedicated services for individuals suffering from personality disorders within the Trust to which the clinical team might have referred Mr. Y, or from where they might have sought advice.

Personality disorder problems are not uncommon in the population served by mental health services. In *New Horizons*[261] the Department of Health noted:

"Personality disorders are common conditions. Estimates of prevalence rate vary between 5 and 13 per cent of adults in the community. Among community mental health patients this rises to between 30 and 40 per cent, and 40 to 50 per cent of mental health inpatients." (p. 72).

The document observes that: "*People with complex problems make frequent and often chaotic use of inpatient mental health, primary care, A&E, social care, and criminal justice and other services. Emerging evidence from the new personality disorder services demonstrates that this can be reduced, and people with this diagnosis can engage in training and work if they receive appropriate support to address their problems. Outcomes from the*

[260] Witness Interview Independent Investigation p. 10
[261] DoH (2009) *New Horizons: Towards a shared vision for mental health*

new services demonstrate the benefits of multi-agency, cross-sector commissioning and collaborative working." (p.72)

The most recent NICE guidance (2009)[262] on the treatment and management of people with personality disorders makes it clear that personality disorder is not only a treatable disorder but that it is the responsibility of the mental health services, usually the CMHTs, to provide a broad based assessment of needs and to institute appropriate interventions. The guidance acknowledges, however, that if clinical staff are to fulfil this role competently then training and support are required.

"Mental health professionals working in secondary care services, including community-based services and teams, CAMHS and inpatient services, should be trained to diagnose borderline personality disorder, assess risk and need, and provide treatment and management in accordance with this guideline.... Training should be provided by specialist personality disorder teams based in mental health trusts.
Mental health professionals working with people with borderline personality disorder should have routine access to supervision and staff support." (p.380/1)

The guidance recommends that Trusts should set up specialist teams to assess and treat those who have particularly complex needs or are at particular risk. These teams should provide consultation and training to those clinicians who do not specialise in the treatment of personality disorder as well as offering a direct clinical service.

Such a service and the associated training and supervision was not available in the Trust when Mr. Y was under its care. Perhaps for this reason Mr. Y's "personality issues" were not explored as fully as they might otherwise have been.

12.4.4.2 The Recovery Model

The Recovery Model is more than an approach which places an emphasis on psychosocial functioning. While there are a number of versions of this model they almost all identify stages through which the individual travels on his/her journey of recovery. These stages represent a changing relationship with mental health services and the assuming of greater

[262] NICE (2009) Borderline Personality Disorder: Treatment and Management

responsibility for one's well-being. This journey of recovery has to be planned. A common planning device is the WRAP, the Wellness Recovery Action Plan. While much of the work done with Mr. Y was aimed at promoting his independence, it cannot be regarded as a robust implementation of the Recovery Model.

12.*4.4.3 Multi-disciplinary Formulation*

As noted above the categorical diagnostic system as employed by ICD 10 (International Classification of Diseases, 10th edition) is not the only basis for formulating and understanding an individual's difficulties. A large part of the care and support Mr. Y received appears to have been aimed at promoting his independence and as such is consonant with the Recovery Model. The care plan drawn up by CPN 2, following his assessment of Mr. Y in July 2006, identified that the focus of the CMHT's intervention would be to address Mr. Y's low self esteem, to help him develop the skills to live more independently and to help him challenge his distressing thought processes. Such a formulation might be seen as sitting within a Cognitive or Cognitive Behavioural model as well as within the Recovery Model.

The issue here is not which was the right model to inform Mr. Y's care and treatment but that there was no agreed formulation of his problems which informed his care. This lack of a clear and agreed formulation reduced the likelihood of Mr. Y receiving the most effective care in a consistent manner. The Care Programme Approach was established to provide a mechanism which allowed different viewpoints, expertise and emphases to be brought together to ensure that a common understanding (formulation or diagnosis) could be arrived at; a formulation which would inform a robust care plan which could be delivered in a consistent manner. That no mechanism was employed to ensure that there was a consistent view of Mr. Y's difficulties and to ensure that his care was informed by this formulation was a weakness.

The lack of a clear formulation was also a source of some frustration to Mr Y's family who felt that a clear diagnosis or formulation would help them understand and, possibly, cope better with his problems.

It cannot be concluded that, had this mechanism been in place, the events of 21 February 2008 would not have taken place. However it is likely that a more co-ordinated formulation of Mr. Y's difficulties would have led to him receiving more consistent and outcome focused care.

- ***Contributory Factor 3: No multidisciplinary mechanism was employed to ensure that there was a clear and consistent formulation of Mr. Y's problems, which identified the desired outcomes and informed a robust care plan. This is likely to have contributed to the less than optimal management of Mr. Y's mental health problems and may have contributed to the deterioration of his mental health.***

- ***Service issue 3: At the time Mr. Y was receiving care from the Trust it did not have in place a service for individuals with a diagnosis of Personality Disorder to which he might have been referred for assessment, treatment or advice. Staff in the CMHTs were not provided with the training to assess and treat individuals with a personality disorder. The absence of such a service deprived individuals with a personality disorder of the type of service recommended by the extant national Best Practice Guidance and those with a suspected personality disorder of an expert assessment which would have informed their treatment.***

12. 5. Treatment

12.5.1 Context

The treatment of any major mental health problem is normally multi-facetted employing a combination of psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), in-patient care, community support, vocational rehabilitation and pharmacological interventions (medication).

Prescribing and organising Treatment: Payment by results

One, currently influential, approach linking the identification of difficulties, the planning of care and the financing of services is the Payment by Results methodology. The last Government, in 2002, introduced a system of Payment by Results (PbR) into the health economy. This is now well established in physical healthcare services and a timetable for its implementation in mental health services has been set out. The current Coalition Government

has indicated that it intends to continue with the Payment by Results approach.[263] Under the Payment by Results methodology individuals are allocated to "clusters." Individuals within a cluster are identified as having similar needs or as being likely to benefit from a common package of care. The South West Yorkshire Partnership NHS Foundation Trust played an influential role in the development of this approach to mental health care.

The Payment by Results approach to the provision of care was informed by the Recovery Model which the National Institute for Mental Health for England (NIMHE) defined as follows:

*"Recovery is what people **experience** as they become **empowered to manage their lives** in a manner that allows them to achieve a fulfilling, meaningful life and a contributing positive sense of belonging in their communities."*[264]

The Recovery Model approach to mental health treatment and care places the service user at the heart of the process, focusing on the individual's strengths and abilities and the improvement of his/her well-being and quality of life, rather than the removal of symptomatology.

12.5.2 Medication

12.5.2.1 Context

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly / monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and / or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

All medication prescribed and administered should be monitored for effectiveness and for unwanted side effects. The most common side effects described for antipsychotic medications

[264] NIMHE (2004) *Emerging Best Practice in Mental Health Recovery*

are called 'extra pyramidal' side effects i.e. tremor, slurred speech, akathisia and dystonia. Other side effects include weight gain and Electrocardiography (ECG) changes. Side effects can be managed either by reducing the dose of medication, or by changing to a different type of antipsychotic medication or by prescribing specific medication to treat the side effects.

In prescribing medication there are a number of factors that must be borne in mind. They include consent to treatment, compliance and the monitoring of medication for its efficacy and for unwanted side effects.

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

The patient's ability to comply with recommended medications can be influenced by his/her level of insight, his/her commitment to treatment and level of organisation.

12.5.2.2. Findings

In his referral letter Mr. Y's GP described Mr. Y as suffering from depression and anxiety. He had initially prescribed the anti-depressant medication Fluoxetine for Mr. Y. However Mr. Y complained that this medication made him feel drowsy and his GP changed to the anti-depressant Zispin. Mr. Y reported this made him feel better, however he did not like taking it as it gave him "aches and pains" in his muscles. Mr. Y's GP reported that Mr. Y's compliance with his medication regimen was poor.[265]

After assessing Mr. Y in June 2004 the Staff Grade Psychiatrist prescribed the anti-depressant Venlafaxine 75 mg for Mr. Y.[266] Venlafaxine is an anti-depressant which is also used to treat generalised anxiety disorders.

[265] Case notes p. 347
[266] Case notes p.345

Mr. Y was admitted to hospital in September 2004 reporting symptoms consistent with a diagnosis of psychosis. His anti-depressant medication was stopped and replaced by the anti-psychotic medication Quetipine 25 mg twice a day.[267]

On 14 September 2004 Mr. Y reported at a ward round that his symptoms were not responding to the medication and that he was feeling worse. His medication was changed to the anti-psychotic medication Olanzapine 10 mg once a day.[268]

Following his readmission to hospital in October 2005 Mr. Y's Olanzapine was increased to 15 mg a day.[269] The anti-depressant Citalopram 20 mg was added on 26 October 2004.
Mr. Y was discharged from hospital on 19 November 2004. His medication regimen remained unchanged and he was given the diagnosis of paranoid psychosis.

Mr. Y was readmitted to hospital on 21 January 2005. At a ward round on 26 January 2005 Mr. Y denied having any abnormal experiences. As there was no evidence of psychosis at this time his anti-psychotic medication, Olanzapine, was reduced from to 5 mg a day with the intention of withdrawing it. His anti-depressant medication remained unchanged.[270] However Mr. Y remained on this medication regimen following his discharge from hospital on 1 February 2005.[271]

When Mr. Y was reviewed in May 2005 he reported that his mood was low. In response to this his antidepressant, Citalopram, was increased from 20 mg to 40 mg a day. [272]

In October 2005 Mr. Y reported paranoid thoughts. His mother reported that he was very emotionally dependent on her, tearful and lacking in energy. Mr. Y's medication was changed to Venlafaxine 150 mg a day and the anti-psychotic medication Aripiprazole to 10 mg a day. [273]

[267] Case notes p. 186 & 538
[268] Case Notes p.274
[269] Case notes p.277 & 550
[270] Case notes p. 286 & 385
[271] Case notes p.312
[272] Case notes p. 163 7 290
[273] Case notes p. 129

When Psychiatrist 1 reviewed Mr. Y in April 2007 Mr. Y reported that he was "*feeling better in himself with less low mood and anxiety symptoms and feels more optimistic about the future.*"[274] Mr. Y was not reporting any symptoms suggestive of a psychosis. He was however, complaining that his medication was making him feel sedated. Psychiatrist 1 wrote to Mr. Y's GP on 2 May 2007 asking him to reduce Mr. Y's Aripiprazole from 10 to 5 mg a day.[275] This reduction did not take place until 8 August 2007.[276]

In July 2007 when Psychiatrist 1 met Mr. Y he reported feeling well, and was not experiencing the symptoms of anxiety nor any symptoms of psychosis. Psychiatrist 1 wrote to Mr. Y's GP suggesting that Mr. Y's anti-depressant, Venlafaxine be reduced to from 150 mg to 75 mg a day.[277] A prescription for this reduced dosage was issued on 8 August 2007.[278]

Psychiatrist 1 saw Mr. Y on 24 September 2007. Mr. Y reported that he was feeling well but was experiencing some muscle spasms. Psychiatrist 1 felt that these might be caused by the anti-psychotic medication and advised that Mr. Y stopped taking this.[279]

Psychiatrist 1 last saw Mr. Y on 12 November 2007. At this time Mr. Y was reporting that he was well and there had been no recurrence of his psychotic like symptoms. Mr. Y spoke about stopping his anti-depressant medication, however he agreed with Psychiatrist 1 to continue with this for a further three to six months. Given Mr. Y's apparently stable improvement Psychiatrist 1 discharged Mr. Y to the care of his GP. Mr. Y continued to be monitored by the CMHT.[280]

12.5.2.3 Conclusion

Throughout the time Mr. Y was under the care of the South West Yorkshire Partnership NHS Foundation Trust he was on either anti-depressant medication or a combination of anti-depressant and anti-psychotic medication. Appropriate medications were employed at recommended dosages.

[274] Case notes p. 587
[275] Case notes p. 587
[276] Archive of the Internal Investigation p. 737
[277] Case notes p.116
[278] Archive of the Internal Investigation p.737
[279] Case notes p. 102
[280] Case notes p. 100

Mr. Y's medication appears to have been reviewed on a regular basis and changed in response to both the symptomatology he was reporting and his report of the side effects he was experiencing.

Although it had been suggested during Mr. Y's in-patient admission in January 2005 that the anti-psychotic medication might be stopped, Mr. Y continued to be prescribed this medication until September 2007. This was a not an unreasonable treatment regimen given that Mr. Y had reported symptoms which might have been indicative of an underlying psychosis, when he became distressed.

When Psychiatrist 1 reduced and then stopped Mr. Y's anti-psychotic medication in 2007 he did this in accordance with good practice. He recommended reducing the Aripiprazole from 10 mg to 5 mg in May 2007. He continued to monitor Mr. Y's mental state and as Mr. Y reported that he felt well and was not experiencing any symptoms suggestive of psychosis Psychiatrist 1 recommended that the Aripiprazole it be discontinued in September 2007.

Mr. Y's medication was not, in fact, reduced until August 2007 but this was not known by Psychiatrist 1 when he made his decision to recommend that Mr. Y's anti-psychotic medication be stopped. That this information was not available to Psychiatrist 1 was a serious weakness and this is discussed elsewhere in this report. However, the decision by Psychiatrist 1 to discontinue Mr. Y's anti-psychotic medication was a reasonable one given the information available to him at that time.

12.5.3 Psychological Therapies

12.5.3.1 Context.

The NICE Clinical Guidelines on the treatment of depression comments:

"A range of psychological and psychosocial interventions for depression have been shown to relieve the symptoms of the condition and there is growing evidence that psychosocial and psychological therapies can help people recover from depression in the longer-term (NICE, 2004a)……People with depression typically prefer psychological and psychosocial treatments to medication (Prins et al., 2008) and value outcomes beyond symptom reduction

that include positive mental health and a return to usual functioning (Zimmerman et al., 2006)".[281] *(p.157)*

The guidance goes on to recommend:

"8.11.3.2 For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT)

8.11.3.3 The choice of intervention should be influenced by the:

- *duration of the episode of depression and the trajectory of symptoms*
- *previous course of depression and response to treatment*
- *likelihood of adherence to treatment and any potential adverse effects*
- *person's treatment preference and priorities".*[282]

The NICE Clinical Guidelines on the treatment of schizophrenia comments:

"Psychological therapies and psychosocial interventions in the treatment of schizophrenia have gained momentum over the past 3 decades. This can be attributed to at least two main factors. First, there has been growing recognition of the importance of psychological processes in psychosis, both as contributors to onset and persistence, and in terms of the negative psychological impact of a diagnosis of schizophrenia on the individual's well-being, psychosocial functioning and life opportunities. Psychological and psychosocial interventions for psychosis have been developed to address these needs. Second, although pharmacological interventions have been the mainstay of treatment since their introduction in the 1950s, they have a number of limitations. These include limited response of some people to antipsychotic medication, high incidence of disabling side effects and poor adherence to treatment. Recognition of these limitations has paved the way for acceptance of a more broadly-based approach, combining different treatment options tailored to the needs of individual service users and their families. Such treatment options include psychological therapies and psychosocial interventions."[283]

The Guidance goes on to recommend:

[281] NICE (2009) *Depression; Treatment and management of depression in adults, including adults with chronic pain.* CG 90 p. 157

[282] Ibid p.298

[283] NICE (2009) Schizophrenia: *Core interventions in the treatment and management of Schizophrenia in adults in primary and secondary care.* CG82 p. 244

"8.4.10.1 Offer cognitive behavioural therapy (CBT) to all people with schizophrenia. This can be started either during the acute phase or later, including in inpatient settings."[284]

12.5.3.2 Findings

From the time of his first meeting with Mr. Y in July 2004 Psychiatrist 1 felt that Mr. Y's problems could be usefully construed within a psychological framework. He began an assessment to identify whether Mr. Y might benefit from psychodynamic psychotherapy.[285] However before this assessment was completed Psychiatrist 1 had begun to suspect that Mr. Y might be in the prodromal phase of a psychotic illness and he referred him to the Early Intervention Service.[286] By 1 September 2004 Mr. Y had been admitted to hospital and Psychiatrist 1 discontinued his assessment.

Following Mr. Y's discharge from hospital it was decided that his assessment for psychotherapy should re-commence.[287] Although Mr. Y reported to the Early Intervention CPN that he felt that he was benefiting from the psychotherapy assessment sessions.[288] Psychiatrist 1 concluded at the end of eight assessment sessions, in June 2005, that Mr. Y was not suitable for psychodynamic psychotherapy. He suggested that Mr. Y might benefit from a more structured approach such as Cognitive Behaviour Therapy (CBT).[289]

Mr. Y was not subsequently offered any individual psychological therapy during the time he was under the care of the Trust. He was offered and attended some groups aimed at helping him deal with anxiety and on being assertive.[290] However the primary emphasis in Mr. Y's care and treatment was placed on engaging him in more activity focused groups such as sports groups, cookery groups, creative writing groups and woodworking groups. He also attended some groups designed to prepare him for returning to work.

Following his assessment by CPN 2 in July 2006 the care plan which was drawn up noted that Mr. Y's low self esteem would be addressed, his distressing thoughts would be challenged and his self confidence promoted. However there is no record in Mr. Y's clinical

[284] Ibid p. 274
[285] Case notes p. 267, 268 & 344
[286] Case notes p. 178
[287] Case notes p. 214 & 165
[288] Case notes p. 225
[289] Case notes p. 162 & 305
[290] Case note e.g. p. 83-87, 136,43, 79, 30, 59

notes that these goals were pursued in a systematic manner as one might expect in a more formal psychological therapy. From the Housing Association notes, however, it appears that Housing Support Worker 1 did undertake some work with Mr. Y based on Cognitive Behavioural principles.[291]

12.5.3.3 Conclusion

Psychiatrist 1 identified that Mr. Y might benefit from individual psychological therapy and assessed his suitability for psychodynamic psychotherapy. He concluded that Mr. Y was not suitable for this form of intervention but that he would benefit from a more structured approach, such as CBT. There is no evidence that this recommendation was pursued or that Mr. Y was referred for CBT or any other form of psychological therapy.

Best Practice Guidelines for both psychosis and depression recommend that service users with these types of problems should have access to psychological therapies. These were not made available to Mr. Y. There were no psychological resources allocated to the community team at this time. This may have made it difficult to access psychological therapies. It may also have reduced the importance accorded to these interventions.

As has been noted elsewhere in this report, the dynamics of Mr. Y's family life played an important role in his presentation. Psychological interventions to explore and address these issues might well have been beneficially provided, however there is no evidence in Mr. Y's clinical notes that such a course of action was considered.

- ***Contributory Factor 4: Best Practice Guidance recommends that psychological interventions should be made available for those diagnosed as suffering from depression or a psychosis. These were not made available to Mr. Y. It is probable that appropriate psychological interventions would have enhanced Mr. Y's mental health and well-being. It cannot reasonably be concluded, however, that the absence of these interventions had a direct causal relationship with the events of 21 February 2008.***

12.5.4 Alcohol

12.5.4.1 Context

[291] Housing notes p. 69

The Department of Health in its Good Practice Guide on services for those with a mental illness and a substance misuse problem noted:

"1.1.2 A fundamental problem is a lack of clear operational definitions of "dual diagnosis". In many areas a significant proportion of people with severe mental health problems misuse substances, whether as "selfmedication", episodically or continuously. Equally, many people who require help with substance misuse suffer from a common mental health problem such as depression or anxiety. Sweeping up all these people together would result in a huge heterogeneous group many of whom do not require specialist support for both mental health and substance misuse issues. Integrating services therefore requires a clear and locally agreed definition of dual diagnosis supported by clear care pathways (care coordination protocols). It is essential to acknowledge that gatekeeping by specialist services is a valid activity which enables them to focus their efforts, and agreed and justifiable gatekeeping practice with clear accountability should ensure that clients are included in the right services, rather than excluded from services they desperately need."[292]

The guidance identifies alcohol as the most common form of substance misuse.

Commenting on the impact of substance misuse the Guidance notes:

"1.5.1 Substance misuse among individuals with psychiatric disorders has been associated with significantly poorer outcomes including:

- *Worsening psychiatric symptoms*
- *Increased use of institutional services*
- *Poor medication adherence*
- *Homelessness*
- *Increased risk of HIV infection*
- *Poor social outcomes including impact on carers and family*
- *Contact with the criminal justice system.*

Substance misuse is also associated with increased rates of violence and suicidal behaviour. A review of inquiries into homicides committed by people with a mental illness identified substance misuse as a factor in over half the cases, and substance misuse is over-represented among those who commit suicide."[293]

[292] DoH (2002) *Dual Diagnosis Good Practice Guide* p.6
[293] Ibid p. 9

Commenting on the assessment and planning of care for individual service users the guidance recommends:

"Specialised assessments are undertaken to determine the nature and severity of substance misuse and mental health problems, and to identify corresponding need. The more comprehensive and focused the assessment the better the understanding will be of the relationship between the two disorders. Since substance misuse can itself generate psychological and psychiatric symptoms, assessment of this relationship should be longitudinal and open to revision."[294]

12.5.4.2 Local Context

The alcohol services available to Mr. Y were provided by Lifeline. This organisation describes itself as follows:

"Lifeline has over thirty years experience of running drug and alcohol services, and of developing and supporting health, social and criminal justice expertise.

Lifeline is committed to ongoing strategic planning and review and is focused on the current and future needs of service users, commissioners and localities.

Lifeline has a track record of engaging and working alongside the hardest to reach. Our collaborative working with service users, communities and professionals has achieved health, social and economic outcomes with drug users including offenders, women, people from black and minority ethnic communities, refugee and asylum seekers, sex workers and the homeless.

Geographically these services are spread across Yorkshire and Humberside, the North East, the North West and London and we work in diverse towns, cities and villages. Lifeline works with individuals who use drugs and with their families and communities, working together to provide integrated support, develop awareness and build the capacity of families and communities to address and prevent substance use and the surrounding issues.

Service user involvement is central to our work and Lifeline values the expertise that people directly affected by substance use bring to the design, development and evaluation of services, and to their integration into communities and localities. Lifeline's recruitment and

[294] DoH (2002) *Dual Diagnosis Good Practice Guide* p.17

workforce development processes support the appointment of volunteers and staff with diverse life experiences and perspectives and we are proud of our skilled and committed workforce"[295]

12.5.4.3 Findings

Soon after Mr. Y was referred to the secondary mental health services his problems with alcohol were identified. Mr. Y was first seen by the secondary mental health services on 21 June 2004 and on 26 August 2004 he was arrested and spent the night in the police cells because he was drunk.[296] There are numerous references to Mr. Y's drinking in his notes. On a number of occasions he came into conflict with the criminal justice system because of his drinking.[297] Mr. Y drinking was identified as a problem in his care plans[298] and included in his diagnosis.[299]

Those looking after Mr. Y frequently discussed the effects of alcohol with him[300] and the Early Intervention CPN reported to Mr. Y's mother that she had employed motivational interviewing techniques to encourage Mr. Y to reduce his alcohol consumption and accept help for his alcohol misuse problem.[301] At times Mr. Y appeared to agree that reducing his alcohol intake was a good idea. However, on at least some occasions, he appeared to be saying what he believed those encouraging him wanted to hear. For example, at a CPA meeting in June 2005 Mr. Y agreed to reduce his alcohol consumption. However on his way out of the hospital he informed the Early Intervention CPN that he had no intention of doing so and was going to get drunk later that day. This he did.[302]

Often, however, Mr. Y said that he did not want to stop drinking and that he did not believe he had a problem. Indeed on a number of occasions he reported that he drank because this relieved his depression, at least in the short term. [303]

[295] www.lifeline.org.uk

[296] Case notes p.183
[297] Case notes p. 229, 231
[298] Case notes p.230
[299] Case notes p,129
[300] Case notes e.g.62,64, 230
[301] Case notes p. 222, 227
[302] Case notes p.222, 230
[303] Case notes e.g. p. 227, 561

Mr. Y's mother discussed her concerns about her son's drinking on a number of occasions. She believed that his drinking resulted in a lowering of his mood.[304] However, despite all this concern, there was little that could be done for Mr. Y without his consent and engagement.

Following a conversation with the Early Intervention CPN in March 2005 Mr. Y's mother took him to his GP who prescribed Antabuse as an aid to stop him drinking.[305] However, with in a few weeks Mr. Y had stopped taking this as it made him feel sick.[306]

The main intervention that was consistently offered to Mr. Y was to engage with the local alcohol services offered by Lifeline. However, neither the staff of the mental health service nor Mr. Y's family had the power to compel Mr. Y to engage with this service. Lifeline, like most similar services, only saw people who were committed to addressing their alcohol misuse problems and did not offer a service working alongside the mental health staff to engage people like Mr. Y who were ambivalent about acknowledging and addressing their problem.

12.5.4.4 Conclusion

Mr. Y had a significant alcohol misuse problem for most of the time he was in contact with the Trust's mental heath service. The detrimental effects of alcohol on his behaviour, his mental state and even on his ability to benefit from the services made available to him were well recognised. Both Mr. Y's family and those providing care and support repeatedly encouraged Mr. Y to address his alcohol problem. Mr. Y's mother accompanied him to his GP who prescribed the medication Antabuse to help Mr. Y stop drinking. However Mr. Y showed no consistent motivation to reduce his alcohol intake and on a number of occasions reported that he used it to ameliorate the distress he experienced associated with his mental health problems.

Given the services available there was little the staff of the Trust could do to affect Mr. Y's drinking without his willing co-operation. This was not forthcoming. They consistently provided him with information about the alcohol service but had no authority to compel him to engage with this service. This was a source of frustration for Mr. Y's family, the staff of the Trust and the staff of the Housing Association.

[304] Case notes p. 62, 64, 222, 227
[305] Case notes p. 222
[306] Case notes p. 227

However the Department of Health's Good Practice Guidance on Dual Diagnosis (2002) recommended:

"…drug and alcohol services provide specialist support, "consultancy", and training to mental health services to support "mainstreaming" of clients with severe mental health problems…without which people will continue to receive poorly integrated or episodic care."[307]

This was the Best Practice Guidance current at the time Mr. Y was under the care of the Trust. The relevant "*support, 'consultancy' and training*" was not available to those caring for Mr. Y.

- ***Contributory Factor 5: Mr. Y's continued misuse of alcohol was detrimental to his mental state and the recommended support, consultancy and training was not available to staff to help Mr. Y address this problem. It cannot be reasonably concluded, however, that this had a direct causal relationship with the events of 21 February 2008.***

12.6. Cultural Diversity

12.6.1 Context

There exists a substantial amount of legislation relating to Human Rights, discrimination and equality. The current Coalition Government has stated its commitment to promoting equality and eliminating discrimination in health care.

"A core principle of the White Paper is the need to eliminate discrimination and reduce inequalities in care. In our drive to secure excellence in NHS services, we will not compromise the need to maintain and improve equity. There will be explicit duties to promote equality and tackle inequalities in the outcomes of healthcare service" [308]

By eliminating prejudice and discrimination, the NHS can deliver services that are personal, fair and diverse and a society that is healthier and happier. For the NHS, this means making it more accountable to the patients it serves and tackling discrimination in the work place.

[307] DoH (200) *Dual Diagnosis Good Practice Guide* p. 11
[308] DoH, (December 2010*) Liberating the NHS: Legislative framework and next steps.*

The Operating Framework for the NHS in England 2011/12 (December 2010) makes it clear that we expect NHS organisations to maintain progress on equality by fulfilling their statutory duties under the Equality Act and to deliver high quality care for patients."[309]

In line with the requirements of the legislation as these applied to public bodies, the Trust published its Equality and Diversity Strategy in 2009. [310] This stated that:
"People who use the Trust's services have vastly different life styles in terms of social circumstances, wealth, housing, employment, where they live, their age, gender, sexual orientation, ethnicity, religion, culture and physical and mental abilities. All these factors affect people's ability to access services or to obtain or retain employment where appropriate. The Trust aims to ensure that services are designed and managed, as far as possible, to respect and value difference. Services should be capable of adapting to meet the needs of service users and their carers from these diverse groups……
Equality is not about treating 'everyone the same', but recognising that everyone is different, and that people's needs must be met in different ways. By embracing difference, we are able to create an environment where everyone feels valued and respected."

12.6.2 Findings

Mr. Y's family were Jehovah's Witnesses. This was identified in the GP's letter referring him to the mental health services. Even at this early stage a relationship between Mr. Y's religious background and his mental health problems was being identified. The GP commented: "*He [Mr. Y] is a devout Jehovah's Witness and I believe some elements of their Christian teaching are making his situation worse. He feels guilt in that he has brought this illness upon himself*."[311]

Religion, like any cultural issue, tends to permeate an individual's life and is not confined to a few circumscribed beliefs. This was the case with Mr. Y. A number of issues, related to religion, were identified as having an impact on his behaviour, his mental health and well-being, his sense of self confidence and self worth and the coping strategies he employed. Some of these are listed below:

[309] DoH (2011) Gateway refs: 15081, 15471, 15641

[310] SWYMHT (2009) Equality and Diversity: Promoting mutual respect."
[311] Case notes p.347

- Mr. Y's relationship with the religion of his family. For example, when Mr. Y was first assessed by the secondary mental health services he reported that although he went to Kingdom Hall about five times a week *"I hate to sit in the audience in Kingdom Hall".* For him being in Kingdom Hall was "*a kind of abuse of the mind.*"[312]

- Mr. Y struggled with and was ambivalent towards the beliefs of the Jehovah's Witnesses. Staff felt that he was often on the brink of rejecting the teachings of the Jehovah's Witnesses but would then speak to members of the faith and feel that he could not reject their teachings. [313]

  In January 2006 Mr. Y's mother wrote to the Early Intervention CPN: "*He tells me that he has had his head messed with yet he is allowing himself to be indoctrinated again.*"[314] A few days later he reported to the Early Intervention CPN that he had decided to rejoin the church and become a brother.[315]

- Mr. Y's sense of guilt and failure because he was not adhering to God's expectations nor the teaching of the Jehovah's Witnesses. For example, on a number of occasions he expressed a strong sense of guilt because he had masturbated.[316] On other occasions he was distressed because he felt that he had let his family down by getting drunk and coming into conflict with the law.[317]

- The role religion played in family relationships. Mr. Y reported that his father was a committed Jehovah's Witness and he had "*always been strict in his teaching of this religion.*"[318] Mr. Y reported that if he did something that his father disapproved of his father would read from the Bible making him feel guilty.[319]

[312] Case notes p. 344
[313] Witness Interview Independent Investigation p.4/5
[314] Case notes p.145
[315] Case notes p.77
[316] Case notes 281
[317] Housing notes p.20
[318] Ibid
[319] Ibid

- Mr. Y's sheltered upbringing and limited experience of life left him vulnerable to exploitation.[320]

As Mr. Y's case illustrates, the effects of religion and culture are both pervasive and subtle. In consequence, those assessing the needs of the individual and planning his care must be mindful of the influence of religious beliefs throughout the assessment and care planning process. Religion and culture cannot be meaningfully assessed as entities independent of the way in which people think, feel and behave.

Assessment

Mr. Y's mental state and level of distress was substantially influenced by his beliefs and his relationship with those beliefs. However, it is probable that his mental state also had an influence on what he believed and on his interpretation of the teaching of the Jehovah's Witnesses. An adequate assessment of Mr. Y's cognitive functioning and thinking style required some familiarity with the beliefs of his church in order to be able to differentiate between rational, if different, beliefs and distorted thinking which might be symptomatic of mental ill-health.

No-one can reasonably be expected to be an expert in all the cultures, religions and belief systems that they might encounter in the course of their clinical work. However, in establishing a robust and reliable structure for assessment it is important that clinicians are alert to differences and seek appropriate advice when undertaking an assessment. In many ways this is easier to do when cultural and religious differences are great. When differences are perceived to be smaller there is the temptation to assume a knowledge that one does not have or assume that the cultural issues are unimportant.

In the case of Mr. Y, while the importance of his religious beliefs and his relationship with these and with the Jehovah's Witness community was identified, there is no record that any advice was sought to enable the clinical staff to understand his belief system and help them distinguish between those beliefs that might have been symptoms of mental ill health and those that were simply different.

[320] Witness Interview Independent Investigation p.4/5

For much of the time it appears that staff assumed that causality ran in one direction: religion was perceived as a source of distress. However, why this was the case does not appear to have been explored. Nor does the possibility that causality might have run in the other direction: that Mr. Y was struggling with his religion because of his mental health problems or, perhaps most plausibly, that there was a dynamic relationship between these two factors.
It is not possible to say, with any certainty, whether access to a more informed view of the beliefs of the Jehovah's Witnesses would have significantly helped with the formulation of Mr. Y's problems and the consequent monitoring of his mental health. However, it seems likely that it would have led to a more reflective exploration of his sense of guilt and failure, questioning whether these were appropriate responses to the teachings of the Jehovah's Witnesses or distortions manifesting his mental ill-health. Similarly a more informed view point may well have allowed those monitoring his mental health to view his concerns about sex and sexual relationships in a more informed light. In this sense, a more informed view point would have led to more sensitive and reliable monitoring of his mental state. This would have been in Mr. Y's best interest.

Intervention

There is a suggestion running through Mr. Y's clinical notes that the health and social care services were struggling against, what they perceived to be, the unhelpful influence of his religion and religious beliefs.

While we do not have any record of what members of the Jehovah's Witness Community may have said to Mr. Y, the Independent Investigation Team were informed that it is not the position of the Jehovah's Witnesses that mental illness is a punishment or that the individual, necessarily, brings his ill health on himself. In as far as this community has a view on this matter, mental ill-health is seen as an illness which should be treated by those appropriately trained to do so.

It would have been beneficial to those assessing Mr. Y's needs to have had access to informed advice on the beliefs and practices of the Jehovah's Witnesses. Similarly it would have been useful to have fashioned a co-operative relationship with this community which could have informed the care of Mr. Y. Individual work with Mr. Y might have been enhanced by access to such support and advice. As it was, no programme was put in place explicitly to help Mr. Y address his religious preoccupations. For much of the time he was

under the care of the Trust the approach adopted was to promote his sense of self esteem and self confidence, on the assumption that this would allow him to address his religious concerns.

A co-operative relationship with the Jehovah's Witness Community might also have informed a family approach to Mr. Y's problems. Again this appears not to have been done.

Who might have facilitated such support?

In the real world with limited resources and significant demands on the clinician's time it is not possible or reasonable to seek out expert advice on each cultural issue that may arise with each patient. The skill of the clinician should be to identify what is likely to be of importance or relevance in understanding and addressing an individual's problems. In the case of Mr. Y, his religious beliefs and the impact of these on both his mental health and his family life was noted from the time of his first contact with the mental health services. Given this, it would have been reasonable to expect those caring for him to have explored these issues and to have sought advice if the relevant knowledge was not available within the multi-disciplinary team.

While it is the responsibility of the individual clinician to ensure that s/he is giving due consideration to religious and cultural issues, it is the responsibility of the organisation to ensure that a culture is in place which promotes this behaviour and that the mechanism are in place to provide the clinicians with appropriate support and advice.

When considering issues of religion the obvious source of expertise within a Trust is normally the Chaplaincy Service or Pastoral Care Team. While this team may not be expert in all religious belief systems they are usually expert in identifying people who do have the necessary knowledge and are skilled at facilitating contact both for the clinicians and for the service user. Disappointingly, pastoral care teams are often peripheral to the work of the mental health teams and their expertise not made best use of. In the case of Mr. Y there is no evidence that this team was consulted or its advice sought.

12.6.3 Conclusion

Religion played a major part in Mr. Y's life and that of his family. This was identified at the beginning of his contact with mental health services. There was a belief that religion, or at least Mr. Y's relationship with his religion and religious beliefs, was a source of distress.

However, why this was the case was never formally explored as part of his assessment. The assumption of the clinicians providing care and support to Mr. Y was that religion was a cause of his distress but the possibility that his problems with religion might also be a manifestation of his mental health problems does not appear to have been considered. Had this been done the monitoring of his mental state may have been more sensitive and reliable.

Despite the acknowledgement of the importance of religion in the life of Mr. Y and of his family, no advice or information was sought on the beliefs of the Jehovah's Witnesses nor was any attempt made to forge a co-operative relationship with the local Jehovah's Witness Community. Such a relationship might have informed the assessment of his mental state and the consequent interventions.

- ***Contributory Factor 6: While the role played by religion and religious beliefs was acknowledged by the clinical team, expert advice was not sought to help the team understand Mr. Y's background, or to help them differentiate normal, if different, beliefs from thinking that might be symptomatic of mental ill-health. Nor was a co-operative relationship sought with the local Jehovah's Witness Community, a relationship which might have informed clinical interventions. Had this been done, it is probable that Mr. Y's mental health would have been more sensitively and reliably monitored and his mental health needs addressed in a more timely fashion. This would have contributed, beneficially, to Mr. Y's mental health and well-being, although it cannot be concluded that it would have affected the events of 21 February 2008.***

12.7. Vulnerable Adults and Safeguarding

12.7.1. National Context

In the preamble to the *Safeguarding Adults: A National Framework of Standards* it is noted that:

"All persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the Human Rights Act (1998) to intervene proportionately to protect the rights of citizens. These rights include Article 2: 'the Right to

life'; Article 3: 'Freedom from torture' (including humiliating and degrading treatment); and Article 8: 'Right to family life' (one that sustains the individual).

Any adult at risk of abuse or neglect should be able to access public organisations for appropriate interventions which enable them to live a life free from violence and abuse. It follows that all citizens should have access to relevant services for addressing issues of abuse and neglect, including the civil and criminal justice system and victim support services." [321]

To promote the realisation of the goal of ensuring that individuals are able to live their lives "*free from violence and abuse"* the Department of Health issued its guidance *No secrets*[322] in 2000. This guidance notes:

***"1.1** In recent years several serious incidents have demonstrated the need for immediate action to ensure that vulnerable adults, who are at risk of abuse, receive protection and support…. This guidance builds on the Government's respect for human rights and results from its firm intention to close a significant gap in the delivery of those rights alongside the coming into force of the Human Rights Act 1998.*

***1.2** The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety. The agencies' primary aim should be to prevent abuse where possible."*

The guidance goes on to define a vulnerable adult as a person who is over the age of 18 and:

"2.3 who is or may be in need of community care services by reason of mental or other disability, age or illness; and

who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

[321] Association of Directors of Adult Social Services (2005) *Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work.* P. 4/5

[322] DoH (2000) *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*

Abuse is broadly defined as:
"2.5 Abuse is a violation of an individual's human and civil rights by any other person or persons."

The guidance goes on to identify a number of forms of abuse including:
"2.7 financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits."

It throws an equally wide net over those who might be abusers:
"2.10 Who may be the abuser? Vulnerable adult(s) may be abused by a wide range of people including relatives and family members, professional staff, paid care workers, volunteers, ***other service users, neighbours, friends and associates****, people who deliberately exploit vulnerable people and strangers."* (Emphasis added).

When considering whether it is appropriate to intervene the guidance offers the following advice:
"2.19 *The seriousness or extent of abuse is often not clear when anxiety is first expressed. It is important, therefore, when considering the appropriateness of intervention, to approach reports of incidents or allegations with an open mind. In making any assessment of seriousness the following factors need to be considered:*
• *the* ***vulnerability*** *of the individual;*
• *the* ***nature and extent*** *of the abuse;*
• *the* ***length of time*** *it has been occurring;*
• *the* ***impact*** *on the individual; and*
• *the risk of* ***repeated or increasingly serious*** *acts involving this or other vulnerable adults."*

12.7.2 Local Context

Section 3.3 of the current Adult Safeguarding policy, to which South West Yorkshire Partnership NHS Foundation Trust subscribes, identifies "*people with mental health problems*" as individuals who are liable to be victims of abuse. [323] With this group of individuals there is often a lack of clarity as to whether they should be the subject of

[323] Calderdale Multiagency Policy and Guidance to Safeguard Vulnerable Adults from Abuse. (2010)

safeguarding procedures. This is particularly the case when it is believed that the individual can make autonomous decisions.

The policy makes the local position on this issue clear:
"3.5 Where a person has the autonomy to make decisions that may involve risk this should be respected, but should not override the duty to protect where this risk would be deemed to be unreasonable or dangerous."
The Safeguarding policy notes that: "*Partner agencies have a duty of care to respond to concerns of abuse or neglect towards vulnerable adults in community, health and care setting."*

12.7.3 Findings of the Internal Investigation

"Vulnerable Adults and Safeguarding:

The records which have been made available to the Inquiry Team, and the evidence which the Team has heard, casts no doubt on the fact that [Mr. Y] was a vulnerable, immature adult with complex needs, who was deeply confused about his life. However, many of the professionals working with [Mr. Y] saw his needs as 'typical' of many individuals who have contact with mental health services.

As [Mr. Y] was subjected to financial exploitation, his vulnerability and the ways of managing it should have been examined under Safeguarding Procedures.

Appointeeship (Department of Work & Pensions) does not appear to have been considered as one possible way of managing [Mr. Y]'s financial vulnerability."

12.7.4 Findings

The victim of abuse and exploitation

From the time of his first contact with the mental health service Mr. Y's lack of assertiveness and his desire to please others was noted. Following his initial assessment by a Staff Grade Psychiatrist on **21 June 2004** she noted that "[Mr. Y] *feels extremely under pressure from his dad and wants to please him all the time…… There is low self-esteem, no assertiveness and he appears quite anxious."*[324]

[324] Case notes p.345

Mr. Y was discharged from in-patient care to a supported housing project on **19 November 2004.** However by **15 December 2004,** less than a month later, the Early Intervention CPN found it necessary to speak with him about lending money to fellow tenants. She recorded in the clinical notes that Mr. Y was "*adamant*" that he was going to continue doing this i.e. lend or give away his money.[325] This is a theme that characterised the rest of Mr. Y's stay in the community.

It was reported on a number of occasions that Mr. Y was giving money to other tenants at the supported housing project, buying them cigarettes and alcohol and shopping for them.[326] On **19 April 2005,** for example, Mr. Y reported to the Early Intervention CPN that another tenant was regularly taking money from him. Mr. Y was afraid of this man who had told him that he had served a prison sentence because he had killed a man and could easily obtain a gun. Mr. Y's fear not only contributed to his willingness to give him money but also interfered with his own care and support. In his efforts to avoid this man Mr. Y avoided answering his door when mental health staff or supported housing staff called at his room. He even considered giving up his supported accommodation and applied for alternative accommodation.[327]

In **November 2005** Mr. Y's mother reported that Mr. Y had spent £2,000 in the previous few weeks. He had also sold a bicycle, which had cost him £250, for £20. She was concerned that he was vulnerable and was being exploited.[328]

In **December 2005** Mr. Y's father contacted the Supported Housing staff to report that a fellow tenant had "*borrowed*" £1,100 from his son. Mr. Y's father felt that this incident proved that his son was vulnerable and could not manage his money.[329].

In **April 2006** Supported Housing Worker 1 pointed out to Mr. Y that he had given away all his savings, around £10,000, in two years. However, as on most occasions when this issue was discussed with him, Mr. Y felt that he could cope, or that he was giving/lending money of his own volition, and he did not want the staff to intervene.[330]

[325] Case notes p.204
[326] Case notes p.225
[327] Case notes p.233, 236
[328] Case notes p.73, 75
[329] Housing notes p. 25
[330] Housing notes p.46

While it is not necessary or useful here to rehearse every incident of exploitation or abuse to which Mr. Y was subjected, it is informative to report what happened in **May** and **June 2007** as this illustrates the extent to which Mr. Y's well-being was put at risk. It appears that Mr. Y allowed a woman to stay in his flat in the hope that they might form a relationship. She, however, brought her boyfriend with her. Both these individuals were abusing drugs. Mr. Y lent them money and in turn tried to borrow money from his mother, becoming angry when she would not lend this to him. This placed a strain on the supportive relationship he had with his mother. Mr. Y fell into arrears with his own rent. Under the influence of his two visitors Mr. Y tried crack cocaine on several occasions. He removed the pipe-work from his flat and broke into a neighbouring flat, again to remove the pipe-work to obtain money to buy drugs. He was questioned by the police and charged with burglary.[331] His mental health deteriorated while these events were taking place.[332]

Were people aware that Mr. Y was vulnerable and being exploited?

In addition to the instances noted above there are numerous examples throughout Mr. Y's records of his parents, staff of the supported housing scheme and mental health staff expressing their concern that Mr. Y was being exploited. Again the instances below are illustrative rather than exhaustive.

On **3 January 2006** the Supported Housing staff informed the Early Intervention CPN that they were concerned that Mr. Y was giving his money to other tenants. When they tried to discuss this with him Mr. Y was insistent that he had given his money voluntarily.[333]

On **4 January 2006** Mr. Y's mother wrote to the Early Intervention CPN informing her that Mr. Y was continuing to be exploited financially.[334]

On **5 June 2006** Mr. Y's parents wrote to the housing association expressing their concern that other tenants were intimidating and financially exploiting their son.[335]

[331] Case notes p.113
[332] Case notes p.113
[333] Case notes p. 76
[334] Case notes p.145
[335] Housing notes p.33

Mr. Y was seen by Psychiatrist 1 on **30 January 2007.** He was accompanied by his mother who was angry that Mr. Y was again being financially exploited.

On **19 June 2007** Supported Housing Worker 1 contacted the CMHT to inform the mental health staff of her continuing concerns regarding Mr. Y's vulnerability to exploitation.[336]

Similarly Mr. Y's vulnerability to exploitation was noted in a number of more formal fora.

At a CPA review meeting on **1 March 2005** it was noted that Mr. Y was at risk of social isolation, abusing alcohol and financial exploitation. The plan was for him to attend a group to promote his assertiveness skills.[337]

On **15 June 2005** a support planning meeting was convened by the housing association. Mr. Y, his mother and the Early Intervention CPN attended the meeting. It was noted that Mr. Y was being exploited by other tenants.[338]

On **20 January 2006,** at a review meeting convened by the Housing Association to plan for Mr. Y's future, it was recorded that his vulnerability was high.[339]

Twenty-two Health of the Nation Outcome Scale (HoNOS) assessments are recorded in Mr. Y's clinical notes. On only two occasions was Mr. Y given a vulnerability rating of 0 or 1 on the five point scale used by this device. One of these appears to be anomalous as on a second HoNOS completed the same day he was given a rating of 3. Between July 2004 and July 2005 Mr. Y was given a maximum rating of 4 on five occasions and a rating of 3 on two occasions. On 13 of 22 assessments Mr. Y was given a rating of 2 on the 5 point scale.

Was anything done in response to these identified concerns?

As has already been noted on a number of occasions, various members of staff spoke to Mr. Y about the fact that others were taking advantage of him. The staff of the mental health team spoke to the staff of the supported housing team. They in their turn offered to confront those tenants who were taking advantage of Mr. Y. However Mr. Y's most frequent response was

[336] Housing notes p. 56
[337] Case notes p.83
[338] Case notes p.136, 229
[339] Case notes p.78

that he did not want the staff to intervene. On one occasion he reported that he was concerned that if the staff did approach other tenants they would be angry with the staff. On **13 June 2005** the Housing Association wrote to Mr. Y's father informing him, amongst other things, that Mr. Y had said that he did not want the staff to confront other tenants who might be exploiting him and they had to abide by his wishes.[340]

However, with support, on **26 July 2005** Mr. Y did make a statement to the police reporting that another tenant was taking money from him. This tenant was later arrested.[341]

Staff, on occasions, offered to hold Mr. Y's money for him, for example in **April 2006** when he had received a loan in preparation for moving into more independent accommodation.[342]

Mr. Y was referred to confidence building and assertiveness groups and the staff dealing with him tried to address his lack of self confidence and assertiveness.[343]

12.7.5. Conclusion

The Independent Investigation Team concluded that the findings of the Internal Investigation were largely in accord with those of the Independent Investigation.

Mr. Y met the established criteria to be formally identified as a vulnerable adult; he was "*receiving community care services by reason of his mental health problems"* and it was generally accepted that he was *"unable to protect himself against significant harm or exploitation".* As such he had a right to expect *protection and support from abuse.*

Intervention appears to have been justified as Mr. Y and the harm he suffered appear to meet the criteria for intervention:

- *the **vulnerability** of the individual;*
- *the **nature and extent** of the abuse;*
- *the **length of time** it has been occurring;*
- *the **impact** on the individual; and*
- *the risk of **repeated or increasingly serious** acts involving this or other vulnerable adults."*

[340] Housing notes 36
[341] Case notes p. 232
[342] Housing note p.33
[343] Case notes p.78, 51.42,54

However it was consistently observed that Mr. Y had the capacity to make a decision and he clearly indicated that he did not wish the staff of either the mental health service or the Housing Association to confront those who were exploiting him. It was right that Mr. Y's views were given central importance, however, as was noted above, the (current) local policy guidance states:

"3.5 Where a person has the autonomy to make decisions that may involve risk this should be respected, but should not override the duty to protect where this risk would be deemed to be unreasonable or dangerous."

This guidance seems to indicate that Mr. Y's wishes should not have been the sole determinant of that action that was taken.

Mr. Y's vulnerability to exploitation was recognised by his family and those caring for him. This vulnerability was acknowledged in various formal arenas and some plans were put in place. However it is evident from the notes that Mr. Y's family were frustrated that nothing more formal was done to protect their son. Staff felt that they were limited in the extent to which they could intervene because Mr. Y usually withheld his consent and they felt bound to comply with his wishes.

The staff understood Mr. Y's vulnerability and consequent behaviour as a product of his upbringing, beliefs and what they regarded as his personality. A clinical witness to the Independent Investigation reported:

"He [Mr. Y] was very vulnerable to financial exploitation…..He found relationships extremely difficult to build and sustain because he was so anxious and so concerned about what other people thought of him …He wanted to please people and he found it very difficult to believe that he had upset or offended any one…..The reason he never had any money was because he gave it away. It was an ongoing theme that we had to try to manage because he never wanted any action taken against anyone …..He had this thing that other people were more needy that himself…..He would actually be hurt by the belief that people could lie….People could stop him in the street and ask for money and he would be upset and

worried about this person who said they did not have enough money to get a bus home. He was a very gentle, sensitive person who believed the best in everyone."[344]

When Mr. Y's mother expressed her concerns that her son was being financially exploited she was advised that while it was true that he was vulnerable, part of the process of growing in maturity was to learn what is appropriate in a relationship, and that one aspect of the learning process is that people make mistakes.[345]

As noted above various members of staff in both the mental health teams and housing association tried to help Mr. Y by explaining to him the consequences of his actions, by working with him on his self esteem and assertiveness skills, by referring him to therapeutic and skills groups and even by offering to look after his money at times. What they did not do was to trigger the Adult Safeguarding Procedures.

Establishing that an individual has the capacity to make a decision involves, amongst other things, establishing that s/he understands the implications of his/her decision. This in its turn implies that the individual has responsibility for his/her decisions and related actions. Identifying an individual as vulnerable, however, implies that, at least to some degree, the individual is influenced to make decisions that are not in his/her best interest and does not have the resources to resist this influence.

Following his involvement in a burglary of a neighbouring flat, the police and the criminal justice system appear to have recognised Mr. Y's vulnerability and dealt with him accordingly. However, those providing care and support for Mr. Y, although they recognised his vulnerability, felt bound by his decisions. They did not trigger the Trust's Safeguarding procedures. There is no record of an apponiteeship, to help protect Mr. Y from financial exploitation, being considered, nor is there any record that advice or supervision was sought on this matter.

There is no guarantee, of course, that this would have significantly reduced Mr. Y's vulnerability or offered him significantly more protection with a consequent improvement in

[344] Witness Interview Independent Investigation p.3-6
[345] Case notes p.592

his mental health and well being It was however a missed opportunity to explore in a more structured and formal way what the *No Secrets* guidance describes as:
"…an effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety. The agencies' primary aim should be to prevent abuse where possible."

The fact that abuse resulting from Mr. Y's vulnerability was not prevented did significantly financially disadvantage him. It also, at least episodically, harmed his mental health and well-being. It would not be reasonable, however, to conclude that the failure to enact the Safeguarding procedures, even if these could have afforded Mr. Y significant protection, had any substantial effect on the events of the 21 February 2008.

- ***Contributory Factor 7: The Trust and its partner organisations have a duty of care to those to whom they provide services. Part of that duty is to protect the individual from victimisation and exploitation as a result of their vulnerability. Mr. Y was recognised as being vulnerable and was the victim of exploitation. However the Trust's Safeguarding policies and procedures were not followed. As a result of the exploitation he experienced Mr. Y suffered significant financial disadvantage. Being the victim of exploitation also harmed his mental health and well-being. It would not be reasonable, however, to conclude that the failure to enact the Trust's Safeguarding procedures had a direct causal relationship with the events of the 21 February 2008.***

- ***Service Issue 4: The fact that Mr. Y was not formally identified as a vulnerable adult and that appropriate procedures were not followed is a service issue which has relevance beyond this immediate case. The Trust and its partner organisations have a duty of care to those to whom they provide services. Part of that duty is to protect the individual from victimisation and exploitation as a result of their vulnerability. Failing to implement the safeguarding policy is a failure to realise this duty of care and puts in jeopardy the individual's mental health and well-being.***

12.8. Service User Involvement in Care Planning

12.8.1. Context

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

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

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

12.8.2. Findings of the Internal Investigation

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

12.8.3. Findings of the Independent Investigation Team

Adherence to the Trust's CPA policy and Best Practice Guidance with respect to care planning has been discussed above and will not be repeated here. As noted earlier, there was little formal planning of Mr. Y's care and in consequence little opportunity for the formal involvement of Mr. Y in the planning of his care.

In the absence of such formal care planning and a process whereby the service users formally indicates their agreement to a care plan, it is difficult to know how involved they are and perceive themselves to be in the assessment of their needs, the setting of goals and the planning of care and treatment.

This is particularly difficult in the case of Mr. Y. He appears to have been ambivalent about his goals, for example, at times he appeared to want to reduce his alcohol consumption, yet at others he reported that he did not believe that he had an alcohol misuse problem and even that

he was using alcohol to reduce his level of distress[346]; at times he said that he wanted to return to work but at others that he did not want to do this[347]; at times he wanted to live independently and at others to return to his family home[348]. A number of the witnesses to the Independent Investigation reported that Mr. Y wanted to please people and would often say what he believed others wanted him to say, making it difficult to engage him in establishing his own goals or expressing an opinion as to how these might be achieved.

It was evident that those interviewed by the Independent Investigation had a genuine concern for Mr. Y's well-being and had a fondness for him. They appeared to try to engage him in making decisions about his future but found his inconsistencies at times a source of frustration and at times a barrier to involving him more fully in planning his care and treatment.

12.8.4. Conclusions

It is the conclusion of the Independent Investigation Team that the care and treatment offered to Mr. Y aimed at promoting his independence, self confidence and assertiveness. To this extent the care provided was user centred. However, in part because of the lack of formal care planning and in part because of Mr. Y's personal characteristics, those caring for Mr. Y found it difficult to engage him in the planning his care and establishing his goals.

12.9. The Family

12.9.1. The National Context

It has long been accepted as good practice that the family and carers of service users should be involved in the assessment and planning of care of those they care for.

In its most recent guidance on the CPA the Department of Health notes:

"To make sure that service users and their carers are partners in the planning, development and delivery of their care, they need to be fully involved in the process from the start.

[346] Case notes p. 230, 561
[347] Case notes p. 74, 390
[348] Case notes p. 197, 380

Processes should be transparent, consistent and flexible enough to meet expectations of service users and carers without over promising or under delivering. Service users will only be engaged if the care planning process is meaningful to them, and their input is genuinely recognised, so that their choices are respected."[349]

Later in the same document it is noted that:
"Trust and honesty should underpin the engagement process to allow for an equitable partnership between services users, carers and providers of services." [350]

The guidance points out that the family and carers should be involved in the assessment and care planning process because they provide a privileged source of information and the implementation of the care plans often requires their co-operation. It continues:
"Mental illness can have a major impact on carers, families and friends as well as on the person with the illness. It may cause social and financial disruption and restrict educational and employment opportunities for both the carer and the person being supported. The demands of caring can also affect the physical and emotional health of the carer……..Their needs can be overlooked by adult services.

Carers… should be identified at the service user's assessment and information provided to them about their right to request an assessment of their own needs. Services should ensure co-ordination of users' and carers' assessments, care and support plans and the exchange of information where agreement has been received to do this. A service user's own caring responsibilities should also be explored and appropriate support, contingency and crisis plans put in place for the service user as a carer and for the person they care for."[351]

However, a review by the King's Fund and The Sainsbury Centre for Mental Health[352] into how well the guidance had been implemented concluded:
"Carers were frustrated and disillusioned with the care their loved ones are given. They felt that professionals did not listen to them and gave little information. They felt that they were

[349] DoH (2008) Refocusing the Care Programme Approach *p. 8*
[350] Ibid p.18
[351] DoH (2008) Refocusing the Care Programme Approach p. 25
[352] Warner, L., Mariathasan, J., Lawton-Smith, S., Samele, C. (2006) *Choice Literature Review.* King's and & The Sainsbury Centre for Mental Health

not regarded as part of the service users' care; rather they were treated like part of the problem. Their main support came from voluntary organisations." [353]

Support of Carers

The importance of the carer in his/her own right has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It established their entitlement to receive an assessment of their ability. This Act ensures that services take into account information from a carer assessment when making decisions about the cared for person's type and level of service provision required.

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

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

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

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

12.9.2. Local Context

In line with best practice guidance the Trust 2010 CPA policy states:

"Carers often make a major and valued contribution to the support received by many people with a mental illness being treated in the community. The foundation of CPA is built on such

[353] Warner, L., Mariathasan, J., Lawton-Smith, S, Samele, C. (2006) *Choice Literature Review.* King's and & The Sainsbury Centre for Mental Health p.80

a contribution. It should be agreed in advance with the carer who should be properly advised both about such aspects of the patient's condition as is necessary for the support to be given, and how to secure professional advice and support, both in emergencies and on a day-to-day basis.

To involve carers, care co-ordinators should:

- *Be aware of who the main carers are and their contact details.*
- *Ensure that the carer has the care co-ordinator's contact details and that these are offered in writing.*
- *Communicate with carers.*
- *Address issues of confidentiality and consent. (These should not pose an automatic barrier to carer involvement.)*
- *Offer and conduct a full carer's assessment when required.*
- *Produce an individual support plan for the carer when required.*
- *Promote authority of the carer in the provision of appropriate services for the service user."*[354]

The policy also provides guidance on the requirement to provide a carer's assessment and on confidentiality.

It has to be noted that this policy was not in place at the time Mr. Y was under the care of the Trust and that the policy in place during most of that time did not provide such comprehensive guidance.

12.9.3. Findings of the Internal Investigation

"Family approach:

In spite of the fact that [Mr. Y] was assessed as having a range of problems arising from his childhood, his relationships with his family, and the fact that both his parents had carers assessments and support, there was a lack of a family approach, although [the Early Intervention CPN] in the early stages had some contact with the family and [Mr. Y]'s mother would, on occasions, accompany [Mr. Y] when he went to see [Psychiatrist 1 in Psychiatric Outpatients."

[354] SWYMHT (2010) The Care Programme Approach and Care Co-ordination p.12

12.9.4. Findings

Three issues arise regarding the involvement of Mr. Y's family in his care:

- the involvement of his family in the assessment of his needs and planning of his care;
- addressing Mr. Y's problems in a family context;
- the assessment and support of his carers.

12.9.4.1. The involvement of Mr. Y's family in the assessment of his need and planning of his care.

There are numerous examples throughout Mr. Y's notes of his parents making contact with both the mental health service and the supported housing project. They alerted the services when they perceived Mr. Y to be posing an increasing threat to himself and, on occasions, to others; they repeatedly made representations on his behalf when they saw him being exploited by others; they expressed their concerns about his level of drinking, which they perceived to be contributing to his mental ill health; and they tried to alert the services when they saw his mental health as deteriorating.

From early in Mr. Y's contact with the mental health service his parents made it clear that they wanted to be involved in identifying his need and planning his care. Soon after he was accepted by the mental health service Mr. Y's mother tried to make contact with Psychiatrist 1 to discuss her son with him; in October 2004 she expressed her concern that her son might be discharged from in-patient care when she felt that he was still at risk of harming himself. In October 2005 she wrote to the Early Intervention CPN expressing her concern that she might discharge Mr. Y and informed her of the importance of her input to Mr. Y's well being, and the importance of her support to herself, enabling her to support her son. In May 2006 Mr. Y's father tried to contact the Early Intervention Service to alert them to his son's deteriorating mental state. While Mr Y's parents understood the need for confidentiality they were, at times, frustrated by being excluded from supporting their son because they were deprived of information which staff felt would breach confidentiality if it was divulged.

While he was under the care of the Early Intervention Service there appeared to be frequent and good communication between the mental health service and, at least, Mr. Y's mother.

However when his care passed to the CMHT the level of contact with Mr. Y's family decreased. Mr. Y's family's main contact during this period appears to have been with the staff of the Housing Association.

However, despite Mr. Y's parents' eagerness to be involved in his care, the frequent contact with Mr. Y's mother, and the fact that that she often accompanied Mr. Y's to his appointments with Psychiatrist 1, there is no evidence that Mr. Y's family were formally or systematically involved in assessing his needs or planning his care. As has already been noted, few care plans were drawn up and there is no evidence that even these were shared with Mr. Y's family.

When Mr. Y was initially assessed by the Early Intervention CPN she did make contact with his family. However there is no evidence that when he was assessed by CPN 2, in July 2006, contact was made with his family. This was despite the fact that the level of contact with the family, while he was under the care of the Early Intervention Service, was recorded in Mr. Y's clinical notes and that, in his referral letter to the CMHT, Psychiatrist 1 noted that Mr. Y was very dependent on his mother.

There is no evidence in Mr. Y's notes that his discharge from the care of the Early Intervention Service was discussed with his family, despite the fact that Mr. Y's mother had made known her concerns about this course of action in a letter in October 2005.

Similarly, despite that fact that Mr. Y's mother at times accompanied him to his out-patient appointments and Psychiatrist 1 had identified Mr. Y's dependency on her, there is no record that she was involved in the decision to discharge Mr. Y from Psychiatrist 1's care.

The appropriateness of Mr. Y being placed on the standard level of CPA has been discussed above and will not be rehearsed again here. However, while it was often the case that there was a limited level of involvement with families and carers of individual's placed on the standard level of CPA, in a case such as Mr. Y's, where his family were so obviously and intimately involved in his life, not to include them more systematically and formally in identifying his needs and planning his care was not good practice.

In part, this failure to involve Mr. Y's family may have been a reflection of the general lack of formal assessment and care planning in Mr. Y's case. While under the care of the Early Intervention Service this shortcoming may, to some extent, have been ameliorated by the frequent contact the family, especially Mr. Y's mother, had with the Early Intervention CPN. However, while under the care of the CMHT, contact with Mr. Y's family was much less frequent and, as a result, the opportunity for even an informal involvement in planning Mr. Y's care was significantly reduced.

12.9.4.2. Addressing Mr. Y's problems in a family context.

The fact that family dynamics played a part in Mr. Y's presentation was identified at Mr. Y's first assessment in June 2004. Psychiatrist 1, in his letters to Mr. Y's GP, provided a diagnosis of "*Psychological problems (linked to judgemental issues re Jehovah Witnesses and family dynamics).*"[355] Conflicts with his brother and father, exposing himself to his sister, his parents separating while he was an in-patient and family tensions relating to religious beliefs were all recorded in Mr. Y's clinical notes.

Despite the consistent and frequent observations relating to the role Mr. Y's family played in his presentation and his ambivalence about his relationship to his family[356] this important issue was not explored in any detail as part of the formulation of Mr. Y's problems.

Given the very substantial literature: on systemic and family therapy, on the importance and potency of family involvement, on expression of emotion, and on the importance of psycho-education for the families of those with longer term mental health problems, it is surprising that some form of family intervention was not considered for Mr. Y and his family. There is no evidence that such an approach was considered, however. This was an important oversight in the care of Mr. Y.

12.9.4.3. The assessment and support of Mr. Y's family and carers.

National guidance and the Trust's CPA policy both identify the importance of assessing the needs of carers and providing them with appropriate support.

[355] E.g. Case notes p.100, 568, 571
[356] Case notes p.285, 380,

Both of Mr. Y's parents were offered a carer's assessment, Mr. Y's father in February 2005[357], and his mother in April 2005.[358] However, although the carers' assessment forms were completed, the accompanying plans were not. This is not to say that no support was given to Mr. Y's parents. Mr. Y's father was in contact with the Trust's Carer's Support Service at least between May 2004 and July 2007, while Mr. Y's mother was in contact with the Carer's Support Service, at least, between June 2005 and December 2007. Both received individual support and attended support groups as they perceived they needed them. In addition Mr. Y's mother was offered more intensive counselling support in 2007.

Mr. Y's mother also wrote to the Early Intervention CPN in October 2005[359] expressing her gratitude for the support that she had been given.

12.9.5. Conclusion

The Independent Investigation Team agrees with the conclusions of the Internal Investigation that there was a lack of a "family approach" to Mr. Y's care.

Involving the families and carers of service users in the assessment of needs and the planning of care is well established as good practice and is enshrined in national best practice guidelines and in the Trust's current CPA policy. Mr. Y's family were not involved, formally or systematically, in the assessment of his needs or planning of his care. This may have been because there was an overall lack of formal care planning in Mr. Y's case and this, in its turn, may have been a reflection of him having been placed on the standard level of CPA. However, given the level of involvement of Mr. Y's family in his life, it would have been good practice to have involved them in the assessment and planning of his care. This was a weakness in the care provided to Mr. Y.

Having identified the importance of the dynamics of Mr. Y's family in his presentation this should have been explored and included in the formulation of Mr. Y's problems. This was not done. Similarly, having identified this issue, consideration should have been given to the provision of some form of family intervention. Again this was not done. This must be regarded as a failing.

[357] Carer's notes p. 3
[358] Case notes p.15
[359] Case notes p. 135

Mr. Y's parents need for support was identified and resources were put in place to meet this need. This was good practice. It would have been better practice if, having carried out the carer's assessment, a plan to meet these needs had been put in place; a plan which was agreed with each of Mr. Y's parents and which was amenable to evaluation over time.

- ***Contributory Factor 8: While there was informal and unstructured contact with Mr. Y's family, failing to involve them in a formal and systematic manner in the assessment of his needs deprived the team caring for him of information which would have improved their understanding of his mental state, family background, sources of tensions and coping strategies. This situation was detrimental to the putting in place of an effective and efficient package of care for Mr. Y. The absence of such a package of care was detrimental to Mr. Y's health and well-being.***

- ***Contributory Factor 9: Throughout the time he was under that care of the Trust Mr. Y's often ambivalent relationship with his family was identified as a factor contributing to his distress, to his mental health problems and to the coping mechanisms he adopted. Failing to address his difficulties in the context of these family dynamics and failing to provide family members with information on how best to support Mr. Y contributed to his mental health problems not being addressed in the most effective and timely manner possible.***

12.10. Communication and Care Co-ordination

12.10.1. Communication and Co-ordination of Care

We have already observed that the core purpose of the Care Programme Approach is to ensure that service users receive a co-ordinated service, with all those having input into the individual's care sharing an understanding of his/her problems and working to a common set of goals.

Communication is the key to the CPA and to effective and efficient multidisciplinary team working in general. While good communication is not a guarantor of good clinical care, it is not a sufficient condition for good clinical care, it is a necessary condition. Without good communication between those caring for an individual it is difficult, if not impossible, to achieve efficient and effective clinical care.

12.10.2. Findings of the Internal Investigation

"Partnership Working:

There were examples of extremely effective joint working between some staff involved in the delivery of [Mr. Y's] care .....

All staff spoke positively of their peers. There was no evidence to suggest inter or intra professional conflict or organisational barriers. "

12.10.3. Findings

Communication within a clinical team and between agencies providing care for a service user is normally underpinned by the CPA process of care planning and reviewing care plans. However, we have identified above that the care planning and review system was weak in the case of Mr. Y. CPA reviews, which are the formal opportunities for reflection and the exchange of views, were not undertaken at times when important decisions about Mr. Y's care were being made. We will not review these issues again here.

12.10.3.1 Communication: Discharge from hospital.

Mr. Y was admitted to hospital for the first time in September 2004. Prior to this admission, other than spending a few nights in temporary accommodation, Mr. Y had always lived at home with his parents. During his stay in hospital the Early Intervention CPN continued to act as his care co-ordinator and she secured a place in a supported housing scheme for him. In preparation for his discharge she arranged for Mr. Y to visit the hostel. Mr. Y was discharged from hospital on the afternoon of Friday 1 October 2004. However, this discharge was not agreed with either the Early Intervention CPN or the staff of the hostel. In consequence Mr. Y was not prepared for this discharge and no plans were in place to support him in this novel environment over the week-end. In the event Mr. Y drank to excess over that week-end. He was assessed by the Early Intervention CPN on the Monday morning. She found that his mental state had deteriorated and he was immediately re-admitted to hospital.

The Early Intervention CPN and the supported housing staff made representations to the ward manager and the nursing manager about this incident.[360] They both felt that discharging Mr. Y without consultation and planning was inappropriate. They also felt that all the available information had not been taken into account when the decision to discharge Mr. Y was made.

The Ward Manager appears to have acknowledged that this incident was not an example of good practice and gave a commitment to the Supported Housing staff that a weekly planning/discharge meeting would be established to which they would be invited when one of their residents was to be discussed.[361]

It is unclear whether this meeting was ever set up. However, throughout Mr. Y's subsequent admission reference is made, when Mr. Y's discharge was being discussed, to keeping the Supported Housing staff informed and obtaining their agreement before he was discharged.

The above incident is an example of a lack of communication. There are also examples in Mr. Y's notes of incorrect information being recorded. For example, the Supported Housing staff were informed that Mr. Y had been described as "settled" prior to his discharge on 1 October 2004.[362] However the Early Intervention CPN had informed the ward round on 28 September 2004 that Mr. Y's weekend leave had not gone well. He had been saying to his parents that his life was not worth living.[363]

There appears to have been a similar breakdown of communication when Mr. Y was discharged from hospital on 1 February 2005. In the discharge summary for this admission the following is recorded:
"Felt much better since he came into hospital. Was regretting trying to take his life. Denied any hallucinations or delusions. ***Wanted to go on overnight leave which went well****. Discharged home with medication and follow-up in the community with [Early Intervention CPN]"*[364] (Emphasis added).

[360] Housing notes p.1, 5; Case notes 194
[361] Housing notes p. 1
[362] Housing notes p.5
[363] Case notes p. 188, 470
[364] Case notes p.318

In fact the overnight leave on the 31 January 2005 had not gone well. Mr. Y had been drunk while at home; he had been throwing himself on the ground and refused to get up; he had been urinating in public and he had exposed himself to his 24 year old sister. His parents had contacted the ward to ask for advice on how to deal with Mr. Y's behaviour. This information was recorded in several places in Mr. Y's clinical notes and it was discussed at the ward round on the day of his discharge.[365]

Discharge is a point of significant vulnerability and yet, on two of the three occasions on which Mr. Y was discharged from hospital, information was incorrectly recorded. That there were no untoward consequences of the recording of incorrect information is fortunate, it nevertheless represents a serious weakness in the system of communication at that time.

12.10.3.2. Communication: prescribing and discharge

The point of communication is to enable clinicians to make informed decisions. When Mr. Y was reviewed by Psychiatrist 1 in April 2007 he reported that he was feeling better and that he had reduced his alcohol consumption. Given this improvement Psychiatrist 1 wrote to Mr. Y's GP on 2 May 2007 advising that Mr. Y's antipsychotic medication, Aripiprozole, be reduced from 10 mg to 5 mg a day. [366]

On 1 October 2007, as no psychotic symptoms had re-emerged and Mr. Y was complaining of the side effects of the medication, Psychiatrist 1 advised the GP to discontinue Mr. Y's antipsychotic medication.[367] Psychiatrist 1 made this recommendation in the belief that Mr. Y had been taking the reduced dosage for four to five months, depending on when Mr. Y's prescription had been issued. In fact the dosage of Mr. Y's medication was not reduced until 8 August 2007.[368] This was approximately three months after Psychiatrist 1 had recommended the reduction. Mr. Y was, therefore, on the reduced dosage not for four to five months, as Psychiatrist 1 believed when he made his recommendation, but just two months.

From the GP prescription records it would appear that Mr. Y received his last prescription for Aripirazole on 30 August 2007. Assuming that Mr. Y took his medication as prescribed, his medication would have run out at the end of September/ beginning of October 2007.

[365] Case notes p. 212, 287, 312,393
[366] Case notes 587
[367] Case notes 102
[368] Internal Investigation archive p.737

In line with good practice Psychiatrist 1 did monitor Mr. Y's mental state following his recommendation that the anti-psychotic medication be discontinued. He saw him on 12 November 2007,[369] this was between five and seven weeks after Mr. Y had discontinued his antipsychotic medication. Psychiatrist 1 felt sufficiently comfortable with Mr. Y's presentation at this time to discharge him from psychiatric out-patient monitoring.

This appears not to have been the only breakdown of communication between the mental health services and the Primary Care Services.

"*Not our patient"* is *w*ritten on two letters from Psychiatrist 1, dated 16 December 2005 and 3 July 2006, in the GP records. There is also a form dated 20 September 2005 indicating that, at that time, Mr. Y had temporary resident's status at another GP surgery.

There is no evidence either in the GP records or in Mr. Y's Trust clinical notes to indicate that the secondary mental health services were informed of a change of GP or who, in Primary Care, held the medical responsibility for Mr. Y during this period.

This was a period of some turmoil for Mr. Y. It was the period when he was discharged from the Early Intervention Service, when some deterioration of his mental state was manifest and when he was referred to the CMHT. However, fortunately, no changes were recommended to Mr. Y's medication regimen. From the record supplied to the Independent Investigation, it appears that the prescribing of Mr. Y's medication was uninterrupted during this period.[370]

12.10.3.3. Communication with other agencies

For almost the whole of the time Mr. Y was under the care of the Trust, he was also accommodated by a Housing Association, whose staff provided Mr. Y with a great deal of support, both practical and emotional. However, as has already been noted, as there were no regular reviews of Mr. Y's care the Housing Support staff were not involved, in a formal or regular manner, in the assessment of Mr. Y's needs or the planning of his care. Nor was there a mechanism in place to ensure that Mr. Y's care and support were co-ordinated and the roles of the staff of the two organisations agreed. There was, however, good, informal liaison

[369] Case notes p. 100, 571
[370] Internal Investigation archive p. 736

between the Supported Housing staff and those co-ordinating Mr. Y's care much of the time he was resident with the Housing Association.

We have already noted how in May 2006 the Supported Housing staff appeared to have been given the role of informal gatekeeper to the mental health service, without discussion.

In February 2007 CCO 1 took over as Mr. Y's care co-ordinator. CCO 1 had seen Mr. Y on only two subsequent occasions, 5 May 2007 and 14 May 2007, when he wrote to Mr. Y to inform him that he would be going on sick leave. In this letter he advised Mr. Y to contact the manager of the CMHT if he had any *"concerns or queries".*[371] There is no evidence that Mr. Y's needs were discussed with the Supported Housing staff, nor that they were consulted as to the best way of caring for Mr. Y during CCO 1's absence. They were not copied into CCO 1's letter and there is no record of them being informed about who to contact should they have concerns about Mr. Y. No system was put in place to monitor Mr. Y's mental health. It seems to have been assumed, without discussion or agreement, that the Supported Housing staff would assume this role.

In the event Mr. Y did run into difficulties while CCO 1 away. This was the period when he took in two visitors, experimented with cocaine and was involved in a burglary. The Supported Housing staff alerted the CMHT of Mr. Y's difficulties and asked that someone take on the role vacated by CCO 1.

The CMHT manager allocated a qualified Social Worker to take on this role. However, in the plan she recorded in Mr. Y's clinical notes on 27 June 2007, she said:
"[Housing support worker] to continue supporting {Mr. Y], provide information re Cloverleaf [the advocacy service], monitor his mental health needs and contact me when necessary."

It is unclear what informal discussion had taken place prior to this plan being drawn up. Certainly no formal assessment was undertaken and no formal CPA review organised. However it was the Housing Support workers who were again given the role of monitoring Mr. Y's mental health. It should be noted that the role of the Housing Association staff was to

[371] Case notes p.119

provide support. It was the role of the mental health services to *"monitor [Mr. Y's] mental health needs."*

Little appears to have been learnt from this episode. Mr. Y had been discharged by Psychiatrist 1 on 12 November 2007 and CCO 1 was the only contact Mr. Y had with the mental health services when he again went on sick leave on 13 December 2007. In Mr. Y's clinical notes he recorded:
"I informed [Mr. Y] of my forthcoming sick leave. [Mr. Y] agreed to contact CMHT office if need arises."[372]

Despite what had occurred in June 2007 when CCO 1 had been absent, there appears to have been no discussion with the Supported Housing staff, there is no record of them being formally told of CCO 1's absence, no assessment was undertaken and no agreed plan put in place.

Perhaps because of the lack of formal care planning and perhaps because the staff of the Housing Association were prepared to be flexible in the way in which they provided support, the assumption appears to have been made that they would make good shortfalls in the provision of the mental health services and take on some of the responsibilities that were properly those of the mental health service. There is no record of any discussions, either at the practitioner level or at the organisational level, that the staff of the Housing Association would assume these responsibilities.

Good communication implies that information flows in both directions. On the 31 January 2008 Mr. Y's mother contacted the staff of the Housing Association to discuss with them her concerns about her son's mental health. He had stopped visiting and was no longer sending her text messages. This was out of character. She reported that Mr. Y had sent her a text message some weeks earlier saying the he wanted to hurt people. Mr. Y's mother was advised to contact CCO 1 and was given his number. The Housing Support worker made a plan to inform CCO 1 that Mr. Y was not taking his medication, was referring to himself in the third person, that his mental state was erratic and that he had sent a text message to his

[372] Case notes p.61

mother saying that he wanted to hurt people. The Supported Housing staff also planned to increase the support they provided to Mr. Y.

Mr. Y's Housing Support key worker contacted CCO 1 on 4 February 2008 following a home visit to Mr. Y. It is not clear what information was passed to CCO 1 but it was sufficiently detailed to persuade CCO 1 to visit Mr. Y within the hour, together with Mr. Y's key worker. During this visit Mr. Y spoke of his low mood and how he had been treated by his father as a child. He also acknowledged that he had stopped taking his anti-depressant medication. In response CCO 1 persuaded Mr. Y to re-start his medication and to re-engage in some activities.

Mr. Y's mother contacted CCO 1 on 6 February 2008. She spoke to him about her concerns for her son's mental health and the effects his drinking had on this. There is no record, however, that she told him of Mr. Y's text message in which he said that he wanted to hurt people.

12.10.4. Conclusions

12.9.4.1 The communication between those planning and providing Mr. Y's care while he was an in-patient was, on occasions, poor. This led, on at least one occasion, to Mr. Y being discharged without an appropriate plan being in place, with the result that he had to be rapidly re-admitted to hospital. Better communication would have improved the care planning and, probably, have reduced the distress Mr. Y experienced at that point in time. It may also have shortened the length of his in-patient admission.

Discharge is a point of significant vulnerability and yet on two of the three occasions on which Mr. Y was discharged from hospital information was incorrectly recorded. That there were no untoward consequences of the recording of incorrect information is fortunate; it nevertheless represents a serious weakness in the system of communication at that time.

12.10.4.2 Communication between primary care and secondary mental health care appears also to have broken down at times. It appears that at times during 2005 and 2006 the secondary mental health service was communicating with the wrong GP about Mr. Y's ongoing care. In the event, this misdirected communication did not result in any serious harm

occurring. This was fortuitous. However this incident manifested a dangerous weakness in the system and one that could, on other occasions, result in a serious untoward incident.

The breakdown in communication between primary and secondary care resulted in Psychiatrist 1 making decisions about Mr. Y's care on the basis of incorrect information. The regime for reducing Mr. Y's medication was not the one that Psychiatrist 1 had planned and not the one he believed he was monitoring. It is impossible to say what effect the delay in reducing Mr. Y's anti-psychotic medication had or what effect the consequent shortening of the period of time he was monitored on the reduced dosage, had.

The Independent Investigation team concluded that the communication system between primary and secondary services that resulted in a clinical decision not being implemented in a timely manner and led a clinician to make decisions on the basis of incorrect information put the service user at increased risk.

12.10.4.3 At the time Mr. Y was under the care of the Trust there was no mechanism in place to ensure the staff of the supported Housing Association were systematically involved in the assessment of his needs or in the planning of his care. The Independent Investigation was informed that currently there is significant variation between CMHTs. Some do include the staff of the Housing Association in care planning and inform them of changes to the care of their residents. Other CMHTs are less inclusive in their way of working. From the point of view of the staff of the Housing Association there is no policy, relating to joint working, that is applied consistently across all CMHT.[373]

12.10.4.4. The responsibilities of the mental health services and the Housing Association appear to have been blurred at times. For example when there was a shortage of resources in the mental health services, the assumption appears to have been made that Housing Association staff would make good this short fall by assuming responsibilities that were proper to the mental health service. To have a confusion of boundaries and responsibilities is not good practice as it places both service users and staff at risk. There should be a formal agreement in place identifying the roles and responsibilities of organisations, and ensuring that staff are properly trained and supported to carry out these roles.

[373] Witness Interview Independent Investigation

- ***Service Issue 5: Communication, both between teams within the Trust and between staff of the Trust and those working in other organisations, failed on a number of occasions. That no serious harm befell Mr. Y was fortuitous, however such weaknesses in the systems of communication place both service users and staff at risk.***

- ***Service Issue 6: The responsibilities of the mental health services and the Housing Association were blurred, at times. It appears that there was an expectation that Housing Association staff would take on responsibilities that were proper to the mental health service. To have a confusion of boundaries and responsibilities is not good practice as it places both service users and staff at risk.***

12.11. The Management of Mr. Y's Care

12.11.1 Context

If a mental health service is to function efficiently and effectively each of its component parts: team, unit and ward, must have a clear remit as to its responsibilities, the functions it is to undertake, the services it is to provide, and the client group it is to serve. Amongst other things this means that each component unit needs a clear, explicit set of criteria identifying who is eligible for its services. These parameters need to be set by the organisation to ensure that there are no gaps in services or duplication of services and function.

Within teams case management ought to be characterised by:

- clear allocation of staff to specific task/roles;
- the establishment of a clear strategy for assessment;
- testing assessments against explicit eligibility criteria;
- establishing clear time frames;
- establishing a clear decision making process;
- ensuring that all relevant information is available within the clinical case notes.

At the level of the individual service user it is the care co-ordinator who has the key role. *Refocusing the Care Programme Approach*[374] observes:

"The care co-ordinator should have the authority to co-ordinate the delivery of the care plan and ensure that this is respected by all those involved in delivering it regardless of agency of origin. It is important that they are able to support people with multiple needs to access the services need." (p.36)[375]

The Department of Health published *New Ways of Working* in 2007[376]. This required a change to the established team working practice. A successful implementation of *New Ways of Working* required clear multi-disciplinary team management and clinical leadership. These roles were no longer identified with particular disciplines. The purpose of introducing this new policy was to promote patient-centred care and to ensure that the available resources were employed most efficiently and effectively for the benefit of service users. In this sense *New Ways of Working* supported the central role given to the care co-ordinators.

12.11.2 Local Context

The operational policy for the North Kirklees CMHT, during much of the time Mr. Y was being cared for by this team, identified the population it served as follows:

"Who is the service for?

Adults for working age (18-64) with a full range of mental health problems.

The sector team performs functions for two groups of people.

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

2) *A substantial minority will remain in the team for ongoing treatment, care and monitoring for longer periods possibly years. (Secondary Care) (Care pathways 3-12). They will include people requiring ongoing specialist care for:*
   i. *Severe and persistent mental disorders associated with significant disability, predominately psychosis such as schizophrenia and bipolar disorders.*

[374] Department of Health (2008) *Refocusing the Care Programme Approach – policy and positive practice guidance.*
[375] Ibid
[376] DoH (2007) Mental Health: *New Ways of Working for Everyone*

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

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

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

v. *Severe disorders of personality where these can be shown to benefit by continued contact and support except where these have been accepted by the Assertive Outreach Team (AOT).''*[377]

Mr. Y was cared for by this team from July 2006 until the time of the incident in February 2008 and was considered, therefore, to have fallen within that group of individuals who required *ongoing treatment, care and monitoring for longer periods.*

The operational policy identifies the importance of a multidisciplinary approach to assessment, care, treatment and care co-ordination:

''Team Approach

Health and social services staff work in a fully integrated way within the teams.

Each service user is assigned a care co-ordinator (not always from within the team) with Care Programme Approach (CPA) responsibility for ensuring appropriate assessment, care and review.

Medical staff are integrated into community, but are not dedicated full time team members.''[378]

The operational policy also identifies the importance of regularly reviewing the needs of service users in a multidisciplinary forum:

''Regular Review

[377] [377] North Kirklees, CMHT, Operational Policy (2006)

[378] [378] North Kirklees, CMHT, Operational Policy (2006)

Weekly team meetings are arranged and include the medical staffing team. Current service users are discussed either to share information or to discuss difficulties and progress. Outcomes are regularly reviewed by individual staff members."[379]

The operational policy identifies the importance of continuity of care:

"Continuity of Care
The care co-ordinator takes responsibility for ensuring continuity of care using home visits, repeat appointments etc. Clear instructions are provided for contact out of hours and who to contact when the care co-ordinator is away.
Contact frequency will vary over time according to need. Care co-ordinators aim to be flexible.
Contact is maintained by the care co-ordinator if the service user is admitted into hospital (in reach).
Contact and communication is maintained with primary care so that the GP is informed of significant changes in mental health etc."[380]

The importance of monitoring medication and liaising with the GP who prescribes the medication is also identified:

"Medication
The team are responsible for monitoring medication where appropriate and assessing for side effects.
Liaison with GP's who prescribe or administer medication is undertaken when required.
Strategies are used to improve concordance with prescribed medication regimes."[381]

12.11.3 Findings of the Internal Investigation

Cover arrangements during staff absence:

The Inquiry process has highlighted that when the Sector CMHT Care Co-ordinators are absent, that there is no safe mechanism for re-designating this responsibility which the Inquiry Team believes needs urgent attention…….

[379] Ibid
[380] Ibid
[381] North Kirklees, CMHT, Operational Policy (2006)

Given that all CMHT managers have finite resources in which to manage their respective services, it would be unrealistic (and unnecessary) to expect that full care co-ordination responsibilities are re-designated to another member of the CMHT who, in turn, would be expected to undertake this role, in full, whilst another member of the member of the team was absent for a two to three week period, unless there was an identified clinical priority to do so. However, the Inquiry Team believe that the system and processes by which cover arrangements are considered, when significant periods of staff leave occur, should be urgently reviewed....."

12.11.4. Findings

Mr. Y was referred to the secondary mental health services by his GP in May 2004. He was initially seen as a psychiatric out-patient and the plan was that he would be monitored by a Staff Grade Psychiatrist as an out-patient and assessed for psychodynamic psychotherapy by Psychiatrist 1, who was also the Consultant responsible for his care.

In July 2004 Mr. Y was referred to the Early Intervention Service by Psychiatrist 1. By September 2004 Mr. Y's mental state had deteriorated to the point where he was admitted to hospital. During his three subsequent in-patient admissions and following his discharge from hospital the Early Intervention CPN acted as Mr. Y's care co-ordinator and, together with another member of the Early Intervention team, provided Mr. Y with a significant amount of support. She also had frequent contact both with Mr. Y's mother and with the supported housing staff.

The Early Intervention CPN was on sick leave for approximately five weeks during November and December 2005. She arranged for a colleague in the Early Intervention Service to cover her caseload in case of need, although no additional resources were allocated to the team. During the period in which the Early Intervention CPN was absent Mr. Y's mother contacted her manager on one occasion to inform him of her concerns about her son.

In February 2006 the Early Intervention CPN discharged Mr. Y from her care. As discussed above there was no formal review or care planning meeting at this point.

Mr. Y missed his out-patient appointment with Psychiatrist 1 in March 2006 and was not seen again by the mental health services until his outpatient appointment at the end of June 2006.

No mechanism had been put in place to ensure that Mr. Y remained engaged with the mental health services during this period.

When Mr. Y was reviewed by Psychiatrist 1 in June 2006 his mental state had deteriorated and Psychiatrist 1 referred him to the CMHT. Psychiatrist 1 asked for a CPA review meeting to be arranged following Mr. Y's assessment by the CMHT. Mr. Y was assessed by CPN 2 in July 2006 but the CPA review never took place. There is no record why this meeting did not take place, nor is there any record of the need for a CPA review meeting being discussed with Psychiatrist 1 or the multi-disciplinary team.

CPN 2 acted as Mr. Y's care co-ordinator between July 2006 and February 2007. During this six month period CPN 2 appears to have seen Mr. Y on approximately 10 occasions. However there was a period of eight weeks between September and November and a further period of seven weeks between mid December 2006 and February 2007 when Mr. Y was not seen. No reason for these gaps is recorded in Mr. Y's notes and no arrangements were put in place to ensure that Mr. Y's mental state was monitored and his needs met during these periods. There is no record that Mr. Y was given any information as to whom he should contact during these periods. .

CCO 1 assumed responsibility for co-ordinating Mr. Y's care in February 2007 and continued in this role until Mr. Y was arrested in February 2008.

CCO 1 was on sick leave for eleven weeks between May and August 2007. Mr. Y was advised to contact the CMHT manager during this period if he had *"any queries or concerns".*[382] No arrangements were put in place, however, to ensure that his mental state was monitored or his needs met during this period.

As discussed above, it was during this period that Mr. Y took in two guests, experimented with cocaine and was involved with a burglary.

Psychiatrist 1 wrote to Mr. Y's GP on 15 November 2007 informing him that he had discharged Mr. Y from his care. CCO 1 went on sick leave a month later for approximately six weeks. Mr. Y was advised to "*contact the CMHT office if need arises*". [383] Again no plan was put in place to monitor Mr. Y's mental state or meet his identified needs.

[382] Case notes p. 119
[383] Case notes p. 62

In January 2008 the staff of the Housing Association contacted CCO 1 to inform him that Mr. Y's mental state was deteriorating and he was not taking his anti-depressant medication.

CCO 1 visited Mr. Y within an hour of receiving this information. He persuaded Mr. Y to re-start his medication and took him to his GP's surgery to pick up his prescription. He also tried to re-engage Mr. Y in a range of activities and tried to persuade him to moderate his drinking. Mr. Y's mood and mental state appeared to improve over the next few days.

However there is no record that Mr. Y was discussed with the multi-disciplinary team, that any formal assessment was undertaken, or that any alternative plans for caring for Mr. Y were considered by the Community Mental Health Team.

CCO 1 last saw Mr. Y on 18 February 2008 when he recorded that Mr. Y appeared brighter in mood and physical appearance and was planning to attend a group at the day centre, supported by CCO 1.[384] Sadly Mr. Y was arrested for killing his father on 21 February 2008.

This brief chronology raises a number of questions about the management of Mr. Y's care in the context of both best practice and the CMHT's operational policy.

12.11.4.1 Continuity and Appropriate Level of Care

Although Mr. Y was under the care of the secondary mental health services for approximately three and a half years there was no clearly managed plan of care in place.

After a period of intensive input from the Early Intervention Service, Mr. Y was not seen for four months because he missed his appointment with Psychiatrist 1. There was no mechanism in place to ensure that Mr. Y remained engaged with the mental health services.

When Mr. Y was assessed by the CMHT, although some of his needs were identified, the assessment does not appear to have included any reference to the eligibility criteria of the CMHT. The CMHT operational policy identified two groups of individuals for whom the team provided care: people with "common metal health issues" requiring 3 - 6 contacts and

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

[384] Case notes p.62

From the care plan drawn up for Mr. Y it would appear that he was seen as belonging to the latter group, needing on-going treatment and specialist care, yet his care co-ordinator was not in contact with him for periods of seven and eight weeks at a time without any arrangements being put in place to meet the needs that had been identified as requiring this on-going and specialist care.

CCO 1 took over from CPN 2 as Mr. Y's care co-ordinator in February 2007. He was also away for prolonged periods, for 11 weeks in one instance. He did inform Mr. Y that he would be absent but the responsibility for remaining in contact with the mental health services was placed on Mr. Y.

The CMHT's operational policy identified the importance of continuity of care:
"*The care co-ordinator takes responsibility for ensuring continuity of care using home visits, repeat appointments etc. Clear instructions are provided for contact out of hours and who to contact when the care co-ordinator is away."*

There is no evidence that plans were put in place to realise this continuity of care or comply with the operational policy consistently other than in a cursory manner.

One is left with the question: If it was felt safe and appropriate for Mr. Y to be left for prolonged periods without contact with the CMHT and without any mechanism being put in place to monitor his needs or mental state, was he appropriately identified as needing on-going and specialist care? If he did need this level of ongoing care, was it appropriate that he was left for prolonged periods without the input designed to meet his identified needs?

12.11.4.2 Continuity and Access to Services
One incident is both illustrative of the lack of mechanism to ensure continuity of care and is of particular concern with respect to the mental health services fulfilling their duty of care.

After more than a year of intense input by the Early Intervention Service, Mr. Y was discharged in February 2006. In May 2006 Mr. Y's father contacted the service to inform it that he was concerned about his son's behaviour and that he had banned him from the family home. Mr. Y's father was advised that as he had been discharged by the Early Intervention

Service and as Mr. Y did not know that his father was making contact, the service could not "*act on [his] concerns."*[385]

He was advised to contact the supported housing staff who could "*talk through [Mr. Y's] behaviour with him."* The supported housing staff could then liaise with the CMHT if they felt it necessary.

This response to the family's request for help for Mr. Y raises a number of concerns.

Firstly, it must have seemed a bizarre response to one concerned about his son's well being to be told that he could not alert the mental health services to the deterioration of his son's condition. Instead he had to go to an organisation which was providing support, but not mental health care, to his son which would act as a gate keeper to the mental health services.

Mr. Y was under that care of the secondary mental health services, at the time he was still seeing Psychiatrist 1, and as such the service had a duty of care towards him. While it is appropriate to divide such large organisations as a secondary mental health service into smaller functional teams, this must not be at the cost of making access to the service more difficult to its users. In this case it was entirely appropriate that Mr. Y's father contacted the part of the mental health system that had been caring for his son. The response of that element of the service should have been to facilitate access to the appropriate part of the service if it no longer had responsibility for his care. In this case the information should have been passed to Psychiatrist 1 for him to take appropriate action.

Secondly, it appears that the staff of the supported housing association were being made informal gate keepers to the mental health service. Given the role and training of these staff, as well as the fact that there was no agreement in place that they should take on such a responsibility, this was inappropriate.

Thirdly, this incident suggests that there was some confusion about confidentiality. The fact that Mr. Y did not know that his father was making contact with the mental health services did not mean that that service could not act on the information made available to it.

[385] Case notes p. 126

Fourthly, the letter to Mr. Y's father was written by a junior member of staff. It would have been more appropriate for the service manager to have dealt with the issue as Mr. Y's care was no longer the responsibility of any member of the team.

12.11.4.3. Learning and the provision of appropriate levels of care

While one cannot guarantee that all the decisions a clinician or a clinical team makes achieve the outcomes that are hoped for, one can expect there to be some process in place which identifies the unwanted outcomes and enables the clinician or clinical team to learn from these experiences.

After a period of intensive input for over a year Mr. Y had no contact with the mental health services for several months in 2006. When he was re-assessed it was found that his mental state had deteriorated.

When CCO 1 was absent for eleven weeks in 2007, Mr. Y was exploited by two drug users, he experimented with cocaine and he was involved in a burglary. When CCO 1 was absent in December 2007 and January 2008 Mr. Y's mental state again deteriorated.

No lessons appear to have been learned from these episodes when the care co-ordinator was absent. No processes were in place to facilitate such learning.

12.11.4.4. Clarity of Roles

On 10 July 2004 Mr. Y was taken by the police to the local Accident & Emergency Department to be assessed by the CRHTT. Following this assessment Mr. Y's mother wanted to discuss the state of her son's mental health. She was advised by the CRHTT staff to contact Psychiatrist 1 who was the Consultant Psychiatrist responsible for his care. [386]

However when Mr. Y's mother contacted Psychiatrist 1 he informed her that, as he was assessing Mr. Y for psychotherapy, it was not useful for him to hear her version of events, at that time. He advised her to speak to another psychiatrist in the clinical team who had assessed Mr. Y when he was referred to the secondary mental health services.

[386] Case notes p. 262

When Psychiatrist 1 was interviewed by the Independent Investigation Team, he explained that prior to him taking up his appointment as a locum Consultant Psychiatrist he had been a Staff Grade Psychiatrist. His role had been to see some people for psychotherapy and others for psychiatric monitoring and intervention.

On reflection, he identified that he had not fully appreciated the difference between this role and that of the Consultant. It was the Consultant Psychiatrist who held overall responsibility for the care of a patient and it was this that allowed him, as a Staff Grade, to see people with a discrete focus on either psychotherapy or psychiatry.

Psychiatrist 1 had felt, at the time he spoke with Mr. Y's mother, that as an experienced psychiatrist colleague was reviewing and monitoring Mr. Y in the psychiatric out-patient department, any information that it was necessary for him to have would be passed on to him and he would be appropriately included in any relevant discussions. Establishing such boundaries, he felt, would allow him to build a relationship of trust with Mr. Y as a foundation for psychotherapy. However, with the benefit of hindsight, Psychiatrist 1 acknowledged that this way of working created an unhelpful tension that was not best suited to exercising the role of the Consultant Psychiatrist, who had overall responsibility for the care and treatment of a service user.

Psychiatrist 1 has now changed his role. He no longer places himself in the situation where he is responsible for the care of a patient but not immediately privy to all the available information, nor accessible to the service user's family.

12.11.4.5 Understanding of the role of the Care Co-ordinator

There also appears to have been a lack of understanding as to the role of the Care Co-ordinator in the delivery of Mr. Y's care. As noted above, the Department of Health in *Refocusing the CPA (2008)* identified that the role of the care co-ordinator is to co-ordinate the individual's care not, primarily, to deliver it. The Trust CPA policy in force from February 2007 states:

"Role Authority and responsibilities of the Care Coordinator"

"The Care Coordinator has responsibility for coordinating care, keeping in touch with the service user, ensuring the care plan is delivered and ensuring that the plan is reviewed as required."[387]

The care co-ordinator, in fulfilling this role, is expected to:

"• Ensure a systematic assessment …. and that the person's CPA level of need is identified;

• Coordinate the formulation and updating of the care plan…;

• Ensure the crisis and contingency plans are formulated…;

• Ensure that the person is equally involved and consulted where appropriate;

• Ensure that carers and other agencies are involved and consulted where appropriate;

• Ensure that the person understands the care coordinator role, knows how to contact the care co-ordinator and who to contact in their absence;

• Ensure that the person is registered with a GP and that he or she is involved and informed as necessary;

• Maintain regular contact with the service user and monitor their progress……;

• Organise and ensure reviews of care take place……. Chair the reviews if appropriate.

• Explain to the service user, relatives, informal carers what the CPA process is and make them aware of their rights and roles;

• Agree and record changes in the care plan, crisis and contingency plan and risk management plan;

• Ensure the date for the next review is set at each review meeting;

• Ensure the services user's details are recorded on the CPA information database."

The range of responsibilities of the care co-ordinator was considerable and entailed far more than being the primary deliverer of care. However, the allocation of a care-co-ordinator for Mr. Y in 2007, and the way the care co-ordinating role was fulfilled, did not reflect the broad remit and range of responsibilities of the care co-ordinator identified in the operational policy.

Earlier in this report it was noted that the regimen Psychiatrist 1 had put in place to reduce Mr. Y's anti-psychotic medication was not implemented as he had planned, with the result that he was making important clinical decisions on the basis of incorrect information.

[387] SWYMHT (2007) *The Journey: CPA Framework* p.14

However a safety net appeared to be in place as Mr. Y continued to be seen and monitored by his care co-ordinator.

CCO 1, however, went on sick leave a month after Mr. Y was discharged by Psychiatrist 1 with the result that he was not monitored by the mental health service for a period of six weeks. Mr. Y's mental state deteriorated during the latter part of this period. To his credit CCO 1 responded quickly when he was alerted to the deterioration in Mr. Y's mental state and it appeared that Mr. Y had responded well to this intervention. However, Mr. Y killed his father less than three weeks after CCO 1 re-engaged with him.

Mr. Y was an individual indentified as needing on-going and specialist care. There had been significant changes in his care: he had been discharged by Psychiatrist 1, whom he had known since he first came into the secondary mental health services, and his anti-psychotic medication had been stopped. He had been unmonitored and unsupported by the mental health services for a period of six weeks. His mental state appeared to have subsequently deteriorated. Yet there is no record that Mr. Y's care was discussed with Psychiatrist 1 by his care co-ordinator nor reviewed in a multi-disciplinary forum as the CMHT operational policy suggests it should have been. No assessment or risk assessment was undertaken. Good practice indicates that such an assessment should have been undertaken given the changes in care and the change in Mr. Y's mental state.

Given both the responsibilities of the care co-ordinator and the operational policy of the team relating to assessment and care planning, continuity of care, monitoring of mental state and well-being, monitoring of medication, liaison with the GP and multi-disciplinary team working, one would have expected the care co-ordinator to have ensured that a robust assessment and care plan were in place.

These events raise two issues of concern: understanding of the role of the care co-ordinator, and the competence of the care co-ordinator.

- *Role of the Care Co-ordinator*

Despite emphasis placed on the co-ordinating role played by the care co-ordinator, CCO 1, like CPN 1 before him, appears to have focused more on the delivery of care than on the assessment of need, the planning of care and facilitating the involvement of those best equipped to undertake particular tasks in delivering a safe and effective service to Mr. Y. One consequence of this was that, when he was not available, the mental health service ceased to

deliver a service, despite the lessons of previous episodes. Following Mr. Y's anti-psychotic medication being stopped, the safely net, which Psychiatrist 1 thought was in place, was missing.

- *Competence of the care co-ordinator.*

While it is the responsibility of the practitioner not to take on responsibilities s/he does not have the training or skills to undertake, it is the responsibility of those managing the clinical team not to allocate tasks or responsibilities to an individual that are outwith his/her skills or training. It is the responsibility of the organisation to ensure that appropriate policies and procedures are in place to ensure that services are delivered in a safe and competent manner. The Trust's current CPA policy states:

"The member of staff identified to co-ordinate an individual's care must be competent, suitably qualified and skilled in delivering mental health care to fulfil the role identified within their job description. Within South West Yorkshire Partnership NHS Foundation Trust this applies to all professionally qualified staff at pay Band 5 or above/qualified social care staff. Therefore the CPA care co-ordinator will be a qualified mental health professional, i.e. a social worker, mental health nurse, occupational therapist, psychiatrist or psychologist and who, through clinical supervision and self assessment has the identified core competences of care co-ordination."[388]

It must be acknowledged that this policy was not in force in 2007/8, nevertheless it identifies the need for individuals to be competent to carry out the task assigned to them and this fundamental assumption has always been part of professional practice.

Despite the fluctuations in Mr. Y's mental state, his identified vulnerability, the serious difficulties he had experienced when CCO 1 had been absent on sick leave, and the fact that he was no longer being reviewed by Psychiatrist 1, there is no record that Mr. Y's need for care co-ordination or the skills required to plan and co-ordinate his care were reviewed. Good practice, as well as the Trust's policy, suggests that this should have been done.

The Independent Investigation concluded that these weaknesses in the system: not regularly reviewing Mr. Y's need for care co-ordination and not identifying whether the allocated care

[388] South West Yorkshire Partnership NHS Foundation Trust (2010) *The Care Programme Approach and Care Co-ordination* p.37

co-ordinator had the skills required to competently carry out the responsibilities of care co-ordination, contributed to Mr. Y's needs and risk not being appropriately assessed in January and February 2008.

12.11.5 Conclusion

The CMHT operational policy identified the eligibility criteria for the service. It also identified the importance of: multidisciplinary working, holding regular reviews, continuity of care, monitoring medication and liaison with the service user's GP. These all reflect both good practice and the CPA process. However, in practice, there were a number of weaknesses in the overall management of Mr. Y's care.

- *Continuity of care*

There was no mechanism in place to ensure that Mr. Y remained in contact with the mental health services when he was discharged from one element of the service. Indeed on one occasion when his family tried to alert the mental health services that his mental health was deteriorating, instead of facilitating access they referred him to another agency.

- *Continuity and the provision of appropriate care*

Although Mr. Y met the criteria for on-going and specialist care there were significant periods when he had no contact with the mental health services. This was not an appropriate provision of care for Mr. Y, and did not realise the continuity of care identified in the CMHT operational policy.

- *Learning and reflective practice*

Perhaps because there was no regular process for reviewing Mr. Y's care, there is no evidence of any reflection on, or learning from, previous experiences, particularly from those episodes when Mr. Y's care co-ordinator was absent and Mr. Y's mental state or behaviour deteriorated. Such reflective practice would have informed Mr. Y's care planning.

- *Clarity of roles*

At times there appears to have been a lack of clarity about roles and responsibilities of members of the multi-disciplinary team. Psychiatrist 1 initially tried to fulfil the roles of both psychotherapist and Consultant Psychiatrist with respect to Mr. Y. On reflection he

acknowledged that this way of working created an unhelpful tension and he has subsequently changed his way of working.

- *Understanding the role of the care co-ordinator*

Despite the emphasis placed on the co-ordinating role of the care co-ordinator in the Trust's CPA policy, Mr. Y's care co-ordinators appear to have focused on the delivery of care rather than on assessment, planning and facilitating the involvement of those best equipped to undertake particular tasks in delivering a safe and effective service to Mr. Y. There is no evidence that the need of Mr. Y for care co-ordination was formally reviewed either on a regular and planned basis or when his circumstances changed. Perhaps because of this and the emphasis placed on the delivery of care, there is little evidence that the skills needed to act as a care co-ordinator for Mr. Y were reflected on.

- *Overall management of Mr. Y's care*

At the service level there was no mechanism in place to ensure that Mr. Y's care was being appropriately managed: that he remained engaged with the mental health services, that he continued to meet the eligibility criteria of the CMHT, that there was on-going appropriate multi-disciplinary involvement, that his needs were being appropriately assessed and he was being allocated an appropriate level of care to meet those needs, that care plans were informed by previous experience, and that he was allocated a care co-ordinator with the requisite skills to assess his needs and plan and co-ordinate the delivery of his care.

It would appear then that the CMHT operational policy was not being implemented in the case of Mr. Y.

One consequence of this lack of overall case management was that when Mr. Y's mental state began to deteriorate after his anti-psychotic medication had been stopped, he had been discharged by Psychiatrist 1 and he had been left unmonitored and supported by the mental health services, the safety net that should have been available to monitor his needs and risk was not in place for prolonged periods and not robust when it was in place. This lack of assessment and consequent care planning contributed to the deterioration of Mr. Y's mental state.

- ***Contributory Factor 10: Following Psychiatrist 1 discontinuing Mr. Y's antipsychotic medication, the mechanism he believed to be in place to monitor Mr. Y's mental state was absent for a significant period of time. When it was noted that Mr. Y's mental state had deteriorated, although immediate support was provided, no multi-disciplinary assessment of Mr. Y's needs and risk was undertaken. Consequently, his care plan was not reviewed or revised.***

  It cannot, reasonably, be concluded that if these action had been undertaken the events of 21 February 2008 would not have taken place. However it is reasonable to assume that the absence of appropriate assessment and the consequent failure to review Mr. Y's care plan contributed to the deterioration of his mental health.

- ***Service Issue 7: The CMHT operational policy identified the importance of ensuring continuity of care. This aspect of the policy does not appear to have been adhered to. There appears to have been no policy in place at the time Mr. Y was receiving care from the Trust to ensure that service users remained in contact with the service. Indeed there was one incident when the approach taken by staff made it difficult for Mr. Y's family to ensure that he received the care that they believed that he needed.***

- ***Service Issue 8: Despite the role of the care co-ordinator being identified in both the Trust's CPA policy and the CMHT's operational policy, this did not appear to inform the choice of the care co-ordinator for Mr. Y nor ensure that his need for care co-ordination was regularly reviewed. Given the central importance of the CPA and care co-ordination, this raises the issue of how adequately Trust policies are implemented.***

12.12. Clinical Governance and Performance

12.12.1 Context

"*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.*"[389]

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

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

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

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

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

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

12.12.2 Findings

12.12.2.1. Clinical Governance Systems and Performance

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

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

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

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

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

Strategy and Policy

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

Clinical Governance

3. To provide assurance to the Trust Board that appropriate and effective clinical governance arrangements are in place throughout the organisation through receipt of exception reports from relevant Directors to demonstrate that they have discharged their accountability for the parts of their portfolios relating to clinical governance. This covers the areas of practice effectiveness, drugs and therapeutics, infection prevention and control, diversity, information governance and clinical documentation, managing violence and aggression, medical education, safeguarding children, research and development, compliance, and health and safety;
4. To provide assurance to the Trust Board that the Trust is meeting national requirements for clinical governance and clinical safety;
5. To assure the Trust Board that the Executive Management Team and Service Delivery Groups have systems in place that encourage and foster greater awareness of clinical governance and clinical safety throughout the organisation, at all levels;

Compliance

6. To monitor, scrutinise and provide assurance to the Trust Board on the Trust's compliance with national standards, including the Care Quality Commission Essential Standards, NHS LARMS, the quality elements relating to Monitor's Compliance Framework and NICE guidance;

7. To provide assurance to the Trust Board that the Trust is compliant with relevant legislation, such as legislation relating to equality and diversity and human rights;
8. To provide assurance that the Trust has effective arrangements for the prevention and control of infection, safeguarding adults and children, information governance and records management, and the safety elements covered by the Health and Safety TAG.

Clinical Safety Management

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

Public and Service User Experience

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

12.12.3. Adherence to Local and National Policy and Procedure

12.12.3.1 Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."*[390] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

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

Corporate Responsibility.

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

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

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

12.12.3.2 Findings

Quality of Local Policies and Procedures

The Independent Investigation Team found that the relevant Trust clinical policies and procedures were appropriate and evidence based. Most policies either had been reviewed or had an identified review date. Those policies that had been reviewed show evidence of being informed by recent best practice guidance.

Implementation of Trust Policies

A number of the Trust's policies were not fully implemented or were inconsistently implemented in the case of Mr. Y. As noted elsewhere in this report, the local Adult Safeguarding procedures were not enacted, and the Trust's CPA, Risk Management policies and CMHT operational policy were not followed in a conscientious fashion.

A critical part of the Governance cycle is identifying when procedures are ineffective or policies are not being implemented. At least in the case of Mr. Y's care there did not appear to be an effective mechanisms in place to identify and address failures to implement Trust policies or adhere to best practice guidance.

Similarly when there was a failure in communication between primary and secondary mental health services, some of which could have resulted in serious harm, there did not appear to be any effective mechanisms in place to identify these problems and address them.

12.12.3.3 Conclusion

It is the conclusion of the Independent Investigation Team that Trust policies and procedures were appropriate and fit for purpose. While it would be inappropriate to generalise to a whole system from a single case, at least in the case of Mr. Y, important Trust policies were not consistently implemented. In Mr. Y's case no effective mechanisms to identify and address these shortcomings in a timely manner were evident.

12.12.4.1. Management and Clinical Leadership

Particularly since the introduction of *New Ways of Working*, the functions of team management and clinical leadership have been distinguished. The functions of these two roles overlap to some extent. The emphasis of the team manager's role is to ensure the delivery of an identified clinical service, to an identified population, adhering to the Trust policies and to ensure effective and high quality care. The emphasis of the clinical leader's role is on ensuring high quality clinical care with particular reference to recent best practice evidence and promoting developments which will enhance the clinical care that the service delivers.

There were a number of clinicians who showed admirable commitment to providing Mr. Y with care and support. Clinicians and housing support workers, at various times, were forceful advocates for Mr. Y. However, clear management, to ensure that the care Mr. Y received complied with Trust policies, and clear clinical leadership, to ensure that his difficulties were clearly understood and addressed in ways that were informed by best practice guidance, were absent.

12.12.4.2. Supervision

12.11.4.2.1 Findings of the Internal Investigation

Supervision:

"The Inquiry Team has not been able to find an Integrated Supervision Policy outlining the process for both Health and Social Care staff working within the integrated mental health service.

Approaches to Supervision appear to have been idiosyncratic with no real clarity about:

- *The purpose of supervision;*
- *How it should function;*
- *What should be discussed;*
- *Whether the same procedure for supervision should be used for both Health and Social Care staff.*

The agenda for supervision appears to have been lead by individual workers…..

The SWYMH Trust's current supervision policy approved in February 2006 (currently under review) sets out standards for both managerial and professional (clinical) supervision. The minimum standard for 'Management supervision' is an annual appraisal whilst the minimum for professional supervision is three times a year.

The Policy has an accompanying Framework which includes good practice guidance and a statement which reads: 'all staff within the Trust and its partner agencies will receive supervision' (2006, pg2, par7). The Policy and Framework do not stipulate the need for more frequent managerial supervision other than that which is described above.

There appears to have been some compliance with the policy in that the Team Manager... had a system of 1:1 clinical supervision in place. The Team Manager also said that he was 'generally available to discuss issues' and that there was a weekly CMHT meeting where team members could discuss issues related to their individual case loads.

…… there seems to have been a blurring between clinical and managerial supervision with no clear mechanisms for systematically monitoring individual practice on a regular basis."

12.12.4.2.2 Findings

Supervision, both management and clinical, is a critical element of good Governance. The Trust supervision policy in place in 2008 firmly placed supervision in the context of Governance when it commented:

"The main aim of supervision is to ensure that the needs of service users and their carers are acknowledged and learnt from. As professionals we have a duty to evaluate and develop ourselves in order to improve our contribution to service user care."[391]

The supervision policy distinguished between management and clinical supervision as follows.

- *"Management supervision - This is management led. All staff employed by SWYMHT has an identified line manager who has a responsibility to ensure that their members of staff have a minimum of an annual appraisal. For staff that provide care directly to service users, management supervision may also include case load review and supervision, although this function may be delegated to the case load manager or equivalent.*

- *Professional supervision - This is led by the individual practitioner and supported via professional leadership. All professionally qualified staff employed by SWYMHT who provide care directly to service users are required to access professional supervision in line with this policy, framework and good practice guidelines. This may be in the form of peer or group supervision and could be part of managerial or case load supervision, and the individual professional agrees this is appropriate."*[392]

However in relation to supervision the Internal Investigation observed:

"Approaches to Supervision appear to have been idiosyncratic with no real clarity about:

- *The purpose of supervision;*
- *How it should function;*
- *What should be discussed.*
- *Whether the same procedure for supervision should be used for both Health and Social Care staff."*[393]

[391] SWYMHT (2006) Supervision Frame work p.9
[392] SWYMHT (2006) Supervision Frame work p.15
[393] Report of The Internal Investigation p. 147

This observation has to be put in context, however, as the Supervision policy document does include the following sections:

1. *What is Supervision?*
2. *What will Supervision offer me?*
3. *What issues can you bring to Supervision?*
4. *What can you expect from your Supervisor?*
5. *What is expected of you as the supervisee?*
6. *Be prepared.*
7. *Contract.*
8. *Documenting sessions.*
9. *Annual record of supervision.*

The issue, once again, appears to be one of compliance with a Trust policy rather than absence of policy or guidance.

The Early Intervention CPN recorded in her clinical notes that she had discussed discharging Mr. Y with her supervisor.[394] That she discussed her intended plan of action in supervision was good practice. However, the decision taken in supervision appears to have been a primarily management orientated one with little discussion of the clinical issues.

CCO 1 received regular supervision. However, there appears to be no record that he ever discussed Mr. Y in supervision.

While Psychiatrist 1 received supervision for his psychotherapy practice he did not receive supervision in relation to his role as Consultant Psychiatrist.

The Internal Investigation commented:
"There seems to have been a blurring between clinical and managerial supervision with no clear mechanisms for systematically monitoring individual practice on a regular basis."[395]

[394] Case notes p.80
[395] Internal investigation p. 148

The Independent Investigation team agrees with this view.

The Trust revised its supervision policy in 2010 and it is now more robust, including reporting mechanisms to ensure that supervision takes place. While clinical fora, such as CPA review meetings, must remain the primary arenas for clinical decision making, the Trust should assure itself that its new policy ensures that all of the cases on a practitioner's caseload are appropriately reviewed in supervision.

12.12.4. 3. Conclusion

It is the conclusion of the Independent Investigation Team that the South West Yorkshire Partnership NHS Foundation currently has clear and appropriate Governance structures in place. It has appropriate policies in place which are updated with reference to current national and best practice guidance. Documentation about the Trust in the public domain, placed there by the Care Quality Commission, indicates that the Trust is performing well.

However, during the period the Mr. Y was under the care of the Trust, its policies were not always implemented in a consistent manner and there was no effective mechanism in place to detect and respond to this in a timely manner. Current policy documents identify who is responsible for ensuring that policies are implemented. This is good practice. The Trust may want to assure itself that this mechanism is working effectively. The Trust's Senior Management Team was able to describe to the Independent Investigation Team a cycle of identifying a service delivery problem, identifying a solution to the problem, disseminating the solution and monitoring the implementation of the solution. That they were able to do so, without the benefit of time to prepare such evidence, was both impressive and reassuring. However, the Trust should consider collecting such information in a systematic manner both to re-assure itself of the efficacy of its Governance mechanisms and to ensure that it has relevant information available for external scrutiny.

High quality services and sound service delivery rest on good leadership both clinical and managerial. The Independent Investigation Team does not feel that it is appropriate to generalise from the information available on Mr. Y's care to the management and clinical leadership in the Trust in general. However, it has to be noted that neither were clearly evident in the care of Mr. Y. Since the events of February 2008 the Trust has introduced a new management training scheme in which both clinical/team managers and psychiatrists

have taken part. This is a positive innovation. The Trust may want to take steps to assure itself that this, together with other Governance mechanisms, is realising the goals of robust and effective management and clinical leadership at all levels of the Trust.

At the level of the individual practitioner, supervision is one of the key mechanisms that ensures that practice is both safe and of an acceptable quality. Amongst other things supervision should ensure that practitioners are adhering to the operational policies of the services within which they work and to Trust clinical policies in general. The Trust revised its supervision policy in 2010. The new policy has mechanisms in place to ensure that supervision takes place. It should now assure itself that supervision is appropriate and of an acceptable quality.

13. Findings and Conclusions

13.1. Root Cause Analysis

In order to ensure that the findings are understood within the root cause analysis methodology each finding is placed within one of the three categories below. These categories are as follows:

1. **Key Causal Factor.** The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team has concluded had a direct causal bearing upon the homicide. In the realm of mental health service provision it is never a simple or straightforward task to unconditionally identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide perpetrated by them.

2. **Contributory Factor.** The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Mr. Y's mental health and/or the failure to manage it effectively.

3. **Service Issue.** The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report, whilst having no direct bearing on the events of 21 February 2008, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

13.2. Key Causal Factors

The Independent Investigation identified no direct causal factors connecting the care and treatment of Mr. Y by South West Yorkshire Mental Health Trust with the events of 21 February 2008.

The main findings of the Independent Investigation are reported below.

13.3.1. The Care Programme Approach: Assessing needs and planning care

The Independent Investigation found that best practice as reflected in the Trust's 2007 Care Programme Approach (CPA) policy with respect to the allocation of a service user to the standard or enhanced levels of CPA was not followed in Mr. Y's case. Perhaps because of this, Mr. Y's needs were not assessed in a systematic and comprehensive manner on a regular and planned basis or in response to his changing life circumstances.

During the time Mr. Y was cared for by the Trust, several care plans were recorded but these were of variable quality and a number of them did not reflect either the comprehensiveness recommended by best practice or the range of needs Mr. Y was known to have. Mr. Y's care plans were not reviewed with a prescribed regularity or in response to his changing circumstances as would have been expected by best practice.

There is no evidence that Mr. Y, his mother, or the staff of the Housing Association, who provided a significant amount of Mr. Y's support, were consistently involved in identifying Mr. Y's needs or planning his care.

Perhaps as a consequence of these factors Mr. Y's care co-ordinators tended to focus their efforts on delivering care rather than on its planning and co-ordination.

Taking these factors together it was concluded that Mr. Y's care did not reflect best practice as set out in the Care Programme Approach or the Trust CPA policy (2007).

- ***Contributory Factor 1: The assessment of Mr. Y's needs and the planning and co-ordination of his care did not meet best practice standards as identified in the Care Programme Approach. While it cannot be concluded that this had a causal relationship with the events of 21 February 2008, the lack of such systematic and comprehensive care contributed to Mr. Y's mental health needs not being identified in a timely fashion and addressed in the most effective manner. This had a deleterious impact on his mental health and well-being.***

- ***Service Issue 1: During the time Mr. Y was under the care of the Trust there did not appear to be an effective mechanism in place to ensure that either best practice or Trust policies, with respect to the Care Programme Approach, were followed at the individual practitioner or team level.***

13.3.2. Risk Assessment and Management

Mr. Y reported experiencing suicidal thoughts and, on occasions, tied a belt around his neck. He drank to excess which was deliterious to his mental health and, at times, made it impossible for those trying to provide care and support to him to be able to do so. His drinking brought him into conflict with the criminal justice system and placed him in danger in the community.

On at least some occasions Mr. Y expressed the idea that he might harm others, for example in September 2004 when he was aggressive towards a nursing assistant, in September 2005 when he told his mother that he wanted to hurt the Early Intervention CPN, and in January 2008 when he sent a text to his mother saying that he had thoughts of hurting people. He fought with his brother, for example, in July 2004 and on one occasion in September 2005 his mother reported that she was fearful of her son. There were, therefore, a number of occasions when the risk Mr. Y posed to himself and to others should have been assessed and risk managment and crisis management plans put in place.

The Health of the Nation Outcome Scales (HoNOS) were employed to assess the level of risk Mr. Y posed. This is too imprecise a device to be used to assess risk. In 2006 the Trust introduced the Sainsbury Risk Assessment Tool to be used with working age adults. This is a more appropiate tool to use in assessing risk but the revised risk management policy was not implemented within the Kirkless CMHT and the Sainsbury Risk Assessment Tool was never employed to assess the risk Mr. Y posed.

Complementing the data provided by the assessment tools should have been a formulation identifying how various identified factors might influence or determine Mr. Y's behaviour. There is no evidence of such analysis, reflection or formulation in Mr. Y's notes.

Having assessed the risk an individual poses, a risk management and crisis plan should have been drawn up as part of Mr. Y's care plan. This should have been done in co-operation with

the service user, his carers and those professionals involved in his or her care. There appear to be only two risk management plans in Mr. Y's notes. These are of a basic standard and do not indicate what needed to be done to manage any risk Mr. Y posed or what the goals of the interventions might be. There is no evidence that Mr. Y or his family were involved in the assessment and development of these plans.

- ***Contributory Factor 2: The HoNOS scales were used, on a number of occasions, to asssess the risk Mr. Y posed to himself or to others. This was not an appropriate device to be used for the pupose of assessing risk. The Sainsbury Risk Assessment Tool, which was approved by the Trust for assessing risk, was not employed to assess the risk that Mr. Y posed. No formulation or care plans, informed by such formulations, were drawn up to manage any risk that Mr. Y might have presented. Mr. Y and his carers were not involved in asessing Mr. Y's risk or in planning how this might be managed.***

- ***Service Issue 2: Although the Trust introduced a revised policy for the assessment and management of risk this was not implemented the case of Mr. Y. There did not appear to be an effcetive mechanism in place to ensure that the Trust's policy was implemented or that members of staff had appropriate supervision to ensure that risk was appropriately addressed in line with the Trust procedures.***

13.3.3. Diagnosis

Mr. Y had a number of diagnostic labels applied to him while under the care of the Trust.

His initial presentation was one of an affective disorder. Later, symptoms suggestive of a psychosis emerged. Over time these appeared to subside and other problems came into prominence: his misuse of alcohol, his vulnerability, his chronic low self esteem and poor survival skills.

From early in his contact with the mental health services clinicians identified "personality issues" associated with Mr. Y's presentation. Unfortunately, at this time, there were no dedicated services for individuals suffering from personality disorders within the Trust, to which staff might have referred Mr. Y or from where they might have sought advice.

Personality disorder problems are not uncommon in the population served by mental health services. Recent NICE guidance (2009)[396] on the treatment and management of people with personality disorders makes it clear that personality disorder is not only a treatable disorder but that it is the responsibility of the mental health services, usually the CMHTs, to provide a broad based assessment of needs and to institute appropriate interventions. The guidance acknowledges that if clinical staff are to fulfil this role competently then training and support are required. The guidance recommends that Trusts should set up specialist teams to assess and treat those who have particularly complex needs or are at particular risk.

The categorical diagnostic system is not the only basis for formulating and understanding an individual's difficulties. Much of the care and support Mr. Y received appears to have been informed by the Recovery Model. One care plan identified the need to address Mr. Y's low self esteem and to help him challenge his distressing thought processes. Such a formulation might be seen as sitting within a cognitive behavioural model. Members of the team caring for Mr. Y adopted different models to inform their clinical decisions but there was no agreed formulation of his problems. This lack of a clear and agreed formulation reduced the likelihood of him receiving the most effective care in a consistent manner.

It cannot be concluded that, had there been a clear and agreed formulation in place to inform Mr. Y's care and treatment, the events of 21 February 2008 would not have taken place. However it is likely that a more co-ordinated formulation of Mr. Y's difficulties would have led to him receiving more consistent and outcome focused care.

- ***Contributory Factor 3: No multidisciplinary mechanism was employed to ensure that there was a clear and consistent formulation of Mr. Y's problems, which identified the desired outcomes and informed a robust care plan. This is likely to have contributed to the less than optimal management of Mr. Y's mental health problems and may have contributed to the deterioration of his mental health.***

- ***Service issue 3: At the time Mr. Y was receiving care from the Trust it did not have in place a service for individuals with a diagnosis of Personality Disorder to which***

[396] NICE (2009) Borderline Personality Disorder: Treatment and Management

he might have been referred for assessment, treatment or advice. Staff in the CMHTs were not provided with the training to assess and treat individuals with a personality disorder. The absence of such a service deprived individuals with a personality disorder of the type of service recommended by the extant national Best Practice Guidance and those with a suspected personality disorder of an expert assessment which would have informed their treatment.

13.3.4 Treatment

Medication

Throughout the time Mr. Y was under the care of the South West Yorkshire Partnership NHS Foundation Trust he was prescribed either anti-depressant medication or a combination of anti-depressant and anti-psychotic medication. Appropriate medications were employed at recommended dosages. Mr. Y's medication was reviewed on a regular basis and changed in response to both the symptomatology he was reporting and his report of the side effects he was experiencing.

A plan for reducing and then discontinuing Mr. Y's anti-psychotic medication was drawn up in 2007. This was in accordance with good practice. However, the plan was not implemented as intended because of a breakdown in communication between primary and secondary care. This represented a serious weakness in the system.

Psychological Therapies

Mr. Y was assessed for psychodynamic psychotherapy but it was concluded that he was not suitable for this form of intervention. However it was suggested that he would benefit from a more structured approach, such as CBT. There is no evidence that this recommendation was pursued or that Mr. Y was referred for CBT or any other form of psychological therapy. Best Practice Guidelines for both psychosis and depression recommend that service users with these types of problems should have access to psychological therapies. These were not made available to Mr. Y.

It was recognised by those caring for Mr. Y that the dynamics of his family life played an important role in his presentation. Psychological interventions to explore and address these issues might have been beneficially provided, however there is no evidence in Mr. Y's clinical notes that such a course of action was considered.

- ***Contributory Factor 4: Best Practice Guidance recommends that psychological interventions should be made available for those diagnosed as suffering from depression or a psychosis. These were not made available to Mr. Y. It is probable that appropriate psychological interventions would have enhanced Mr. Y's mental health and well-being. It cannot reasonably be concluded, however, that the absence of these interventions had a direct causal relationship with the events of 21 February 2008.***

Alcohol

Mr. Y had a significant alcohol misuse problem for most of the time he was in contact with the Trust's mental heath service. The detrimental effects of alcohol on his behaviour, his mental state and even on his ability to benefit from the services made available to him were well recognised. Both Mr. Y's family and those providing care and support repeatedly encouraged Mr. Y to address his alcohol problem. Mr. Y's mother accompanied him to his GP who prescribed the medication Antabuse to help Mr. Y control his drinking. However Mr. Y showed no consistent motivation to reduce his alcohol intake and on a number of occasions reported that he used it to ameliorate the distress he experienced associated with his mental health problems.

Given the services available there was little the staff of the Trust could do to affect Mr. Y's drinking without his co-operation. This was not forthcoming. They consistently provided him with information about the alcohol service but had no authority to compel him to engage with this service.

The Department of Health's Good Practice Guidance on Dual Diagnosis (2002) recommended:

"…drug and alcohol services provide specialist support, 'consultancy', and training to mental health services to support 'mainstreaming' of clients with severe mental health problems…without which people will continue to receive poorly integrated or episodic care."[397]

[397] DoH (200) *Dual Diagnosis Good Practice Guide* p. 11

This was the Best Practice Guidance current at the time Mr. Y was under the care of the Trust. The relevant "*support, 'consultancy' and training*" was not available to those caring for Mr. Y.

- ***Contributory Factor 5: Mr. Y's continued misuse of alcohol was detrimental to his mental state and the recommended support, consultancy and training was not available to staff to help Mr. Y address this problem. It cannot be reasonably concluded, however, that this had a direct causal relationship with the events of 21 February 2008.***

13.3.5. Cultural Diversity

Religion played a major part in Mr. Y's life and that of his family. This was identified at the beginning of his contact with mental health services. There was a belief that religion, or at least Mr. Y's relationship with his religion and religious beliefs, was a source of distress. However, this was never formally explored as part of his assessment. The assumption of the clinicians providing care and support to Mr. Y was that religion was a cause of his distress but the possibility that his problems with religion might also be a manifestation of his mental health problems does not appear to have been explored. Had this been done the monitoring of his mental state may have been more sensitive and reliable.

Despite the acknowledgement of the importance of religion in the life of Mr. Y and of his family, no advice or information was sought on the beliefs of the Jehovah's Witnesses nor was any attempt made to forge a co-operative relationship with the local Jehovah's Witness Community. Such a relationship might have informed the assessment of his mental state and the consequent interventions.

- ***Contributory Factor 6: While the role played by religion and religious beliefs was acknowledged by the clinical team, expert advice was not sought to help the team understand Mr. Y's background, or to help them differentiate normal, if different, beliefs from thinking that might be symptomatic of mental ill-health. Nor was a co-operative relationship sought with the local Jehovah's Witness Community, a relationship which might have informed clinical interventions. Had this been done, it is probable that Mr. Y's mental health would have been more sensitively and reliably monitored and his mental health needs addressed in a more timely fashion. This would have contributed, beneficially, to Mr. Y's mental health and well-being,***

although it cannot be concluded that it would have affected the events of 21 February 2008.

13.3.6. Vulnerable Adults and Safeguarding

Mr. Y's vulnerability to exploitation was recognised by his family and those caring for him. This vulnerability was understood as a product of Mr. Y's upbringing, beliefs and what was regarded as his personality. Various members of staff in both the mental health teams and the housing association tried to help Mr. Y by explaining to him the consequences of his actions, by working with him on his self esteem and assertiveness skills, by referring him to therapeutic and skills groups and by offering to look after his money. What they did not do was to trigger the Adult Safeguarding Procedures.

Mr. Y's family were frustrated that nothing was done which protected their son. However, staff felt that they were limited in the extent to which they could intervene because Mr. Y usually withheld his consent for them to confront those exploiting him. They felt bound to comply with his wishes.

Establishing that an individual has the capacity to make a decision involves, amongst other things, establishing that s/he understands the implications of his/her decision. This in its turn implies that the individual has responsibility for his/her decisions and related actions. Identifying an individual as vulnerable, however, implies that, at least to some degree, the individual is influenced to make decisions that are not in his her best interest and does not have the resources to resist this influence.

Following his involvement in a burglary of a neighbouring flat, the police and the criminal justice system appear to have recognised Mr. Y's vulnerability and dealt with him accordingly. However, those providing care and support for Mr. Y, although they recognised his vulnerability, felt bound by his decisions. They did not trigger the Trust's Safeguarding procedures. There is no record of an appointeeship, to help protect Mr. Y from financial exploitation, being considered nor is there any record that advice or supervision was sought on this matter.

There was no guarantee that following the Adult Safeguarding procedures would have significantly reduced Mr. Y's vulnerability or offered him significantly more protection with a consequent improvement in his mental health and well being. It was, however, a missed opportunity to explore, in a more structured and formal way, what the *No Secrets* guidance describes as

"…an effective response to any circumstances giving grounds for concern or formal complaints or expressions of anxiety."

The fact that abuse resulting from Mr. Y's vulnerability was not prevented significantly financially disadvantaged him. It also, at least episodically, harmed his mental health and well-being. It would not be reasonable, however, to conclude that the failure to enact the safeguarding procedures had any substantial effect on the events of the 21 February 2008.

- ***Contributory Factor 7: The Trust and its partner organisations have a duty of care to those to whom they provide services. Part of that duty is to protect the individual from victimisation and exploitation as a result of their vulnerability. Mr. Y was recognised as being vulnerable and was the victim of exploitation. However the Trust's Safeguarding policies and procedures were not followed. As a result of the exploitation he experienced Mr. Y suffered significant financial disadvantage. Being the victim of exploitation also harmed his mental health and well-being. It would not be reasonable, however, to conclude that the failure to enact the Trust's Safeguarding procedures had a direct causal relationship with the events of the 21 February 2008.***

- ***Service Issue 4: The fact that Mr. Y was not formally identified as a vulnerable adult and that appropriate procedures were not followed is a service issue which has relevance beyond this immediate case. The Trust and its partner organisations have a duty of care to those to whom they provide services. Part of that duty is to protect the individual from victimisation and exploitation as a result of his/her vulnerability. Failing to implement the safeguarding policy is a failure to realise this duty of care and puts in jeopardy the individual's mental health and well-being.***

13.3.7 Service User Involvement in Care Planning

It is the conclusion of the Independent Investigation Team that the care and treatment offered to Mr. Y aimed at promoting his independence, self confidence and assertiveness. To this extent the care provided was user centred. However, in part because of the lack of formal care planning and in part because of Mr. Y's personal characteristics, those caring for Mr. Y found it difficult to engage him in planning his care and establishing his goals.

13.3.8. The Family

Involving the families and carers of service users in the assessment of needs and the planning of care is well established as good practice and is enshrined in national best practice guidelines and in the Trust's current CPA policy. Mr. Y's family were not involved, formally or systematically, in the assessment of his needs or planning of his care. This may have been because there was an overall lack of formal care planning in Mr. Y's case and this, in its turn, may have been due to him having been placed on the standard level of CPA.

Having identified the importance of the dynamics of Mr. Y's family on his mental health and well-being this should have been explored and included in the formulation of Mr. Y's problems. This was not done. Similarly, having identified this issue, consideration should have been given to the provision of some form of family intervention. Again this was not done.

Mr. Y's parents' need for support was identified and resources were put in place to meet this need. This was good practice. It would have been better practice if, having carried out a carer's assessment, an agreed plan, to meet the identified needs, had been put in place.

- ***Contributory Factor 8: Failing to involve Mr. Y's family in a formal and systematic manner in the assessment of his needs deprived the team caring for him of information which would have improved their understanding of his mental state, family background, sources of tension and coping strategies. Failing to involve them in the planning of his care reduced the probability that Mr. Y was given consistent advice and support and increased the probability that he received confused messages as to what was expected of him. This situation was detrimental to the putting in place of an effective and efficient package of care for Mr. Y. The***

absence of such a package of care was detrimental to Mr. Y's health and well-being.

- ***Contributory Factor 9: Throughout the time he was under that care of the Trust Mr. Y's often ambivalent relationship with his family was identified as a factor contributing to his distress, to his mental health problems and to the coping mechanisms he adopted. Failing to address his difficulties in the context of these family dynamics, and failing to provide family members with information on how best to support Mr. Y, contributed to his mental health problems not being addressed in the most effective and timely manner possible.***

13.3.9. Communication and Care Co-Ordination

The communication between those planning and providing Mr. Y's care, while he was an in-patient, at times, failed. This led to Mr. Y being discharged, on one occasion, without an appropriate plan being in place with the result that he had to be rapidly re-admitted to hospital. Better communication would have improved the care planning and, may have reduced the distress Mr. Y experienced. It may also have shortened the length of his in-patient admission.

Discharge is a point of significant vulnerability and yet on two of the three occasions on which Mr. Y was discharged from hospital information was incorrectly recorded. That there were no untoward consequences is fortunate. This, nevertheless, represented a serious weakness in the system of communication at that time.

Communication between primary care and secondary mental health care also appears to have broken down at times. On one occasion the secondary mental health service was not informed that Mr. Y had changed his GP. They continued to write to his former GP about Mr. Y's care. In the event, this misdirected communication did not result in any serious harm. This was fortuitous. However this incident manifested a weakness in the system and one that could, on other occasions, result in a serious untoward incident.

The breakdown in communication between primary and secondary care resulted in decisions about Mr. Y's care being based on incorrect information. The timing of the reduction of Mr. Y's medication was not the one that had been planned and not the one the psychiatrist caring

for him believed he was monitoring. It is impossible to say what effect the delay in reducing Mr. Y's anti-psychotic medication had. Again this incident manifested a dangerous weakness in the system which could result in a serious incident occurring.

At the time Mr. Y was under the care of the Trust there was no mechanism in place to ensure the staff of the supported Housing Association were systematically involved in the assessment of his needs or in the planning of his care. The Independent Investigation was informed that currently there is significant variation between CMHTs. Some include the staff of the Housing Association in care planning and inform them of changes to the care of their residents. Others CMHTs are less integrated in their way of working. From the point of view of the staff of the Housing Association there is no policy relating to joint working which is applied consistently across all CMHTs.[398]

The responsibilities of the mental health services and the Housing Association appear to have been blurred at times. When there were shortages of resources the assumption seems to have been that Housing Association staff would make good the shortfalls by assuming the responsibility to monitor the mental health of services user. That the staff of the Housing Association were prepared to take on this role may have been an example of flexibility and user-centred services or it may have been an example of informal co-operation between the staff of the two organisations. However, the confused boundaries and responsibilities did not constitute good practice as it placed both service users and staff potentially at risk.

- ***Service Issue 5: Communication, both between teams within the Trust and between staff of the Trust and those working in other organisations, failed on a number of occasions. That no serious harm befell Mr. Y was fortuitous, however such weaknesses in the systems of communication place both service users and staff at risk.***

- ***Service Issue 6: The responsibilities of the mental health services and the Housing Association were blurred, at times. It appears that there was an expectation that Housing Association staff would take on responsibilities that were proper to the***

[398] Witness Interview Independent Investigation

mental health service. To have a confusion of boundaries and responsibilities is not good practice as it places both service users and staff at risk.

13.3.10. The Management of Mr. Y's Care

The CMHT operational policy identified the eligibility criteria for the service. It also identified the importance of: multidisciplinary working, holding regular reviews, continuity of care, monitoring medication and liaison with the service user's GP. These all reflect both good practice and the CPA process. However, in practice, there were a number of weaknesses in the overall management of Mr. Y's care.

- *Continuity of care*

There was no mechanism in place to ensure that Mr. Y remained in contact with the mental health services when he was discharged from one element of the service.

- *Continuity and the provision of appropriate care*

Although Mr. Y met the criteria for on-going and specialist care there were significant periods when he had no contact with the mental health services. This was not an appropriate provision of care for Mr. Y, and did not realise the continuity of care identified in the CMHT operational policy.

- *Learning and reflective practice*

Perhaps because there was no regular process for reviewing Mr. Y's care, there is no evidence of any reflection on or learning from previous experiences, particularly from those episodes when Mr. Y's care co-ordinator was absent and Mr. Y's mental state or behaviour deteriorated. Such reflective practice would have informed Mr. Y's care planning.

- *Clarity of roles*

At times there appears to have been a lack of clarity about the roles and responsibilities of members of the multi-disciplinary team. Psychiatrist 1 initially tried to fulfil the roles of both Psychotherapist and Consultant Psychiatrist with respect to Mr. Y. On reflection he acknowledged that this way of working created an unhelpful tension and he has subsequently changed his way of working.

- *Understanding the role of the care co-ordinator*

Despite the emphasis placed on the co-ordinating role of the care co-ordinator in the Trust's CPA policy, Mr. Y's care co-ordinators appear to have focused on the delivery of care rather than on assessment, planning and co-ordinating the delivery of care. There is no evidence

that the need of Mr. Y for care co-ordination was formally reviewed either on a planned basis or when his circumstances changed. Perhaps because of this and the emphasis placed on the delivery of care, there is little evidence to suggest that the skills needed to act as a care co-ordinator for Mr. Y were reflected upon either by individuals or the collective team.

- *Overall management of Mr. Y's care*

At the service level there was no mechanism in place to ensure that Mr. Y's care was being appropriately managed: that he remained engaged with the mental health services, that he continued to meet the eligibility criteria of the CMHT, that there was on-going appropriate multi-disciplinary involvement, that his needs were being appropriately assessed and he was being allocated an appropriate level of care to meet those needs, that care plans were informed by previous experience, and that he was allocated a care co-ordinator with the requisite skills to assess his needs and plan and co-ordinate the delivery of his care.

It would appear that the CMHT operational policy was not being implemented in the case of Mr. Y.

One consequence of this lack of overall case management was that when Mr. Y's mental state began to deteriorate, the safety net that should have been available to monitor his needs and risk was not in place for prolonged periods and not robust when it was in place. The lack of assessment and consequent care planning contributed to the deterioration of Mr. Y's mental state.

- ***Contributory Factor 10: Following Psychiatrist 1 discontinuing Mr. Y's antipsychotic medication, the mechanism he believed to be in place to monitor Mr. Y's mental state was absent for a significant period of time. When it was noted that Mr. Y's mental state had deteriorated, although immediate support was provided, no multi-disciplinary assessment of Mr. Y's needs and risk was undertaken. Consequently, his care plan was not reviewed or revised.***

  It cannot, reasonably, be concluded that if these actions had been undertaken the events of 21 February 2008 would not have taken place. However it is reasonable to assume that the absence of appropriate assessment and the consequent failure to review Mr. Y's care plan contributed to the deterioration of his mental health.

- ***Service Issue 7: The CMHT operational policy identified the importance of ensuring continuity of care. This aspect of the policy does not appear to have been adhered to. There appears to have been no policy in place at the time Mr. Y was receiving care from the Trust to ensure that service users remained in contact with the service. Indeed there was one incident when the approach taken by staff made it difficult for Mr. Y's family to ensure that he received the care that they believed that he needed.***

- ***Service Issue 8: Despite the role of the care co-ordinator being identified in both the Trust's CPA policy and the CMHT's operational policy, this did not appear to inform the choice of the care co-ordinator for Mr. Y nor ensure that his need for care co-ordination was regularly reviewed. Given the central importance of the CPA and care co-ordination, this raises the issue of how adequately Trust policies are implemented.***

13.4. Conclusions of the Independent Investigation into the Care and Treatment of Mr. Y

The primary aim of an investigation undertaken under the auspice of HSG 94 (27) is to ensure that learning takes place which promotes the development of safer and higher quality services. This means that it is necessary to go beyond asking what happened and consider why things happened in the way they did. To achieve this goal of understanding why things happened in the case of Mr. Y it is useful to consider what happened at a number of levels: at the level of the delivery of care to the individual, at the process and systemic levels and at the corporate level.

At the individual level, while there was a great deal of care and support provided to Mr. Y, assessments were not undertaken at appropriate times, care plans were not put in place, relevant people were not always told when important decisions were made and people did not always respond to requests for action.

At the procedural and systemic level, while it must be acknowledged that staff demonstrated a great deal of care and empathy, this was not informed by a clear formulation of Mr. Y's problems or structured by the CPA process. There was an absence of care co-ordination.

Because there were no effective care management structures in place, Mr. Y, at times, received high levels of care and support and then, because the person delivering his care was absent or Mr. Y was transferred between services, at other times he received no service at all, in one instance for several months.

There was little multi-disciplinary consideration of Mr. Y's care and little evidence of structures being in place to ensure that learning took place. The latter is surprising given that the Independent Investigation found high levels of reflection on their clinical practice amongst those witnesses interviewed as part of this investigation.

There were weaknesses in communication both within the mental health services and between the mental health services and other organisations. It is noteworthy that at times communication was excellent, while at others it appears to have been absent. This suggests that the level of communication was a reflection of individual practice and not guaranteed by the system. At times there was an impressive amount of collaboration between staff of the mental health service and the staff of the Housing Association, with an admirable willingness to be flexible in ensuring that care was delivered to Mr. Y. However, as there were no joint working protocols in place, staff of the Housing Association were not consistently involved in the assessment and care planning processes. Flexibility at times led to a blurring of roles and responsibilities.

While the importance of Mr. Y's family was noted, they were not involved in his care in a consistent manner. Nor was the importance of his family included in a formulation of Mr. Y's problems nor family intervention considered.

At the corporate level, the Trust put in place a number of relevant clinical policies: the CPA policy, the Clinical Risk Management policy, the Safeguarding Vulnerable Adults policy and the CMHT operational policy. These were all informed by best practice guidance. However

they were not implemented in a consistent manner and the Trust governance structures did not identify this and address this issue.

The Independent Investigation concluded that there were a number of weaknesses in the care and support Mr. Y received from the South West Yorkshire Mental Health Trust. These have been identified in this report as contributory factors in that, as a result of these weaknesses, Mr. Y received a service which was less effective than might reasonably be expected. This contributed to the deterioration of Mr. Y's mental health. However the Independent Investigation could not, reasonably, concluded that any of these factors had a direct casual relationship with the events of 21 February 2008.

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

The following section sets out the response of South West Yorkshire Mental Health Trust to the events of 21 February.2008.

14.1. The Trust Serious Untoward Incident Process

The South West Yorkshire Mental Health Trust's *Incident Management and Patient Safety Policy*[399] in force in February 2008 required that a Management Briefing report be completed within twenty-four hours of the death of a service user. This report was completed on 22 February.2008 by the service manager and updated by the assistant director on 26 February.2008 in line with Trust policy.

The report identified that Mr. Y had last been seen by his care co-ordinator on 18 February 2008. It also identified that Mr. Y had been discharged from psychiatric care on 12 November 2007 but identified the wrong psychiatrist.[400]

The report provided a brief history of Mr. Y's care by the Trust. It also recorded that the service manager attempted to contact Mr. Y's mother but that her phone was switched off. The identified plan was for Mr. Y's mother to be directed to the Carers' Support Service, to whom she was already known, for support. Mr. Y's brother was provided with the contact details of the CMHT with which he made contact the next day.[401]

It was noted that counselling was to be offered to staff.[402] Mr. Y's psychiatric and CMHT notes were secure in accordance with Trust policy and good practice.[403]

[399] South West Yorkshire Mental Health Trust (2007) *Incident Management and Patient Safety Policy and Procedures*
[400] Internal Investigation Archive p.5
[401] Ibid p.7
[402] Ibid p.4
[403] Ibid p.5

The immediate response to the incident complied with the Trust's policy and exemplified some good practice.

14.2. The Trust Internal Investigation (Structured Investigation Report)

14.2.1 Internal Investigation

The Trust's Incident Management Policy in force in February 2008 stated:
"The investigation team will aim to complete the investigation and present the investigation report and recommendations within 6 weeks of the incident. The SHA require a copy of the report and action plan within 8 weeks."[404] A revised policy was issued in October 2008. It retained this reporting standard.[405]

An Internal Investigation was commissioned in early March 2008. This investigation presented its final report on 2 October 2008.

14.2.2 Terms of reference for the Internal Investigation

The following terms of reference were provided for the Internal Investigation:

"To examine:

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

To identify:

[404] South West Yorkshire Mental Health Trust (2007) *Incident Management and Patient Safety Policy and Procedures* p.43
[405] South West Yorkshire Mental Health Trust (October 2008) *Incident Reporting and Management* p.32

7. Any actions taken following the incident to manage the immediate situation; provide support to those affected and to improve services.

8. Any significant care concerns including:

(a) Those that had a direct impact on the outcome of the incident.

(b) Those that did not have an impact on the outcome of the incident.

9. Any areas of particularly good practice.

10. Findings and learning points for improving systems, services and professional practice.

To undertake:

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

To make:

12. Realistic recommendations to address the findings and learning points to improve systems and services; learn lessons for the future."[406]

14.2.3 Investigation Team

The Trust appointed an independent consultant with significant experience in undertaking such investigations to Chair the Internal Investigation. The other members of the team which undertook the Internal Investigation were an Associate Medical Director from the Trust, the Head of Nursing from the Trust and a Social Care Manager from the Local Authority. In addition an Assistant Director from the Trust, provided senior managerial oversight and support to the Internal Investigation.

14.2.4 Methodology

The Internal Investigation reported that it was *"conducted in accordance with the SWYMH Trust's Serious Untoward Incident Procedure which forms part of the Incident Management and Patient Safety Policies and Procedures*." [407]

The Internal Investigation employed a Root Cause Analysis methodology and reported using a number of Root Cause Analysis tools including: "*the construction of a narrative*

[406] Internal Investigation Report p.4
[407] Ibid p.5

chronology, the application of the 5 Why's, the development of a tabular time line in discussion with members of the multidisciplinary team (and managerial staff), and the development of fishbone diagrams."[408]

The Investigation Team was supplied with a photocopy of the medical, nursing, carers' support records and the SWYMH Trust's Management Briefing Report. It was noted that "*In part the photocopying was of poor quality which challenged the work of the Inquiry Team.*"[409] The medical member of the team read the psychotherapy notes.[410]

The Internal Investigation reviewed a relevant set of Trust policy documents. It also interviewed a comprehensive set of witnesses. These interviews were professionally transcribed. It also sought an expert opinion on issues relating to the Jehovah's Witness religion.

Mr. Y's mother was interviewed *"to discuss the Terms of Reference with her and to provide her with an opportunity to raise anything she wished to say before the Inquiry Team commenced the inquiry process."*[411]The Internal Investigation team also met with Mr. Y's sister.

The Internal Investigation report noted that the Investigation team wanted to meet Mr. Y "*but due to the poor state of his mental health, this was not possible.*"[412]

14.2.5 Conclusion

The Internal Investigation identified a number of points of good practice. It had clear and relevant terms of reference which reflected the guidance provided in the Trust policy on investigating serious incidents. It appointed an experienced team of senior staff to undertake the Investigation and the Investigation was chaired by an external consultant with experience in undertaking such reviews. The victim's wife, who was also the mother of the perpetrator, was invited to comment on the terms of reference and the victim's daughter was interviewed

[408] Ibid p.
[409] Ibid p.7
[410] Ibid
[411] Ibid
[412] Ibid

as part of the Investigation. The Investigation also sought to speak to Mr. Y but was advised that this was not possible because of his mental state.

The methodology, Root Cause Analysis, was specified in the terms of reference for the Investigation and evidence was provided in both the report and the investigation archive that this methodology was employed.

The Trust policy, however, specified that the Internal Investigation should be completed within six weeks of an incident and an action plan be drawn up within eight weeks. This, very comprehensive, Investigation did not report until October 2008, over seven months after the event occurred.

The Trust might wish to reflect on the utility of undertaking investigation with more limited scope which report more quickly. The Trust policy comments:

"Why investigate incidents?

Investigating incidents enables us to find out and understand what happened and why. We can then use this information to change and improve systems and processes to prevent the same things happening again."[413]

While this is both true and reflects good practice, it is useful to differentiate between investigations. A broader more encompassing investigation is more likely to realise the goal of "*improving systems and processes*". However its very comprehensiveness means that it is a relatively slow process and not well suited to ensuring immediate safety. In reviewing its policy on managing Serious Untoward Incidents the Trust may wish to differentiate between the goals of the immediate response to a serious incident; the focused and relatively quick internal investigation and the slower, more comprehensive review. It might then attach appropriate procedures and timescales to these various activities.

The Internal Investigation was a robust and very competently conducted investigation which provided clear evidence of it collecting relevant information and employing a Root Cause Analysis to scrutinise the data.

[413] South West Yorkshire Mental Health Trust (2007) *Incident Management and Patient Safety Policy and Procedures* p.38

14.2.6 Findings of the Internal Investigation

Having provided a detailed commentary on the care and treatment Mr. Y received from the Trust, the Internal Investigation identified its findings under the following headings:

- Risk Assessment and Risk Management;
- Care Programme Approach (CPA), Care Planning and Discharge from In-patient services;
- Cover arrangements during staff absence;
- Recovery Model;
- Diagnosis;
- Vulnerable Adults and Safeguarding;
- Supervision;
- Record Keeping;
- Partnership Working;
- Family approach.[414]

The Internal Investigation concluded that there was no factor that it could identify as having a causal relationship with the events of 21 February 2008. However, it identified a number of contributory factors and presented these in a series of four fishbone diagrams relating to the periods: July 2006-March 2007, April 2007-September 2008, October 2007-February 2008 and the 24 hours prior to the fatal incident.

The report also summarised the contributory factors it identified as follows:

- *"An underestimation of [Mr. Y's] psychotic illness;*
- *Poor risk assessment and insufficient analysis of key events;*
- *Excellent examples of individual practice, but ineffective whole-team functioning;*
- *The role of a Care Co-ordinator, as opposed to a key worker/community worker, especially during the last 20 months;*
- *Insufficient focus on and involvement of the family in the care planning; process and interventions which comprise the care and treatment plan;*

[414] Internal Investigation report p.139

- *The application of the Care Programme Approach which fell short of acceptable standards;*
- *Key information not being passed on to key people, resulting in communication errors e.g.:*
    - *[Mr. Y] speaking in third person shortly before the fatal incident was not passed on to[CCO 1] by Connect Housing;*
    - *The text which [Mr. Y] sent to his mother several weeks prior to the fatal incident regarding "getting even" with anyone who had upset him was known to Connect Housing but was not known to[CCO 1].*
- *Implementation difficulties at operational level with RiO (electronic care record);*
- *Lack of CMHT staff continuity during significant absences of Community staff;*
- *Supervision arrangements;*
- *Multiple clinical formulations;*
- *Dual diagnosis (alcohol misuse and illicit drug episode(s);*
- *Mr. Y receiving the higher dose of Aripiprazole from his GP for longer than he should have done;*
- *The role of a Consultant Psychiatrist who was also for a period of time Mr. Y's Psychotherapist;*
- *The use of HoNOS as a risk assessment tool when its application was designed primarily as an outcome measure;*
- *Individual practitioners, with best intentions, subscribing to a recovery model, which may have affected clinical judgment in respect of Mr. Y's mental illness;*
- *Practitioners and services operating in parallel, as opposed to whole-team functioning."*[415]

The Internal Investigation report goes on to comment:

"The Inquiry Team do not consider there are any specific causal factors which could be attributed to the fatal incident. If such factors were to be suggested, then the Inquiry Team believes the possibilities to be:

1. *The mistaken belief that Mr. Y was on a reduced dose of Aripiprazole during which time there were no signs of relapse into psychotic symptoms, which lead to a decision*

[415] Internal Investigation Report p. 154

to discontinue anti psychotic medication. This has to be balanced against a service user, who at times, demonstrated poor compliance with treatment and therefore even if the drug error has not occurred, there is no certainty that Mr. Y would have been taking the prescribed dose at the frequency it was prescribed.

This mistaken belief was due to a systems failure relating to the communication and implementation of a clinical decision, exacerbated by ineffective monitoring of medication in the community by the designated Care Co-ordinator, who for a period of time was on planned sick leave.

2. *The designated Community Care Co-ordinator being unaware of 4 significant pieces of communication relating to (1) a text which Mr. Y sent to his mother several weeks before the fatal incident in which he said he was going to get even with everyone who had upset him; (2) Mr. Y speaking in the third person on 31 January 2008; (3) the text which Mr. Y's mother sent to him in connection with a missing girl, on 19 February 2008; and (4) the telephone call which Mr. Y made to his mother on 20 February 2008 in which he alleged that he had been sexually abused by his father.*

On the first count, the designated Care Co-ordinator was on planned sick leave for which there was no re-designation of this role during his absence.

On the second count, an agency housing support worker was advised to pass on information but omitted to do so. This occurred shortly after he had taken up post and coincided with a change over from one key worker to another.

On the third and fourth counts information was not passed between Mr. Y's mother and Mr. Y's Care Co-ordinator.

3. *The possibility that the text which Mr. Y's mother sent to Mr. Y on 19 February 2008, to inform him that a little girl had gone missing, may have inadvertently had an adverse affect on Mr. Y's mental state, triggering his belief that his father had sexually abused him, although this is conjecture on the part of the Inquiry Team as there is no evidence to substantiate this.*

4. *The possible degree of abandonment which Mr. Y may have experienced when people who he saw as central to his well-being were no longer part of his support network…"*[416]

14.2.7 Recommendations of the Internal Investigation

Following its identification of contributory factors the Internal Investigation made the following recommendations:

"1. Risk Assessment and Risk Management

1.1 *The SWYMH Trust should review the impact that the use of the Sainsbury Risk Assessment Tool is having on clinical risk to determine if the identification and management of clinical risk meets an acceptable standard of practice.*

1.2 *There should be an audit in respect of the use of the Sainsbury Risk Assessment Tool across Kirklees (north) to ensure that all practitioners are using the tool in routine practice and further training should be provided where appropriate.*

1.3 *The Trust should clarify the use of HoNOS Plus in the context of risk assessment.*

2. CPA, Care Planning & Discharge from In-patient Services

2.1 *CPA practice in North Kirklees should be audited to ensure that it is complying with statutory and local policies and procedures.*

2.2 *Staff should routinely convene a multidisciplinary meeting to review the care provided to individuals with complex needs.*

2.3 *The Trust is developing a new policy to reflect the national changes to CPA (CPA Lead Group). The project implementation plan associated with the new policy should be reviewed to ensure that it makes provision for:*

- *The translation of policy into practice;*
- *Regular formal multidisciplinary reviews of all individual service users who are receiving services from a CMHT. Such reviews should involve family members/significant others (with the agreement of the service user) and other relevant agencies who are involved in the service user's care.*

2.4 *The Trust should review the current governance arrangements to ensure that CPA practice reflects the Trusts CPA Policy and that remedial action is taken which*

[416] Internal Investigation Report p.154

secures a systematic approach and that the operating the specified standard is achieved across the Integrated Mental health Service.

2.5 *In reviewing the SWYMH Trust's Discharge Policy, the Trust should ensure that the new policy is compatible with the Trust's CPA Policy and that quality discharge is an integral part of Pathways of Care and Care Packages.*

3. Care Co-ordination

3.1 *The Trust should review its policy in respect of care co-ordination in order to satisfy itself that there is clarity of role and clear delineation of responsibility, particularly in relation to Registered/Qualified and care officers/assistants.*

3.2 *When there is a transfer of one Care Co-ordinator to another it should be underpinned by a comprehensive summary which includes relevant background details, relapse signatures, risks, key interventions, medication and aims and objectives for care.*

4 Safeguarding of Vulnerable Adults

4.1 *The Trust's lead on vulnerable adults, in partnership with the local authorities, should consider if the current policy, its interpretation and implementation best practice and that the Policy is fully understood by managers and practitioners.*

4.2 *Mental health practitioners should ensure that any work with vulnerable persons complies with local safeguarding policies.*

5. Staff Supervision

5.1 *A joint Health and Social Care Supervision Policy for staff working in the integrated Mental Health Service should be developed. This policy should be underpinned by training to support its successful implementation.*

5.2 *This policy should distinguish and be clear about the arrangements for both 'clinical' and 'managerial' supervision.*

5.3 *Periodic audits of supervision practice should be undertaken to monitor the agreed operating standard and remedial action taken when appropriate to secure best practice.*

6. RiO

6.1 *The views of front line staff and managers should be incorporated into existing RiO implementation work streams.*

6.2 *An audit to ascertain the impact this system is having should be undertaken so that appropriate action can be taken to ensure that the full benefits of this system are realised.*

7. Family approach

7.1 *When carrying out assessments and devising care plans, staff should always consider the individual within the context of their family and social circumstances.*

7.2 *Staff should be encouraged to involve significant carers in the care planning process where this is relevant and acceptable to service users.*

8. Connect Housing Association – employment of agency staff

8.1 *Connect Housing Association may wish to review the employment, orientation and induction systems which are currently in place in respect of the employment of agency staff to satisfy the organisation that agency staff are clear about their roles and responsibilities and the relevance of communicating significant information to ensure that Care Co-ordinators are in receipt of key information.*

9. Cover arrangements for periods of staff leave.

9.1 *The Assistant Director, Adult Services, should review the systems and processes in respect of the management and allocation of resources in relation to clinical priorities within the Sector CMHT, with particular attention to Care Co-ordinator responsibilities during staff absence.*

10. Tracking and interpreting psychiatric and psychological phenomena in the context of service user's faith/religion, social and cultural backgrounds.

10.1 *Information regarding an individual's social, cultural and religious background should be sought as a matter of routine so that psychiatric/psychological phenomena can be examined against such contextual background. This may entail mental health practitioners accessing specialist advice and training.*

11. Medicines management

11.1 *The Trust should remind mental health practitioners that the checking of a service user's prescribed medication in respect of the correct dosage, concordance with treatment and tolerance in respect of side effects, should be an integral and ongoing part of the clinical review and care management processes."*[417]

14.2.8 The Trust's Response to the Internal Investigation's Recommendations.

The Trust drew up an action plan relating to each of the recommendations. The actions in response to each of the recommendations and the progress made towards completing these are reported in the table below.

Table 2: the Trust action plan in response to the recommendations of the Internal Investigation

Recommendation	Action in response to recommendation	Completed
1.1	*"SWYMHT have successfully bid for SHA monies for a nationally recognised trainer….. to deliver refresher courses of the Sainsbury risk assessment/management tools."*	Completed
1.2	"*Audit tool to be developed between service and CQST (Clinical Governance Support Team)* ***Update 24/09/10*** *"The audit has now been competed as part of the trust wide audit. The [Mr. X] results were extrapolated from the overall audit and evidenced an 85% compliance with the completion of the Sainsbury risk assessment."*	Completed
1.3	*"Work undertaken within the Pathways and Packages project HONOS plus now replaced by SARN."*	Completed

[417] Internal Investigation report p.160

2.1 -2.5	*"SWYMHT has now appointed a Trust wide CPA lead who will incorporate these recommendations in the next stage development of the CPA policy and procedure within SWYMHT. This work will be monitored by the CPA Trust Action Group which is chaired by the Director of Nursing Compliance & Innovation."*	Fourth quarter, 2010.
3.1-3.2	"Policy has been reviewed and implemented, including flow-charts outlining the process and procedures at the launch of 'new' CPA levels in October 2008. Policy is being reviewed. An interim position was taken with the role of the Care Co-ordinator linked with the launch of 'new' CPA in October 2008. This included flow-charts outlining the process and procedures. The trust is currently involved in the national CPA training pilot, which focuses on the core competencies and responsibilities of care co-ordination. This involvement will support the full review undertaken by the trust wide CPA lead."	Third quarter, 2010**.**
4.1	*"Each Assistant Director of the Care Groups represents SWYMHT on the Safeguarding Boards of Calderdale, Kirklees and Wakefield."*	Completed
4.2	*"There is an ongoing programme of training facilitated by the Trust Lead with full access to training within the local authorities."*	*"Training remains on-going as per SWYMHT Training Policy."*
5.1	*"There is a Trust-wide Supervision Policy."*	October 2008
5.2	*"There remains on-going dialogue between Heads*	October 2008

	of Nursing and Social Care leads to ensure all professional requirements are met"	
5.2	*"There is a planned audit on a proposed annual basis."*	Fourth quarter, 2010.
6.1	*"The implementation of RiO is overseen by the Trust wide RiO Editorial Board."*	Stage 2 roll out of RiO planned to commence February 2009
6.2	*"Staged roll out of RiO is agreed with each care group with opportunities for front line feedback***."**	Stage 2 roll out of RIO planned to commence February 2009
7.1-7.2	*"This is planned to be incorporated in the new CPA policy guidance"*	Fourth quarter 2010
8.1	*"Connect Housing Association have confirmed that as a result of the RCA review, they have reviewed their recruitment and usage of agency staff, reviewed induction processes and reviewed communication processes with care co-ordinators such as weekly updates by email."*	January 2009
9.1	*"Process has been reviewed, and process in place to involve Service Manager of CMHT and relevant Team Leader."*	November 2008
10.1	*"This will be considered within the Supervision of the practitioner within the Supervision policy. Specialist advice can be sought through the Trust's Pastoral Care Unit."*	October 2008

14.2.9 Good practice Identified by the Internal Investigation

The Internal Investigation also identified a number of examples of good practice. These are reported below:

- *"The quality of relationships between the professionals working with [Mr. Y];*
- *Record keeping, in general, was of a high standard;*
- *[The Supported Housing staff] showed a high level of commitment in their work with [Mr. Y]. They showed a deep understanding of [Mr. Y's] complex needs and the support they offered to him is to be commended;*
- *[The Early Intervention CPN] went to great lengths to facilitate a better life for [Mr. Y], in which she worked closely with [Housing Association, ….and [Mr. Y's] family, in particular his mother;*
- *[CCO 1] showed a high level of support and commitment in the individual care he gave to [Mr. Y], and in doing so, he worked very closely with [the Housing Association]. His records clearly demonstrated his plan of action which was adapted in response to [Mr. Y's] needs;*
- *[Psychiatrist 1], in the early stages, wanted to avoid a vulnerable young man being labelled with a serious mental illness and the damaging consequences this would have entailed;*
- *[CPN 2] obtained [Mr. Y's] permission for information to be shared amongst the team and [Mr. Y's] mother, albeit he did not make use of this permission to any significant degree;*
- *Both parents were in receipt of support from the Trust's Carers Support Service;*
- *The six monthly Support Plan Reviews which form part of [the Housing Association's] standard operating procedures were well documented and thorough in the exploration of [Mr. Y's] presenting issues, his care needs and significant events;*
- *The high level of skill in the key worker support which both Housing Support Workers 1 and 2] and I gave to Mr. Y;*
- *The enthusiasm and commitment to the recovery model and cognisance of the stigmatising nature of mental illness by those who worked with Mr. Y;*
- *Nurses on Ward 18 demonstrated excellent practice in their engagement (as opposed to merely watching over) of Mr. Y during times when he was on heightened levels of observation;*

- *The early Intervention CPN kept regularly in touch with Mr. Y whilst he was an inpatient on Ward 18.*
- *The high standard of Appropriate Adult notes taken by CPN 2 whist Mr. Y was in custody".*[418]

4.2.10 Conclusion

Having undertaken a comprehensive and robust investigation the Internal Investigation produced findings which are generally in accord with the findings of the Independent Investigation. The Internal Investigation concluded that there was no factor that could be identified as having a causal relationship with the events of the 21 February2008. The Independent Investigation agrees that this is a reasonable conclusion.

The Independent Investigation organised its findings in accordance with its terms of reference for the Investigation. It identified a range of contributory factors and discussed these under meaningful thematic headings. The Independent Investigation used its finding as the basis for relevant recommendations.

Perhaps the major difference between the Internal Investigation and that of the Independent Investigation is one of emphasis. The Independent Investigation places rather more emphasis on the role of Governance and the importance of having in place mechanisms which ensure that Trust policies are implemented in a consistent manner.

The Internal Investigation identified the importance of information not having been communicated and speculated as to the possible consequences of this. While the Independent Investigation Team agrees that the breakdown in communication was an important factor it has tended to place the emphasis on why communication failed rather than that it failed.

The Trust responded to the findings of the Independent Investigation with a comprehensive set of action plans. From the information supplied to the Independent Investigation most of these have now been completed. Given the importance of implementation the Independent Investigation is keen to support the Trust in ensuring that its initiatives are well embedded and inform clinical practice.

[418] Report of the Internal Investigation p. 156

14.3. Dissemination and Staff Involvement

The Trust, in its Serious Untoward Incident Policy of 2007 and in subsequent related documents, has identified that the main objective of investigating an adverse event is to ensure that lessons, which will lead to safer, more effective and high quality services, can be learned. The 2007 Document lists a number of groups which played a role, at that time, in identifying and disseminating learning including: the Extended Executive Management Team, the Clinical Governance Committee, the Service Delivery Groups, the Trust Action Groups and the Area Service Specialist Advisers Group. These groups ensure learning at the corporate level and it is important for any organisation to ensure that leaning is generalised across the organisation.

The policy document recognises the importance of sharing findings with individual practitioners. The document identifies a number of ways in which the learning can be communicated to staff including:

a) *"Formal presentation of the investigation report to the teams or services involved in the incident, usually by the lead investigator. The purpose of this presentation is to learn the lessons from the investigation and agree how recommendations can be most effectively applied within the service;*
b) *Team brief;*
c) *The Source;*
d) *Trust intranet and e-mail system;*
e) *Presentations to Ward Managers/Team Leaders events;*
f) *Staff supervision;*
g) *Academic meetings;*
h) *Minutes of meetings with specific incident reports discussed."* [419]

While these are all perfectly reasonable methods of disseminating information, they are essentially passive methods from the point of view of the staff members. There is no active participation in shaping the learning or making it relevant to the local context.

[419] South West Yorkshire HNS Mental Health Trust (2007) *Incident Management and Patient Safety Policy and Procedures* .p. 51

When this issue was discussed with the Trust's senior management team they were aware of a tension between striving for independent scrutiny and engaging staff. They acknowledged the importance of capitalising on the knowledge of the staff and fostering ownership of the lessons learnt. The Independent Investigation Team were informed that current practice is that once recommendations are made following an investigation, the clinical teams are involved in the drafting of action plans. This is good practice. The Trust might reflect on how it might engage and involve staff in the whole of the learning and service improvement process.

Most of those interviewed by the Independent investigation reported that there had been significant changes since the time of the Internal Investigation but they were not clear which, if any, of the changes related to the recommendations of the Internal Investigation. Some felt that the emphasis of the Internal Investigation had been on scrutinising the practices of individuals. This impression was based on their own experiences at interview. Without any familiarity with the Trust's action plan it was difficult for them to see how the goal of the Investigation was to achieve generalised learning and for established practices to change across the Trust.

The culture of reflection demonstrated by the witnesses to the Independent Investigation was noteworthy and very impressive. Disappointingly most of this reflection was done on an individual basis and never shared across teams. Given that a culture of reflection is present in the Trust, it might consider ways of capturing the produce of this reflection, following any future event, so that learning might be shared.

14.4. Staff Support

14.4.1 Context

The Trust policy on managing Serious Incidents, in force in February 2008, acknowledged the importance of providing support to those who have been involved in an incident:

"Some incidents can be distressing or traumatic for those who have been either directly or indirectly involved; service users, carers, relatives and/or the staff involved. Care should be taken to ensure that those people who may be affected or traumatised by an incident are

identified and every effort made to engage them and offer appropriate support both immediately post incident and in the longer term." [420]

14.4.2 Findings

Immediately after the Trust had been informed that Mr. Y had been arrested in connection with the death of his father, the need to arrange supportive counselling was identified in the Management Briefing Report on 22 February.2008, in line with Trust policy.[421]

In preparation for the Internal Investigation the Chair of the Staff Side (trade unions/professional bodies) was briefed in advance of staff being invited to give evidence. In addition, those members of staff who were interviewed as part of the Internal Investigation were advised in writing that they could be accompanied by their trade union representative, a colleague or a friend, though not acting in a legal capacity.

It was evident that Scott and Salmon compliant procedures were adhered to by the Internal Investigation Team.

Staff who had given evidence to the Internal Investigation had the opportunity to read the final draft report between 15 and 30 September 2008 to check the report for accuracy. The Internal Investigation reported that three witnesses had not read the report by the time it was submitted to the Trust. These members of staff were to be approached via their line management.

The Internal Investigation report recorded that relevant managers would be offered an opportunity to "*consider the draft edited report in order that they are briefed on the report's findings, conclusions and recommendations*."[422]

The Internal Investigation Team met with those who had been interviewed as part of the Investigation. The feedback from this meeting recorded in the Internal Investigation report was *"The general view was that the report is thorough, balanced and fair and that it contained opportunity for learning and development*."[423] (p. 163

[420] SWYMHT (2007) Serious Untoward Incident Procedure p.10
[421] Internal Investigation Archive p.4
[422] Internal Investigation report p. 163
[423]Internal Investigation report p. 163

It was also planned that a representative of the Trust would arrange for the Internal Investigation report to be shared with Mr. Y's mother.

14.4.3 Staff support during the Independent Investigation

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

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

14.4.4 Conclusion

14.4.4.1 Support

Most of those involved in the care of Mr. Y learned informally that he had been arrested in connection with the death of his father. This was probably unavoidable. But there is no record of a subsequent Trust response to identify those involved in Mr. Y's care and to provide them with accurate information as to what had happened and what support they could access.

Witnesses to the Independent Investigation varied in the amount of support they reported receiving in relation to the Internal Investigation process; some felt well supported, others arranged their own informal support systems and some felt unsupported throughout the process. Although the need to make counselling available was identified immediately after the Trust was informed that Mr. Y had been arrested, at best, very limited use was made of this resource.

A similar range of experiences was reported in relation to the Internal Investigation itself. While all the witnesses found the process difficult, distressing or even "harrowing", some of those interviewed reported that those interviewing them had been supportive, while others reported that some members of the Internal Investigation Team had been confrontational, and

one witness described the questioning as being aggressive. Whilst an investigation has to be rigorous, witnesses should not be subject to questioning that is either aggressive or lacking in courtesy.

14.4.4.2 Feedback to Witnesses

Witnesses were given an opportunity to read the draft Internal Investigation report between the 15 and 30 September. This had to be done on Trust premises. Witnesses to the Independent Investigation observed that one consequence of this arrangement was that they did not have the time they would have liked to consider the report and its findings. If witnesses were to be asked to comment at this stage, and this was good practice, it would have been more beneficial to have provided the opportunity for them to read the report and make their responses in a more considered manner.

All witnesses were invited to a feedback workshop with the Internal Investigation Team. This was good practice and provided the opportunity for witnesses to reflect upon the findings of the Internal Investigation.

14.5. Being Open

14.5.1 Context

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006[131]. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who have been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;

- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done.[132].

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

14.5.2 Local Context

The Trust issued its *Being Open policy in 2008.* This document echoes the national guidance.

In particular it states that service users and their carers:

- *Are treated fairly and given open and honest information about what has happened and the actions the Trust is taking as a result, as soon as possible after the incident.*
- *Have their questions answered*
- *Receive an apology (regret) for any harm caused*
- *Are offered support and information about services that might be able to help*
- *Are given the name of a person in the Trust to speak to*
- *Are given updates on the findings of any investigation and the actions the Trust will take as a result of this.*[424]

It also notes that staff should:

"Document the process as a separate record linked to the case notes with a complete, accurate record of the discussion(s) including date and time of each entry, what the service user and/or carer have been told and a summary of agreed action plans."[425]

14. 5.3 Findings

The South West Yorkshire Mental Health Trust was informed by the police on 21 February 2008 that Mr. Y had been arrested in connection with the death of his father. The Trust

[424] SWYMHT (2008) *Being Open p.4*
[425] Ibid p.9

immediately made available a member of staff to act as an Appropriate Adult for Mr. Y. This was a member of staff who was known to Mr. Y but was not working with him at that time. This was good practice.

An attempt was made to contact Mr. Y's mother. She was not available but a plan was put in place to ensure that she could receive support from the Carers' Support service. Mr. Y's mother was already familiar with this service and had received support from it previously. This, again, was an example of good practice.

Contact was also made with Mr. Y's brother.

The Independent Investigation has no information on any contact between the Trust and other members of Mr. Y's family immediately following the death of Mr. Y's father.

The Trust reported that when Mr. Y's mother was visited by a senior officer of the Trust to share the terms of reference for the Internal Investigation, a verbal, formal acknowledgement and expression of condolence was given to both Mr. Y's mother and his sister. The Carer Liaison Officer was also present at this meeting, as noted above she was already known to Mr. Y's mother. The Carer Liaison Officer continued to provide emotional support to Mr. Y's mother until the time of Mr. Y's death in January 2011.

As part of the Internal Investigation Mr. Y's mother was consulted about the terms of reference for the Investigation. She was also interviewed by two members of the Investigating Team and was able to share her views and concerns. Mr. Y's sister was also interviewed and was able to share her concerns. The Internal Investigation reported that it would have liked to have met with Mr. Y and other members of his family but this was not possible.

The Trust reported that its lead officer visited Mr. Y's mother on approximately a six weekly basis to keep her updated on the progress of the Internal Investigation and to offer emotional support.

On completion of the Internal Investigation Mr. Y's mother was offered "supported readings" of the draft report. The Trust reported that before the report of the Internal Investigation was

finalised Mr. Y's mother was provided with a copy of the draft report to check for factual accuracy. A copy of the report was left with Mr. Y's mother at this time. A further "supported reading" with Mr. Y's mother took place in November 2008 shortly after the Internal Investigation report was finalised.

In August 2009 Mr. Y's brother contacted the Trust's lead officer and a "supported reading" of the Internal Investigation report was arranged for him. A "supported reading" of the report was also arranged for Mr. Y's sister when she made contact with the Trust's lead officer in early 2010.

The Trust reported that throughout 2009 Mr. Y's mother was visited at approximately three monthly intervals by the Trust's lead officer to inform her of the progress being made on the action plan which had been drawn up following the Independent Investigation.

The Trust was of the view that offering Mr. Y's mother and family "supported readings" of the Internal Investigation report was the most appropriate course of action. However Mr. Y's mother had understood that following the final draft of the report being submitted she would be provided with a summary of Internal Investigation report.

14.5.4 Conclusion

In the spirit of *Being Open* the Trust did make contact with Mr. Y's family and offered support.

Being Open identifies that family members:

- receive acknowledgement of the distress that the incident has caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards.

The Trust identified a lead officer who visited Mr. Y's mother and gave a "verbal, formal acknowledgement and expression of condolence" to Mr. Y's mother and his sister. This was good practice.

Mr. Y's mother was consulted on the terms of reference for the Internal Investigation and provided with a "supported reading" of the Internal Investigation report and its recommendations. This was good practice. However Mr. Y's mother had understood that she would be given a written summary of the Internal Investigation report while the Trust believed that providing Mr. Y's family with "supported readings" of the report was the most appropriate course of action. It would have been appropriate to discuss this issue with Mr. Y's mother and to have arrived at a clear, agreed course of action on this matter to avoid confusion and disappointment.

Following the death of her son Mr. Y's mother received support from senior members of the Trust's management team and from the staff of the secure unit to which Mr Y had been admitted. She also received significant support from the Carer's Support service. This represents good practice.

It is important to record at this point that Mr. Y's mother identified three issues which she felt would have helped her support her son:

1. for her son to have been given a clear diagnosis and the family informed what the implications of the diagnosis were and how they might have helped Mr. Y;
2. that her concerns about Mr. Y's vulnerability and inability to look after himself had been heard. Mr. Y's mother felt that her son needed to be accommodated in a hostel which was staffed 24 hours a day, seven day a week;
3. that the Trust reviews its rules on confidentiality so that parents are not excluded from supporting their children but are actively involved their care.

The Trust has reported that Mr. Y's mother identified similar concerns when the findings and recommendations of the Internal Inquiry were discussed with her.

The importance of having a clear diagnosis has been discussed above and the Trust is taking steps to ensure that all service users now have at least a working diagnosis.

The Trust has identified that access to supported accommodation is available within the Kirklees area if an individual is identified as needing this. However, as discussed earlier, Mr. Y's mother feels that she was not appropriately involved in the assessment of her son's needs and his inability to look after himself was not fully

appreciated. The Trust revised its Care Programme Approach policy in 2010 with the aim of improving the assessments of needs, care planning and care co-ordination. The new policy is clear as to the importance of involving family and carers in the assessment of needs and the planning of care.

With respect to Mr. Y's mother's observations on confidentiality the Trust reports that there is now a clear policy in place providing guidance on working with carers, identifying the importance of listening carefully to carers and acknowledging the carer's needs. This issue is also addressed in the current CPA policy and in the current care co-ordination training. Staff can now seek supervision and professional leadership should they require further advice in relation to patient confidentiality.

This issue was identified as a priority in the Trust's 2011/12 Quality Account.

15. Notable Practice

It is perhaps the nature of an Investigation that its emphasis is on things that can be improved and, in consequence, the reports of such Investigations can appear somewhat unbalanced and overly critical. Although the current report, too, focuses on what might be improved this is not to be read as indicating that good practice was not also present. The Independent Investigation Team noted a substantial amount of good practice and commitment by those involved in the care and support of Mr. Y.

15.1 High levels of care and support were provided to Mr. Y over prolonged periods of time. There are a number of examples of staff responding promptly when problems arose. The Early Intervention CPN provided continuity when Mr. Y was admitted as an in-patient. Staff acted as forceful advocates for Mr. Y throughout much of the time he was in contact with the mental health services.

15.2 The approach that was adopted towards the care of Mr. Y was one that attempted to promote normalisation, attempted to be holistic and avoided imposing stigmatising labels too quickly. While this approach may have had weaknesses at times it seems to have promoted the treatment of Mr. Y as an individual, a person with whom the staff had a relationship and not as a "case" to whom a package of care had to be delivered.

15.3 Again, while communication at times broke down, there are many examples of good communication. The general standard of the note keeping was good, particularly the clinical notes of the Early Intervention CPN, of CCO 1 and the in-patient nursing notes. CCO 1 noted his intended plan as the conclusion of each entry in response to Mr. Y's changing needs. This was good practice. At the informal level there appears to have been good communication between the Housing Association staff and, particularly, the Early Intervention CPN and CCO 1.

15.4 In general the support provided by the Housing Association staff was of a very high quality. As an organisation the Housing Association showed exceptional understanding of Mr. Y's difficulties. The review and support plan that was drawn up for Mr. Y by the

Housing Association was of a high standard and Mr. Y, his mother and the mental health staff caring for Mr. Y were invited to be involved with this. The individual support given to Mr. Y demonstrated considerable commitment, displayed significant competence and was of a high standard.

15.5 At the organisational level the Trust made available support to Mr. Y's parents through the Carers' Support Service. Both parents availed themselves of this, particularly at times of stress and crisis. At an individual level, the Early Intervention Nurse and Housing Support Worker 1 had good and supportive relationships with Mr. Y's mother, relationships that were important to her and which she valued.

15.6 The Independent Investigation Team was particularly impressed by the openness, reflectiveness and willingness to learn of the staff of both the mental health service and the Housing Association.

15.7 The Trust's management of the post incident arrangements ensured that substantial learning was both identified and put into practice in the form of service developments. These initiatives were set out in a detailed action plan that was worked through and implemented fully.

Since the Internal Investigation was undertaken in 2008 the Trust has strengthened its Governance structures to enhance the dissemination of learning and the involvement of staff.

In October 2008 the Trust implemented new incident management policies and procedures which included new procedures for learning from experience, and specific policies for supporting staff and *Being Open* following a serious incident. More recently further actions have been taken to strengthen these processes through the establishment of an Incident Review group (a sub-group of the Clinical Governance Committee), which shares the lessons learned from Serious Incidents and peer review of investigation reports.

Following a Serious Incident review, where recommendations have been made, an action plan is now always developed by local services to address the issue. Where necessary this will include Trust wide and strategic level actions. Implementation of these action plans is monitored and reported both to the Executive Management Team and to the Incident Review

group. The recommendations from Serious Incident reviews are shared at the Executive Management Team meeting.

As an off-shoot of the work of the Incident Review group a workshop is planned for later in 2011 to develop a Trust-wide Learning Framework to explore effective ways of bringing together and disseminating key learning for staff in the organisation. At a more local level the Kirklees Business Development Unit shares learning information through a standing agenda item at its Service Management meeting.

The Trust has developed its Performance Framework. Relevant operational information from this, such as CPA and training, is circulated at the organisational level and to clinical services and teams. This ensures that teams are aware of the key priorities of the organisation and the Trust's performance on these.

15.8 The Trust was in the process of developing a new Care Programme Approach policy and practice at the time Mr. Y was receiving his care and treatment from it. The new CPA policy and procedure was completed in 2010 with the agreement of the Trust's three Local Authority partners. This has now been implemented and is supported by associated training for staff, and monitoring and audit processes are in place.

The Trust has reported that all individuals referred into secondary mental health services delivered by South West Yorkshire Partnership NHS Trust will have their needs assessed by the appropriate service. The outcome of the assessment will identify if the individual is in need of care co-ordination and services under CPA or Standard Care. This initial assessment process will include the assessment of health and social care needs, risk assessment and the completion of the Mental Health Clustering tool.

Those individuals requiring CPA will have been assessed as having complex needs and will have presented with higher risk. Those individuals identified as requiring secondary mental health services but who do not present as having complex needs or higher levels of risk will have their care managed through the Standard Care process. Both CPA and Standard Care have clear and robust processes for assessment, care planning, review and transitions in care. Both processes have identified professionally qualified clinicians who undertake the role of care co-ordinators. In the case of CPA this is usually a Community Mental Health Nurse or

Social Worker attached to one of the Trust's community or specialist clinical teams. These care co-ordinators work within the context of a multi-disciplinary team and are, therefore, best placed to undertake this role.

If a service user is admitted to an in-patient facility following assessment, in the absence of an existing identified care co-ordinator, a care co-ordinator will be allocated from the admitting service until a transfer to a community service is agreed. The care co-ordinator will be identified as part of this transfer. The care co-ordinator will work in partnership with the service user, identified carers and other professionals and will undertake specific responsibilities around care co-ordination. These include:

- Comprehensive needs assessment;
- Risk assessment and planning;
- Crisis planning and management;
- Assessing and responding to carers' needs;
- Care planning and review;
- Transfer and discharge.

All invitations to care reviews are now recorded.

The Trust has identified the following values and principles which it has embedded into the current policy:

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

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

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

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

5. Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practices based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communication, understanding, clarification and organisation of diverse opinions to deliver value, appropriate, equitable and co-ordinated care. The quality of the relationship between service user and the care co-ordinator is one of the most important determinants of success.

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

Best practice relating to the delivery of CPA and Standard Care process is fully supported by Business Development Units. CPA training, risk training and systems training supporting CPA is available to all staff. Effective monitoring of CPA now includes:

- *Monthly reporting on the Trust's Key Performance Indicators relating to the care plans being offered to service users. The Trust consistently reports figures above its 80% target and is constantly working to maintain and improve this. These figures are reported to service managers and disseminated to teams to alert them of any significant changes relating to the Key Performance Indicators.*
- *Annual audit of CPA based on good practice standards. The audit includes:*
    - *Interrogation of clinical recording from a random sample of electronic and paper records covering areas of demographic information, assessment standards, care plan standards, review standards. CPA registration and standards relating to effective delivery of Care co-ordination;*
    - *Staff survey related to care co-ordination and training;*
    - *A service user and carer survey based on a random sample;*
    - *Triangulation of standards in relation to what the Trust says it is doing the with patients' experience.*

- *A multi-agency CPA group is in place which brings together key staff from Trust services and partner agencies including the Three Local Authorities. This group reviews policy, reviews performance and audit information and works towards positive outcomes."*

16. Lessons Learned

The aim of this section is not to repeat what has already been said but to draw together, under broad thematic headings, some of the lessons that might be learned from reflecting on the care Mr. Y received from the Trust.

16.1 Perhaps the most important lesson to be learnt is the importance of good Governance. The Trust had a comprehensive set of policies in place. These were informed by best practice guidance. The weakness that was manifested in Mr. Y's case, however, was that a number of these policies: the CPA policy, the Risk Management policy, the policy on Safeguarding Vulnerable Adults and the CMHT operational policy, were not implemented as had been intended. This lack of implementation does not appear to have been identified and addressed during the time Mr. Y was under the care of the Trust. The lesson to be learned is that ensuring that policies are implemented is as important as drawing up the policies.

16.2 The second lesson to be learnt relates to the importance of the active management of an individual's care within approved policies and guided by explicit models for understanding the individual's problem. Perhaps as a consequence of not fully implementing the Trust's policies Mr. Y's care was fragmented. There were periods during which he received intensive care, assertive advocacy and support, with good liaison with his family. There were also unplanned periods when he was out of contact with the services for, on one occasion, several months at a time. There is a strong suggestion that Mr. Y's mental state and behaviour deteriorated during these latter periods. However, because there was no overall structure for managing his care, lessons which might have been learned about the effects of withdrawing support, were not learned and the pattern of intensive input then withdrawal, with associated deterioration, was repeated several times.

All the Trust policies identified above have built into them a mechanism to ensure that those providing care for an individual pause and reflect on the service user's needs and how these might best be understood. This reflection is not evident in the provision of Mr. Y's care. While individual practitioners did identify needs and acted to meet these, the process of attempting to understand why Mr. Y was behaving as he was, was not evident. The result of

this was that several explanations of his behaviour were employed, encompassing both different diagnoses, from paranoid psychosis to borderline personality disorder, and different models from the categorical diagnostic model to psychological formulation to the Recovery Model. The implications of these models for assessment and the delivery of care do not appear to have been explored either in depth or within a multi-disciplinary forum.

The Internal Investigation noted that the Recovery Model was perhaps the main determinant of the care Mr. Y received. While there was certainly a strong psychosocial element to the care that he received while under the care of the CMHT, the Recovery Model is more than this. .All versions of the Recovery Model emphasise the importance of hope. Although the aspiration that Mr. Y might return to work was at times identified, the promoting of hope is not evident in the care Mr. Y received. Almost all versions of the Recovery Model identify stages through which the individual progresses in the journey of recovery. These stages are characterised by different relationships with services and a differential ability to assume responsibility for one's life. These are captured in a plan often referred to as a Wellness Recovery Action Plan (WRAP). This was not evident in the service Mr. Y received.

The lesson to be learnt here is that all good care is based on reflective practice informed by a clear understanding of the model being employed. This informs the assessments that are undertaken and it results in care being planned. Good care is seldom merely a reaction to immediate demands and seldom ignores large elements of the individual's experience and how these might be addressed.

16.3 The third lesson relates to communication. Again, perhaps because of the lack of a culture of reflective practice and multi-disciplinary team working, communication was at best inconsistent. There were breakdowns in communication between individuals, between the mental health service and Mr. Y's family and between organisations. Poor communication at times resulted in less than optimal care for Mr. Y and could have resulted in serious harm. The lesson to be learned is that a culture of good communication needs to be fostered and mechanisms need to be put in place to ensure that important information is sent, received, and responded to.

16.4 The fourth lesson relates to the need for clarity of responsibility both with respect to the individual practitioner and to organisations. Again one might want to trace this lack of clarity

back to the lack of reflective practice, sound care planning and adherence to Trust policies. The lack of clarity, like poor communication, can lead to duplication, which represents a waste of scarce resources, or tasks not being undertaken which is detrimental to the care of the individual. It can also lead to responsibility being inappropriately assumed or allocated. This places the service user, the practitioner and the organisation at risk.

16.5 The fifth lesson relates to seeing the individual within a meaningful context and using this to inform the understanding of the individual and his behaviour. The importance of the family and of issues of equality and diversity are identified in various Trust policy documents. From the time of his first contact with mental health services the important role played by Mr. Y's family and his relationship with his religion was noted. However these factors were not explored and did not appear to inform the care and support Mr. Y received. As with the other lessons identified here, there is little point in having policies if they do not inform practice. It is one of the roles of Governance to ensure that policies do inform practice.

17. Recommendations

17.1 The Care Programme Approach: Assessing needs and planning care

17.1.1

- ***Contributory Factor 1: The assessment of Mr. Y's needs and the planning and co-ordination of his care did not meet best practice standards as identified in the Care Programme Approach. While it cannot be concluded that this had a causal relationship with the events of 21 February 2008, the lack of such systematic and comprehensive care contributed to Mr. Y's mental health needs not being identified in a timely fashion and addressed in the most effective manner. This had a deleterious impact on his mental health and well-being.***

- ***Service Issue 1: During the time Mr. Y was under the care of the Trust there did not appear to be an effective mechanism in place to ensure that either best practice or Trust policies, with respect to the Care Programme Approach, were followed at the individual practitioner or team level.***

17.1.2 Trust Service Update

The Trust reports that it has now put in place new policies and systems relating to the Care Programme Approach, assessment and care planning. The new CPA policy identifies good practice principles and audit provides outcome evidence.

- Information about the expectation in relation to the roles and responsibilities of Care Co-ordination are delivered through training. This is further supported through the development and introduction of '*The care co-ordinator's self assessment of competences and identification of learning and the development of needs'* document, which will support KSF, supervision and appraisal processes;
- The CPA Policy now clarifies and clearly identifies individuals who are able to undertake care co-ordination responsibilities:
  "The member of staff identified to co-ordinate an individual's care must be competent, suitably qualified and skilled in delivering mental health care to fulfil the

role identified with their job description. Within South West Yorkshire Partnership NHS Foundation Trust this applies to all professionally qualified staff at pay Band 5 or above/qualified social care staff. Therefore the CPA care coordinator will be a qualified mental health professional, i.e. a social worker, mental health nurse, occupational therapist, psychiatrist or psychologist and who, through clinical supervision and self assessment, has the identified core competencies of care co-ordination";

- The annual CPA audit (Level 2) examines care co-ordination, supervision and training;
- Kirklees have developed a joint Health and Social Services supervision policy to support and clarify arrangements for staff working in jointly provided teams and services.

17.1.3 Recommendations

Recommendation 1:

In line with current CPA guidance and the Trust's own current CPA policy the Trust should undertake regular quality audits to ensure that:

- all those referred to its secondary mental health services have a comprehensive assessment of their needs;
- there is a clear formulation of the individual's difficulties and needs;
- care plans are informed by appropriate assessment and formulation;
- all care plans have clear goals or outcomes;
- service users and, with their consent, their families and carers, are involved in the assessment of need, the planning of care, and any changes to either the care plan or the care co-ordinator;
- the agreement of families and carers is obtained before care plans are finalised which involve actions on their part;
- families and carers, with the agreement of service users, are provided with current care plans, including crisis management plans;
- where there is multidisciplinary or multi-agency involvement all those involved in delivering care and support are appropriately involved in the assessment and planning process with the knowledge and consent of the service user.

17.2. Risk Assessment

17.2.1

- ***Contributory Factor 2: The HoNOS scales were used, on a number of occasions, to asssess the risk Mr. Y posed to himself or to others. This was not an appropriate device to be used for the pupose of assessing risk. The Sainsbury Risk Assessment Tool, which was approved by the Trust for assessing risk, was not employed to assess the risk that Mr. Y posed. No formulation or care plans, informed by such formulations, were drawn up to manage any risk that Mr. Y might have presented. Mr. Y and his carers were not involved in asessing Mr. Y's risk or in planning how this might be managed.***

- ***Service Issue 2: Although the Trust introduced a revised policy for the assessment and management of risk this was not implemented in the case of Mr. Y. There did not appear to be an effective mechanism in place to ensure that the Trust's policy was implemented or that members of staff had appropriate supervision to ensure that risk was appropriately addressed in line with the Trust procedures.***

17.2.2 Trust Service Update

The Trust reports that a new risk assessment, mangement and training policy was developed in October 2008. This reflected the Department of Health's *Best Practice in Managing Risk* (Deparment of Health, 2007) good practice guidance, and confirmed the use of the Sainsbury Risk Assessment Tool across adult and older people's services. The policy clearly states who is expected to attend risk training, and attendance at training is monitored. Use of risk assessment tools has been incorporated into the new CPA policy and procedures, to reinforce risk assessment and management as an integral part of care planning and the care co-ordination process.

Risk assessment and management training is currently delivered based upon the Department of Health's 2007 guidance. This training, including the appropriate and effective use of the Sainsbury Risk Assessment Tool, has been incorporated into the CPA and Care Co-

ordination training. Funding has recently been obtained to support development of an e-learning CPA and risk management package.

Use of the risk management tool is included as part of the annual CPA audit. This has identified the need to undertake some work with teams to look at the best use of level 1 and level 2 risk assessments.

A joint Health and Social Services supervision policy is now in place in Kirklees to support and clarify arrangements for staff working in joinly provided teama and services. This initiative supports the supervision of risk assessment and management.

17.2.3 Recommendations

Recommendation 2:

Having revised its risk assessment, mangement and training policy the Trust should institute a regular quality audit to ensure:

- that the formulation of the individual's problems and needs informs the understanding of his/her risk;
- that robust and meaningful care plans are put in place;
- that the service user and other relevant individuals are involved in the assessment and planning process;
- that the risk management plan is appropriately disseminated.

17.3. Diagnosis

17.3.1

- ***Contributory Factor 3: No multidisciplinary mechanism was employed to ensure that there was a clear and consistent formulation of Mr. Y's problems, which identified the desired outcomes and informed a robust care plan. This is likely to have contributed to the less than optimal management of Mr. Y's mental health problems and may have contributed to the deterioration of his mental health.***

17.3.2 Trust Service update

The Trust reports that it is disseminating the message to its medical staff that making a diagnosis or a differential diagnosis is an essential conclusion to any psychiatric assessment. While it is possible that a final diagnosis may not be reached until a period of information gathering and repeated assessment or observation has taken place, nevertheless a working diagnosis has to be in place during this period.

This position has been communicated to all the Trust's medical staff in the following ways:

- It has been discussed in two consecutive Medical Staff Committee meetings;
- It has been discussed with the In-patient and Crisis Doctors' forum;
- The Medical Director and the AMD for Education have organised two consecutive monthly joint academic psychiatric seminars, to include all psychiatrists, with invited speakers and case presentations, to emphasise the importance of making a diagnosis. These seminars have lasted a total of four hours.
- The Trust ensures that each patient has an ICD 10 code. This cannot be allocated without a clearly documented diagnosis for both mental as well as physical health. This coding is monitored through the Trust's monthly and quarterly performance reports.

17.3.3

- ***Service issue 3: At the time Mr. Y was receiving care from the Trust it did not have in place a service for individuals with a diagnosis of Personality Disorder to which he might have been referred for assessment, treatment or advice. Staff in the CMHTs were not provided with the training to assess and treat individuals with a personality disorder. The absence of such a service deprived individuals with a personality disorder of the type of service recommended by the extant national Best Practice Guidance and those with a suspected personality disorder, of an expert assessment which would have informed their treatment.***

17.3.4 Trust Service Update

The Trust reports that the 2009 NICE guidance relating to services for people with a diagnosis of personality disorder has been reviewed and steps have been taken towards implementation.

The NICE guidance on Antisocial Personality Disorders (NICE CG077) has been reviewed by the low and medium secure services and working age adult community services. The Trust does not have a dedicated Personality Disorder Network or commissioned Personality Disorder service. Currently service users with these problems are referred to appropriate organisations. All other aspects of the guidance are now being complied with.

The Trust reports that it has made significant progress against some aspects of its action plan for the implementation of the NICE guidance on Borderline Personality Disorders (NICE CG078). The internal risk rating for this guidance has been reduced to 'yellow'. Currently the Trust feels that it cannot make further progress in this area until clarification has been obtained from its commissioners.

The local severe non-psychotic pathway has been renamed the 'Wellbeing' pathway. This has not yet been re-configured. Local clinical psychology teams have started to develop ways of enhancing services to individuals identified as having a personality disorder. In Kirklees and Wakefield Dialectical Behaviour Therapy (DBT) groups have now been established. In the Kirklees area there are members of staff with a specialist knowledge of DBT who support the local service by providing DBT groups on a regular and systematic basis. In Wakefield a DBT therapist has been appointed. A special interest group in DBT has also been established.

It is planned that an audit of the NICE recommendations relating to Personality Disorders will be undertaken in the fourth quarter of 2011/2012.

17.3.5 Recommendation

Recommendation 3:

South West Yorkshire Partnership NHS Foundation Trust should review, with its commissioners, the provision of services for individuals with a diagnosis of personality disorder. This review should identify how a comprehensive service, complying with the relevant NICE guidelines, will be established. Any plans should ensure that there is equity of access to services for individuals from all the localities served by the Trust.

In line with the Trust's current plans there should be an ongoing audit, agreed with the Trust's commissioners, to ensure that the Trust is complying, or moving towards compliance in a planned and agreed manner, with the relevant NICE guidelines on personality disorders.

17.4. Treatment

17.4.1

- ***Contributory Factor 4: Best Practice Guidance recommends that psychological interventions should be made available for those diagnosed as suffering from depression or a psychosis. These were not made available to Mr. Y. It is probable that appropriate psychological interventions would have enhanced Mr. Y's mental health and well-being. It cannot reasonably be concluded, however, that the absence of these interventions had a direct causal relationship with the events of 21 February 2008.***

17.4.2 Trust Service update

The Trust reports that following a period of investment by both the Kirklees Primary Care Trust and South West Yorkshire Partnership NHS Foundation Trust access to psychological therapies has been improved.

The Trust commenced delivery of the Improving Access to Psychological Therapies Service (IAPT) in April 2009 as part of the national role out programme. This service provides a rapid access to Psychological Therapies to people who are experiencing low to moderate common mental health problems. Cognitive Behaviour Therapy (CBT) and guided self help therapies are offered for up to a maximum of 20 weeks, with access into treatment being set at no longer than 10 days for guided self help and 12 weeks for CBT. As a result of this development, in Kirklees the Trust now provides the whole of the Psychological Therapy pathway, from primary into secondary care services and, where necessary, service users are stepped up from IAPT to secondary care services.

Secondary Care Psychological Therapy services are delivered across the Kirklees District and a recent improvement programme has developed a new framework of service delivery in order to deliver treatment within the contractual 18 weeks access targets set by the

commissioners. The Secondary Care Psychology Service currently offers a range of therapeutic interventions for severe and complex non-psychotic presentations, including specialist interventions for personality disorders, such as: Dialectic Behaviour Therapy, Schema Focused Cognitive Behaviour Therapies, longer term Psychoanalytic Psychotherapy and Systemic Family Therapy. Consultation to teams working with 'difficult to treat' patients is also delivered.

In the future, the formation of the Community Therapy Pathways will encompass all Psychological Therapy services in addition to functional therapy and community services. They will enable services within the pathway to provide co-ordination of care to the most complex of clinical presentations such as people with Personality Disorders and more complex psychological needs.

The Trust acknowledges that there is a current deficit of psychological therapies for people suffering from a psychosis, although the recent appointment of a medical psychotherapist will enable an increase in consultation to community teams in general and particularly to those working with perplexing and complex presentations. It is likely that these will include those individuals suffering with a psychotic type illness. The district intends to address these remaining deficits in partnership with local commissioners within the development of the Care Management pathway which focuses on providing a range of interventions for people with a psychotic illness.

17.4.3 Recommendation

Recommendations 4:

In line with the recent developments in the provision and delivery of Psychological Therapies in the Trust, together with its commissioners, the Trust should review this provision to ensure that it complies with the recommendations of relevant NICE guidelines. In particular the Trust should ensure that those individuals with more serious, complex and enduring mental health problems have access to psychological interventions in a timely manner as recommended by the relevant NICE guidelines.

Having agreed appropriate standards with its commissioner the Trust should institute a regular cycle of audits to establish that, especially, those individuals with serious, complex and enduring mental health problems have appropriate access to Psychological Therapies.

17.4.4

- ***Contributory Factor 5: Mr. Y's continued misuse of alcohol was detrimental to his mental state and the recommended support, consultancy and training was not available to staff to help Mr. Y address this problem. It cannot be reasonably concluded, however, that this had a direct causal relationship with the events of 21 February 2008.***

17.4.5 Trust Service update

The Trust reports that, following joint work with the Kirklees Primary Care Trust and the Drug and Alcohol Action team for Kirklees, the Trust introduced a Dual Diagnosis service in Kirklees in late 2008, initially with the appointment of a Specialist Nurse. A part time Consultant Psychiatrist was appointed to the service in 2010. The Trust has identified the following progress in the delivery of this service:

- Assessment clinics, treatment planning and the provision of advice have been established;
- A Dual Diagnosis strategy is being developed;
- A training plan has been developed for Trust and Lifeline staff, training will be delivered jointly for the staff of the two organisations;
- Improved partnership working with Lifeline, including the development of an information sharing protocol, has been developed;
- Supervision and joint working of complex cases in the Trust, Lifeline and the Community Link Team has been established;
- The National Drug Treatment Monitoring System has been implemented and is being monitored;
- An operational policy has been put in place. This establishes clear, defined outcomes and a monitoring system;
- Sessions on alcohol and substance misuse issues are now included in the University based nurse training.

The Trust has identified the following work which needs to be undertaken or completed:

- The establishment of a workforce development plan;

- The development of care pathways between community drug and alcohol teams and mental health teams;
- Training for mental health staff in the assessment and clinical management of substance misuse;
- Further efforts to prevent drug misuse, including cannabis misuse, in people with a severe mental health problem;
- The prevention of drug misuse in in-patient units.

17.4.6 Recommendation

Recommendation 5:

The Trust has identified that progress has been made in the delivery of substance misuse services. It should now put in place a system, including an audit cycle, to assure itself and its commissioners that these developments are realising the intended and identified outcomes.

The Trust has identified a number of issues which need to be addressed. Together with its partner organisations the Trust should agree an action plan to address the issues it has identified and put in place a monitoring system to assure itself and its commissioners that the identified actions have been completed and the agreed goals realised.

An audit cycle should be put in place to ensure the ongoing improvements of this service.

17.5. Equality and Diversity

17.5.1

- ***Contributory Factor 6: While the role played by religion and religious beliefs was acknowledged by the clinical team, expert advice was not sought to help the team understand Mr. Y's background, or to help them differentiate normal, if different, beliefs from thinking that might be symptomatic of mental ill-health. Nor was a co-operative relationship sought with the local Jehovah's Witness Community, a relationship which might have informed clinical interventions. Had this been done, it is probable that Mr. Y's mental health would have been more sensitively and reliably monitored and his mental health needs addressed in a more timely fashion. This would have contributed, beneficially, to Mr. Y's mental health and well-being,***

although it cannot be concluded that it would have affected the events of 21 February 2008.

17.5.2 Trust service update

The Trust reports that it now has a Governance Framework for Equality and Inclusion in place which is supported by the following:

- Director and non Executive Director lead;
- Equality and Inclusion Strategy into Action Group;
- Equality and Inclusion Team;
- Single Equality Scheme;
- Improving People Strategy;
- Human Resources Strategy;
- Membership Strategy;
- Equality Impact Framework;
- The Trust is fully compliant with regards to Equality Impact Assessments on services and functions, and it is the Trust's policy that all current policies have an Equality Impact Assessments;
- Positive Action Traineeships (for which the Trust was runner up in the Healthcare People Management Association awards in June 2011);
- Exemplar Employer Framework - Mindful Employer and Two Tricks for Disability;
- Third Sector Partnership Strategy;
- Customer Experience Framework.

Although the legal aspects to equality and inclusion have been incorporated, the main driver for this agenda within the Trust has been service improvement and community empowerment, which fits with the indicators outlined in the Mental Health Strategy, the replacement for the National Service Framework. The Equality and Inclusion Strategy into Action Group and the Equality and Inclusion Team will support this agenda within the Trust.

The Equality and Inclusion Strategy into Action Group is an overarching group chaired by the Director of Corporate Development and attended by the Business Development Unit Directors and other key directors. This group links directly with the Executive Management Team, Clinical Governance and Clinical Safety Committee and the Trust Board. This group will ensure that the organisation is complaint with the Equality and Inclusion agenda at a

corporate and strategic level. It will also deal with any issues that might emerge from the Business Development Units and monitor any trends that might emerge across the Trust.

In addition the Trust has plans in place to develop the Equality and Inclusion agenda at a local level, focusing on the operational level of the organisation. The Local Action Groups are a sub-group of the corresponding Business Development Units (Barnsley, Calderdale, Kirklees, Wakefield and Forensic Services). Each of the local action groups will have their own set of Equality and Inclusion Key Performance Indicators that will be monitored through each Business Development performance framework.

The groups will support and co-ordinate equality, involvement and social inclusion initiatives locally and build on the strong existing local working relationships with Trust professionals, service users, carers and with partner agencies. The focus of the groups will be on the current equality strands of race, disability, gender, age, sexual orientation and religion and belief, and any new strands covered in the new Equality Act. They will also provide a steer for the local dialogue and focus groups and will ensure that the Trust meets its statutory responsibilities and Care Quality Commission Standards.

The Trust is planning its own version of the *Count Me In* survey to run in Autumn 2011. This will be based on the nine protected characteristics of the Equality Act. This will provide the Trust with a snapshot of the make-up of people who use its services from an equality perspective and will enable the Trust to identify any issues that might be emerging along care pathways and identify improvements resulting form the Trust's action planning.

The Trust is in the final stages of producing a strategy for spiritual and pastoral care. This includes a recommendation to provide training and awareness raising for staff in relation to providing care on spiritual and religious issues.

17.5.3 Recommendation

Recommendation 6:

South West Yorkshire Partnership NHS Foundation Trust should ensure that the aims of its Equality and Diversity policy are translated into practice in the clinical arena by:

- ensuring that cultural and religious issues are included in the assessment of need in a routine manner;

- ensuring that staff receive appropriate training to enable them to address cultural and religious issues as part of the assessment process;
- ensuring that staff receive appropriate and regular supervision in this area;
- undertaking regular audits to monitor the implementation of the Trust's Equality and Inclusion Strategy in clinical practice.

Recommendation 7:

South West Yorkshire Partnership NHS Foundation Trust should take action to ensure that the Spiritual and Pastoral Care Team, or another suitable resource, is available to raise awareness of cultural and religious issues within the clinical arena and that clinical staff have timely access to appropriate advice, consultation and supervision on these matters

17.6. Vulnerable Adults and Safeguarding

17.6.1

- ***Contributory Factor 7: The Trust and its partner organisations have a duty of care to those to whom they provide services. Part of that duty is to protect the individual from victimisation and exploitation as a result of their vulnerability. Mr. Y was recognised as being vulnerable and was the victim of exploitation. However the Trust's Safeguarding policies and procedures were not followed. As a result of the exploitation he experienced Mr. Y suffered significant financial disadvantage. Being the victim of exploitation also harmed his mental health and well-being. It would not be reasonable, however, to conclude that the failure to enact the Trust's Safeguarding procedures had a direct causal relationship with the events of the 21 February 2008.***

- ***Service Issue 4: The fact that Mr. Y was not formally identified as a vulnerable adult and that appropriate procedures were not followed is a service issues which has relevance beyond this immediate case. The Trust and its partner organisations have a duty of care to those to whom they provides services. Part of that duty is to protect the individual from victimisation and exploitation as a result of their vulnerability. Failing to implement the safeguarding policy is a failure to realise this duty of care and puts in jeopardy the individual's mental health and well-being.***

17.6.2 Trust service update

The Trust reports that the Safeguarding Vulnerable Adult's process is now supported and closely monitored within the Trust with robust links in place with Local Authority partners. The policy, procedures and protocols are regularly reviewed and updated in liaison with Local Authority partners and are available through the Trust intranet.

Safeguarding Vulnerable Adults training is available to all staff and a workbook to support this training has been developed. Attendance at the training is monitored. An e-learning package is now available.

Safeguarding Adults is now included in the induction for all staff, when the workbook is also given to new staff.

17.6.3. Recommendation

Recommendation 8:

The Trust should assure itself and its Local Authority partners that the Safeguarding policies and procedures which it has put in place and supported with training are being implemented. It should include audits of compliance with its Safeguarding policies in its regular audit cycle.

17.7. Service User Involvement in Care Planning

17.7.1

It is the conclusion of the Independent Investigation Team that the care and treatment offered to Mr. Y aimed at promoting his independence, self confidence and assertiveness. To this extent the care provided was user centred. However, in part because of the lack of formal care planning and in part because of Mr. Y's personal characteristics, those caring for Mr. Y found it difficult to engage him in planning his care and establishing his goals.

17.7.2 Trust service update

The Trust reports that service user involvement in care planning is an integral part of the way in which the Care Programme Approach is delivered. It is clearly identified in the Trust's

CPA policy and procedures and it is reinforced through the CPA and care co-ordination training.

The Trust has produced a CPA information leaflet which received a 'Highly Commended' award at the CPA Association national awards in 2011.

17.8. The Family

17.8 The Family

17.8.1

- ***Contributory Factor 8: Failing to involve Mr. Y's family in a formal and systematic manner in the assessment of his needs deprived the team caring for him of information which would have improved their understanding of his mental state, family background, sources of tension and coping strategies. Failing to involve them in the planning of his care reduced the probability that Mr. Y was given consistent advice and support and increased the probability that he received confused messages as to what was expected of him. This situation was detrimental to the putting in place of an effective and efficient package of care for Mr. Y. The absence of such a package of care was detrimental to Mr. Y's health and well-being.***

- ***Contributory Factor 9: Throughout the time he was under that care of the Trust Mr. Y's often ambivalent relationship with his family was identified as a factor contributing to his distress, to his mental health problems and to the coping mechanisms he adopted. Failing to address his difficulties in the context of these family dynamics and failing to provide family members with information on how best to support Mr. Y contributed to his mental health problems not being addressed in the most effective and timely manner possible.***

17.8.2 Trust service update

The Trust reports that the Kirklees Carer Support service now provides care co-ordinators with support to undertake the Carer's Assessment process. Care co-ordinators are able to contact the Carer Support staff for expert help and advice regarding carer issues where the

need arises. The Carer Support services currently provide training on the completion of the Carer's Assessment and general carer support issues to all community mental health teams.
A new ‘carer support navigation’ process has been developed within the Trust to assist in the development of support packages for carers. This includes supporting the carer in accessing a wide range of support services from 1:1 counselling to carer support groups and carer led activities.

The Carer Assessment documentation has been incorporated into the Trust's RiO system, together with the resulting carer support plan and the support plan review. This system provides evidence that a carer’s assessment has been completed for monitoring and audit purposes.

The Trust reports that it supports Psycho-Social Interventions (PSI) training and approaches. PSI training is providing within the Trust.

Secondary Care Psychological Services in Kirklees currently offer a range of therapeutic interventions for severe and complex non-psychotic presentations including specialist interventions for personality disorders such as Dialectic Behaviour Therapy (DBT), Schema Focused Cognitive Behavioural Therapies, longer term Psychoanalytic Psychotherapy and Systemic Family Therapy. Consultation to teams working with ‘difficult to treat’ individuals is also delivered.

17.8.3 Recommendation

Recommendation 9:

Access to appropriate family interventions should be available to services users under the care of the CMHT.
CMHT staff should receive training and supervision in appropriate family work and interventions.
The Trust should monitor the provision of this service, including using regular audits, to ensure that those individuals who might benefit from family interventions are able to access them in a timely fashion.

17.9. Communication and Co-ordination of Care

17.9.1

- ***Service Issue 5: Communication, both between teams within the Trust and between staff of the Trust and those working in other organisations, failed on a number of occasions. That no serious harm befell Mr. Y was fortuitous, however such weaknesses in the systems of communication place both service users and staff at risk.***

17.9.2 Trust service update

The Trust reports that its communication and care co-ordination have been improved in a number of ways over the last few years:

- The development of the RiO electronic clinical record system now ensures that information which is recorded on RiO is accessible to all clinicians involved in an individual's care;
- There is now one CPA process Trust-wide, across all CMHTs;
- The CPA policy clearly identifies the roles and responsibilities of care co-ordinators relating to a whole systems approach and effective communication with all individuals and agencies, which is further supported through planned reviews of care;
- This policy is supported by a CPA and care co-ordination training package;
- A CPA information leaflet is in place which has recently received a 'Highly Commended' award in the 2011 CPA Association national awards;
- Funding has been obtained to develop a CPA e-learning package which will include risk assessment and management as an integral part of CPA;
- Regular audits on record keeping are undertaken;
- There is a monthly Key Performance Indicator on the offer of care plans made available to service and team managers; monthly performance management reports are now available on the Trust's intranet for all managers of CMHTs which reports against individual case loads in relation to CPA good practice standards;
- An annual CPA audit is in place which alerts the Business Development Units to variations in performance;
- The next audit cycle has been further developed to include the quality of care plans.

17.9.3 Recommendation

Recommendation 10:

The PCT should put in place a system to ensure that there is timely communication between primary care and secondary care services. This should include:

- a mechanism to ensure that Secondary Services are informed, in a timely manner, who has clinical responsibility in Primary Care, for a service user where this person is different from the original referrer or when responsibility changes/is transferred;
- the requirement that information and/or advice from secondary mental health services is acted on in a timely manner and where it is not then the secondary services are informed so that the clinicians can make informed decisions about the service user's care;
- the requirement that this system should be audited within six moths of its implementation to ensure that it is working effectively.

17.9.4

- ***Service Issue 6: The responsibilities of the mental health services and the Housing Association were blurred, at times. It appears that there was an expectation that Housing Association staff would take on responsibilities that were proper to the mental health service. To have a confusion of boundaries and responsibilities is not good practice as it places both service users and staff at risk.***

17.9.5 Trust service update

The Trust reports that a shared agreement, *The Relationship between Secondary Mental Health Services and Supported Accommodation Providers 2010,* is now in place between the Trust (Kirklees District) and its partner organisations (Kirklees MC and Housing) to define the relationship and expectations of each in terms of supported accommodation related care planning. This clarifies roles and responsibilities of services and the communication and support needed between them in order to provide the best care to service users. It operates in line with the Trust's multi agency Information Sharing protocol.

In addition to this agreement two further protocols are in draft:

- 2011 Information sharing protocol between Kirklees Neighbourhood Housing and the Trust - the aim of this protocol is to avoid legal proceedings where possible by ensuring that support is available as early as possible.
- 2011 Acute Pathway development - this identifies that accommodation issues will be flagged up on admission to in-patient mental health service.

17.9.6 Recommendation

Recommendation 11:

Given that new protocols have now been put in place the local Housing Associations, the Trust and the commissioners of mental health services should institute a monitoring system to ensure that:

- the proper roles and responsibilities of these organisation are adhered to;
- the protocol for sharing information is adhered to;
- staff are properly trained and supported to carry out their agreed roles;
- there is a clear mechanism for identifying unmet need.

17.10. Management of Mr. Y's Care

17.10.1

- ***Contributory Factor 10: Following Psychiatrist 1 discontinuing Mr. Y's antipsychotic medication, the mechanism he believed to be in place to monitor Mr. Y's mental state was absent for a significant period of time. When it was noted that Mr. Y's mental state had deteriorated, although immediate support was provided, no multi-disciplinary assessment of Mr. Y's needs and risk was undertaken. Consequently, his care plan was not reviewed or revised.***

  It cannot, reasonably, be concluded that if these actions had been undertaken the events of 21 February 2008 would not have taken place. However it is reasonable to assume that the absence of appropriate assessment and the consequent failure to review Mr. Y's care plan contributed to the deterioration of his mental health.

- ***Service Issue 7: The CMHT operational policy identified the importance of ensuring continuity of care. This aspect of the policy does not appear to have been adhered to. There appears to have been no policy in place at the time Mr. Y was receiving care from the Trust to ensure that service users remained in contact with the service. Indeed there was one incident when the approach taken by staff made it difficult for Mr. Y's family to ensure that he received the care that they believed that he needed.***

- ***Service Issue 8: Despite the role of the care co-ordinator being identified in both the Trust's CPA policy and the CMHT's operational policy, this did not appear to inform the choice of the care co-ordinator for Mr. Y, nor ensure that his need for care co-ordination was regularly reviewed. Given the central importance of the CPA and care co-ordination, this raises the issue of how adequately Trust policies are implemented.***

17.10.2 Trust Service update

The Trust reports that the following policies are now in place to improve care management and ensure effective continuity of care for service users both at points of transfer of care and when under the care of one clinical team for a prolonged period of time:

- The CPA policy, 2010;
- The risk assessment, management and training policy;
- The discharge policy 2010 includes good practice standards around the transfer of care.

Glossary

Appointeeship	The Department of Work and Pensions can appoint someone to receive a client's benefits and to use that money to pay expenses such as household bills, food, personal items and residential accommodation charges. An appointee should be someone who is regularly in contact with the client and could be a close relative or friend. When a client has no one who can take on this responsibility, it is possible in certain circumstances for an officer of the Council to become an appointee.
Appropriate Adult	The Appropriate Adult role was created by the Police and Criminal Evidence Act (PACE) 1984, with the intention of safeguarding the rights and welfare of young people and vulnerable adults in custody.
Antabuse	Antabuse (Disulfiram) is a medication prescribed to help people stop drinking alcohol. It interferes with the metabolism of alcohol resulting in unpleasant effects when alcohol is consumed.
Aripiprazole	Aripiprazole is an anti-psychotic medication used to treat the symptoms of schizophrenia and other psychoses. It is also sometimes used with an anti-depressant to treat depression when symptoms cannot be controlled by the antidepressant alone. Aripiprazole is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.

Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.
CBT	Cognitive Behavioural Therapy (CBT) is a talking psychological therapy that aims to help people solve emotional, behavioural and cognitive problems. CBT employs behavioural and cognitive techniques. It is goal-oriented and uses a systematic, structured procedure.
Citalopram	Citalopram is an anti-depressant medication. It belongs to the class of anti-depressant known as Selective Serotonin Re-uptake Inhibitors (SSRIs). It works by increasing the amount of serotonin in the brain.
Fluoxetine	Fluoxetine is an anti-depressant medication of the Selective Serotonin Re-uptake Inhibitor (SSRI) type. It works by increasing the amount of serotonin in the brain.
Mental Health Act (1983)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition
NICE	The National Institute for Health and Clinical Excellence, known as NICE, is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
Olanzapine	Olanzapine is an anti-psychotic medication used to treat the symptoms of schizophrenia and other psychoses. It belongs to a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts.

PRN	The term "PRN" is a shortened form of the Latin phrase *pro re nata*, which translates roughly as "as the thing is needed". PRN, therefore, means a medication that should be taken only as needed.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Quetiapine	Quetiapine is an anti-psychotic medication used to treat the symptoms of schizophrenia and other psychoses. It belongs to a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain.
Risk assessment	An assessment that systematically details a persons risk to both themselves and to others.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
Venlafaxine	Venlafaxine is an anti depressant drug which becomes effective within two to four weeks of commencement.
Zispin	Zispin (Mirtazapine) is an anti-depressant medication. It works by increasing the availability of noradrenalin and serotonin in the brain.

Appendix 1: Timeline Mr. Y

Date	Event
15.3.82	Date of Birth.
17.05.04	Mr. Y.'s father is referred to Carers Support Services via self-help group Batley.
18.05.04	Father meets carer support staff and was signposted to Mental Health Services via GP.
28.5.04	Referral from GP: Urgent; Severe depressive, suicidal thoughts, anxiousness; Elements of Jehovah Witness teaching making maters worse. Referral received: 8.06.04. Note of Appt 21.6.04.
21.06.04	OP appt. Seen by Staff Grade Psychiatrist Depressed since 11; Anxious about upsetting people; If does something father dislikes he will shout and read from the Bible "Being at Kingdom hall is a kind of abuse of the mind." Thoughts of suicide but doesn't want to upset people; No perceptual abnormalities. Medication: Venlafaxine 75mg To be assessed for psychotherapy. Education history: After school: Health studies for 5 months Catering for 7 months Plumbing. Letter to GP: 22.06.04 Impression: Depressed as a result of living situation; under pressure from father who he wants to please, mainly related to father's religious beliefs. Wants to escape the situation but does not want to displease father. Low self esteem, no assertiveness, anxious. Discussed self-esteem, anxiety management and assertiveness groups. Mr. Y could not face group situation. Discussed referral to CMHT. Mr. Y wants time to think about these options

2.07.04	Seen for assessment by Staff Grade and Psychiatrist 1. Appeared anxious. Reported that he had been depressed for a long time. When asked about relationship with father: "There is a distance between us." It seems to be difficult for Mr. Y to express his feelings or what is going on in his mind. Psychiatrist 1 explained that Mr. Y should not label himself as someone suffering from a psychiatric illness. Mr. Y has a lot of emotional problems. Psychiatrist 1 to see Mr. Y on a weekly basis to assess suitability for psychotherapy. Letter to GP.
19.07.04	Referred by police: Assessed by CRHTT 2 phone calls by Mr. Y's parents saying Mr. Y was arguing with brother and using abusive language which is unusual. Mr. Y's father called the police because Mr. Y left family home and threw stones. Conflict with family members. Low mood but no thoughts of self harm. Placed in temporary accommodation.
19.07.04	HoNOS: Overactive/aggressive = 2 Suicidal = 0 Self harm = 0 Drinking = 0 Cognitive problems = 0 Physical illness = 0 Hallucinations = 0 Unreasonable beliefs = 0 Depressed mood = 2 Relationships = 1 ADL = 2 Living Conditions = n/a Occupation/activity = n/a Engagement = 0 Vulnerability = 1
19.07.04	Mr. Y's mother advised by CRHTT to discuss her concerns with Psychiatrist 1. Copy of Crisis team assessment given to Psychiatrist 1.
19.07.04	Psychiatrist 1 tells Mr. Y's mother that as he is assessing Mr. Y for psychotherapy it is not useful to hear her version of events. Advised her to talk to the other psychiatrist in the team and gives her the number of carers' support service.
19.07.04	Psychiatrist 1 speaks to Kirklees Council. Mr. Y is homeless. They have spoken to Mr. Y's mother and are concerned about vulnerability and aggression. Psychiatrist 1 shares HoNOS scores and said that he felt the risks were low.

19.07.04	Mr. Y's father called the help line. He was upset that the Homeless Person's unit would not give him Mr. Y's address on the basis of confidentiality.
28.07.04	Appt letter from Early Intervention CPN to do home visit on 23.08.04.
9.08.04	DNA: Psychiatrist 1.
25.08.04	Home visit. Homeless after an argument at home when police called.
26/27.08.04	Arrested and spent some time in police cells. ? Drunk.
27.08.04	Referral sheet (Early Intervention Service). Been seen by Psychiatrist 1 for 6 weeks. No evidence of psychosis disclosed. Requesting assessment to exclude psychosis.
27.08.04	Early Intervention CPN met Mr. Y at 8.30 a.m. in Dewsbury. He had just been let out of cells. Charge sheet said: "Behaviour which might cause distress to others." Fined £80. Completed Supported Housing application form. Ideas of reference; Delusional thinking; Thinks he has a mission to complete but vague about what it is or when it will happen.
28.08.04	No Fixed Abode - as a result of fighting. Early Intervention CPN located Mr. Y at the Little Saddle. Stayed with him for 2 hrs in a café. • Ideas of reference; • delusional thinking; • suicidal ideation/better off dead/said he may try (to commit suicide) again; • low mood; • low self esteem; • low confidence; • suspicious; • struggling with faith (Jehovah's Witness); • suspicious of CPN. "Continuously says I have something up my sleeve"; • "[Mr. Y] is possibly experiencing psychosis." Plan • Contact Psychiatrist 1 re: admission as Mr. Y expressing wish to die; • To continue to see Early Intervention CPN; • To look at housing urgently as Little Saddle is "Totally unsuitable."

1.09.04	Phone call from Mr. Y's mother. Mr. Y had tried to hang himself with a belt on the day before. Early Intervention CPN went to Little Saddle to find Mr. Y. Assessed: Suicidal, ideas of reference, hallucinations. Mr. Y thinks he might have some influence over the Russian hostages. Admitted to ward 18 at 19.30. Had been arrested for "behaviour causing distress". Got into an argument at the Principle pub with men who thought he was laughing at them. Spent the night in police cell. Returned home and had argument with parents over his behaviour. Asked to leave family home and found accommodation at the Little Saddle. This was not thought to be suitable accommodation. Suspicious behaviour, paranoid thoughts and 3 suicide attempts.
1.09.04	HoNOS: Overactive/aggressive = 3 Suicidal = 4 Self harm = 0 Drinking = 3 Cognitive problems = 0 Physical illness = 0 Hallucinations = 3 Unreasonable beliefs = 3 Depressed mood = 4 Relationships = 3 ADL = 2 Living Conditions = 4 Occupation/activity = 4 Engagement = 0 Vulnerability = 4
3.09.04	Early Intervention CPN visited Mr. Y on the ward. Plan to prescribe psychotropic medication next week. Mr. Y tells Early Intervention CPN that he heard muffled voices last night and feels he is part of a conspiracy. Feels he has a mission and has an influence on what is happening in Russia.
4.09.04	Mr. Y missing from ward. Police and CHTT informed. Mr. Y returned soon after this was done.
6.09.04	Early Intervention CPN visited Mr. Y on ward. Had interview for Supported Housing. Talking about a Mission.
6.09.04	Letter from Early Intervention CPN to Supported Housing supporting Mr. Y application. Assessment on going but noted : Ideas of reference, paranoia, hallucinations. Mr. Y had lost his job, family relations had broken down and he was homeless.

7.09.04	Letter to Support Housing from Psychiatrist 1. Mr. Y is low and angry and possibly in prodromal phase of "a psychiatric illness".
7.09.04	Ward Round with Ward Consultant Psychiatrist: • Giggly, Drug screen was negative; • "Muddle voices"; • Had been a meeting at Supported Housing Re: accommodation; • Talking of suicide. Society would benefit. Diagnosis: Psychosis. Medication: Stop Venlafaxine. Observation level: II (reduced).
9.09.04	Mr. Y accepted for Supported Housing. Early Intervention CPN noted that Mr. Y is tired after being prescribed Quitiapine.
9.09.04	Late back on to the ward. Mr. Y had had 3 pints of beer. Smelt of alcohol and was banging his head gently on the wall. Said he felt angry and suicidal. "Aimed his anger verbally towards [Nursing Assistant] as she was the one who pointed out that he was late back. Stated that she was a 'bitch' and if he came across her and her partner whist out he would 'give him a good kicking.'" Verbally aggressive to staff after returning from the pub.
10.01.04	Nursing notes: "Making impulsive dashes to run off the ward. Same closed." Mr. Y was saying that he wishes to commit suicide at this time.
11.09.04	On call duty SHO was asked to see Mr. Y. He wanted to leave the ward to go to the pub. Level of Observations increased day before to level III. Staff concerned about going out with him. Concerned about harm to self and to others. SHO discussed what had happened the day before: Mr. Y was involved in an altercation when he returned to the ward after going to the pub and having "a few pints". Advised Mr. Y to stay on the ward over the week-end and review on Monday. Mr. Y agrees "happily" to remain on the ward. Mr. Y polite and pleasant to the SHO. Nursing notes: Mr. Y tries to push past staff to leave the ward saying he wanted to go to the pub. He appeared suspicious and guarded. Staff were concerned for his safety when off the ward. Mr. Y's parents inform staff that he has been abusive towards them during the visit for no apparent reason.

	Mr. Y says that that his parents have always treated him like a child. "Spoke about his escaping from the unit. He is adamant that he would do so as being here is doing him no good."
13.09.04	Early Intervention CPN takes Mr. Y to visit Supported Housing. Mr. Y reports that he hears a female voice that he cannot make out. He also has a message to deliver to the world about happiness. He had stopped taking his medication. Mr. Y reports that alcohol takes away the confusion. Mr. Y continued to laugh inappropriately to himself. Mr. Y's mother and Early Intervention CPN say (some) of this is a nervous laugh.
14.09.04	Ward round: Ward Consultant Psychiatrist; Nursing staff report Mr. Y remains paranoid. Tells people he is hiding his tablets. Report of being verbally aggressive to staff on Friday after going out to the pub. Looks drowsy. Self report: feels worse: "My mind is all over the place." Poor memory. Plan: Stop Quitiapine; Start Olanzapine; PRN Haloperidol.
15.09.04	HoNOS: Overactive/aggressive = 2 Suicidal = 3 Self harm = 0 Drinking = 0 Cognitive problems = 0 Physical illness = 0 Hallucinations = 3 Unreasonable beliefs = 2 Depressed mood = 2 Relationships = 2 ADL = 0 Living Conditions = 1 Occupation/activity = 2 Engagement = 2 Vulnerability = 3
17.09.04	Early Intervention CPN visited Mr. Y on ward. He was not taking his medication.
17.09.04	Parents split up. Nursing note that Mr. Y did not appear to be "unduly upset" at the news. Not taking medication.
20.09.04	Early Intervention CPN visits on ward. Mr. Y prescribed Olanzapine.
20.9.04	Ward round: Ward Consultant Psychiatrist:

	Feels staff know about him. Hearing voices. Diagnosis: paranoid psychosis.
23.09.04	Mr. Y's mother informs nursing staff that he is upset following a phone call with her. Mr. Y reports that he is upset because he feels guilty. He feels that he is making his mother ill because of her worrying about him.
23.09.04	Ward round: Psychiatrist 1: Improving, going out- no problem. Parents getting divorced. (This was inaccurate as Mr. Y's parents' religion did not permit divorce) Continue with same plan.
24.09.04	Early Intervention CPN visits on ward. Mr. Y speaks of "Life is a living hell" and wanting to end it all. Spoke of being torture by hell fire. Nursing note: Care Plan and assessment have been completed.
25.09.04	HoNOS: Overactive/aggressive = 1 Self harm = 2 Drinking = 0 Cognitive problems = 0 Physical illness = 0 Hallucinations = 2 Unreasonable beliefs = 2 Depressed mood = 2 Relationships = 2 ADL = 0 Living Conditions = 1 Occupation/activity = 2 Engagement = 2 Vulnerability = 2
28.09.04	Ward round: Ward Consultant Psychiatrist: Mr. Y doing well. Mr. Y went out with his mother: Didn't go well. Wants to leave. No voices but sees ghosts some times. Plan: Day leave.
28.09.04	Early Intervention CPN attends ward round then takes Mr. Y off ward shopping. Early Intervention CPN informs ward staff that week-end leave to parents had not gone well. Mr. Y had bee saying that life was not worth living.
29.09.04	Early Intervention CPN visits Mr. Y on ward and introduces Early Intervention Worker who will also work with him.
1.10.2004	CRHTT assess Mr. Y. "It will not be therapeutically beneficial to detain him on the ward if he wants to leave." CRHTT offer to support Mr. Y either while he is on leave or on discharge. Tried to contact Early Intervention CPN but she is not working until

	Monday
1.10.04	Early Intervention Worker collected Mr. Y from ward and took him to a music group. Mr. Y asked if could come again. Told Early Intervention Worker that he would be discharged on Monday (4.10.04).
1.10.04	Discharged. Nursing notes: 16.00 "For discharge to-day…. (*Can't read*) following ward round. Mr. Y will come to the ward at to collect his medication at 6.30."
3.10.04	Ward round: Ward Consultant Psychiatrist: Mr. Y had said he would jump on rail line. But now says it was a "slip of the tongue". No paranoia; no voices.
4.10.04	Early Intervention CPN discovers that Mr. Y has been discharged. She spoke to ward staff and crisis team to discover who had made the decision. There was no record of a decision to discharge in the medical notes. Obtained an agreement that a mistake had been made and Mr. Y was re-admitted.
4.10.04	Entry by SHO: Mr. Y discharged 1.10.04. Early Intervention CPN concerned that he was depressed, anxious, agitated and suicidal. Re-admitted. Plan: Informal admission to monitor mental health in a safe environment. Monitor compliance with medication. Olazapine 15 mg.
4.10.04	Depressed and suicidal, agitated and anxious. Re-admitted. Nursing notes: Discharged on Friday as planned at ward round. Mr. Y had deteriorated over the week-end and had drunk alcohol "excessively". Bizarre behaviour and expressing wish to self harm.
4.10.04	HoNOS: Overactive/aggressive = 2 Suicidal = 2 Self harm = 0 Drinking = 2 Cognitive problems = 0 Physical illness = 0 Hallucinations = 0 Unreasonable beliefs = 2 Depressed mood = 2 Relationships = 3 ADL = 1 Living Conditions = 2 Occupation/activity = 2 Engagement = 2 Vulnerability = 2

4.10.04	Housing Support Worker 1 and Early Intervention CPN discuss Mr. Y's discharge. This had been discussed with neither of them. Housing Support Worker 1 intends to send a letter of complaint to ward manager. Phoned ward manager to complain. Said she was aware and was planning weekly meeting/discharge meeting to which Supported Housing would be invited. Mr. Y had been to the pub over week-end, room smelt of alcohol and there were 8 cans of larger in his fridge.
5.10.04	Housing Support Worker 1 speaks to the nursing manager about Mr. Y's discharge and lack of consultation. Mr. Y had spent the week-end unsupported, suicidal and drinking. He said the nursing notes for 30th had described Mr. Y as "Settled". Housing Support Worker 1 questioned this as she had been informed that on the 29.09.2004 Mr. Y had been described as delusional and having hallucinations. Manager to speak to Charge Nurse and call back.
5.10.04	Early Intervention CPN visits Mr. Y and takes him shopping. He is very confused.
5.10.04	Ward round: Ward Consultant Psychiatrist: Mr. Y reports feel better. No voices, no paranoia, no suicidal thoughts. Wants to leave and promises to take medication. A few days previously Mr. Y had threatened to jump in front of a train. He now says he cannot recall this and it was a "slip of the tongue". Plan: Staff Nurse to discuss sexual issues; Time off ward at nurses discretion; Medication: Unchanged. Nursing notes: Mr. Y says that he does not experience hallucinations but pictures people and things in "environmental areas". Discharged from CRHTT.
6.10.04	Mr. Y's mother expresses concern to ward staff that Mr. Y might be discharged again before he is ready. She believes that he is a suicide risk
7.10.04	Early Intervention CPN visited Mr. Y on ward. Reported feeling very guilty about masturbating. Early Intervention CPN recommends a male key worker on the ward. Mr. Y admits that he does not tell ward staff things. Nursing notes: Mr. Y says he hears a patient's voice telling him to "get up". He was unsure if this was a hallucination.
8.10.04	Early Intervention Worker picks Mr. Y and takes him to the music group. Reports he is frustrated on the ward as he is not being allowed off the ward.

11.10.04	Ward round: Ward Consultant Psychiatrist: • No hallucinations; • No ideas of self harm.
13.10.04	Early Intervention CPN contacted ward to discover what was decided at ward round. Attended but Mr. Y not been discussed by time she had to leave. Mr. Y spent Sunday with his mother. Report it went well. Allowed off ward for 2 hours. Early Intervention CPN took Mr. Y to sports centre. "I have seen his family this evening 5.30 pm for family therapy/interventions left house 7.40 pm.
13.10.04	Letter: Early Intervention CPN to GP informing him that: Mr. Y had been placed on her case load; He is experiencing psychotic symptoms; On the Priestly unit after trying to hang himself; Will work with him post discharge on: Occupation and education
18.10.04	Early Intervention CPN took Mr. Y to? Garage. Will be making referrals to groups. Mr. Y "very low in mood".
18.10.04	HoNOS: Overactive/aggressive = 2 Suicidal = 1-2 Self harm = 0 Drinking = 1 Cognitive problems = 0 Physical illness = 0 Hallucinations = 2 Unreasonable beliefs = 2 Depressed mood = 1 Relationships = 1 ADL = 0 Living Conditions = 1 Occupation/activity = 2 Engagement = 2 Vulnerability = 2
19.10.04	Ward round: Ward Consultant Psychiatrist: • Coping reasonably well; • No thought of self harm; • Week-end leave to Supported Housing; • Stop Velotab.
20.10.04	Housing Support Worker 1 accompanied Mr. Y to apply for housing benefit.
20.10.04	Ward nursing staff inform Supported Housing of Professionals Meeting.

22.10.04	Mr. Y's mother contacted Early Intervention CPN. Mr. Y is homesick. She asked Early Intervention CPN's opinion about Mr. Y coming to live with her (mother). Early Intervention CPN felt that this would be detrimental to her and to Mr. Y.
26.10.04	Ward round: Ward Consultant Psychiatrist: Depressed; suicidal thoughts; Not hearing voices. Mr. Y doesn't think he is well enough to be discharged.
26.10.04	Ward round: Ward Consultant Psychiatrist: Mr. Y: no voices, no suicidal thoughts, still feels depressed and anxious. Does not feel ready for discharge.
30.10.04	Mr. Y's mother contacts the ward concerned about Mr. Y's "dietary intake".
2.11.04	Ward round: Ward Consultant Psychiatrist: Supported Housing staff report that Mr. Y's confidence is low and he does not mix with staff. Mr. Y feels he has broken religious rules having masturbated. Denied paranoid thought. Plan: Leave at Supported Housing.
2.11.04	Ward round: Ward Consultant Psychiatrist: Staff from Supported Housing attended. No voices reported. Mr. Y says Olanzapine is helping. Not plans for self harm. More overnight leave at Supported Housing.
5.11.04	"Nursing notes: assessed for timely discharge" by CHTT.
6.11.04	Ward round: Ward Consultant Psychiatrist: No thoughts of self harm; No voices. Plan: Discharge when Supported Housing agrees.
7.11.04	Phone call from CRHTT saying that they are concerned about Mr. Y's presentation: suicidal and depressed mood. To be discussed at ward round. Early Intervention CPN does not feel that Mr. Y needs CRHTT support.
9.11.04	Ward round: Ward Consultant Psychiatrist: No voices, no thoughts of self harm. Mr. Y reports feeling better. Leave to continue.

11.11.04	Planned overnight leave at Supported Housing.
12.11.04	Mr. Y requested week-end leave at Supported Housing. Granted.
15.11.04	Early Intervention CPN visited Mr. Y on ward. Mr. Y reported that leave went well. Looking forward to discharge.
16.11.04	Ward round: Leave at Supported Housing went well; Doing well; Mood 7/10. Granted leave until Friday.
16.11.04	Ward Round: Ward Consultant Psychiatrist: Mr. Y: mood 7/10. No suicidal ideas. Mr. Y wants to be discharged.
19.11.04	Discharged: Reporting no symptoms. Fit to be discharged. Diagnosis: paranoid psychosis. Risk to others: None; Risk to self: minimal.
19.10.04	Ward staff inform Supported Housing about discharge.
22.11.04	Early Intervention CPN took Mr. Y to a garden centre. He wanted to look at Christmas tree. Sad that Jehovah's Witnesses do not celebrate Christmas.
24.11.04	Mr. Y did not attending Day Centre as planned. Early Intervention Worker also called on Mr. Y.
26.11.04	Early Intervention Worker telephone call. Mr. Y does not want to attend music group.
29.11.04	Missed planned appointment with Early Intervention Worker. Gone to Scarborough.
6.12.04	Early Intervention Worker took Mr. Y for a walk. Discussed engaging in day time activities.
7.12.04	Home visit: In room drinking and smoking. Refusing to go to day centre. Wants to return to hospital. Said he felt depressed. No clinical depression evident.
8.12.04	Early Intervention CPN called to take Mr. Y to sports centre. He was 45 minutes late and admitted avoiding her as he did not want to go to centre.
10.12.04	Early Intervention Worker telephone and Mr. Y said he wanted to go to group. Early Intervention Worker called for him and he said he did not want to go.
13.12.04	Early Intervention Worker took Mr. Y out. Looked at Christmas shopping. Mr. Y said he intended to go to the sports group on Wednesday.
15.12.04	Early Intervention Worker phoned and Mr. Y attended sports group. Discussed joining a week-end team.

	Early Intervention CPN discussed plan for inquiring about a part time job at Tesco's the following week. Seemed ready to make plans for the future. Discussed Mr. Y lending money. Mr. Y "was adamant it was going to continue."
18.12.04	Assessed by Crisis team. Declines admission. Reporting overvalued idea/delusions. Concerned about plumbing work he had done c. 13 months earlier. Had thoughts of hanging himself but will not act on these. Given Lorazapam. Has Citralopram and Olanzapine. To be re-assessed next day by crisis team.
18.12.04	Supported Housing contact CRHTT to ask about Mr. Y's mental health assessment. He has fix paranoid delusions ideas. Asked if Mr. Y was sectionable under the Mental Health Act. CRHTT thought not. Supported Housing felt that measures need to be put in place by CRHTT to support Mr. Y.
20.12.04	CRHTT contact Early Intervention CPN to inform her that Mr. Y contacted CRHTT. Worried he had not fitted gas right and someone might be blown up. Been contacting Transco (Gas Co). Given Lorazepam. Mr. Y refused admission. Early Intervention CPN visited Mr. Y. He had been contacting ex-employer and pipe manufacturer. Early Intervention CPN challenged his beliefs but Mr. Y could not accept this. Early Intervention Worker took Mr. Y shopping for clothes but this did not distract from his worries. Mr. Y reports he has no thoughts of suicide.
20.12.04	HoNOS: Overactive/aggressive = 0 Suicidal = 2 Self harm = 0 Drinking = 0 Cognitive problems = 0 Physical illness = 0 Hallucinations = 0 Unreasonable beliefs = 0 Depressed mood = 2 Relationships = 3 ADL = 2 Living Conditions = 0 Occupation/activity = 3 Engagement = 0 Vulnerability = 4
20.12.04	Mr. Y is asked by housing support staff about concerns about pipe fittings/gas leaks. He is very worried and has continued to phone his old manger. He has also contacted the manufacturers. Early Intervention CPN feels that Mr. Y is trying to cause "Chaos and mayhem to get attention". Early Intervention CPN stated that Mr. Y could be showing signs of Personality Disorder". Supported Housing staff felt that Mr. Y was showing distress about pipe fittings and his

	ideas were fixed. He was also expressing suicidal ideas
29.12.04	Early Intervention Worker visited. Mr. Y did not answer his door. Staff did not know he was in his room on Christmas day until they were leaving. The Housing Support staff did not have any concerns about Mr. Y.
4.01.05	Early Intervention Worker calls to tell Mr. Y there is a sports group the next day. He has spent the night at his parents.
5.01.05	Mr. Y did not attend the sports group.
7.01.05	Telephone call. Supported Housing staff report that Mr. Y has been ring his mother and CRHTT saying he is going to hang himself. CRHTT advised Mr. Y to talk to other tenants and get some sleep. Housing Support Worker 1 feels it could be related to rent/savings and DHSS rules. Advised to speak to staff daily at 9.30. Mr. Y says he feels alone all of the time. Advised not to isolate himself. Housing Support Worker 2 reported that Mr. Y had: "no other thoughts of self harm or thought through the process of how he was going to hang himself." Early Intervention CPN visited but Mr. Y at his parents. Made phone call but Mr. Y said it was difficult to speak. Arranged a meeting for Monday.
7.01.05	Mr. Y had informed other tenants that he was going to hang himself. Supported Housing informed CMHT.
13.01.05	Notice to "seek possession" of his room from Housing Association.

21.01.05	Mr. Y had presented to A&E at 20.40 saying he would hang himself with belt. Father had phoned at 19.20. He reported Mr. Y had put belt round neck and attached it to door handle at home in the presence of his father.
	• While in A&E put belt round neck and hit head on wall.
	• Psychosis and suicidal ideation.
	• Mr. Y reported:
	  • He was in pain;
	  • No enjoyment;
	  • Might explode;
	  • Unhappy;
	  • Frustrated and angry;
	  • Staying with parents since Christmas.
	Asked if he wanted to die: "No I want to live a normal life."
	Mr. Y banged his head on the door.
	
	• "Some confusion surrounding diagnosis and management."

	• Historical conflict with parents and siblings. • Currently no problems with alcohol reported. Admitted to hospital.
21.01.05	HoNOS: Overactive/aggressive = 1 Suicidal = 0 Self harm = 2 Drinking = 0 Cognitive problems = 0 Physical illness = 0 Hallucinations = 0 Unreasonable beliefs = 0 Depressed mood = 2-3 Relationships = 2-3 ADL = 2 Living Conditions = 0 Occupation/activity = 0 Engagement = 0 Vulnerability = 0. Slightly different scores on p. 401 Overactive/aggressive = 2 Suicidal = 2 Self harm = 2 Drinking = 0 Cognitive problems = 0 Physical illness = 2 Hallucinations = 0 Unreasonable beliefs = 2 Depressed mood = 3 Relationships = 3 ADL = 2 Living Conditions = 3 Occupation/activity = 2 Engagement = 2 Vulnerability = 3.
22.01.05	Mr. Y says he did not feel safe at home. However he intended to return to his parent's home rather than to Supported Housing.
23.01.05	Mr. Y informs nurse, on questioning, that he put a belt around his neck at his parent's home "so that the hospital staff would take him seriously as he did not think he could relay this verbally." Denies auditory hallucinations. Given BDI - scored 18.

24.01.05	Phone call from Supported Housing to report that Mr. Y was not engaging. Supported Housing Worker 2 had seen Mr. Y on Friday and discussed this with him. Told him: • it was important that staff could monitor his mental health; • He might have to pay more rent as DSS have discovered that he has transferred money to another account. His mother has written to say he has given the money to the Church; • Mr. Y said he liked his room and the associated freedom; • Also liked it at home but it was too strict; • He spoke of moving back to his parents' home. Supported Housing staff had not been informed that Mr. Y had been admitted.
24.01.05	Early Intervention CPN visited Mr. Y on ward. Tells her he has no intention of harming himself.
25.01.05	Mr. Y key nurse records that she has completed first part of suicide risk assessment: indicated low risk. Mr. Y wanted to be discharged. Persuaded to speak to the doctor and attend Ward Round. Ward staff spoke to Supported Housing. Provided an update and invited to them to ward round. Supported Housing call back - all staff on training and not able to attend Ward round.
25.01.05	Mr. Y bangs his head against wall when parents visit him after being refuses PRN Lorazipam. Had been explained that he appeared over sedated.
25.01.05	HoNOS: Overactive/aggressive = 2 Suicidal = 1 Self harm = 2 Drinking = 0 Cognitive problems = 0 Physical illness = 1 Hallucinations = 0 Unreasonable beliefs = 1 Depressed mood = 2 Relationships = 3 ADL = 1 Living Conditions = 1 Occupation/activity =1 Engagement = 2 Vulnerability = 2

25.01.04	Ward review. Mr. Y more settled. Prior to admission was having constant thoughts of suicide. Attempted to take his life by trying string around his neck. Regrets this. Say it was a cry for help. Wants to live with his parents. Denies voices or thoughts of self harm. Requests over night leave but is happy to stay.
25.01.05	Supported Housing discuss Mr. Y with Early Intervention CPN. Mr. Y is not engaging with staff of supported housing or mental health staff. Early Intervention CPN says she thinks Mr. Y may have BPD. Housing staff say it is not their job to make a diagnosis. Mr. Y wanted to be at both Supported Housing and at his parents. He did not know what he wanted.
26.01.05	Ward round: Ward Consultant Psychiatrist: • No evidence of psychosis; • Does not want to move on with life/no motivation; • Mr. Y reports feeling low and depressed; • No psychotic symptoms; • Medication; Reduce and stop: Olanzapine. Nursing note: Early Intervention CPN reported that every time she discusses employment Mr. Y threatens to kill himself. "Diagnosis discussed/. BPD? any psychosis or depression." Reported that father has said that if Mr. Y's behaviour continues he does not want him home. Professionals' meeting booked. Carers Support referral form completed.
26.01.05	Early Intervention CPN attended Ward round. Mr. Y saying he wanted to attend day centre "despite refusing to go before." Early Intervention CPN to accompany him.
27.01.05	Risk assessment completed: Rated Low.
28.01.05	Supported Housing staff confirm that they will attend review.
31.01.05	Supported Housing call to say unable to attend case conference but it appears that Housing Support Worker 2 does attend. Professionals meeting: Diagnosis "not one of depression any more"; Recommence psychotherapy with Psychiatrist 1; Encourage Mr. Y to stay at Supported Housing while he decides his longer term future; Risk of self harm low as he always informs people of his intentions. Prior to meeting Early Intervention CPN met Mr. Y he was feeling better and filled in an application form for a job at McDonalds. Nursing note: Early Intervention CPN reported that Mr. Y "sabotages" attempts to return him to work and will not attend the day centre.

	Psychiatrist 1 suggests a diagnosis of "psychological problems with an element of depression rather than psychotic illness." Early Intervention CPN to discuss with mother that the Supported Housing is a comprehensive service and Mr. Y must engage with it to promote his independence.
31.01.05	Housing support worker recorded that they had attended ward round and that Mr. Y's diagnosis had been changed from depression to Personality Disorder.
31.01.05	Care plan: Admitted to Ward 21.01.05; Evidence of psychosis and suicidal ideation; Mr. Y had refused day services preferring to get a job; He had presented at A&E and crisis team with a belt around his neck; Mr. Y has had periods of leave from the ward and stayed with parents; "There is some confusion over diagnosis and management"; Independent "normal life style would be beneficial"; Discharge needs to be planned for. Plan: • Resume psychotherapy with Psychiatrist 1; • Review medications; • Get advice re: housing arrears; • Plan for discharge as soon as possible; • Continue to see Early Intervention CPN; • OPD involvement. Contingency Plan: "Inform: [Early Intervention CPN; Contact Psychiatrist 1; Contact CRHTT. Aim to maintain in the community."
31.01.05	Phone call from Mr. Y's mother (18.55). He had drunk c. 7 cans of beer. He had been lying in the garden and would not get up so she threw water over him. Mother would like to speak to a doctor about Mr. Y's diagnosis. Mr. Y returned to ward smelling of alcohol then left again to go to sleep at his parents' house.
31.01.05	Letter from Housing Association giving Mr. Y notice because he has broken his tenancy agreement.
1.02.05	Ward round with Psychiatrist 1: Telephone call from mother reported. She said: Mr. Y is drinking heavily (7 cans of larger); he had exposed himself to his 24 year old sister; Mr. Y says he does not remember any of the incidents; Mr. Y reports still feeling depressed. Diagnosis: Depression. Discharged.
1.02.05	Mr. Y's father contacted the ward to tell them that Mr. Y had been throwing himself on floor outside and urinating in public. His mother had thrown water over him. Nursing notes: Mr. Y's father called the ward to inform them that Mr. Y

	had been drinking all day and had just exposed himself to his 24 year old sister. He requested advice on whether to call the police. Told he must make the decision. Nurse spoke to Mr. Y who said he had no recollection of the incident. Advised to go to bed and return to ward in morning as planned. Ward staff liaise with Early Intervention CPN re: discharge. She feels that it should go ahead and she will do the 7 day follow-up
2.02.05	Early Intervention CPN visits Mr. Y and takes him to woodwork group. He claims that he has no recollection of exposing himself to his sister.
2.02.05	Copy of letter of notice sent to Early Intervention CPN.
2.02.05	Letter to Mr. Y's father from Early Intervention CPN asking him to make contact for a carer's assessment.
5.02.05	Early Intervention CPN meets with Mr. Y's mother. She reports that Mr. Y: Has been masturbating or urinating in public; Exposed himself to sister; Threw himself on to the floor on several occasions. Early Intervention CPN to inform Psychiatrist 1 as Mr. Y to resume psychotherapy (assessment).
5.02.05	Early Intervention CPN receives copy of letter to Mr. Y to end tenancy. She notes that this is dated before the professionals' meeting on 31.1.05 at which Housing Association were present but this was not discussed this. Confronted Housing Support worker.
5.02.05	Housing Support Worker 2 phones Early Intervention CPN to inform her that: Mr. Y's housing benefit has been sorted out; Mr. Y has been informed that he can remain at Supported Housing.
7.02.05	Early Intervention CPN discussed Mr. Y with Psychiatrist 1 who says he is due to see Mr. Y on his return form leave. He will also organise a brain scan as requested by Mr. Y's mother.
11.02.05	Carer's assessment of Mr. Y's father by Early Intervention CPN. Support plan is blank.
22.02.05	Out with Early Intervention Worker. Mr. Y is laughing and smiling inappropriately. "Looking at chef's gun and sharp knife." Felt that Mr. Y wanted her to comment. Not eating but drinking alcohol.

23.02.05	HoNOS: Overactive/aggressive = 0 Suicidal = 0 Self harm = 0 Drinking = 3 Cognitive problems = 0 Physical illness = 0 Hallucinations = 0 Unreasonable beliefs = 0 Depressed mood = 3 Relationships = 3 ADL = 2 Living Conditions = 0 Occupation/activity = 3 Engagement = 0 Vulnerability = 4
23.02.05	Early Intervention CPN takes Mr. Y out. He reports having a take-away the previous evening and being sick. Denies this might have been due to alcohol. No symptoms noted.
23.01.05	Early Intervention Worker phones Supported Housing to ask them to monitor Mr. Y's eating. Supported Housing Worker 2 says he thinks he has seen Mr. Y eating. Reported that Mr. Y is showing "attention seeking behaviour" such as lining all his cans of alcohol up on the wall outside, no matter what the weather." The staff are not "making an issue of this".
23.02.05	Letter to GP from SHO Diagnosis: • Psychosis (under remission); • Depression mild. Medication: • Olanzapine 5mg; • Citalopram 20mg. • Denies hallucinations but felt that something was pulling his arms when in bed. Could hear music. Mr. Y suggested this might have been caused by anxiety. • Focus on activities and social interventions.
25.02.05	Early Intervention Worker visited Mr. Y. He was drinking Guinness when she arrived. Reporting that he is not eating. Mr. Y looked "O.K". He had food in his room and room was tidy.
1.03.05	Early Intervention CPN visited. Mr. Y drinking his seventh can of Guinness. Said he needs to eat only one meal a week. Had a take-away the previous evening. No visible weight loss.

1.03.05	CPA review/plan. Risks: • Social isolation; • Alcohol and drugs; • Has attempted self harm in the past: belt around neck; • Mr. Y has been to Court: drunk and disorderly, acting out of character when drinking; • Some psychotic features; • Vulnerable to exploitation; • May benefit from CBT in future. It was noted that Mr. Y had made progress although he was still at risk. Plan: • Early Intervention CPN to arrange out patient appointment; • Mr. Y to attend day centre groups for depression and assertiveness skills; • Address employment issues when ready; • Early Intervention CPN and Housing Support Worker 2 to monitor situation re: fellow resident (exploitation); • Early Intervention CPN and Housing Support Worker 2 to monitor/address drinking. CPA Plan not signed and not clearly dated.
8.03.05	Early Intervention CPN visits Mr. Y. He had drunk 16 pints of beer the previous day and was feeling very unwell. Discussed long term effects of this behaviour.
11.03.05	Early Intervention CPN visits. Mr. Y not had any more alcohol. Intends to moderate his drinking but denies he needs specialist help. Reading his plumbing books. Not yet heard from befriending service.
15.03.05	Out Patient appointment with SHO: No thoughts of self harm; not tearful, mood "O.K."; No voices, hallucinations or delusions; Not taking medication regularly; Drinking a bottle of cider a day. Encouraged to take medication and reduce alcohol intake.

15.03.05	Early Intervention CPN visits Mr. Y's parents. They are distressed by Mr. Y's drinking and "interest in pornography". Some discussion of religious beliefs and Early Intervention CPN tries to "normalise" Mr. Y's behaviour.
15.03.05	At c. 6.p.m. housing support staff heard Mr. Y shouting loudly in his room: "*Get off the fucking bed now. Get out you fucking*… last word not heard" Knocked on his door to ask who he was talking to. "He was clearly intoxicated." He was asked to come to the office where he reported that he was shouting at the ghosts who pulled him out of bed on occasions. He said he did not expect anyone to believe him as this only happened after he had been drinking.
16.03.05	Early Intervention CPN visited Mr. Y. He was "extremely drunk".
17.03.05	Letter to GP from SHO: Diagnosis: • Psychosis; • Depression. Medication: Olanzapine: 5 mg; Citalopram: 20 mg; Not taking medication regularly. • Drinking a bottle of cider per day, smelt of alcohol at interview; Strongly under the influence of alcohol; • Denies hallucinations or delusions; • Ghost pulls him out of bed.
21.03.05	Early Intervention CPN discussed Antabuse and Lifeline (Alcohol Misuse Service) with Mr. Y's mother in a phone call. Early Intervention CPN informs Mr. Y's mother of her leave and that a colleague will be looking after Early Intervention CPN's clients.
31.03.05	Assessment appointment for psychotherapy.
12.04.05	Phone call from Housing Support Worker 1 to Early Intervention Worker. Mr. Y has stopped taking his Antabuse as it made him feel sick. He had a visit from the befriending service but will not get a befriender for 6 months. Tenancy extended for 6 months.
18.04.05	Early Intervention Worker telephones Housing Support Worker 1. She feels that Mr. Y is not drinking as much and showing less attention seeking behaviour. He had been to woodwork once on his own. Reported that he enjoyed it.
19.04.05	Early Intervention Worker visits but Mr. Y does not answer his door.
19.04.05	Early Intervention CPN visits Mr. Y who appears brighter, not drinking or smoking. Mr. Y reports to Early Intervention CPN that another resident is regularly taking his money. Mr. Y is very afraid of this man who says he can get a gun from his brother and has served a 10 yr prison sentence for

	killing a man (manslaughter). Mr. Y does not answer his door in case it is this man. That is why he appears not to be in when Early Intervention CPN or Early Intervention Worker call. Early Intervention CPN to talk to Supported Housing manager.
21.04.05	Carer's assessment of Mr. Y's mother by Early Intervention CPN. Plan not completed. Referred to carer's support service.
3.05.05	Early Intervention CPN visits. Drinking is "much better" but Mr. Y still getting intoxicated. Attending psychotherapy and feels it is benefiting him. No plans to work. Still under pressure to buy alcohol and cigarettes for fellow tenant.
6.05.05	Early Intervention CPN takes Mr. Y to music group. He talks about wanting to move.
11.05.05	Early Intervention CPN visits. No answer.
13.05.05	Letter to GP from SHO: Diagnosis: Unchanged. Medication: Olanzapine: 5 mg; Citalopram: 40 mg (increased). Low mood, no thoughts of self harm; Has strange thoughts but denies voices or hallucinations; Rarely drinks/can of beer a day; No drugs.
27.05.05	Arrangement made to take Mr. Y cycling but when worker calls Mr. Y does not answer door.
30.05.05	Report in preparation for Housing Support Plan Review. Initially Mr. Y found it difficult to settle in to Supported Housing. Around Christmas time he disengaged from Housing Support staff and CPN. He was only living at the scheme once a week. He was also drinking heavily. Case conference held. Mr. Y is socially isolated.
31.05.05	Mr. Y heard shouting in his room by another tenant. He is not engaging with Supported Housing staff. Early Intervention CPN informed of this.
31.05.05	Early Intervention CPN visits Mr. Y. He had been drinking heavily the night before and was hung over. Mr. Y insists that he does not have a drink problem. Discussed reports of Mr. Y swearing at a ghost: "*Get out you evil bastard."* Mr. Y cannot remember this. Says he will attend activities during the week.
31.05.05	HoNOS: Overactive/aggressive = 2

	Suicidal = 0 Self harm = 0 Drinking = 3 Cognitive problems = 0 Physical illness = 0 Hallucinations = 2 Unreasonable beliefs = 2 Depressed mood = 3 Relationships = 3 ADL = 3 Living Conditions = 2 Occupation/activity = 3 Engagement = 0 Vulnerability = 2
1.06.05	Mr. Y attends sports centre with worker.
3.06.05	Psychiatrist 1 has seen Mr. Y for 8 session of psychodynamic therapy assessment. Not suitable for this approach. Possible CBT.
5.06.05	Letter from Mr. Y's mother to supported housing alerting them to the fact that Mr. Y is being exploited.
5.06.05	Letter from Mr. Y's parents to Housing association expressing their concern that other tenants are exploiting and intimidating him.
7.06.05	Phone call from Mr. Y's mother to Early Intervention CPN. She is worried about the level of Mr. Y's drinking. Early Intervention CPN reports that she has tried motivational interviewing and Mr. Y says he wants to continue drinking.
08.06.05	Carers' Support services contact Early Intervention CPN to ask if Mr. Y's mother had had counselling in the past. They will offer counselling
10.06.05	Early Intervention CPN visited Mr. Y. He had been arrested for being drunk and disorderly. Due in court 14.6.05.
13.06.05	Reply from Housing association to letter of 5.6.05. • Housing Association aware of the situation and are monitoring it; • Issue ahs been discussed with Mr. Y and he did not want staff to discuss issue with specific tenants. He was "adamant" about this; • Issue discussed at tenants' meeting and a new house rule relating to tenants asking each other for money was introduced; • Key worker looking for assertiveness and confidence building sessions; • Housing Association must respect Mr. Y's wishes.
14.06.05	Early Intervention CPN attended court with Mr. Y. He pleaded guilty. Bailed until July.
14.06.05	HoNOS: Overactive/aggressive = 4 Suicidal = 0 Self harm = 0 Drinking = 4

	Cognitive problems = 0 Physical illness = 0 Hallucinations = 0 Unreasonable beliefs = 0 Depressed mood = 3 Relationships = 3 ADL = 3 Living Conditions = 2 Occupation/activity = 3 Engagement = 0 Vulnerability = 4
15.06.05	Housing Support plan: • Exploitation by other residents: referred to assertiveness course; • Mr. Y does not want action take against other tenants but after some discussion Mr. Y gave permission for Housing staff to talk to tenant who was borrowing money; • Alcohol misuse - arrested in ASDA for being drunk. Mr. Y did not want any help with this; • When drinking alcohol becomes aggressive verbally and to self; • Social isolation; • Accommodation: not ready to live independently.
23.06.05	Mr. Y taken out by worker. Discussed becoming involved in more activities, attending day centre etc. Mr. Y reported that his drinking helped his depression. His medication was not effective.
27.06.05	Brief notes on CPA review: Concern about heavy drinking; Mr. Y wants to be prescribed Venlafaxine; To be discussed with Psychiatrist 1.
27.06.05	Early Intervention CPN attended a case review. (?CPA). During the review Mr. Y agreed to cut down his drinking however on his way out of the hospital he said that he intended to get drunk.
27.06.05	Loud noises heard from Mr. Y's room. When staff knocked on his door he was very intoxicated. Called CRHTT to inform them. Phoned police at 6.53 p.m. Police arrived at 7.00 and called an ambulance.
27.06.05	Police and ambulance called to Mr. Y's accommodation. Very drunk and banging his head. Charged with breach of the peace.
28.06.05	Mr. Y tells housing support staff that he can only be happy by drinking. Supported Housing staff contact Early Intervention CPN to inform her of what had happened. Mr. Y was very distressed when speaking to housing staff, tearful, asking for reassurance and saying that he had let his parents down.

	Early Intervention CPN says that as far as she was aware Mr. Y's parents did not put nay expectations on him but wanted him to stop drinking. Mr. Y, however, wanted to continue drinking. He had told the Housing Support staff that alcohol made him feel better.
29.06.05	Early Intervention CPN visits. Mr. Y has recovered but does not remember much of the incident.
12.07.05	Attended Court supported by Early Intervention CPN. Bound over to keep the peace for 6 months. Fined £50.
12.07.05	HoNOS: Overactive/aggressive = 0 Suicidal = 0 Self harm = 0 Drinking = 0 Cognitive problems = 0 Physical illness = 0 Hallucinations = 0 Unreasonable beliefs = 0 Depressed mood = 3 Relationships = 3 ADL = 3 Living Conditions = 3 Occupation/activity = 3 Engagement = 0 Vulnerability = 4
19.06.05	Mr. Y reminded of depression group but does not attend.
22.06.05	Support worker visited Mr. Y. Made a list of the exploitative behaviour he was experiencing. Agreed to report these to the police on following Monday.
26.07.05	Mr. Y makes a statement about resident taking money from him to police. They explained that they could: - Warn under the Harassment Act; - Arrest. They later informed Mr. Y that they would arrest the person who was exploiting him.
1.08.05	Tenant about whom complaint had been made had been around during the week-end. Mr. Y had not answered his door. Mr. Y completes application form for council accommodation.
5.08.05	Early Intervention CPN took Mr. Y to see an accommodation project: Making Space.
8.08.05	Early Intervention Worker visits but Mr. Y not available.
8.08.05	Early Intervention CPN takes Mr. Y to housing dept. They agree to move him to Bed & Breakfast accommodation because of recent events

	(Exploitation and arrest of tenant). Mr. Y decided to wait until a suitable property was available.
9.08.05	Early Intervention Worker takes Mr. Y out. He reports not drinking. Looks well.
11.08.05	Early Intervention CPN visits Mr. Y. He is doing well. Not drinking and looking forward to moving. Mr. Y is due to go on holiday with his parents. Due back 19.08.05.
11.08.05	Early Intervention Worker takes Mr. Y out. He reports that he has not drunk for a couple of weeks. Also feels that his change of anti-depressant is beneficial. Mr. Y looking forward to his holiday. Arranged to meet weekly when Mr. Y returned from holiday.
22.08.05	Early Intervention CPN completes application form for Making Space. Early Intervention CPN spoke to Mr. Y's mother, who reports that Mr. Y would spend all day in bed if allowed to. She is "upset at Mr. Y's attitude to Mum and Dad's separation."
25.08.05	Early Intervention Worker visited but Mr. Y not answering his door.
30.08.05	Early Intervention Worker visits and takes Mr. Y out. Mr. Y reported that he enjoyed his holiday.
1.09.05 - 13.09.05	Mr. Y refuses to see Early Intervention CPN when she calls
2.09.05	Care plan: (Signed) valid until 1.06.06: • Reduce impact of alcohol; • Psychotherapy (Psychiatrist 1); • Medication for depression; • Housing; • Social activity.
?	Crisis Plan: Mr. Y "attempts suicide". Plan: Admission.
7.09.05	Mr. Y misses interview with Making Space.
10.09.05	Early Intervention CPN discussed Mr. Y with Supported Housing staff. They had seen him and reported that he was presenting as "quite well".
10.9.05	Early Intervention CPN accompanied Mr. Y to housing department. He is paying a higher rent because DSS believe he has £9000 savings. Mr. Y says he no longer has this money. On return to Supported Housing Mr. Y is informed that he owed £784.86 in rent. If this was not paid his tenancy would not be renewed. Debt would also make it difficult to obtain another tenancy.

12.09.05	Telephone call from Mr. Y's mother who reports that Mr. Y is angry with Early Intervention CPN and "feels like hitting me". Early Intervention CPN felt that Mr. Y was saying these things to get a reaction and he posed no threat to her. Early Intervention CPN informed Mr. Y's mother that she would not be visiting unless Mr. Y made contact.
12.09.05	HoNOS: Overactive/aggressive = 2 Suicidal = 0 Self harm = 0 Drinking = 0 Cognitive problems = 0 Physical illness = 0 Hallucinations = 0 Unreasonable beliefs = 0 Depressed mood = 3 Relationships = 3 ADL = 3 Living Conditions = 2 Occupation/activity = 3 Engagement = 0 Vulnerability = 2
13.09.05	Message that Mr. Y had been trying to contact Early Intervention CPN. No messages had been left/recorded. Appt. made for next day.
14.09.05	Early Intervention CPN informs Mr. Y that if he continues to sabotage plans he will be discharged. Interviewed by Making Space. Discussed Mr. Y's inappropriate sexual behaviour.
19.09.05	Mr. Y's mother discusses her fear of Mr. Y, physically and sexually. Early Intervention CPN advised her that Mr. Y's behaviour was an expression of his desire to be needed.
20.9.05	Home visit. Not in. Did not get a place at Making Spaces.
21.09.05	Home visit. Arranging a social outing.
26.09.05	Took Mr. Y out. Bright and cheerful - taking medication. "Discrepancies with housing benefit". Early Intervention CPN to take Mr. Y to housing department later in the week.
2.10.05	Reference for Making Space Housing from Psychiatrist 1: Mr. Y had been aggressive to family members.
11.10.05	Mr. Y's mother upset about Mr. Y's rent situation. Confirms he no longer has £9000 savings. He gave it to his mother as he was giving it to the church. She has used it to "help" members of the family. Mr. Y's mother to go with Mr. Y to DSS to make a statement.

	She will "see if [Mr. Y] can go and live with his father". But his sister will not be happy.
11.10.05	Early Intervention CPN received a telephone call from Mr. Y's sister who is upset that Mr. Y may be returning home. Early Intervention CPN could not discuss because of confidentiality. To be discussed at the family's meeting that evening.
17.10.05	Mr. Y's mother reports that Mr. Y has sold a £250 bike for £20 to fellow tenant. Supported Housing confirm that this is the case. She is upset. Mr. Y informed that he must pay rent arrears and must attend his key worker sessions.
18.10.05	Early Intervention CPN took Mr. Y to Leeds for a coffee. Mr. Y is bright. Happy he has a new friend. Discussed employment and accommodation. Mr. Y does not feel ready to leave Supported Housing. He reports that he is "too depressed to look for work". Refuses to attend "traditional services" but is not prepared to go out with Early Intervention Worker. "Denies any problem with [Early Intervention Worker]." Mr. Y's mother has put in place boundaries. He can only visit on Monday, Wednesday and Friday.
19.10.05	Letter from Mr. Y's mother to Early Intervention CPN Worried because "I sense that things have not been going too well between you and progress has been limited." Mr. Y has been angry and difficult to cope with. Mr. Y has been avoiding visits and "you will discharge him from your care." Mr. Y's mother notes that she values Early Intervention CPN's support for her self and well as for her son.
19.10.05	Letter to GP from Psychiatrist 1: Diagnosis: • Psychological problems; • Personality issues; • Low mood and anxiety; • Alcohol misuse. Medication: Venlafaxine: 150 mg; Aripiprazole 10mg. (Note medication changed). • "Not too bad"; • Sleeping and lacking energy; • Clingy to mother.
11.10.05	Mr. Y's sister is very unhappy at the idea that he might return home.
11.10.05	HoNOS: Overactive/aggressive = 2 Suicidal = 0 Self harm = 0 Drinking = 0

	Cognitive problems = 0 Physical illness = 0 Hallucinations = 0 Unreasonable beliefs = 0 Depressed mood = 3 Relationships = 3 ADL = 3 Living Conditions = 3 Occupation/activity = 3 Engagement = 0 Vulnerability = 2
25.11.05	Mr. Y's mother reports that Mr. Y has spent £2000 in last few weeks. She believes that he is vulnerable and being exploited. She has not spoken to the Housing Support staff as she believes that this would jeopardise Mr. Y's tenancy. (Signed CMHT Manager).
10.12.05	Mr. Y's father reported to Supported Housing that Mr. Y had lent a fellow tenant £1100. Fellow tenant had said this was for a headstone for his mother. Mr. Y's father had "blasted" the tenant for this and told him to return Mr. Y's money. Mr. T has contacted the police but they could not do anything. He felt that this proved that Mr. Y cannot manage his money and he should not be threatened with eviction. He was informed that: • Mr. Y had not been threatened with eviction; • Staff do talk to Mr. Y about money but either he does not tell them when he is being exploited or says he happy and then changes his mind; • Staff will continue to discuss issue with Mr. Y but "he may continue to repeat his behaviour."
16.12.05	Letter to GP from Psychiatrist 1 (Appt 5.12.05): Diagnosis: No Change; Medication: No change; • Medication working; • Some voices Mr. Y attributes to God: critical and derogatory; • No alcohol since June; • No suicidal thoughts.
26.12.05	Letter from Housing Support Worker 1 inviting Early Intervention CPN to a support planning meeting. Mr. Y is not engaging with staff. Issues identified: • Vulnerability; • Move-on.
29.12.05	Early Intervention CPN visited Mr. Y. He was in but did not answer his door.
30.12.05	Early Intervention CPN tried to contact Supported Housing to arrange a visit.

3.01.06	Mr. Y refused to answer door to Early Intervention CPN. Housing staff inform Early Intervention CPN that Mr. Y is reluctant to engage. Informed that Mr. Y had given another resident £11000(?). Mr. Y insisted that he gave this "Through choice". Early Intervention CPN to discuss this with him.
4.01.06	Letter to Early Intervention CPN from Mr. Y's mother. She reports that Mr. Y is sleeping all the time and has no energy. She is concerned that Mr. Y is still being exploited financially. She also reports that Mr. Y's father is doing Bible studies with him and instructing him as a Jehovah's Witness. "*He tells me that he has had his head messed with yet he is allowing himself to be indoctrinated again*."
6.01.06	Mr. Y informs Early Intervention CPN that he wants to "become a brother" again and is having Bible lesson with his father. Early Intervention CPN surprised at amount of weight Mr. Y has put on. Mr. Y medication was changed 3 month earlier.
10.01.06	HoNOS: Overactive/aggressive = 0 Suicidal = 0 Self harm = 0 Drinking = 0 Cognitive problems = 0 Physical illness = 0 Hallucinations = 0 Unreasonable beliefs = 0 Depressed mood = 2 Relationships = 3 ADL = 3 Living Conditions = 2 Occupation/activity = 3 Engagement = 0 Vulnerability = 2
11.01.06	Early Intervention CPN escorted Mr. Y to careers office. Investigating a training scheme. Also exploring whether Mr. Y can complete his plumbing qualification.
13.01.06	Early Intervention CPN visits at Mr. Y's request. Mr. Y says he is not ready for work. Early Intervention CPN will continue to explore options. Discussed confidence building groups at the day centre.
20.01.06	Review at Supported Housing. Decided that Mr. Y's tenancy will not be renewed. Mr. Y given application form for work scheme.
24.01.06	Anxious about move and wants to be considered unwell. Saying "inappropriate things" to "cause effect", to Early Intervention CPN and Housing Support Worker 1.
31.01.06	Early Intervention CPN rang to discover if Mr. Y had attended Self-esteem course. Information was that, as far as was known, he had.
4.02.06	Mr. Y cannot view flat as keys not available. Mr. Y is attending self esteem group and participating well.
6.02.06	Early Intervention CPN visited but Mr. Y had gone to sports group.

14.2.06	Home visit by Early Intervention CPN at Mr. Y's request: Mr. Y bright and communicative. He had decided he would: • Isolate himself; • Start drinking; • Start smoking; • He did not want a job but would follow through on building scheme; • Early Intervention CPN felt the Mr. Y had the capacity to make an informed choice. Supported Housing will support Mr. Y with moving on. • Discussed Mr. Y with supervisor and decided to discharge Mr. Y. Discharge by Early Intervention CPN.
	Letter to GP, Psychiatrist 1, and Supported Housing Hostel to inform them that Mr. Y had been discharged by Early Intervention CPN.
7.03.06	DNA appointment with Psychiatrist 1.
17.03.06	Housing Support Worker 1 reports that Mr. Y is "feeling bad" because he has told Housing Support Worker 1 that he has a crush on her. Nature of professional relationship is discussed.
24.04.06	Mr. Y received an abusive letter from his brother. He read this to Housing Support Worker 1. Mr. Y is very upset by the letter.
27.04.06	Key worker session with Housing Support Worker 1. Mr. Y still upset about letter from brother but feels that brother is unwell. In discussing his finances and keeping his crisis loan safe Housing Support Worker 1 reminded Mr. Y that he had given away all his savings c. £10,000 in two years Mr. Y said he was thinking of going back to Kingdom Hall "as he could not cope with the hassle from his family."
28.04.06	Staff offer to hold Mr. Y's crisis loan money (for new flat) in office in case Mr. Y is persuaded to give this away.
3.05.06	Phone call to father. No reason given.
11.05.06	Phone call to father. Answered by sister. Father at work. No reason given.
19.05.06	Letter to Mr. Y's father from Early Intervention Worker. Mr. Y's father had made contact as he is concerned about Mr. Y's behaviour and has banned him from the family home. Mr. Y is discharged from the service but Supported Housing staff are working closely with him. As Mr. Y does not know of his father contacting the service it "cannot act on your concerns." Advice: talk to staff at Supported Housing who can "talk through [Mr. Y's] behaviour with him". Supported Housing staff can liaise with CMHT if necessary.
26.06.06	Out patient appointment (See letter 10.07.06) Psychiatrist 1.
3.07.06	Letter from Psychiatrist 1 to GP (Appt: 27.06.06).

	Same as letter on 10.07.06.
7.07.06	Mr. Y calls CMHT asking about the progress of his referral. Informed CPN 2 to be his CPN.
10.07.06	Letter to GP (Re: Appt 26 or 27.06.06) from Psychiatrist 1: Diagnosis: • Psychological problems; • Personality issues; • Low mood and anxiety; • Alcohol misuse; • ?psychotic illness. Medication: Venlafaxine: 150 mg; Aripiprazole 10mg. Plan: • Assess by CMHT and then arrange a CPA meeting; (This was never arranged) • Paranoid thoughts and voices; • Believes people can read his thoughts; • Preoccupied by God and religion; • Distressed and crying, clinging to mother, praying to be released from suffering; • Laughing inappropriately; • Can't look after himself; • Spends a lot of time pacing; • Noted that Mr. Y had been discharged by Early Intervention CPN.
10.07.06	Out-patient appointment with Psychiatrist 1: • Don't live up to God's standards; • Don't feel secure; • Carrying Grandfather's coffin on Friday; • Needy from mother; • Not seen father for 3 weeks/not living as God wants; • Alcohol makes less depressed; • Diagnosis: BPD.
10.07.06	Initial Home visit by CPN 2. Mr. Y was drunk lying on floor of neighbour's flat. According to his neighbour Mr. Y had drunk half a bottle of brandy since he had seen Psychiatrist 1 that morning. He had been drinking "cans" over the weekend.

17.07.06	Initial assessment CMHT. Referred by Psychiatrist 1 after Out-patient appointment 27.6.06. "Difficulties": • Distressing though; religious, masturbation, preoccupied, paces; • Low self esteem, low social confidence: no friends or social network; • Alcohol: spending lot of money on alcohol, not addicted but becomes preoccupied after a few pints; • Managing self-care; • Not suicidal or violent. Plan: • Work on self esteem; • Challenging thought processes; • Activities of Daily Living and social-confidence. Risk: • No current suicide plans; • No risk of violence; • No self care risks.
17.07.06	HoNOS: Disruptive, aggressive behaviour, = 2 Suicidal = 1 Self harm = 0 Cognitive problems = 0 Physical Problems = 0 Hallucinations = 2 Unreasonable beliefs = 2 Depressed mood = 2 Relationships = 2 Drinking = 2 ADL = 2 Vulnerability = 2 Engagement = 0 (Scores 0-4)
3.08.06	Home visit by CPN 2. Mr. Y reported that he was drinking less; Attending MIND one day/week; Socialising in pubs; Discussed confidential aspect of his thoughts.
1.09.06	Home visit by CPN 2. Mr. Y "appeared ever more positive in outlook." Worklink said they might be able to find him a placement, doing plumbing for one day/week. Mr. Y has been revising his plumbing handbooks. No problems with self care. Agencies involved in Mr. Y's care: • MIND day care - one day/week; • Supported Housing outreach - one day week; • Psychiatric out patients;

	• CPN - fortnightly visits.
12.09.06	Letter to GP from Psychiatrist 1: Diagnosis: • Psychological problems; • Personality issues; • Low mood and anxiety; • Alcohol misuse. Medication: Unchanged. Not heard voices in last month; Feels more optimistic; Noted after community assessment arrange CPA. No evidence that this was done
29.09.06	Planned home visit by CPN 2. Self report: continuing to make improvement; Working one day/week in charity shop; Mr. Y said that he preferred to keep his distressing thought "confidential with me."
23.11.2006	Seen by CPN 2. Continued progress with self esteem; Planning to do a 13 week work course; Continues to struggle with beliefs and ideas of God; Mr. Y rated himself as 5:10 on a wellness scale.
27.11.06	Cancelled Out-patient appointment.
12.12.06	Letter to GP from Psychiatrist 1: Diagnosis: Unchanged. Medication: Unchanged. Distressed with ideas on a religious theme - failure; Returned to Kingdom Hall to please his "parents". He feels pressure to return and "feels judged and persecuted by this religious group." (Mr Y's mother had stopped attending Kingdom Hall in 2000 and "parents" here is probably inaccurate), Very negative self report/image. Cannot look after himself and his flat is in disorder.
14.12.06	Mr. Y phoned CPN 2 to cancel planned home visit. Self report that he was making progress He had been attending a "Back to Work" course. Felt positive. Planned to spend Christmas at mother's flat. Planned next meeting in New Year.
2.02.07	Home visit by CPN 2. Mr. Y positive. Attending MIND 2-3 times week and a back to work course. CPN 2 informs Mr. Y that he will be leaving and a new worker will be identified.
12.02.07	Mr. Y's mother had phone Carer's Support who contacted CPN 2. He phoned Mr. Y's mother. Mr. Y's neighbour is taking advantage of Mr. Y, taking money, getting Mr. Y to do his shopping and had suggested the Mr. Y live with him when he, the neighbour, moved.

	Carers' Notes say CPN 2 was not aware that Mr. Y was lending money to neighbour. CPN 2 to contact Supported Housing.
12.02.07	Letter to GP from Psychiatrist 1(appt: 30.1.07): Diagnosis: • Psychological problems; • Low mood and anxiety; • Misuse of alcohol. Medication: Unchanged. Accompanied by mother who was angry about Mr. Y being exploited.
16.02.07	Care plan from 16.02.07 - 05.07 prepared by CPN 2. • Manage distressing thoughts; • Develop social confidence; • Develop skills to gain employment; • Skills to not be exploited. Plan: • Visit Mr. Y every 2-3 weeks; • Review structure of daily activities; • Review strategies to gain employment; • Review coping strategies re: distressing thought; • Review assertiveness skills and refer to assertiveness group; • Liaise with: GP, Psychiatrist, Supported Housing, Mr. Y's mother "As required". Not signed.
16.02.07	CPN 2 visits with provisional care plan and to introduce new care co-ordinator, CCO 1.
20.02.07	Mr. Y's mother starts counselling with Carers' support worker.
22.02.07	Mr. Y complained that a neighbour was kicking his door. Police called and they advised that Mr. Y and neighbour avoid one another.
5.03.07	Home visit by CCO 1: • Drinking 4 cans beer Saturday - trying to control drinking; • MIND back to work course; • Not getting on with neighbour; • Good relations with parents; • No thoughts of self harm.
3.04.07	Letter from Occupational Health Physician. Mr. Y has applied for a work experience post.

16.04.07	Letter to Occupational Health Physician from Psychiatrist 1: History: • Low mood and harsh critic of self; • Vulnerable personality coupled with critical and judgemental family dynamics; • Internal voices of a persecutory nature; • Excessive use of alcohol to manage distress. Diagnosis: Depression with anxiety with psychological problems linked to family dynamics.
2.05.07	Letter to GP from Psychiatrist 1: (Appt: 30.04.07). Diagnosis: • Psychological problems (Related to Jehovah's Witnesses - judgemental and family dynamics); • Low mood and anxiety. Medication: o Venlafaxine 150mg; o Aripiprazole 5mg (**NB reduced**). • Mr. Y reports feeling a little better; • Alcohol reduced to 4 cans/day.
14.05.07	Home visit. Neighbour has moved out but Mr. Y continues to visit him. Mr. Y continuing computer course and has a befriender. Reports drinking 4 cans beer week. Visits parents at weekend. Referred to anxiety management and assertiveness courses. No concerns.
14.05.07	CCO 1writes to say he will be on sick leave from 15.05.2007. Mr. Y should contact CMHT manager or CRHTT.
14.05.07	HoNOS: Disruptive, aggressive behaviour, = 1 Suicidal = 0 Self harm = 0 Cognitive problems = 0 Physical Problems = 0 Hallucinations = 1 Unreasonable beliefs = 2 Depressed mood = 2 Relationships = 2 Drinking = 2 ADL = 1 Vulnerability = 2 Engagement = 0 (Scores 0-4)
19.06.07	Housing Support Worker 1 contacts CMHT to register her concerns about Mr. Y vulnerability, (His inability to say "No").

22.06.07	Housing Support Worker 1 tried to contact CMHT to inform them that Mr. Y was likely to be evicted and someone needed to support Mr. Y in CCO 1's absence.
26.06.07	Call from Housing Support Worker 1 to CMHT Manager: • Mr. Y has disengaged over last 6 weeks; • 2 people had been squatting with Mr. Y and he was lending them money. He is now in rent arrears; • Police informed; • Police questioned Mr. Y re: burglary; • Mr. Y due Court for burglary; • Mr. Y is in breach of tenancy; • Heroine and crack cocaine found in Mr. Y's flat; • Mr. Y admits to trying crack cocaine. Housing notes: CMHT Manager to allocate another worker in CCO 1's absence.
26.06.07	E-mail from Housing Support Worker 1 to CMHT manager at 11.32 a.m.: • Mr. Y disengaged from 23 .05.07. This is unlike him; • Flat opposite was burgled; • Visited Mr. Y on 15.06.07 and two other people living there. He couldn't pay his rent as he had given his money to these people; • Advised Mr. Y to ask them to move out. Mr. Y said they were his friends and he was not being intimidated. • 22.05.07 during home visit confessed: o To burglary; o Heroine and crack cocaine was being used daily by his friends and others; o He had taken crack cocaine c. 6 times; o He taken the pipework from his own flat to get money; o Police were informed and Mr. Y arrested and charged. Due in Court 3.07.07; o He may be evicted but support will be offered; o CCO 1 has been off sick can someone else "offer support to Mr. Y"; o Can a referral be made to Clover leaf (Advocacy Service); o "I would greatly appreciate it if some extra support could be provided to Mr. Y, prior to [CCO 1's] return.
26.06.07	Phone call to inform CMHT that Mr. Y was to be evicted. 2 months earlier had damaged neighbours property.

27.06.07	• Housing Support Worker 1 makes statement as Mr. Y is due in court for burglary (3/7/07); • Mr. Y had cut off all contact with support agencies; • Girl moved in as his girlfriend then moved in her boyfriend. They exploited Mr. Y and used his flat to use heroine on a daily basis; • Mr. Y used crack cocaine 6 or 7 times; • Burgled flat to finance drugs; • To be supported by housing worker and referred to CMHT housing liaison. • (See Housing Support Worker 1's letter 26.6.07). Note: • No re-assessment needs assessment or risk assessment at this time. • No review of the care plan. • No CPA meeting.
27.06.07	Referred to Housing Liaison Service.
10.07.07	Letter to GP from Psychiatrist 1 (Appt: 9.07.07): Diagnosis: • "Psychological problems (linked to judgemental issues re Jehovah's witness and family dynamics); • Low mood and anxiety. Medication: • Venlafaxine XL 75 mg (**NB reduced**); • Aripiprazole 5mg. • No psychotic symptoms; • Drinking under control; • Had shaved off hair and eyebrows; • Reported burglary and possible eviction; • Supported by SW 1and CCO 1(Letter copied to both).
10.07.07	Letter to GP from Psychiatrist, (Appt 9.07.07): Diagnosis: unchanged. Medication: • Venlafaxine XL 75 mg (**NB reduced**); • Aripiprazole 5mg. • Doing well; • Not drunk for 2 weeks; • Joining a job club.
10.07.07	Mr. Y's mother informs Carer's Support Worker that Mr. Y had been visiting her and pleading with her to borrow money. He became verbally aggressive when she refused and she called the police "after one of his late night visits when this couple were using his flat."

	He is not welcome at his father house and his sister and brother do not want contact with him.
13.7.07	Home visit by SW 1. Informs her that he is bailed until 24.7.07.
13.07.07	SW 1 visits Mr. Y. Offers to see him fortnightly if he feels that he needs extra support with his mental health.
20.07.07	Letter from Housing Association: • Breached tenancy agreement; • Tenancy demoted to assured tenancy; • Must pay cost of damages; • Final warning.
20.07.07	Mr. Y reports to Housing Support Worker that he is taking medication as prescribed.
25.07.07	Mr. Y's father tells Carer's Support Worker that he "has chosen not to have contact" because of Mr. Y involvement in drugs and alcohol.
30.07.07	Final written warning from Housing Association - Not evicted.
1.08.07	Mr. Y calls CMHT asking for phone number of Samaritans as he is in financial difficulties. Advised that Samaritans would not offer practical support and advised to contact Housing Support Worker. Mr. Y said he felt unable to do this as he could not contribute to his rent. No support or advice recorded.
1.08.07	Mr. Y called Housing Support Worker 1 and reports that he is feeling low and has suicidal thoughts. He is given the phone number for the Samaritans. Arranged to see the SW 1 next day and Housing Support Worker 1 the following day.
2.08.07	Housing called SW 1 to inform her about conversation with Mr. Y. She confirms appointment for same day.
6.08.07	CCO 1returns. Contacts agencies involved with Mr. Y for update. Contacts anxiety management and assertiveness courses to see if Mr. Y has a place. Anxiety: 20.08.07; Assertiveness - waiting. Contacts Making Space re: referral.
8.08.07	Home visit: Mr. Y described recent events. Says that he has learned his lessons.
13.08.07	Mr. Y's mother expressed apprehension about Mr. Y during a forthcoming family holiday. She was advised to contact Housing Support Worker and CMHT care worker. She had not done this by the carers' meeting on 29.08.07.
24.08.07	Message from anxiety group to say Mr. Y had attended 1st day of group but phoned on second day to say he had a headache.

29.08.07	Home visit CCO 1 with Student Nurse: • Mr. Y remorseful; • Attended sports group; • Good relations with parents; • No concerns; • Rejected by Making Space; • Been to London to take part in a football competition. - "*gave me confidence."*
6.09.07	Feed back from anxiety management group. Mr. Y attended first session (20.08.07) but called in with a "stress headache" on second day.
27.09.07	Mr. Y's mother tells the Carer Support worker that she believes that Mr. Y's progress is being hampered by the lack of support he receives from his father and sister.
1.10.07	Letter to GP from Psychiatrist 1 (Appt: 24.09.07) Diagnosis: • "Psychological problems (linked to judgemental issues re Jehovah's witness and family dynamics); • Low mood and anxiety. Medication: • Venlafaxine XL 75 mg. • No complaint other than no friends; • Not drunk alcohol for two weeks. Plan • Stop Aripiprazole because of side effects; • Mr. Y informed that the next appt would be the last time he would see Psychiatrist 1 but he might be seeing another psychiatrist.
18.10.07	HoNOS: Disruptive, aggressive behaviour, = 1 Suicidal = 0 Self harm = 0 Cognitive problems = 0 Physical Problems = 0 Hallucinations = 0 Unreasonable beliefs = 2 Depressed mood = 2 Relationships = 2 Drinking = 0 ADL = 1 Vulnerability = 2 Engagement = 0 (Scores 0-4)
18.10.07	Mr. Y's mother informs carer's support worker that her husband, son and daughter will not allow Mr. Y into the family home.

22.10.07	CCO 1: No obvious deterioration in mental health; Going grocery shopping with support worker Housing Support Worker 1; Discussed referral to Pathways.
30.10.07	Letter informing Mr. Y he had been referred to the OT service and was on a waiting list.
6.11.07	Offered place at anxiety management group starting 12.12.07.
9.11.07	Key worker meeting with Housing Support Worker 1. Mr. Y's depression score lower than "couple of weeks" earlier. Mr. Y said he thought this was because he was busier/engaged in more activities. Identified from mood diary that his mood was at its worst when he was in the flat on his own. Housing Support Worker 1 looked at type of mood and thoughts provoking moods with Mr. Y.
15.11.07	Letter to GP from Psychiatrist 1.(Appt 12.11.07): Diagnosis: • Psychological problems (linked to judgemental issues re Jehovah Witness and family dynamics); • Low mood and anxiety. Medication: Venlafaxine XL 75 mg. • No psychotic symptoms; • Discharged from psychiatric out-patient care. • Continues to receive community support from CMHT. No CPA meeting/review at this point
16.11.07	Letter informing Mr. Y he was not being offered a place on Making Space Supported Housing project.
20.11.07	Letter advising Mr. Y he has been discharged from Housing Liaison service. Advised not to give up tenancy for less secure tenancy.
20.11.07	Mr. Y cancels appointment with CCO 1. CCO 1 calls to rearrange appointment - no response
21.11.07	CCO 1 phones housing support worker to ask her to pass on message re: appointment on 23.11.07.
21.11.07	Cookery course contacts Housing Support Worker 1 to inform her that Mr. Y had been low the day before and had left course early.
22.11.07	Housing Support Worker 1 reviewed mood ratings, thoughts and triggers with Mr. Y. Reviewed mood day before at cookery course and use of drinking to deal with moods. Identified Mr. Y's achievements.

23.11.07	Home visit by CCO 1: • Mr. Y continues to do well; • More day time activities e.g. Looking Ahead group, cookery group; • Relationship with parents "reasonable".
23.11.07	HoNOS: Overactive/aggressive = 1 Suicidal = 0 Self harm = 0 Drinking = 0 Cognitive problems = 0 Physical illness = 0 Hallucinations = 0 Unreasonable beliefs = 2 Depressed mood = 2 Relationships = 2 ADL = 1 Living Conditions = 1 Occupation/activity = 1 Engagement = 0 Vulnerability = 2
6.12.07	CCO 1 accompanied Mr. Y to Pathways.
7 & 10.12.07	Numerous calls to Mr. Y by CCO 1but no response.
11.12.07	Home visit by CCO 1: • Mr. Y reports that he has lost his phone charger and so had no phone contact. • Anxiety management course confirmed. Mr. Y to attend: creative writing, cookery courses. • Some "low level anxiety".
12 & 13.12.07	CCO 1 took Mr. Y to group session at Pathways; CCO 1 informed Mr. Y of his sick leave; Mr. Y to contact CMHT if "needs arise".
15.11.07	Letter to GP from Psychiatrist 1: • Mr. Y reported feeling well; • Anti depressant medication is helping with anxiety; • No "psychotic like symptoms"; • Discharged from psychiatric Out Patients.
6.01.08	Mr. Y is informed by letter that the OT service, which he had been referred to, had been closed.
11.01.08	Letter to CCO 1 informing him that Mr. Y successfully completed Anxiety management course which started on 12.12.07.
29.1.08	Numerous calls by CCO 1 to Mr. Y but no response. CCO 1 contacted Housing Support Worker 1to pass on a message. She had seen Mr. Y and expressed had no concerns. But informed CCO 1 that Mr. Y's drinking had increased
31.1.08	Home visit CCO 1- No reply.

31.1.08	Home visit by Housing Support Worker 3: • Mr. Y displayed no motivation. Sitting in the chair smoking. Flat dirty and messy; • Mr. Y reported feeling very negative; • Smoking and drinking a lot. Lots of beer cans and cigarette butt around his flat; • Talking about himself in third person; • Continually questioned about other people talking about him; • Lots of medication packets on his table some opened some not, when asked if he had been taking his medication at first he said "Yes" then changes to "No".
31.01.08	Mr. Y's mother calls Housing Support Worker 1 to express concerns over Mr. Y's mental health. Mr. Y had had sent a text to his mother a "few weeks ago" expressing thoughts of wanting to hurt people. (No one specific). Housing Support Worker 1 advise her that extra support would be offered to Mr. Y to manage his mental health issues. Plan: Inform CCO 1 • Mr. Y not taking his medication; • Referring to self in 3rd person; • Mental health erratic; • About text message to mother; • "Staff to visit Mr. Y twice if possible week".
31.01.08	Mr. Y's mother expresses concerns about Mr. Y to housing support worker. He has stopped visiting her. Will not let her come to his flat and does not text her any more. Advised will give extra support to Mr. Y, work with CCO 1. Housing Support Worker 1 gave Mr. Y's mother CCO 1's phone number. Plan to discuss concerns with CCO 1.
4.02.08	Mr. Y's mood "up and down". One minute happy to be visited the next saying that he could not go out as "people were looking down on him." Did not know last time he took anti-depressant medication.

4.02.08	11.15 a.m.: Housing Support Worker 3 called on Mr. Y. Lots of beer cans in Mr. Y's flat, not eating. "Looks depressed". 11.45 a.m. CCO 1 visits with Housing Support Worker 3. • Low mood, stopped taking anti-depressants. Agree to re-start medication; • CCO 1 contacted the GP Surgery. Last script had been on 27.12.07; CCO 1 arranged for a new script to be available for next day; • Mr. Y spoke about how his father had treated him in past; • CCO 1 reviewed helpful activities with Mr. Y; • Mr. Y had stopped attending groups - low self; • Confidence/esteem a problem; • Mr. Y reported that he had not had a drink since "last week". Plan: • Mr. Y agreed to re-start medication (script ready 5.02.07); • Mr. Y agreed to attend sports group CCO 1 to accompany; • Mr. Y agreed to moderate his drinking; • Mr. Y to reconsider attendance at other day time activities; • Mr. Y agreed to go food shopping with Housing Support Worker 3.
6.02.08	Phone call from Mr. Y's mother to CCO 1: • Mr. Y has been drinking. He wanted to drink at her house. She asked him to leave. She is very concerned; • Both CCO 1 and Mr. Y's mother noted mood lower when he drinks; • CCO 1 advised Mr. Y's mother to encourage Mr. Y to use "Lifeline"; • Mr. Y's mother has had more contact with Mr. Y now and is buying household items.
6.02.08	Home visit by CCO 1: • Mr. Y did not want to go to sports group; • Had not picked up script; • CCO 1 accompanied him to do this; • Mr. Y reluctant to seek/accept help for drinking; • Does not see as a problem. Plan: • Mr. Y to keep appt with Housing Support Worker 3; • Mr. Y to reconsider help with drinking; • Mr. Y top re-start anti-depressant; • CCO 1 to accompany Mr. Y to sports group.

6.02.08	HoNOS: Disruptive, aggressive behaviour, = 1 Suicidal = 0 Self harm = 0 Cognitive problems = 0 Physical Problems = 0 Hallucinations = 0 Unreasonable beliefs = 2 Depressed mood = 2 Relationships = 2 Drinking = 2 ADL = 1 Vulnerability = 2 Engagement = 0 (Scores 0-4)
7.02.08	Mr. Y seen by Housing Support staff Heat 10.30 a.m. He was described as "very good". He had seen CCO 1 the day before and received some medication.
8.02.08	CCO 1 called Housing Support Worker 3. Housing Support Worker 3 had seen Mr. Y and reported that there was some improvement in his mood.
13.02.08	Home visit by CCO 1. No response. CCO 1 contacted Housing Support staff. Asked them to pass on message that CCO 1 will escort Mr. Y to pathways on 18.02.08. CCO 1 sends a letter to confirm this. Informed that Housing Support Worker 3 was due to see Mr. Y next day (14.02.08)
14.02.08	Housing staff unable to contact Mr. Y. To initiate missing persons procedures as he has not been seen for a week. Letter to Mr. Y to remind him of appointment at Pathways.
15.02.08	8.30 a.m. Phone call to Mr. Y's mother by CCO 1. He asked her to remind Mr. Y of his appointment with CCO 1. Mr. Y's mother expressed "generalised concerns" over Mr. Y's drinking and isolation. She agreed that low mood and isolation are a result of increased drinking. CCO 1 pointed out that Mr. Y must agree to accept a service. Plan: • CCO 1 to accompany Mr. Y to pathways; • Try to re-engage Mr. Y in services; • Reiterate to Mr. Y the negative effects of alcohol on Mr. Y's mental health.
18.02.08	CCO 1 accompanies Mr. Y to Pathways. • Mr. Y had visited his mother day before, went for a walk with her in the park. She reminded Mr. Y of the appointment; • Mr. Y is brighter in mood and physical appearance; • He is anxious about the visit to Pathways; • CCO 1 agreed to facilitate first two weeks of attendance at Pathways (by accompanying him there) - group is 7 weeks.

	Plan: • Continue medication (Venlafaxine); • Moderate drinking; • Keep appointments; • Attend singing group.
19.02.08	Mr. Y reported that he was feeling better than last time he was seen; Sleeping better; But still sitting at home dwelling on things; Mr. Y feels the need to be more motivated; Mr. Y said if he felt better he would go out to a restaurant and enjoy some good food and good social conversations.
21.02.08	Home visit by CCO 1 to accompany Mr. Y to Pathways. (9.55 a.m. - 10.05 a.m.). No answer. CCO 1 left a message on Mr. Y's answer phone. He also sent a letter asking Mr. Y to make contact.
21.02.08	14.00: Seen at Dewsbury police stations by Section 12 Doctor: • Arrested following murder of father; • Been feeling unwell for 2-3 days: "Bad thoughts" about physical and sexual abuse by his father as a child; • Mother had sent him a text message about a missing child in Dewsbury and as a result he had not been able to "hold it together" with his father in relation to past abuse; • Mr. Y said he was 99% certain that it (his belief) was true; • "This does appear to be delusional to me"; • Is fit to detain and interview with an appropriate adult.
21-22.02.08	Record of Appropriate Adult of police interviews (CPN 2): • Restless the night before and needed to confront his father about matters in the past (sexual abuse). Did not mean to kill him. Mr. Y "Lost it"; • He had a pipe bender (plumbing tool) in a bag; • Felt restless and feelings were "haywire"; • Put it to his father: "*Who is the paedophile you or me*"; • Mr. Y "lost it" and lashed out at father; • Father shouted "*Call an ambulance*" and was screaming; • Mr. Y thought the only way to stop him screaming was to quieten him, so he stamped on his father head c. 8 times; • Mr. Y said that his father was still out there and could interfere with someone. Mr. Y reported that: • he had flashbacks of when he was a child; • was hit with a belt and kicked as a child; • was constantly dwelling on the past; • he had 4 cans of lager the day before (20.02.2008) and was awake all night listening to music; • Had phoned his mother early in the morning but her phone was off; • Received a text message about a girl who had gone missing and

	thought about his own past; • He knew that his father was a paedophile by mother's reaction when he had spoken to her on the phone; • Mr. Y felt a quote on a cigarette paper: "Although prepared for martyrdom it may be postponed" had some significance; • Mr. Y said that he thought his mother had said his father said "W… (can't read) you have a paedophile in your house." • A witness statement was read to Mr. Y. He said he did not hear his sister saying "He's raped me"; • Mr. Y's mother's statement was read to Mr. Y; • She felt he had deteriorated since his medication was stopped two months earlier; • Some weeks earlier she had received a text message from Mr. Y saying "I am going to get everyone who has upset me"; • Mother thought Mr. Y had been taking drugs in past weeks. Mr. Y said this was not the case; • Mr. Y had possibly been dominated by father, brother and sister.