

An independent investigation into the care and
treatment of a person using the services of
Bradford District NHS Care Trust

Undertaken by Consequence UK Ltd

November 2012

2010/12698

This is the report of an independent investigation commissioned by the NHS Yorkshire and the Humber to conform with the statutory requirements outlined in the Department of Health (DH) guidance "*Independent investigation of adverse events in mental health services*", issued in June 2005. The guidance replaces paragraphs 33-36 in HSG (94)27 (LASSL (94)4) concerning the conduct of independent inquiries into mental health services.

The requirement is for an independent investigation of the care and services offered to mental health service users involved in adverse events, defined as including the committing of homicide, where there has been contact with specialist mental health services¹ in the six months prior to the event.

The Independent Investigation Team members were:

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- Jo Lawrence, Clinical Services Lead, Early Intervention in Psychosis, South London and the Maudsley NHS Foundation Trust;
- Dr Mark Potter, Consultant Psychiatrist and Associate Medical Director, South West London and St George's Mental Health Trust.

Acknowledgements

The Independent Investigation Team wishes to thank:

- Mr S, the service user;
- West Yorkshire Police;
- Mr S's consultant forensic psychiatrist;
- Staff at Bradford District NHS Care Trust (known as Bradford District Care Trust);
- The family of the deceased;

for their co-operation with the Independent Investigation Team.

Throughout this report, the Independent Investigation Team is referred to as the Independent Team.

¹ Specialist mental health services are those mental health services that are provided by mental health trusts rather than GP and other primary care services. Usually, persons in receipt of specialist mental health services will have complex mental health needs.

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Executive Summary

Incident overview

On 21 September 2010, Mr S attacked and fatally wounded his wife. He had been under specialist mental health services in Bradford since 2006, having last attended for an outpatient appointment on 26 January 2010. Following the death of his wife, Mr S admitted to manslaughter on the grounds of diminished responsibility in March 2011 and was subsequently sentenced to remain in a secure hospital environment under section 37/41 of the Mental Health Act. The Independent Team wishes to extend its sincere condolences to the family of the deceased.

Purpose of the investigation

The purpose of this investigation was to assess the investigation conducted by Bradford District Care Trust to determine its reasonableness and whether there was any reason to conduct a further independent re-investigation of Mr S's care and treatment.

Conclusion

As a consequence of its considerations, the Independent Team confirms its conclusion that:

- The BDCT investigation was reasonable.
- The range of recommendations and subsequent actions taken by BDCT were appropriate and will contribute to the Trust's determination to reduce the risk of the care and treatment lapses identified with regards to Mr S and his wife from reoccurring.
- On the balance of probabilities, the incident that occurred was not predictable by BDCT staff. Although a constant feature of his paranoia when unwell was unhealthy thoughts about his wife, there is no evidence after 2006 that there was any domestic abuse between Mr S and his wife. His threat to harm her in November 2009 was made with an equal threat towards himself. Before going on home leave, Mr S had reported to staff that he no longer felt this way towards his wife or himself. There were independent family reports that the leave period went well and Mr S was appropriate in his behaviour. It is not reasonable to suggest that, on the basis of Mr S's presentation in 2009, and his past history, staff should or could have predicted that he would kill her.
- With regards to preventability, there are three things that must be considered. Staff must have had
 - Knowledge that an incident was both likely and imminent;
 - The legal means to prevent it; and
 - The opportunity to prevent it.

On all three counts the Independent Team is confident that the BDCT did not have any of the necessary means or knowledge to have prevented what occurred, even if they had contact with him in May and August 2010. Mr S's history shows that when unwell on all previous occasions he had actively sought the input of primary care services, or the police, or A&E services. He made no approach to any of these services between December 2009 and

September 2010. Importantly, neither did the local Family Protection Unit have the knowledge or the means to prevent what occurred to Mrs S. At no time during the four years Mr and Mrs S were resident in Bradford did Mrs S or any family member raise any concern regarding domestic abuse with:

- The mental health services;
- Domestic abuse services;
- Health visiting services.

Recommendations

It is clear that BDCT have engaged in a wide-ranging spectrum of work since this incident occurred. However, based on its analysis and review, the Independent Team does have additional recommendations for BDCT to consider. These recommendations are intended to build upon and enhance the effectiveness of actions already taken by BDCT.

Recommendation 1: BDCT commissioned its own review of the CMHT under which Mr S was managed. The report of this review was published in March 2012. The Independent Team recommends that BDCT provides its commissioners with a detailed breakdown of its considerations of the recommendations made in this report and any actions that are being implemented as a consequence of this, with a timetable for completion.

In particular, the Independent Team would expect actions taken forward to include:

- The development of a robust and workable process for reviewing a service user's s.117 aftercare status and seeking discharge from this where appropriate.
- A clear statement of what the role and responsibilities of the interim care co-ordinator are and how this individual interfaces with the rest of the CMHT.

Recommendation 2: Safeguarding children

Because the assessment of risk to children is central to the contemporary assessment of risk, and because it is a complex issue, BDCT and the provider of its electronic records system should consider including a dedicated section in its risk assessment form for safeguarding children. This would enable the form to include more discrete questions about possible threats to child safety and well being, and thus assist staff in delivering their professional accountabilities in this regard.

The following are examples of the types of questions that could be considered:

- Has there been any direct threat made towards the children by the service user?
- Are there any recorded instances of physical violence towards the children (including smacking)?
- Are there any known instances of neglect towards the children?

- Are there concerns about the service user's capability to discharge their parenting duties to the children when mentally unwell?
- Are you, the mental health professional, confident that the needs of the children are being adequately and safely met by the service user's spouse or partner?
- Is the service user a single parent?

Expert advice should be sought from the Trust's safeguarding lead and Children and Family Services at the local authority if this suggestion is taken forward.

Target Audience: The Deputy Chief Executive/Director of Nursing.

Timescales: Because this recommendation is not something BDCT can take forward without the active support and participation of their RiO provider, it is not appropriate to impose timescales for the implementation of this recommendation. However, the Independent Team considers that it is reasonable that the Trust should be able to update its commissioners on its decision about this recommendation and any communications the Trust has with its RiO provider within three months of the publication of this report.

Recommendation 3

Although the Trust's internal investigation report demonstrated a sincere commitment to the conduct of an effective investigation, there are a number of elements that the Trust needs to improve to ensure that future investigations:

- Maintain objectivity;
- Deliver good practice standards in investigative interviewing techniques;
- Demonstrate a good working understanding of how 'root-cause analysis' applies to mental health incidents such as homicide.

To achieve the above, the Independent Team recommends the following:

- That future investigation teams are considerably smaller than that convened for the Mr S investigation. It should be possible to deliver an effective investigation with a three-person team (one lead investigator, one medical advisor and one nursing/social care advisor). If other subject-matter advisors are needed, these could be accessed on an as-required basis.
- Staff identified as 'investigative leads' must know how to conduct a good investigative interview and appreciate the value of:
 - the 'tell all' instruction;
 - broad open questions;
 - closed questions for clarification purposes;
 - the funnelling technique;
 - avoiding leading and asking questions in such a way as to suggest the answer;
 - avoiding expressing opinions during the interview.

Investigative leads must also:

- appreciate that the investigation is an 'enquiry' into what happened and to ensure that the investigation team understands this from the perspective of the professionals involved; it is essential that there is sufficient depth of exploration, not simply a question and answer approach;
 - appreciate the need for a forensic analysis and exploration of key aspects of clinical practice. This appreciation is an essential competency for an investigative lead.
- Staff identified as investigative leads acquire a more complete understanding of how the National Patient Safety Agency's human factors framework can be applied during the information analysis part of the investigation and how, from this process, root causes can be agreed on.

1.0 INTRODUCTION

Consequence UK Ltd (CUK) (the Independent Team) was commissioned by NHS Yorkshire and the Humber to undertake an independent review of the care and treatment of Mr S, who was accused of the unlawful killing of his wife on 21 September 2010. He was subsequently convicted and sentenced in March 2011. He was sentenced to remain in a secure hospital setting under s.37/41 of the Mental Health Act.

Because at the time of the incident Mr S was a patient of the mental health service provided by Bradford District Care Trust (BDCT), the incident fell within the health circular guidance HSG (94)27. This guidance requires that in such circumstances there is an independent analysis of the care and treatment provided to the service user by mental health services to determine:

- its reasonableness;
- whether or not the incident as it occurred was predictable by mental health services; and
- whether or not the incident as it occurred was preventable by different care and treatment of the service user.

In addition to the above, it is expected that the retrospective analysis will be proportionate and not unnecessarily repeat elements of the Trust's own internal investigation where the Independent Team assesses this to be of a reasonable standard. This means that the Independent Team considers, following its analysis, that the Trust's report meets local and national expectations of a serious untoward incident investigation, in particular the application of systems analysis where significant lapses in care and/or treatment have been identified.

When initially presented to the Independent Team, as part of the tendering process, the internal investigation report provided to NHS North (Yorkshire and The Humber SHA) seemed to be comprehensive and demonstrated that the Trust's investigation team had applied systems thinking and the NPSA's human factors framework to the issues it had identified as falling below the expected standards of practice and thus requiring detailed analysis. Consequently, it was decided in the first instance that a proportionate approach to the independent investigation process would be to conduct a detailed review of:

- Mr S's clinical records from Pennine Care Trust and Bradford District Care Trust.
- The interview records compiled by the Bradford District Care Trust's internal investigation team.
- Relevant policies and procedures at the time;

to determine:

- Whether BDCT's investigation team had identified the right issues of concern.
- Whether the interview records compiled by BDCT's investigation team demonstrated an appropriately thorough analysis of the issues.
- Whether the content of the Bradford District Care Trust's internal investigation report accurately reflected the information gathered, and presented a balanced and complete analysis.

- Whether the recommendations made by Bradford District Care Trust's investigation team were appropriately targeted.

And whether the Independent Team agreed with BDCT's conclusions regarding predictability and preventability of the incident that occurred.

It was agreed between the Strategic Health Authority and the Independent Team that, following the completion of the above, the Independent Team would provide the SHA with a report suitable for publication and advise the SHA of any further work required and why.

This report therefore sets out the Independent Team's findings in relation to the above.

2.0 TERMS OF REFERENCE

The terms of reference for this HSG (94)27 investigation were as follows:

To undertake a validation review of the internal investigation report provided by Bradford District Care Trust into the care and treatment provided by them to Mr S.

The Independent Team was asked to:

- ❑ Establish whether the timeline was accurate and all-encompassing, ensuring that the Trust has considered all the relevant evidence; for example, Trust documentation, including relevant policies and procedures, key witness statements and interviews.
- ❑ Undertake a scoping exercise to identify whether all necessary agencies have been considered and included in the internal investigation. Where this has not been the case, to assess whether the inclusion of the information into the timeline could affect the findings.
- ❑ Assess whether the investigation and analysis undertaken by the Trust was reasonable and proportionate and accurately reflected and explained any relevant issues of concern in relation to Mr S's care and treatment.
- ❑ Review relevant Trust policies and procedures to validate their compliance and that this was accurately reflected in the internal investigation report, paying particular attention to:
 - The Care Programme Approach;
 - The risk assessment process;
 - Care plans; and
 - The Mental Health Act assessment.
- ❑ Establish whether the recommendations set out in the Trust's internal investigation report were realistic, measurable, specific, appropriate action-orientated and time-bound. Furthermore, the Independent Team was asked to comment on the reliability of recommendations and/or action plans and whether they would mitigate against the issues identified.
- ❑ Identify any additional learning from this investigation, including learning in relation to the conduct of the investigation process, through applying root-cause analysis tools and techniques as applicable.
- ❑ Report the findings of this investigation to NHS North (Yorkshire and The Humber SHA).
- ❑ Produce a report that complies with all relevant legislation to enable the publication of the report and to report these findings and recommendations to the Board of NHS North of England via the North of England Quality Assurance Committee.

3.0 CONTACT WITH MR S AND HIS FAMILY

The Independent Team first made contact with Mr S via his current clinical team on 21 March 2012. This resulted in the provision of Mr S's consent for the Independent Team to have access to his:

- Mental Health records in Pennine Care Trust and Bradford District Care Trust.
- GP records, if required.
- Relevant police records.

Representatives of the SHA and the Independent Team also met with Mr S on 1 May to discuss the independent process with him. There were no significant questions arising from this meeting.

Contact was made with the brother of Mr S and also the representative of the family for the deceased, Mrs S, on 4 April 2012. No response to the Independent Team's letter was received from Mr S's family. The representative for Mrs S's family declined to meet with the Independent Team, but expressed an interest in reading the investigation report when it was complete.

Contact was made with the families of Mr S and his wife on 10 September 2012 advising them that the independent process was complete and offering to meet with them to go through the report and to share with them the findings, conclusions and recommendations. At the time of submitting the final report, 26 October 2012, no response had been received from either family.

Correspondence was sent to Mr S and his current clinical team on 12 September 2012 advising them of the completion of the independent process and offering the opportunity of a meeting so that the findings conclusions and recommendations could be shared. No response to this correspondence had been received by 26 October 2012. Clarification of Mr S's wishes was sought from Mr S's clinical team on 28 October 2012 by email.

4.0 AN OVERVIEW OF MR S'S CONTACT WITH MENTAL HEALTH SERVICES

Pennine Care Trust

28 February 2005, the first contact:

Mr S was assessed by a duty doctor and an approved social worker at the request of the police. Mr S had presented at a walk-in centre and accused his wife of abusing their children and also of trying to poison him.

Following police attendance at Mr S's home to check on the welfare of the children, there was consideration of mental health issues for Mr S.

The assessment revealed that Mr S had held paranoid delusions that:

- His wife had been trying to kill him for a number of months, and that she was in league with an ex-girlfriend of his.
- His wife was controlling his thoughts and those of others.
- Things were moving around the house.
- There was poison in his water.
- Everyone was against him.

He also believed that something was "*inside him*" and that his wife had caused this.

Under a heading 'violence and aggression', it was recorded that he had hit his wife and that she had made him hit the children; however, he had not done this in the preceding four months. The children were aged three years, two years and four months respectively.

There was no significant physical health history and no previous mental health history.

The general impression at this time was of a co-operative but distracted gentleman, casually dressed, who appeared to be frightened of his wife. The record noted that Mr S was hearing 'ASIs' and had no thoughts of harming himself or others.

Mr S's insight was noted to be poor; he was resistant to admission and reported that he was "*fine now*".

The impression was of first presentation paranoid psychotic illness with ideas of reference, delusions and hallucinations.

Risks were noted as mainly to his wife, as a consequence of his beliefs and lack of insight; however, it was noted that there were also risks to the children.

The plan was to admit Mr S under s.2 of the Mental Health Act for further assessment. Medication prescribed at the time was as-required Haloperidol and Lorazepam.

29 February to 3 March 2005:

Mr S remained suspicious and worried that his wife would harm their children. The child team had been contacted by the approved social worker. Risperidone was commenced at 1mg on 2 March and then increased to 1mg twice a day on 3 March, increasing to 4mg twice a day.

4 March to 17 March 2005:

Mr S was noted to be requesting home leave, but, because of his limited improvement and continuing lack of insight, no unescorted leave was granted because of his risk of acting on persecutory ideas.

By 7 March Mr S was noted to be much improved. He was able to admit to having had “weird” thoughts and acting bizarrely. He denied hearing voices and accepted that he had probably not been well when he had thoughts that his wife was plotting against him. Mr S was reported as acknowledging that he required medication to stay well. As a consequence of his improvements, a period of unescorted leave home was commenced.

The records show that Mr S continued to improve on a daily basis and recounted to staff more detail about the triggers that may have impacted on his psychotic episode. These triggers included:

- Family tension about property.
- Suspecting his wife of infidelity.
- Feeling that his wife would leave him, taking the children with her.
- Smoking cannabis with colleagues.

At discharge from in-patient services on 17 March 2005, Mr S’s medication was Risperidone 2mg twice a day.

31 March 2005:

Mr S attended at the local accident and emergency department. There were again signs of emerging paranoia. He had not been fully treatment-compliant and had missed some doses of medication. He had also been to see a holy person with his brother, but then felt that “*someone was after him*” and that his “*head felt heavy*”. He reported being frightened of children’s TV programmes.

The impression was one of psychotic relapse. It was also noted that there was no collateral history available from Mr S’s wife, who spoke little English. Conducting a robust risk assessment was noted as difficult in the absence of any collateral history.

A decision was made to re-admit Mr S because of the previous history of violence towards his wife, the lack of collateral history and because Mr S wanted to be admitted. Although an informal admission, this was converted to a hospital detention under s.5(2) of the Mental Health Act when Mr S tried to discharge himself and it was clear that his delusions continued. Mr S’s Risperidone was increased to 3mg twice a day. It was also recommended that Mr S be detained under s.3 of the Mental Health Act.

19 April 2005:

Mr S remained an in-patient. There was a meeting with Mrs S on this day in the presence of an interpreter (the records are almost illegible here).

22 April 2005:

Mr S and Mrs S were both seen on the SHO's round. Time was also spent with Mrs S on her own. The records noted that she did not report any aggression or violence towards her. She was reassured that whatever she revealed would be treated in confidence.

3 May 2005:

Mr S was discharged home with outpatient follow-up on 18 May (two weeks after discharge). A diagnosis of schizophrenia was noted in the records and Mr S's medication at discharge was reduced to 1mg Risperidone in the morning and 4mg at night. CPN follow-up was to occur on a monthly basis.

18 May to 17 August 2005:

Mr S attended at his first outpatient appointment, missed his second appointment of 13 July, but attended at the appointment offered for 17 August. Initially, Mr S continued to ruminate on his problems and reported not feeling well. His Risperidone was increased to 6mg a day. By August, Mr S was noted to be feeling better, his appetite had improved and he reported that he was getting on well with his wife and children. He denied any auditory hallucinations; he denied any of the previous thoughts involving his wife that had led to his admission; and completely denied any cannabis use, saying he would never use it. He reported wanting to work. Mr S denied all thoughts of harm to self or others, including his wife and children.

Mr S remained settled until January 2006.

30 January 2006:

Mr S self presented at A&E. It was noted that Mr S stopped his Risperidone in the latter part of December and he was experiencing a re-emergence of his paranoia and delusions. He reported no thoughts of harm to his wife. Medication was recommenced (6mg Risperidone, 2mg in the morning and 4mg at night). The initial plan was for discharge and outpatient follow-up in eight weeks. However, Mr S was re-assessed prior to his discharge from A&E and he was not willing to re-commence medication. A recommendation for further senior review before discharge from A&E was therefore recommended. As a consequence, Mr S was admitted to hospital on an informal basis, with the understanding that if he tried to leave the ward then he would be detained under s.5(2) of the Mental Health Act. A feature reported to have contributed to the decision to admit was a telephone call overheard by a healthcare assistant between Mr S and his wife, when she reportedly told him he was not coming home because he hit her.

1 February to 13 February 2006:

Mrs S informed the ward that she was content for her husband to have leave to come home. This was agreed providing Mr S took his medication on the ward. Leave was also agreed on subsequent days, and this was reported to have gone well. Consequently, weekend leave was also agreed, providing his mental state remained stable.

Because Mr S remained stable and there were positive reports regarding his time at home, leave was granted between 6 and 10 February and then over the weekend of 11 and 12 February 2006.

Mr S was subsequently discharged on 10 February 2006. Outpatient follow-up was booked for two weeks after discharge and CPN follow-up was also to occur. Risperidone was to continue at 6mg a day.

17 March 2006:

Mr S had moved to Bradford. His plan to move was not known by mental health services and it was discovered when his care co-ordinator went to visit him at home. This care co-ordinator then wrote to the city community mental health team in Bradford, advising them of the following:

- ❑ Mr S had moved suddenly, so there was no opportunity for a planned hand-over of care.
- ❑ Mr S had been known to Rochdale services since 2005.
- ❑ Mr S had two admissions under the Mental Health Act.
- ❑ Mr S was subject to s.117 aftercare.
- ❑ That Mr S had three pre-school children and that he and his wife were expecting their fourth child in April 2006.
- ❑ Mr S spoke very good English, but that his wife spoke Mirpuri and Urdu with limited English.
- ❑ An overview of his psychosis.
- ❑ That no action had been taken by children's services.
- ❑ That there had been reference to past aggression towards Mrs S by Mr S and also that Mr S had used cannabis in the past.

Her letter concluded with:

"On the basis of my last visit and recent telephone conversations I have had with [Mr S] I do not have any immediate concerns with regards to his mental health. However, I feel a prompt response from your team would be beneficial as he may experience an increased level of stress from his move and may also overlook sorting out [his] medication, both of which could induce a relapse in [his] mental health."

This care co-ordinator also wrote to Mr S advising him that she was transferring his care to a community mental health team in Bradford, but that until this process was completed he could contact her if he was concerned about anything.

18 April 2006:

The Specialist Registrar working with Mr S wrote to Mr S's new GP and copied the letter to the city CMHT in Bradford. This letter also highlighted that when Mr S became psychotic it led to paranoia about his wife and aggressive outbursts.

26 April 2006:

The care co-ordinator from Pennine Care Trust sent the team manager for the community mental health team to which Mr S was to be connected copies of:

- the weighted risk indicator; and
- a risk diagram completed on 16 March 2006.

Both documents identified Mr S as a low risk of harm to self, low risk of neglect and low risk of harm to others.

11 May 2006:

Mr S received his first visit from Bradford District Care Trust. At this visit Mr S was noted to be well with no evidence of psychotic phenomena. However, it was also noted that "*when he becomes ill he hears voices and becomes paranoid about going out, believing that people are talking about him and watching him, etc*". However, on the day of the visit none of these symptoms were apparent.

Mr S was informed by the community psychiatric nurse that outpatient follow-up would be arranged for him. Contact numbers were also provided to Mr S should he need further support. The first outpatient appointment was arranged for 27 June 2006. However, in the event, Mr S was not seen until 1 August 2006.

1 August 2006:

Mr S was seen by his consultant psychiatrist. This consultant set out a comprehensive history that he had gathered from Mr S. This was also reflected in his subsequent correspondence to Mr S's GP. The documents clearly identify:

- The chronology of Mr S's mental health issues;
- Mr S's persecutory ideas and that these were focused predominantly on his wife.

The plan was noted as:

- Risperidone reduced to 4mg at night instead of 6mg a day.
- Mr S was to engage himself more in activities and work.
- A medical review in four months.

It was noted that Mr S was provided with the contact numbers for the duty team in case he needed support.

1 August 2006 to 16 February 2009:

Mr S remained relatively well in the community and attended reliably for outpatient follow-up. He was noted to be medication-compliant. Mr S was unaccompanied at all appointments.

16 February 2009:

Mr S was noted as feeling stressed at this outpatient appointment. He reported that he had been increasingly arguing with his wife and that he had fleeting thoughts that she may poison him. However, the thoughts spontaneously disappeared. On assessment, there was no evidence of hallucinations and his cognition was noted as intact and that he had "*good insight*". The plan was to continue with four-monthly outpatient follow-up and for Mr S's Risperidone to continue.

28 July 2009:

Mr S contacted the community mental health team and left a message. His call was returned the following day, 29 July. Mr S reported:

- Feeling depressed and lonely as his wife was in Pakistan.
- That his GP had told him there was nothing wrong with him.
- That he was feeling suicidal and unable to cope, but that he had no plans to kill himself.
- That he was angry about his wife's departure.
- That he had an outpatient appointment in September but he could not wait until then.
- That his appetite was depressed, but he could drink water.
- That he was not sleeping.

Mr S was advised to make contact with his wider family for support. His outpatient appointment was also brought forward. This was for 30 July 2009. This was the only appointment available. The record noted that it was not brought forward to 30 July because of any assessed level of urgency.

30 July and 31 July 2009:

Mr S attended at outpatients on his own and was assessed by the SHO to his consultant psychiatrist. The record noted that Mr S had experienced deterioration in his mental state. His wife and children were visiting her family and had been away for two weeks. Mr S was experiencing a re-emergence of his persecutory symptoms and also thoughts about his wife trying to harm him. On assessment, there was no evidence of thought insertion; he denied any hallucinations; and the SHO could not detect any signs that Mr S was responding to unseen stimuli. Mr S was noted to build a quick rapport with the SHO. The SHO also noted that Mr S's insight was lacking.

The plan at this time was:

- Follow-up in one to two months.
- Risperidone to increase from 3mg at night to 4mg.
- Mr S encouraged to seek the support of his own and his extended family while his wife was away.

The following day Mr S was referred to the Intensive Home Treatment Team. Mr S had been taken to A&E by the police, having presented as concerned and unwell to them. As a consequence of Mr S's past history and the current situation, and Mr S's willingness to engage with the Intensive Home Treatment Team, he was taken on to their caseload for a short period.

2 August 2009 to 27 September 2009:

Over this 6-week period Mr S had nine contacts with the intensive home treatment team. The contacts up to 1 September were to support him in dealing with his persecutory ideas and also the absence of his wife. After 21 September, the contact involved his wife where possible. The Intensive Home Care Team identified a Muslim worker to attend at some appointments so that collateral information could be gathered. The notes make it clear that the Intensive Home Treatment Team hoped that having a member of staff present who could speak with Mrs S in her own language would help her speak more freely. No information suggestive of ongoing domestic abuse was elicited.

Over this period Mr S was specifically encouraged to attend at the local community centre to look at the benefits to which he might be entitled. This was within walking distance of his home.

3 November 2009:

Mr S attended his outpatient appointment with his consultant psychiatrist. Mr S was noted to be doing well, working full-time. However, other than work, he was not going out, as thoughts about his wife continued. Mr S was reported as telling his consultant that, although his thoughts continued, the feelings were not so overpowering and he could put them to one side. Mr S also reported telling his consultant that his medication was helpful.

The plan at this time was for medical review in six months.

19 November to 1 December 2009:

Mr S was an in-patient.

Mr S was admitted via A&E to in-patient mental health services on 19 November. On this occasion he informed staff that if he was not admitted he would kill either himself or his wife. The clinical records clearly stated that if Mr S tried to leave the ward then he was to be detained under s.5(2)² of the Mental Health Act.

On 24 November consent was obtained from Mr S for the staff to speak with his wife on her own.

On 25 November the Specialist Registrar was able to speak with Mr S's wife on the phone, but only for a short time.

² Section 5(2) is a doctor's holding power. It can only be used to detain in hospital a person who has agreed to informal (wilful) admission but then changed his mind and wishes to leave. It can be implemented following a (usually brief) assessment by the consultant psychiatrist or his deputy, which, in effect, means any hospital doctor, including psychiatrists, but also those based on medical or surgical wards. It lasts up to 72 hours, during which time a further assessment may result in either discharge from the Section or detention under a Section 2 assessment order or Section 3 treatment order.

On 26 November Mr S went home on 'home leave'. His wife and family were supportive of this.

Mr S did not attend the ward for review as agreed, but phoned the ward instead, returning from leave on Monday, 1 December. Mr S was discharged on this day.

26 January 2010:

Mr S attended at his outpatient appointment with his consultant psychiatrist. The subsequent letter to Mr S's GP noted that Mr S had been stable since his discharge and that Mr S denied hearing voices or feeling paranoid.

This was the last time Mr S was seen and assessed by mental health services. He did not attend his appointments of 10 May 2010 or 11 May 2010.

The incident occurred on 20 September 2010, eight months after Mr S's contact with services.

The following section addresses in more detail Mr S's contact with mental health services in Bradford

5.0 FINDINGS OF THE INDEPENDENT TEAM

To deliver the terms of reference for this HSG investigation, the Independent Team undertook a detailed analysis of Mr S's clinical records between 28 February 2005 and 26 January 2010. The investigation tool used to support this analysis was a structured analytical timeline. The replication of Mr S's chronology using this tool enabled the Independent Team to forensically examine the care and treatment given to Mr S by the specialist mental health services provided by Pennine Care Trust and Bradford District Care Trust (BDCT).

In addition to its analysis of Mr S's clinical records, the Independent Team had access to:

- The written interview records made by Bradford District Care Trust's own internal investigation team, which comprised 104 pages and related to the following staff:
 - Three staff nurses on the in-patient ward, November 2009.
 - A senior house officer (SHO) on the in-patient ward, November 2009.
 - The in-patient consultant psychiatrist, November 2009.
 - The in-patient specialist registrar, November 2009.
 - Mr S's community consultant psychiatrist, 2006 to 2010.
 - The team manager of the community mental health team.
 - A community mental health team nurse.
 - The manager of the in-patient ward, November 2009.
 - The '7-day discharge' care co-ordinator, November 2009.
 - The team manager of the Intensive Home Treatment Team, November 2010.
 - Four Intensive Home Treatment Team workers.
 - The safeguarding-adults lead at the Trust, November 2009 and November 2010.
 - The safeguarding-children lead at the Trust.
 - The health visitor to Mr S's children.
 - The Trust's medical director.
- Bradford District Care Trust's policies on:
 - Failure to attend appointments, 2007 and 2008.
 - Safeguarding Children Policies and Procedures, August 2009.
 - Safeguarding Vulnerable Adults, August 2009.
 - Care Programme Approach Policy 2009.
- Records from Cheshire Police:
 - Impact statements from the parents of the deceased.
 - Domestic abuse records dated 18 January 2004, 27 February 2005 and 31 January 2006. (None of these reports were of sufficient severity to trigger the vulnerable adults' process or to place either Mr S or his wife at risk.)

As a consequence of its analysis of all of the above, the Independent Team members were all agreed in their conclusion that there is no substantial reason to

conduct an independent re-investigation of Mr S's mental health care and treatment prior to his index offence.

The rationale for this conclusion is three-fold:

The BDCT investigation was sufficiently searching to render the potential for additional learning opportunities over and above those which BDCT had already identified as being unlikely.

The Independent Team conducted its own analysis of Mr S's clinical records prior to reviewing the BDCT investigation in depth. The Independent Team is satisfied that the issues identified by the BDCT investigation team were correct.

Although not as searching as it could have been, the BDCT analysis as presented in their internal investigation report reflects accurately the information provided to the BDCT investigation team by those staff interviewed. Furthermore, the depth and breadth of analysis was sufficient for the Independent Team to have a reasonable level of understanding regarding the contributory factors and root causes for most of the lapses in care and treatment for Mr S.

Although the Independent Team would have preferred a greater depth of exploration around:

- ❑ CPA (2006 to 2009);
- ❑ Risk Assessment practice (2006 to 2009);
- ❑ Supervision of staff;
- ❑ How quality standards were monitored at the level of the in-patient ward and the CMHT;

the recommendations were for the greater part well focused and addressed the areas the Independent Team considered needed attention.

For all of the above reasons, the Independent Team considers that in this case (Mr S) the likelihood of additional learning opportunities arising from a further independent investigation are low and thus the Independent Team does not recommend this.

Information not available to BDCT at the time of their investigation but which influences the Independent Team in its decision

The police investigation into the death of Mrs S did not establish any evidence of domestic abuse between Mr S and his wife. The only reports of domestic abuse were made between 2004 and 2006. On two of the occasions, concerns were raised by Mr S about his wife's behaviour and on one occasion a concern was raised about Mr S's behaviour. In view of the nature of the incident, it is therefore unlikely that the mental health services would have been able to predict the seriousness of the incident that occurred or to have prevented the death of Mr S's wife had they maintained contact between January 2010 and September 2010.

5.1 Information detailed within Mr S's clinical records that show where he was provided with a reasonable standard of care

The Independent Team considers that the following aspects of Mr S's care and treatment require acknowledgement in the context of this report.

Pennine Care Trust:

- ❑ On 30 January 2006 the community mental health team contacted interpreter services as they needed to establish whether or not Mrs S felt safe at home with her husband.
- ❑ On 31 January 2006 there was an urgent outpatient review for Mr S. He had stopped his Risperidone in the latter part of December because someone had told him that he shouldn't take it long-term. He was, as a consequence, experiencing a re-emergence of his bad thoughts regarding his wife and that people were following him, although he did not know whom. Mr S was assessed by a total of three doctors, two in training and one consultant. He was re-commenced on medication and allowed to return home. The SHO took care to ensure that Mr S's care co-ordinator was informed of the management plan and the situation at the time.
- ❑ 17 March 2006: Mr S moved unexpectedly from his home and outside of the boundaries of the then Pennine Care Trust to a location that fell within the boundary of Bradford District Care Trust. The then care co-ordinator for Mr S wrote to what she believed was the correct community mental health team for Mr S's home. Once she had determined Mr S's new address, she also wrote to him advising that she had referred him to a new team and that he could contact her at any time until he was allocated to a new care co-ordinator.

Bradford District Care Trust:

- ❑ Mid-August 2009: Although it was not entirely necessary for Mr S to be followed-up by the Intensive Home Treatment Team, the Intensive Home Treatment Team demonstrated flexibility in their approach by trying to meet the needs of Mr S, who clearly was not coping well on his own at home during his wife's absence.
- ❑ The Intensive Home Treatment Team appropriately liaised with the health visitor for Mr S's children to explore what, if any, safeguarding issues were in evidence. This information was taken from interviews the Trust's investigation team conducted with the home treatment team staff. The clinical records were not as complete as they could have been about the team's adherence to good practice expectations.
- ❑ The Intensive Home Treatment Team correctly involved one of their support workers with Mr S and his family towards the end of September 2009 as he could speak the same language as Mr S's wife. The home treatment team were aware that they lacked collateral history from Mrs S and that they needed to establish to what extent she was at risk from her husband when he was unwell.

- On 20 November 2009 the nurse who undertook the admission assessment for Mr S set out a comprehensive summary of the antecedents to Mr S's admission. Relevant points documented were:
 - Mr S was open and engaging, willing to give information;
 - Mr S expressed thoughts that he felt he was being victimised by his work colleagues, saying that they were trying to kill him;
 - Mr S reported that his wife was having an affair and was trying to poison him;
 - That his wife was a barrier between him and his family. Mr S reported that his wife did not get on with his family.
- On 22 November a 'bank nurse' set out a detailed nursing record. The record clearly demonstrated that the nurse spent about an hour with Mr S, and that the nurse went through a range of activities which might help Mr S deal better with his experiences/symptoms; for example, mindfulness and yoga. The record also shows that the bank nurse spent time assessing Mr S's mental state. The record concluded that Mr S's risks as they presented on admission had receded. It is the perspective of the Independent Team that this nurse's record showed a thoughtful approach to the care of service users.
- On 24 November the in-patient consultant responsible for Mr S requested his Pennine Care Trust records. This was a good plan.
- On 25 November 2006 the specialist registrar spoke with Mrs S on the phone. The aim was to meet with her, but a telephone conversation was all that could be achieved. The specialist registrar was mindful that in this case collateral history and establishing to what extent Mrs S understood her husband's mental illness was important. That this doctor was not able to engage Mrs S in the depth of conversation she hoped for does not detract from the fact that she attempted to achieve this.
- On 26 November the specialist registrar to the in-patient consultant was appropriately cautious regarding Mr S's and his family's request for him to have home leave over the Eid period. Because Mr S was an informal patient, the specialist registrar asked that Mr S be assessed to determine whether or not he was detainable, and if not then to allow overnight leave. Mr S was assessed as 'not detainable', so leave was granted. The plan agreed with Mr S was as follows:
 - The ward was to call him at home the following day to check all was OK.
 - Mr S was provided with all relevant contact numbers in case he felt unwell.
 - Mr S was to return to ward on the Saturday for assessment and if all remained well he could then return home again. The planned leave period was for four days.

Under the circumstances and the desire of Mr S's family to have him home, including his wife, and the fact that he was not considered to be detainable, it is the perspective of the Independent Team that the specialist registrar made the leave arrangements as robust as was possible at the time.

The above identified points broadly correspond with the positive feedback the BDCT investigation team set out in its report.

5.2 The Independent Team's Findings in relation to the Terms of Reference set by NHS Yorkshire and the Humber

5.2.1 Term of reference 1

Establish whether the timeline was accurate and all-encompassing, ensuring that the Trust has considered all the relevant evidence; for example, Trust documentation, key witness statements and interviews.

The BDCT investigation team set out Mr S's chronology in three sections of its report:

- in section 1.3 entitled Background and Context;
- in section 2.1 entitled Chronology of Events; and
- Appendix 3, the full chronology.

Section 1.3 of the BDCT's investigation report provides a succinct overview of Mr S, his social circumstance, and his diagnosis. It also sets out the length of time Mr S was in contact with mental health services (2005 to 2010), and that initially he was under the care and treatment of services in Pennine Care Trust (2005 and 2006), initially being admitted under s.2 of the Mental Health Act (1983) before transferring to BDCT (2006 to 2010). Section 1.3 also sets out the background in relation to Mr S's contact with the different elements of its services, these being:

- The Intensive Home Treatment Team.
- The community mental health team.
- In-patient services.

However, s.1.3 of the BDCT report does not set out an overview chronology of key events for Mr S during his contact with the specialist mental health services in Bradford. This is addressed in s.2.1 of the BDCT report, where a succinct overview of key dates and events is provided. The inclusion of this at an earlier juncture in the report may have been beneficial to the reader of the report.

The above being said, the detailed chronology set out at Appendix 3 is well laid out and contains an appropriate depth of detail. For future reports, BDCT might consider signposting the reader of the report to the full chronology; e.g. "*See appendix Y (page Z) for the detailed chronology of Mr S's contacts with BDCT*".

5.2.2 Term of reference 2

Undertake a scoping exercise to identify whether all necessary agencies have been considered and included in the internal investigation. Where this has not been the case, to assess whether the inclusion of the information into the timeline could affect the findings.

The relevant agencies in this case were:

- Pennine Care Trust;
- West Yorkshire Police.

The BDCT investigation team did access the Pennine Care Trust clinical records and included Mr S's contacts with them in its chronological timeline. This constituted good practice. However, the BDCT investigation team did not critique the care and treatment interventions provided by Pennine Care Trust. This was not unreasonable in view of the 4-year period BDCT had been responsible for the care and treatment of Mr S prior to the incident occurring. However, the Independent Team identified that when Mr S first presented to Pennine Care Trust he met all of the criteria for the early intervention service.³ In the context of the incident that occurred, the Independent Team considered that establishing why Mr S was not initially managed by the early intervention service was important. It is the perspective of the Independent Team that had Mr S been under early intervention services then, if good practice protocols were in place and followed, his care and treatment in all likelihood would have been transferred to the early intervention service operating in Bradford (if established). In such a circumstance many of the concerns the BDCT investigation team identified about decisions made regarding the non-allocation of a non-medical care co-ordinator would not have occurred. Furthermore, although Mr S's presentation would have meant that he would have been considered one of the lower risk early intervention service users, he may have had greater access to input by psychological services. He would have received a more intensive and comprehensive service. The work undertaken would have involved his wife, as carer, to a much greater degree. There would have been a focus on his early-warning signs, and a relapse prevention plan involving both Mr S and his wife would have been in place. During the period between 2004 and 2006, early intervention services were in the process of set-up and development in many parts of the country. In 2005 Pennine Care Trust did not have an early intervention service in Rochdale. This was not established until 2006. Therefore there was no opportunity for him to receive care and treatment from this emerging initiative. However, if an individual were to present in similar circumstances as Mr S did, now in 2012 he would receive care and treatment from early intervention services.

However, even had Mr S been in receipt of early intervention services between 2005 and 2008, it is not possible to extrapolate that the subsequent events of 2010 would not have occurred. By mid-2008 Mr S would, in all likelihood, have been discharged

³ An early Intervention service is a service specifically designed for individuals, usually between the ages of 16 and 30-35, who are experiencing a first episode of psychosis.

from early intervention services, and his existing chronology shows that up until 2009 he was stable in the community, requiring only outpatient follow-up.

With regards to West Yorkshire Police, at the time of the BDCT internal investigation the criminal justice investigation would have been running in parallel and it would not have been possible for BDCT to access material relevant to the defence or Crown Prosecution case.

5.2.3 Term of reference 3

Assess whether the investigation and analysis undertaken by the Trust was reasonable and proportionate and accurately reflected and explained any relevant issues of concern in relation to Mr S's care and treatment.

The Independent Team suggests that the whole purpose of a retrospective investigation is to conduct a detailed analysis of the service user's care and treatment to determine the extent to which the care and treatment delivered met with expected standards, and whether or not there were any significant lapses in the standard of service and care provided. If, during the review process, significant lapses are identified, then the purpose of the investigation is to explore these as thoroughly as possible from a clinical practice and systems-based perspective so that appropriate improvements can be implemented to remedy the identified weaknesses. In addition, the purpose of any investigation is to determine whether what happened was predictable, and also to determine whether the incident was preventable had the care and treatment been of a consistently good standard.

The ability of an NHS Trust to deliver the above will be influenced by the robustness of the terms of reference provided for the investigation process. The terms of reference the BDCT investigation team were working to were as follows:

BDCT Terms of Reference

“i) Purpose

To identify the root causes and key learning from an incident and use this information to significantly reduce the likelihood of future harm to service users.

ii) Objectives

To establish the facts, i.e. what happened (effect), to whom, when, where, how and why (root causes). The investigation will aim to:

- Look for improvements rather than to apportion blame*
- Establish how recurrence may be reduced or eliminated*
- Formulate recommendations and an action plan*
- Provide a report and record of the investigation process and outcome*
- Provide a means of sharing learning from the incident*
- Identify routes of sharing learning from the incident.*

iii) Key questions/issues to be addressed

- The chronology of events leading up to the incident.*
- The care and treatment that Mr S was receiving leading up to and at the time of the incident, including the factors that may have contributed to them.*
- The context in which care was delivered, including the interfaces and communications between professionals, other organisations and family members.*
- The suitability of that care in view of the service user’s history, identified risks and assessed health and social care needs, and the monitoring arrangements for this.*
- The extent to which the care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies and procedures.*
- The appropriate exercise of professional judgement.”*

The above terms of reference are generic and not specifically targeted to the needs of the Mr S investigation. The terms of reference also allude to the determination of the cause of what occurred; in this case the unlawful killing of Mr S’s wife. This is not the purpose of a mental health homicide investigation. How the incident occurred and the motivation for it was the business of the criminal investigation and not the health investigation. Because this type of investigation is usually preceded by the local manager’s 24-hr or 72-hr report which sets out the chronology of a service user, a more relevant approach to the terms of reference of this case might have been to set specific questions for the investigation team to respond to, such as:

Example Terms of Reference

- When Mr S transferred to the care and responsibility of specialist mental health services in Bradford, was there:
 - An appropriate assessment of his needs?
 - Appropriate allocation of CPA (i.e. standard or enhanced)?
- Did Mr S have a care plan that set out his needs and was that plan delivered between:
 - 2006 and June 2009;
 - July 2009 and the end of August 2009;
 - September 2009 and 18 November 2009;
 - 19 November 2009 and 7 December 2009;
 - 8 December 2009 and 26 January 2010;
 - 27 January and the date of the incident?
- Did Mr S have appropriate and timely risk assessments conducted and did those risk assessments inform his care management and CPA level:
 - Between 2006 and June 2009;
 - Between July 2009 and 18 November 2009;
 - During his in-patient episode, 19 November to 1 December 2009;
 - At discharge from in-patient services on 1 December;
 - At discharge from the interim CPN's caseload back to the sole care of the consultant psychiatrist on 7 December 2009?
- Was there appropriate communication between mental health professionals and Mr S's wife and other relevant family members:
 - Between 2006 and June 2009;
 - Between July 2009 and 18 November 2009;
 - During his in-patient episode, 19 November to 1 December 2009;
 - At discharge from in-patient services on 1 December;
 - At discharge from the interim CPN's caseload back to the sole care of the consultant psychiatrist on 7 December 2009?
- Was the incident that occurred on 21 September 2010 predictable on the basis of the information BDCT mental health professionals had access to, or reasonably could or should have had access to?
- Was the incident that occurred on 21 September 2010 preventable on the basis of the information BDCT mental health professionals had access to, or reasonably could or should have had access to, such as:
 - Were staff knowledgeable that an incident was both likely and imminent?
 - Did staff have the legal means to prevent it?
 - Did staff have the opportunity to prevent it?
- To identify any 'added value' learning that arises as a consequence of undertaking the investigation but that is unrelated to the above questions.
- To make recommendations to address the root causes of any significant practice or systems lapse.
- To write a clear and logical report that addresses each of the questions set out in this terms of reference.

Note: In addressing the above, if the investigation determines that Mr S's care and treatment fell significantly below BDCT's expected standards, then the investigation team is expected to set out the contributory factors and root causes to each significant lapse.

Such a terms of reference leaves the appointed investigation team in no doubt as to what is required and the depth of analysis that is expected.

In the case of Mr S, the BDCT investigation team did present an investigation report that delivered the terms of reference provided to it. Furthermore, the BDCT investigation did address all the specific areas of clinical practice highlighted by the Independent Team's example terms of reference set out above. However, the depth of analysis of some aspects of clinical practice and systems functionality was not as searching as the Independent Team would have expected, given the severity of the incident. The Independent Team suggests that, had more specific terms of reference been utilised, then it would have guided the BDCT investigation to a deeper level of exploration.

The remainder of this section will address in detail the extent to which the BDCT *"investigation and analysis undertaken was reasonable and proportionate and reflected and explained any relevant issues of concern in relation to Mr S's care and treatment"*.

5.2.3.1 The issues identified and addressed by the BDCT investigation team

The BDCT investigation team identified eight areas of concern as a consequence of its assessment of Mr S's mental health records. These were:

1. Mr S was subject to s.117 of the Mental Health Act. However, despite the consultant psychiatrist in the CMHT being aware of this, his rights under s.117 were not fully met whilst he was a service user in BDCT, specifically in relation to the opportunity to receive appropriate aftercare via the local authority.
2. Mr S did not have an appropriate care co-ordinator allocated on admission to the CMHT in BDCT, despite his diagnosis and the fact that he was subject to s.117 aftercare.
3. The discharge meeting held by the in-patient service did not result in a robust risk assessment and the care plan being developed prior to discharge.
4. The interim care co-ordinator discharged Mr S back to the care of his consultant psychiatrist after a 7-day follow-up visit.
5. The process for outpatient appointments was flawed in that Mr S was not seen for nine months prior to the incident occurring.
6. There was no discussion with or referral to the safeguarding adults or safeguarding children's leads within BDCT by any staff team involved with Mr S's care.
7. There was no evidence that Mr S's wife was informed by either the in-patient services or the CMHT of the threats made against her in November 2009.
8. There was no evidence of referral for either psychological interventions or specific social support.

In relation to the above, the Independent Team considered that:

1. Section 117 aftercare: It agrees that there was a lapse in policy compliance in relation to Mr S's s.117 aftercare. Mr S was transferred to BDCT on s.117 aftercare and this should have been picked up and acted upon as a consequence of the referral, assessment and allocation process.
2. The non-allocation of a care co-ordinator to Mr S in 2006: The Independent Team agrees in principle with this finding. However, the Independent Team considers that the matter of the levels of CPA Mr S was placed on was an issue that continued throughout his contact with BDCT. To have confined the problem statement around CPA to the allocation of a medical care co-ordinator between April and June 2006 stated the concern around CPA too narrowly. The Independent Team considers that something along the lines of the following would have been more inclusive:

“The Investigation found that Mr S’s management under CPA did not meet BDCT’s policy expectations in:

- 2006;
- September 2009; and
- December 2009.

On all occasions Mr S met the criteria for enhanced CPA/CPA and he was only placed on standard CPA/non-CPA.”

3. The lack of risk assessment prior to the discharge of Mr S from in-patient services in 2009: The Independent Team agrees with this. However, as above, it considers that the BDCT investigation team stated its concern too narrowly. The effectiveness of Mr S's risk assessments needed to be addressed when he was first accepted into the BDCT service in 2006, again between July and September 2009, during his in-patient episode between 19 November and 1 December 2009, and at the point of discharge both on 1 December from in-patient services and when the interim care co-ordinator discharged Mr S from his caseload on 7 December 2009.
4. The discharge of Mr S by the interim care co-ordinator at the 7-day visit post-discharge: The Independent Team agrees completely with the BDCT investigation team.
5. The lack of follow-up of Mr S's non-attendance at outpatient appointments in 2010: The Independent Team agrees entirely with the BDCT investigation team.
6. The lack of discussion with or referral to BDCT's safeguarding leads (adult and children): As with the previous concerns identified by the BDCT investigation team, this issue could and should have been more broadly stated. The complexity of this issue highlights the merits of setting out more carefully crafted questions in the terms of reference with which an investigation team can work. For example, in this case the BDCT investigation team could have been asked to respond to the following questions:

“Did BDCT staff make reasonable efforts to determine whether there were any safeguarding children issues which required escalation to the Trust’s safeguarding children lead?” and

“Did BDCT staff make reasonable effort to determine whether there were any safeguarding adult issues that required escalation to the Trust’s safeguarding adults lead?”

Alternatively, the BDCT investigation team itself could have been more precise and inclusive in the formulation of their care management concern. For example:

“The BDCT investigation team found insufficient consideration of safeguarding issues in the clinical records in relation to Mr S’s children”;

and

“The BDCT investigation team were concerned at the lack of apparent exploration and/or consideration of potential domestic abuse issues between Mr S and his wife by:

- *the Intensive Home Treatment Team in September 2009;*
- *in-patient services, 19 November to 1 December 2009; and*
- *the interim care co-ordinator on 7 December 2009.”*

The Independent Team suggests that separating out the concern regarding Mr S’s children and his wife would have enabled each issue to have been given specific attention and for the investigation to have been more targeted and appropriately bounded.

7. The lack of information provided to Mrs S with regards to the threats made towards her in November 2009: The Independent Team agrees with the BDCT investigation team that the issue of how Mrs S was informed about the direct threat made against her was important to treat as a distinct and separate issue to problem statement No 6. However, it does not agree with the way this problem statement was worded by the BDCT team. This issue is addressed on pages 79-81 of this report.
8. The lack of psychological intervention and/or specific social support: The Independent Team does not particularly agree that the lack of psychological intervention and/or social support constituted lapses in Mr S’s care. The Independent Team suggests that, had the care planning issue been addressed in a more rounded way, then consideration of psycho-social support could have been addressed as a component of this.

Independent Team comment

Although the Independent Team has critiqued the direction and formulation of the care management concerns identified and addressed by the BDCT investigation team, we (the Independent Team) are addressing each aspect of the BDCT investigation report from the position of the expert investigation practitioner. The reader of this report needs to bear this in mind, as few NHS staff are able to achieve this level of skill alongside their day-to-day clinical and/or managerial duties.

The constructive comments made are just that: constructive. The Independent Team hopes that these comments will aid BDCT to continue to improve upon its clear

commitment to deliver thorough investigations when serious incidents occur involving service users actively engaged with their services.

Overall, and on balance, the Independent Team is satisfied that the BDCT investigation did identify the core issues that needed to be explored/analysed for its investigation to have met the standard required for the severity of incident that occurred.

The two issues that the BDCT investigation team did not identify were in relation to driving safety and also the reasons why Mr S was not managed under early intervention services by the previous Pennine Care Trust.

Because neither of these issues can be causally linked to the incident that occurred, the Independent Team is content to highlight these areas as examples of issues that might constitute 'the added value learning' that often arises as a consequence of conducting any retrospective analysis of a service user's care and treatment. The Independent Team does not consider that the omission of these issues is sufficient to warrant an independent re-investigation of Mr S's care and treatment.

5.2.3.2 The depth of analysis undertaken by the BDCT investigation team of the eight care concerns it formulated

To conduct a meaningful assessment of the analysis undertaken by BDCT, the Independent Team took the entire collection of interview data gathered by BDCT during its investigation and conducted a re-analysis against the eight care management concerns identified by BDCT.

The findings of the Independent Team are presented on a care management by care management problem basis below.

BDCT 1: Mr S was subject to s.117 of the Mental Health Act. However, despite the consultant psychiatrist in the CMHT being aware of this, his rights under s.117 were not fully met whilst he was a service user in BDCT, specifically in relation to the opportunity to receive appropriate aftercare via the local authority.

Context:

Everyone with mental health needs is entitled to a community care assessment to establish what services they might need. However, s.117 goes much further than this and imposes a duty on health and social services to provide aftercare services to certain patients who have been detained under the Mental Health Act.

Section 117 states that aftercare services must be provided to patients who have been detained in hospital:

- for treatment under s.3;
- under a hospital order pursuant to s.37 (with or without a restriction order);
- following transfer from prison under s.47 or 48;

This also includes patients on authorised leave from hospital and patients who were previously detained under s.3 but who stayed in hospital after discharge from section or who are now under a different section; for example, guardianship.

However, s.117 does not apply to:

- patients detained in hospital for assessment under s.2;
- patients detained in an emergency under s.4;
- patients detained while already in hospital under s.5(2);
- patients who were not detained under any section (informal or voluntary patients);
- patients under guardianship or discharged from guardianship.

Mr S fell within the category of patients entitled to s.117 aftercare.

Ordinarily, it is the responsibility of the relevant local authority and primary care trust to deliver s.117 aftercare responsibilities to a service user as the 'aftercare' is usually contained to aspects of social care and support required and not specialist mental health care provision. However, the BDCT 2009 policy on s.117 aftercare in its second paragraph states:

"In Bradford, Airedale and Craven, Bradford District Care Trust operates some of the aftercare services traditionally provided for people with a mental health

problem by the LSSA⁴ and so BDCT also has a responsibility under s.117(2) as a 'Health Authority' that is providing both Health and Social Care under the S.75 (National Health Service Act 2006) agreement with the LSSA."

In 2009 the BDCT s.117 Aftercare policy also said:

"In order to provide good quality Aftercare under S.117 and as laid out in the Code of Practice (chapter 27), professionals in Bradford should follow the comprehensive Care Co-ordination Policy for the implementation of the Care Programme Approach.

This includes a section on the use of CPA for people who are detained in hospital and planning for discharge from hospital. This will ensure that everyone who has been subject to compulsion under the act has an ongoing nursing care plan and discharge care plan that then becomes a joint CPA/S.117 care plan on discharge.

Guidance on CPA introduced in 2008 removes the Standard Level of CPA. Patients who have a right to S.117 Aftercare and a need for Aftercare on Discharge should always be placed on CPA and to continue to be on CPA until they no longer need Aftercare.

Aftercare will continue until BDCT, the Local Authority and, when appropriate, the PCT are agreed that it is no longer necessary. This decision will be made in a CPA Care Planning meeting and will be dependent on the level of services provided and the nature of the person's care needs and mental health problems."

Although the above policy statement applies to 2009 onwards, the same principle was set out in the 2006 policy document relating to s.117 aftercare. However, in 2006 there were two levels of CPA: standard and enhanced. Not all service users requiring s.117 aftercare required an enhanced CPA package of care, so they were allocated to standard CPA. This was the circumstance for Mr S, as the staff assessed him as being of low risk and non-complex. At the time, the Independent Team considers that taking Mr S's presentation at face value was not inappropriate. However, it was not appropriate that there was a lack of regard to Mr S's s.117 aftercare status and the lack of any joint care planning with the local authority/social care staff to determine whether Mr S continued to require s.117 aftercare or whether he could be discharged from this. It is the contention of the Independent Team, based on the information provided to BDCT by Pennine Care Trust, and Mr S's documented recount of his stability to his new consultant psychiatrist in June 2006, that it is possible that, had there been appropriate liaison with and involvement of the local authority, Mr S may have been discharged from s.117 aftercare. There was no consideration by the BDCT investigation team of this possibility.

⁴ LSSA is the Local Social Services Authority

The BDCT internal investigation

The BDCT internal investigation team discussed Mr S's s.117 aftercare status with a number of the staff it interviewed, including staff from the Intensive Home Treatment Service, the Clinical Director, the team manager for the CMHT, Mr S's consultant psychiatrist, and the interim care co-ordinator. The Independent Team's review of these interviews reveals an over-focus on Mr S's CPA status at the time and the CMHT's caseload and insufficient exploration of staff's understanding of:

- their responsibilities under s.117 aftercare;
- the BDCT's then policy and position in relation to s.117;
- what staff consider with the benefit of hindsight should have happened in relation to Mr S's s.117 aftercare status;
- the number of service users on the CMHT's caseload subject to s.117 aftercare where there is no joint care plan, or where the service user is not managed under CPA.

Consequently, the Independent Team doesn't have a clear sense of why there was no specific consideration of Mr S's s.117 aftercare status and why the Trust's then policy was not followed.

The information the Independent Team gathered from the interviews undertaken was as follows:

- That Mr S's team were made aware of Mr S's s.117 status. The letters from the then Pennine Care Trust state this explicitly and Mr S's BDCT consultant psychiatrist also reported at his BDCT interview being aware that Mr S. was under s.117 aftercare.
- Uncertainty with regards to Mr S's s.117 aftercare status was reported by the then CMHT manager. This uncertainty calls into question the robustness of the referral and allocation process at the time and the manner in which relevant features requiring attention were being documented.
- That there was no central s.117 register accessible to BDCT staff. Staff reported to the BDCT investigation team that the register was held by the local authority.
- That Mr S's consultant psychiatrist had a caseload of 400 service users and individual non-medical care co-ordinator caseloads of 30+ that were unmanageable. For the consultant psychiatrist in particular, any reliance on him to identify specific issues such as s.117 aftercare and to raise this with the wider CMHT was an unreasonable expectation.
- That there was a lack of direction in the then relevant s.117 aftercare policy document regarding practical processes and procedures to be followed so that BDCT staff were able to deliver the Trust's obligations under s.117 and to its service users. For example, the policy did not direct staff to make direct contact with the relevant local authority.

The subsequent actions taken by BDCT to improve practice with regards to s.117 aftercare

BDCT's action plan in January 2012 reported:

Action Number	Requirement	Responsible Lead	Action taken/ Progress made	EVIDENCE Assurance and outcome	Date for completion & RAG
<p>Recommendations 3, 8 & 12: 3 - Where a service user is subject to s.117 of the Mental Health Act this should be clearly documented on RiO and communicated to the LA. 8 - An audit of service users on a s.117 (Aftercare) should be undertaken to ascertain whether appropriate CPA/s.117 care plans are in place. 12 - Staff must ensure that the requirements of s.117 of the Mental Health Act are followed.</p>					
16	Write to relevant staff (Care Co-ordinators & Consultant Psychiatrists) referencing the guidance on s.117 contained in the Mental Health Act Policy & Procedures Manual (page 73)	Head of Operations, AMH	A formal memo has been issued by the Head of Operations, AMH, to all Team Managers and Senior Managers for Community Teams addressing this issue	Correspondence	January 2011
17	Guidance to be issued reminding care co-ordinators and other relevant staff to record s.117 status	Head of Operations, AMH	See below	Correspondence	31/1/2011
<p>Action: A formal memo has been issued by the Head of Operations, AMH, to all Team Managers and Senior Managers for Community Teams addressing this issue.</p> <p>In addition, further work has been identified which will be addressed through the relevant RiO groups aimed at simplifying the process for recording s.117 status on RiO.</p>					

Action Number	Requirement	Responsible Lead	Action taken/ Progress made	EVIDENCE Assurance and outcome	Date for completion & RAG
18	Awareness raising re s.117 requirements to be implemented across AMH services through use of existing communications/IT systems	Head of Operations, AMH	See below	Correspondence	28/2/2011
	Action: A formal memo has been issued by the Head of Operations, AMH, to all Team Managers and Senior Managers for Community Teams addressing this issue.				
19	A sample audit will be conducted to identify whether service users subject to s.117 have appropriate support plans in place	Head of Operations, AMH	Audit completed August 2011	Audit tool Audit report	June to August 2011
20	The programme of work to assign care clusters to all service users during 2011 will enable CPA and MH Act status to be reviewed and updated as required	Head of Operations, AMH		Completion of Care Clustering process	December 2011
	All Service Users current to Adult Mental Health (AMH) will be reviewed and assigned a care cluster during 2011. Because the process is tied to CPA reviews there is an additional opportunity to ensure CPA status and MH Act status are correct and current.				

The action plan devised and implemented is sufficiently robust that BDCT should be able to produce for its commissioners the results of its baseline audits completed in 2011 and further repeat audits in 2012 or 2013 that show an improvement in practice and policy compliance.

BDCT may wish to consider undertaking a survey of staff's knowledge of their responsibilities with regards to s.117 aftercare and also their knowledge of the Trust's position with regards to s.117 aftercare. This could be accomplished as a component of management supervision.

One of the issues the BDCT internal investigation identified was the lack of direction in the then s.117 policy document. The contemporary policy also lacks in this regard and this is also something BDCT should address when it next reviews the document.

BDCT2: Mr S did not have an appropriate care co-ordinator allocated on admission to the CMHT in BDCT despite his diagnosis and the fact that he was subject to s.117 aftercare.

Context – What did the BDCT CPA policy say at the time?

There are four key points at which consideration should have been given to Mr S's CPA status whilst he was in receipt of services from BDCT:

- On referral to the BDCT community service in 2006;
- When Mr S experienced his first relapse as a patient of BDCT in July/August 2009;
- When Mr S again experienced a re-emergence of his relapse symptoms in September 2009;
- In November/December 2009, when Mr S was admitted to in-patient services and then discharged from CPA at the time of his 7-day discharge visit.

In determining whether or not BDCT's analysis of Mr S's care and treatment as it relates to CPA compliance was reasonable, the Independent Team evaluated the investigation of this aspect of practice as presented by the BDCT's interview records in respect of the two main care management concerns BDCT identified and the four above-listed bullet points.

The BDCT investigation

CPA consideration when Mr S moved to Bradford in 2006

At the time Mr S moved to Bradford he had been under the care and treatment of Pennine Care Trust and was at the time of his move on enhanced CPA. Mr S's CPA status was clearly stated in a letter from a Specialist Registrar working with Mr S's Pennine Care Trust consultant psychiatrist on 18 April 2006. This letter was sent to Mr S's GP and copied to the city CMHT at BDCT. The letter sets out that Mr S had risk issues. *"There are risk issues with [Mr S]; when he becomes psychotic he believes that his wife is trying to control his thoughts and poisoning him. This leads to aggressive outbursts towards her. We have had no reasons to suggest that he was ever violent towards his children. We will copy this letter to the City CMHT at ... where a care co-ordinator can be allocated."*

The letter sent by Mr S's then social work care co-ordinator (Pennine Care Trust) said: *"[Mr S] has been known to our services since 2005; he has two formal admissions to hospital and is subject to section 117 Mental Health Act 1983. ... When unwell, [Mr S] suffers psychosis, he presents as paranoid, suspicious and guarded. In the past his thoughts have related to his wife poisoning/putting glass in his food and he has become very concerned that she is also harming their children. On occasion he has informed the Police and A&E staff about his concerns. However, on investigation his children seemed happy and well and there has been no action with regards to child welfare. ... [Mr S] has also reported experiencing low mood and has disclosed having suicidal thoughts, but without a plan of how he would act on these. ... There is reference to [Mr S] being aggressive towards his wife and there is also mention of [Mr S] using cannabis, which appears detrimental to his mental health. ... On the basis of my last visit and recent telephone call ... I do not have any immediate concerns about his mental health. However, I feel a prompt response from your team would be beneficial as he may have experienced an increased level of stress from his move and may also overlook sorting out his medication, both of which could induce a relapse in his mental health."*

The Independent Team considers that objectively Mr S did not meet the criteria for enhanced CPA at the time. It also has to be acknowledged that it is not uncommon for the number of service users meeting the baseline criteria for CPA to exceed the capacity of a CMHT to deliver this. Consequently, CMHT team managers and their team often have to make difficult decisions about CPA so that those service users with the greatest need and complexity are on CPA and those with lesser needs are not, even if at face value they meet CPA criteria. This situation prevailed in 2006 and it prevails now.

What was important in determining the reasonableness of the decision the CMHT arrived at with regards to Mr S's CPA level was the process the team went through in assessing Mr S, his history and his current needs.

The information from the interview records relating to Mr S's CPA allocation was as follows: *"We felt that initially he didn't need a care co-ordinator; there were not enough risk factors involved. We would expect the consultant to alert us in the future if anything changed. CPA and risk assessment were requested and nothing indicated to us there was a major problem, so an ordinary outpatient appointment was deemed best"* (the CMHT manager).

The CMHT team manager also reported that: *"We normally ask the consultant to screen someone first of all and then decide whether a care co-ordinator was needed in addition to the consultant. I can't recall if we were aware if he was on a section 117; I recall we did know there were no risks to other people present. Some paranoia, but no risks to others."*

He also reported that: *"The consultant is inevitably the care co-ordinator. In an ideal world, we would have more care co-ordinators who could visit people at home, like a community worker. But volume of work means we have to assess risks all the time"*

and look at the criteria of CPA and a lot of people just have outpatient appointments only.”

Mr S's consultant reported at his BDCT interview that the CMHT did have a weekly allocation meeting that medical and support staff attended. It was at this meeting that decisions about patients were made and they decided how care was going to proceed.

There is nothing in the interview records to show that the BDCT investigation team explored the extent of the consultant's first assessment appointment with Mr S or the length of this appointment. (One would usually expect a first appointment to last at least one hour. The Independent Team's consultant psychiatrist currently allows 90 minutes to gather all the information required.)

However, the letter Mr S's consultant wrote to the GP on 15 August 2006 showed that the consultant had undertaken a detailed assessment with Mr S, and that as a consequence of this he had discussed Mr S's presentation with him and was therefore knowledgeable about the core issues for Mr S, notably:

- That Mr S was subject to s.117 aftercare.
- His paranoia about his wife, in relation to thoughts that she would kill him and also his belief that she was doing something to their children.
- That Mr S's symptoms re-emerged in January 2006 when he had stopped his medication around Christmas 2005. The predominant symptom again was his wife. This time Mr S had phoned the police reporting that his wife was hitting his children. This resulted in detention in hospital under s.3 of the Mental Health Act.
- A lack of any significant current risk.

There was also information in the nursing progress records that pre-dated the consultant's assessment which clearly say that:

- Mr S was eating lunch with his wife and children on his arrival and that all appeared happy.
- There were four children, the eldest aged about 6 years and the youngest 2 days old.
- Mr S reported that his mental health was stable and had been so over the past months.
- His sleep was changeable owing to the newborn baby, but that his concentration and appetite were 'OK'.
- There was no evidence of psychotic phenomena but that when Mr S was ill he heard voices and became paranoid about going out (people watching him and talking about him, etc). Mr S noted as saying that currently none of these things were happening.
- Mr S was noted as saying that he was *“happy to be seen by the CMHT”*.

The assessing CPN wrote: *“I said I'd arrange an OPA with the consultant psychiatrist and gave him my number to contact me should the need arise in the meantime. ... Arranged OPA for 27 June 2006.”* (This in fact occurred on 1 August 2006.)

On the basis of the documentary information, the Independent Team is satisfied that the two members of staff engaged in the assessment of Mr S undertook this to a reasonable standard. However, the Independent Team has seen nothing that illuminates how and why the team determined standard CPA for Mr S. This is something the Independent Team would have expected to have found in the BDCT interview records, as exploration of the decision-making process was central to coming to an opinion about the reasonableness of the decision made at the time. It was a matter of concern to the Independent Team that the range of questions asked by the BDCT investigation team suggest that the BDCT investigation held a view that, because of his s.117 aftercare status, Mr S should have been on enhanced CPA by default. The Independent Team does not necessarily agree with this, and furthermore it is not good investigation practice to interview from a fixed perspective.

Mr S remained relatively well and stable in the community during the period 2006 to July 2009 and attended at his outpatient appointments and caused no concern. There were no apparent complexities of care, multiple services involved or concerning levels of risk that might have warranted enhanced CPA. Section 117 on its own does not mean that someone meets the criteria for enhanced CPA.

Other aspects of Mr S's care contacts with BDCT where his CPA status should have been considered

By 2009 there had been significant changes to the national approach to CPA. The previous two levels had been abolished and service users were either 'on CPA' or were 'non-CPA', sometimes referred to as 'standard care' by BDCT. The BDCT CPA policy at the time said:

"23.1 The Refocusing of CPA has introduced a wider set of inclusion criteria, which Care Co-ordinators and multi-disciplinary teams must use to determine the appropriate level of support a Service User requires.

Characteristics to consider when deciding if the support of CPA is needed:

Severe mental disorder (including personality disorder) with a high degree of clinical complexity.

*Current or potential **risk(s)** including:*

Suicide, self harm, harm to others (including history of offending)

Relapse history requiring urgent response

Self neglect/non concordance with treatment plan

Vulnerable adult; adult/child protection e.g.

- Exploitation e.g. financial/sexual*
- Financial difficulties related to mental illness*
- Disinhibition*
- Physical/emotional abuse*
- Cognitive impairment*
- Child protection issues*

Current or significant history of severe distress/instability or disengagement.

Presence of non-physical co-morbidity e.g. substance/alcohol /prescription drugs misuse, learning disability.

Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.

Currently/recently detained under the Mental Health Act or referred to crisis/home treatment team.

Significant reliance on carer(s) or has own significant caring responsibilities.

Experiencing disadvantage or difficulty as a result of:

- *Parenting responsibilities.*
- *Physical health problems/disability.*
- *Unsettled accommodation/housing issues.*
- *Employment issues when mentally ill.*
- *Significant impairment of function due to mental illness.*
- *Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices); sexuality or gender issues.*

Key groups who would normally need the support of CPA are service users who:

- *Have parenting responsibilities.*
- *Have significant caring responsibilities.*
- *Have a dual diagnosis (substance misuse).*
- *Have a history of violence or self harm.*
- *Are in unsettled accommodation.*
- *Are subject to Supervised Community Treatment (SCT) or Guardianship (s.7) under the Mental Health Act 1983.*

If these service users are not supported through CPA, the reasons must be clearly documented in the records.”

CPA consideration when Mr S required Intensive Home Treatment support between July and August 2009

Mr S was successfully managed via outpatient appointments between 2006 and July 2009. There were some elements of social support that may have benefited him had there been an appropriate CPA/s.117 care plan, but largely his situation was consistently reported as stable. This changed in July 2009 when his wife went away for an extended holiday to see her parents, taking their children with her. Mr S made contact with his CMHT on 29 July, a consequence of which was a bringing forward of his outpatient appointment. Mr S reported to the SHO he met at his outpatients appointment that he had been *“troubled by persistent diarrhoea, and that he had been having thoughts about people being after him and trying to kill him. These [Mr S reported] have become more persistent and intrusive and are causing him distress.”* Mr S also reported that *“his thoughts were terrible and he also thought about his wife possibly poisoning him”*. He was noted to deny suicidal and homicidal thoughts.

There was no evidence of thought insertion, withdrawal broadcasting or echo and Mr S was reported to deny any form of hallucination. The plan at this visit was to increase Mr S's Risperidone.

Mr S was also provided with the contact details for the duty team in case he felt things were deteriorating further. On the provision that there was no further deterioration, follow-up was to occur in one to two months' time. The medical documentation shows no consideration of CPN follow-up. However, in the event Mr S was referred to the Intensive Home Treatment Team on 31 July. Mr S was accepted by this service and continued to receive support from them until mid-August, when he was discharged. At this time, although Mr S had expressed some paranoid thoughts about his wife, he had expressed no homicidal ideation or suicidal ideation. The primary reason for his support requirement was an inability to manage on his own at home and the escalation in his symptoms this triggered. At the point of discharge from the Intensive Home Treatment Team, Mr S's CPA level remained at standard CPA, which was not unreasonable in the circumstance.

CPA consideration when Mr S was re-referred to the CMHT and received subsequent Intensive Home Treatment support in September 2009

He was then re-referred to the CMHT on 1 September by his GP. At this time he was again presenting with his relapse indicators:

- Expressing ideas about his wife, stating that she was trying to kill him by poisoning his food. (The GP felt there was no foundation to this claim.)
- Interrupted sleep.

The CMHT record noted that at the time the referral was made Mr S's GP did not consider that Intensive Home Treatment input was required, but that if Mr S's situation was left unattended then he would deteriorate. Consequently, Mr S's outpatient appointment was brought forward from 3 October 2009 to 3 September 2009, two days after the GP's communication. Before this appointment could happen, Mr S remade contact with the CMHT requesting a home visit because he could not cope. A home visit was arranged for the following day. It was to be a joint home visit with the Intensive Home Treatment Team (IHTT). This constituted good practice. Mr S was again taken on to the Intensive Home Treatment Team caseload for four weeks. When he was accepted as an IHTT client, the discharge plan initially documented said: *"Intensive Home Treatment feels that [Mr S] needs long term support in the community. He has two admissions to IHTT in a brief period of time. He has quite strong psychotic features which are persisting despite treatment."*

The subsequent discharge letter to Mr S's GP on 1 October 2009 said: *"he was referred to the CMHT for a care co-ordinator. However, they felt that he wasn't appropriate for this service. Initially, [Mr S] said he'd like a care co-ordinator to visit, but had changed his mind at the end of this admission. He will continue with outpatient appointments."*

There is no information in the BDCT interview records to show that the decision made by the CMHT was explored during the course of the internal investigation process and it should have been.

It is the perspective of the Independent Team that at this point Mr S did meet the criteria for CPA. The Independent Team's rationale for this consideration is:

- Two recent Intensive Home Treatment Team episodes;
- An apparent increase in his psychotic symptoms that were persistent;
- Parenting responsibilities.

These features suggest *"relapse history requiring urgent response"* (as stated under 'clinical complexity' in the BDCT 2009 CPA policy).

CPA consideration following Mr S's admission to hospital on 19 November 2009 and subsequent discharge back to the sole care of his consultant psychiatrist on 7 December 2009

At the time of his admission to hospital, Mr S met the following criteria from the Trust's CPA policy:

- *"Suicide, self harm, harm to others (including history of offending)*
- *Vulnerable adult; adult/child protection e.g.*
 - *Financial difficulties related to mental illness*
 - *? Physical/emotional abuse*
 - *? Child protection issues**Specifically child protection issues, and possibly emotional abuse.*
- *Current or significant history of severe distress/instability or disengagement.*
- *Currently/recently detained under the Mental Health Act or referred to crisis/home treatment team.*
- *Had significant parenting responsibilities."*

In accordance with the Trust policy at the time of his admission, a care co-ordinator was requested by in-patient services and then allocated to Mr S by the relevant CMHT. The individual appointed was referred to as an interim care co-ordinator. This was a locally developed role because of the caseload pressures for the CMHT at the time. It was also a role developed by the CMHT to help them meet the performance standard requirement for a 7-day discharge visit once a patient had been discharged from hospital.

The role of the care co-ordinator, as set out in the BDCT 2009 (and current policy document), was to carry out:

- Comprehensive needs assessment;
- Risk assessment and management;
- Crisis planning and management;
- Assessing and responding to carers' needs;
- Care planning and review; and
- Transfer of care or discharge.

The BDCT policy said that:

"29.6 As part of their role the Care Co-ordinator will therefore need to:

Ensure a comprehensive, multi-disciplinary and multi-agency assessment of the person's health and social needs is carried out (including an assessment of risk and any specialist assessments);

Co-ordinate the formulation and updating of the care plan, ensuring that all those involved understand their responsibilities and agree to them. Ensure that the care plan is sent to all concerned;

Arrange for someone to deputise if absent, and pass on the Care Co-ordinator role to someone else if no longer able to fulfil it;

Familiarise themselves with past and present records about the service user;

Ensure that crisis and contingency plans are formulated, updated and circulated;

Ensure that the person is equally involved and has choice, and assist him/her to identify his/her goals;

Ensure that carers and other agencies are involved and consulted where appropriate;

Ensure that the person understands the role of the Care Co-ordinator;

Ensure that the person knows how to contact the Care Co-ordinator, and who to contact if the Care Co-ordinator is not available;

Ensure that the person is registered with a GP, and that s/he is involved and informed as necessary;

Maintain regular contact with the person and monitor his/her progress, whether at home or in hospital, regardless of setting. If a person who remains vulnerable refuses to take part in the CPA process, all steps should be taken to find out why, and to continue to attempt to engage him/her;

Maintain regular contact with people who have been sent to prison (including RiO-to-RiO contact where possible), and liaise with mental health staff working with the person in prison, in order to provide continuity of care. It is vital to be aware of any changes in location within the prison estate and likely release dates, so that proactive care can be planned for their release. In this situation, contact with and support for carers should also continue;

Organise and ensure that reviews of care take place and that all those involved in the person's care are invited, consulted, and informed of any outcomes. Chair the reviews if appropriate (see section x, Reviews, Outcomes and Evaluation);

Explain to the person, their relatives and informal carers what the CPA process is and make them aware of their rights and roles;

Consider the need for advocacy for the person, or carers if appropriate, and make them aware of any advocacy or self-advocacy schemes taking into account the Mental Capacity Act 2005;

Identify unmet needs and communicate any unresolved issues to the appropriate managers, through the appropriate systems;

Ensure that other care systems requirements are met where necessary, including consideration of local eligibility criteria in respect of FACS (Fair Access to Care Services), Person Centred Planning (PCP), Single

Assessment Process (SAP), Health Action Planning (HAP) and Children's Assessment Framework (CAF);

Consider and explore Direct Payments with eligible persons and carers, with the aim of promoting their independence;

Take responsibility for ensuring continuity of care, using home visits (including visits to prisons), repeat appointments, etc. Providing clear written instruction on how to contact team members responsible for aspects of the care are made available to all those who need them; and

Have RiO-to-RiO contact with the service user within a week of discharge from in-patient care.”

Because the role of 'interim care co-ordinator' was not a corporate initiative, there was and remains nothing in the Trust's CPA policy document addressing the role and role limitations of an interim care co-ordinator. Clearly, meeting all of the above-listed expectations was not and is not practical or achievable.

The BDCT interview records show that the BDCT investigation team explored with staff the role and expectation of the interim care co-ordinator. The then CMHT team manager reported that an interim care co-ordinator was appointed to all in-patients. He also reported that the role of the interim care co-ordinator was to liaise with the in-patient ward about the service user, to attend reviews and to be involved in the discharge review and to advise the CMHT if any further service was required.

The appointed interim care co-ordinator told the BDCT interview team that his role was to do the 7-day follow-up and further follow-up on a short-term basis only. If longer-term support was required, then he would take the case to the CMHT allocation meeting for the appointment of a substantive care co-ordinator.

This professional also informed the BDCT investigation team that his role as interim care co-ordinator worked best at the hospital site in close geographical proximity to the CMHT to which he was attached. It did not work so well at other in-patient facilities that were geographically more remote. In the 'near to' in-patient unit, the Interim Care Co-ordinator attended at the in-patient unit on regularly scheduled days to conduct patient reviews. However, at the more geographically distanced sites this was not practicable and he attended on an 'as required' basis. However, this meant that his attendance could be hampered by pre-existing work commitments. The frequency with which his role and responsibilities as an interim care co-ordinator was thwarted when attending at one of the 'geographically distant' sites was not established by the BDCT investigation team. Neither did it establish:

- whether other staff acting in an interim care co-ordinator capacity experienced similar challenges to the execution of their role; or
- the frequency with which this interim care co-ordinator was unable to attend at discharge ward rounds.

Information in relation to both points would have added value to the investigation conducted.

The context of Mr S's admission and key presenting features

Mr S was admitted to in-patient services at BDCT on 19 November 2009. The trigger for his admission was his self-presentation at a local police station saying he *"wanted to kill himself because his wife won't cook or talk to him"*. This information was recorded in Mr S's A&E record at 15.40hrs. At 17.15hrs a mental health liaison nurse also wrote that Mr S had continuing thoughts of wanting to kill himself or his wife. This professional also noted that Mr S was *"unwilling to engage with IHTT"*, but would consider informal in-patient admission.

Mr S's in-patient care plan identified a range of issues for him. Relevant to this independent process are the following:

- reports by Mr S that he was being bullied by his co-workers;
- that Mr S was low in mood and suspicious;
- that Mr S had four children (aged 7 to 3 years);
- that Mr S had expressed suicide ideation;
- that *"recently Mr S had thoughts of killing his wife"*; and
- Mr S has *"paranoid beliefs of colleagues trying to kill him"*. It was also noted that he believed that his wife may have been having an affair and that she might have been trying to poison him.

The subsequent risk assessment document stated that Mr S *"has expressed wishes to harm his wife with a knife. Due to these risks his children may be at risk as they share the same house."* The summary statement at the end of this form said: *"Due to [Mr S's] current thoughts towards his wife, and colleagues, it would appear that this could be affected by his mental state. As [Mr S's] family have not reported his presentation, it would appear that they are unaware of the risk."*

On 19 November in-patient services faxed Mr S's CMHT and requested the allocation of a care co-ordinator. The interim care co-ordinator was allocated and this individual attended the clinical ward round review on 24 November.

The outcome of this ward round was noted as:

- To obtain Mr S's notes from Pennine Care Trust.
- *"Wife—→ needs to contact"* the in-patient consultant psychiatrist.
- Chase up old notes from the location of Mr S's outpatient appointments.
- DVLA need to be informed.
- Specialist Registrar to speak with Mr S's GP about a medical certificate for driving.
- Mr S expressed a wish to go on leave for Eid on Friday. The leave plan to be arranged with the Specialist Registrar and Mr S's wife.

The contemporaneous record reported that Mr S told those present that he had been stressed, and that he *"wanted to punish"* his wife. She was not talking to him, *"only swearing at him"*. Mr S reported that his wife did not like him and he didn't know why that was. He didn't know what to do; hence his presentation at the police station. He also reported that now he was less stressed and that he wanted to go home and be with his children and his wife wanted him back. It was also recorded that Mr S denied

“feeling like this before”. It was also recorded that Mr S admitted finding it hard to trust anyone.

Later the same day the interim care co-ordinator contacted the in-patient ward, advising that he had Mr S’s ‘Old’ BDCT notes. The in-patient record shows that the interim care co-ordinator’s impression from reading Mr S’s old BDCT notes was that *“whenever [Mr S] got stressed out, his presentation remained the one he is currently on and that he will respond quickly with the increased dose of medication”*. It was also noted that the interim care co-ordinator suggested involving the Intensive Home Treatment Team to effect an early discharge for Mr S. In-patient services provided the interim care co-ordinator with the contact details for the Specialist Registrar so that he could communicate this plan to her.

Following further improvement in Mr S’s presentation, and as a consequence of patient and family pressure, Mr S went on home leave for the Eid period on 26 November 2009. Then, on 1 December 2009, at the consultant ward round, it was noted that Mr S wanted to be discharged. It was also noted that the interim care co-ordinator was not able to attend that ward round/CPA review. He was, however, contactable by phone.

At the time Mr S made his request he was an informal patient; he had just returned from four days of home leave which reportedly went well. He also reported to the staff present that his persecutory thoughts were dissipating and that his wife was talking with him again and wanted him to come home.

He also reported that his community consultant would see him every 3 to 4 months.

Notably, Mr S also told the BDCT staff that he had depression, revealing a profound lack of insight into his mental health diagnosis. He also asked when he could start driving a taxi again.

At the time of this ward round Mr S was not detainable under the Mental Health Act. The Independent Team is satisfied that this was the case.

The plan, therefore, was as follows:

- The interim care co-ordinator to follow-up Mr S in 7 days.
- For follow-up with the community consultant psychiatrist in four weeks’ time.
- For Mr S to see his GP and talk through regarding his ability to drive. Advised that he could not drive presently because of his medication.
- For the Specialist Registrar to speak with the interim care co-ordinator.

The discharge planning sheet completed the same day correctly identified the interim care co-ordinator as the relevant CPN; however, Mr S’s CPA status was not recorded. The contents of the discharge section of the BDCT records suggest that, along with the discharge summary, a copy of the in-patient care plan and risk assessment was also sent to the GP and the interim care co-ordinator. However, the risk assessment and care plan do not look to have been fully updated to reflect the current risk position and issues remaining outstanding at discharge such as

achieving clarity regarding Mrs S understanding about her risk exposure should her husband relapse and present in a similar manner to that which occurred in November 2009.

Also on 1 December the electronic nursing records show that the interim care co-ordinator made contact with Mr S and arranged to visit him at home on 7 December.

On 4 December there is a nursing entry by the interim care co-ordinator that is represented below:

Verified

CPA Review
Date: 4 December 2009 13:00
Review Type: Discharge
Attendees: Discharge
* Interim CC (Care Co-ordinator)
* Mr S (Client)
* Review unmet needs

* Client view

* Carer view

* What worked well

* What did not work well

* Other notes

* Safeguarding Children
no concerns.

It is clearly an uncompleted document. The interim care co-ordinator openly informed the BDCT investigation team that at the time he was unfamiliar with RiO and did not have access to the relevant information from in-patient services to complete it. Then on 7 December the following was recorded:

Reviewed at home 7 day face to face completed. [Mr S] to be discharged back to [his consultant] same informed. [The consultant] to bring forward OPA.

It is this last contact with Mr S that was the most significant in terms of Mr S's ongoing CPA status and the most significant in terms of Mr S's ongoing care package.

The depth of analysis and understanding the BDCT investigation team achieved, as confirmed by the quality of their interview records, is therefore an important component in determining the adequacy of BDCT's investigation in respect of the care concern they identified as important and with which the Independent Team agrees.

From the clinical records the Independent Team knows that Mr S was recorded as being on the 'new standard' CPA on his RiO care plan that was printed on 1 December 2009.

The 2009 BDCT policy (point 23.2, page 17) said:

*“Service users who don’t need the support of CPA (Standard Care)
Those service users with more straightforward needs: one agency or no problems with access to other agencies support. Services should consider at every formal review whether the support provided by CPA will be needed, as a service user’s needs change or the need for co-ordination support is minimised. Moving towards self directed support will be the natural progression”.*

In Mr S’s case, at a superficial level he met the above criteria for ‘Standard Care’ or ‘non-CPA’ care. However, there were unresolved issues in relation to his presentation leading to admission and also with regards to the level of understanding of Mr S’s family about his condition and in relation to the safety of his children.

Although there was no evidence of Mr S causing harm to his children between 2006 and 2009, his emotional instability between July 2009 and November 2009 would have been a matter of concern. Furthermore, although unknown to BDCT at the time, Mr S had hit his children before, reportedly because his wife insisted that he did (Rochdale Records). The period July 2009 to November 2009 also demonstrated that Mr S was angry with his wife for leaving him to go on an extended holiday, angry that she would not cook or speak with him. He also made a direct threat of harm towards her to achieve admission and continued to hold this thought after admission, expressing how he would harm her *“with a knife”*.

Mr S had achieved unescorted leave home over the Eid period in a timeframe it seems not all clinicians were entirely comfortable with, but in view of his informal status, the settling of his symptoms and the pressure from Mr S’s family and wife, that he be allowed home would have been difficult to avoid. Mr S did not comply with the agreements made with staff regarding contact and attendance on the ward over the leave period. He returned from leave seeking discharge from hospital. Again, for all the reasons just listed, the clinical team did not have reasonable grounds to enforce his continued in-patient status.

In view of the above, it is clear that Mr S should have been on a CPA care package. However, as already identified, the documentation only reports *“standard care”*. The BDCT investigation suggests that the situation with regards to CPA was not clear. The Independent Team considers that the RiO care plan made Mr S’s CPA status explicit, i.e. ‘Standard Care’, and thus non-CPA, and thus there was no lack of clarity about the perspective of the staff at the time.

As with previous comments about the BDCT investigation, the Trust’s investigation team did not explore in depth with the CMHT or the interim care co-ordinator how Mr S was left on ‘standard care’.

The BDCT team did, however, elicit the following information:

“If [he] had had concerns at the 7-day follow-up, [he] would not have discharged back to [the consultant psychiatrist]. [He] would have discussed this with [the consultant] at some stage, following [his] assessment.”

This professional also told the BDCT investigation team:

“I would usually base my decisions on the risk assessment and CPA plan. I am not aware of any criteria for 7-day follow-up – I use my professional judgement, liaise with others and if there are no concerns raised, then that makes part of the decision.

I would generally update the care plan and risk assessment, but did not on this occasion.

I was aware there had been issues regarding the wife and children, but felt these were mitigated against and felt happy at the 7-day follow-up. I cannot be 100% clear whether I was aware of the threats to stab the wife.”

The Independent Team accepts that the BDCT interview took place on 15 November 2010, and that it occurred in the home of the interim care co-ordinator. The Independent Team is also mindful that the interview occurred 11 months and two weeks after the interim care co-ordinator’s only substantive contact with Mr S. The interview records suggest that the memory recall of the interim care co-ordinator was lacking at interview, and this is entirely understandable. Nevertheless, because the incident occurred some nine months after the interim care co-ordinator discharged Mr S back to his consultant psychiatrist, the BDCT investigation team should have explored in detail with this professional his rationale for making the decision he did. In conducting such an exploration, the Independent Team would have expected the BDCT investigation team to have:

- Walked the interim care co-ordinator through the antecedents to Mr S’s hospital admission in November 2009.
- Reviewed the care plan and risk assessments completed in the in-patient service with the interim care co-ordinator to determine to what extent he was aware of the salient features of Mr S’s admission to hospital and thus the risks he potentially posed to his wife when unwell.
- Asked the interim care co-ordinator if i) he had received copies of the care plan and risk assessment along with the discharge summary sheet; and ii) if yes, had he read them prior to attending to meet with Mr S?
- Asked the interim care co-ordinator when he attended on 24 November at the ward round whether he had read Mr S’s in-patient records and the relevant A&E records contained within them.
- Asked him to recall his visit to Mr S’s home (it is clearly documented in the records that the visit occurred at Mr S’s home).
- Asked, with the benefit of hindsight, under a similar set of circumstances whether he would do anything differently. In asking this, the professional must be directed to put from his mind the incident that subsequently occurred.

None of the above activities or questions was delivered by the BDCT's internal investigation team. BDCT needs to ensure that in future its investigation teams understand the necessity for a complete interview process that fully explores what happened, and that interview notes are full and accurate accounts of the depth and breadth of what was discussed.

In addition to the above, the BDCT investigation team should have asked the in-patient consultant and the in-patient named nurse whether or not they considered that Mr S was a CPA patient at the time and whether in their opinion he required long-term ongoing support in the community with a non-medical care co-ordinator in addition to outpatient follow-up.

The then CMHT team manager acknowledged to the BDCT investigation team that *"technically he [Mr S] should have had a care co-ordinator, but in this case we decided the consultant was sufficient"*. At the time of his interview this team leader should have been asked to set out the CMHT's rationale for this decision. Furthermore, the team leader should have been asked how he assured himself that the interim care co-ordinator was making reliable decisions regarding those service users who did not require CPA, and how he assured himself regarding the quality of the 7-day assessment visits conducted and the quality of the documentation around the 7-day discharge visits. Because the documentation at the time was acknowledged as of unsatisfactory standard, an observation with which the Independent Team agrees, how standards are monitored and maintained was an important issue for the BDCT investigation team to have established.

Independent Team comment

Although the depth of exploration and analysis in the BDCT interview records does not demonstrate a detailed exploration of CPA practice, with specific regards to Mr S's discharge from the interim care co-ordinator's caseload there was sufficient information contained in the interviews for the Independent Team to have confidence that the key issues contributing to this occurrence were:

- The role of the interim care co-ordinator was a local initiative developed to address a significant shortfall in care co-ordinator posts. This shortfall meant that the community mental health team needed to evolve such a role in order to assure delivery of the 7-day post-discharge from hospital visit, in keeping with national practice standards. The shortfall of care co-ordinators was, the Independent Team understands, as a consequence of insufficient investment by the local commissioners in the community mental health service. There was, however, no formalisation of what the individual's role was, and what standards were expected of such an individual when determining, in isolation from other colleagues, that a service user did not require a CPA care plan/care package.
- The interim care co-ordinator was not a party to the discharge CPA review on the in-patient ward. Although this was not avoidable at the time, it contributed to a lack of contextual information in the interim care co-ordinator about Mr S.
- The Trust's electronic record-keeping system RiO was in the early stages of implementation. The interim care co-ordinator felt he was doing the right thing

by trying to use it, but he was so unfamiliar with it that his normal standard of documentation lapsed.

- The relevant CMHT had a significant capacity issue for accepting and managing CPA service users in accordance with good practice principles at the time.
- The interim care co-ordinator was not able to demonstrate that he followed basic good practice principles when assessing Mr S and making the decision to discharge him to the sole care of his consultant psychiatrist. The clinical record provides no detail of the home visit, the assessment undertaken or of the interim care co-ordinator's consideration of relevant historical and contemporary risk factors associated with Mr S.

In addition to the above, the Independent Team is not at all confident that at the time this incident occurred there were robust and/or reliable performance-monitoring processes operating in Mr S's CMHT.

BDCT's recommendations

BDCT undertook a raft of actions connected to CPA. These are set out below. A number of the actions implemented are marked with ♦. The ♦ denotes those actions that, although appropriate, are of low reliability. That is, they are unlikely to invoke or sustain the desired improvements in practice.

Action Number	Requirement	Responsible Lead	Action taken/ Progress made	Evidence Assurance and outcome	Date for completion & RAG
Recommendation 1: A review of the Community Mental Health Teams should be undertaken in line with the key areas for action identified.					
Key area for action: The use of consultants as care co-ordinators, including the size of consultant caseloads.					
1	Personal action plan developed with Mr S's consultant	Medical Director	Action plan developed and being implemented	Action plan - email	26/1/2011
2	Wider discussion with consultants across the organisation in relation to the expectations regarding caseload management and care co-ordination	Medical Director		Memo + email Notes of meetings	31/3/2011
	Discussion has taken place at Medical Council and a Learning event was held in May 2011. Outcome: Agreement for additional Care Co-ordinators to be appointed with identified roles within each team. [Updated June 2011]				

Action Number	Requirement	Responsible Lead	Action taken/ Progress made	Evidence Assurance and outcome	Date for completion & RAG
3	Medical Director to liaise with the IT dept to identify a system for producing caseload lists, including 'flags' for specific issues, e.g. risk assessment	Medical Director	See below	Relevant 'flags' added to RiO system	28/2/2011
	Informatics have developed a reporting process. RiO updates provide individual caseload information. [Updated June 2011] Updated and rated green following discussion at 11 September Committee				
4	Consultants to review the above information and undertake a data cleansing exercise to ensure accuracy	Consultant Psychiatrists	Work completed in line with allocation of care clusters [December 2011]	Revised and accurate caseloads on RiO	29/4/2011
5	Consultants to review caseload with Medical Director/Medical Leads and prioritise caseload identifying clear actions (e.g. discharge from caseload/ allocation of care co-ordinator)	Medical Director	See below	Final caseloads on RiO, including prioritisation	31/5/2011
	Medical Director is liaising with Informatics concerning reports regarding caseloads for consultants. [Updated June 2011] Work of new care co-ordinator resource will be used to take this forward. [December 2011]				

Key area for action: The capacity of consultants to provide supervision to Senior House Officers (regarding clinics), including: Administrative support in respect of consultant appointment systems and reviewing how clinics are arranged (ensuring that in the early part of junior medical staff's rotation, clinics are not booked when the incoming juniors have already made commitments such as holidays).					
Action Number	Requirement	Responsible Lead	Action taken/ Progress made	Evidence Assurance and outcome	Date for completion & RAG
6	Communicate current expectations/ requirements to all consultants	Medical Director	Action completed; memorandum sent to all consultants & Team Leaders	Correspondence	21/1/2011
7	Explore the way clinics are structured and identify approaches to ensuring that appointment systems and supervision of clinics are more effective	Medical Director	This work is ongoing. Reinforcement of the need to use the DNA Policy [Updated June 2011]	External Review Report	31/5/2011
Key area for action: Review of capacity of CMHT staff to undertake the care co-ordinator role.					
8	Healthy Ambitions ⁵ work will address underlying capacity and demand issues and referral pathways	Head of Operations		Project Steering Group Minutes	Ongoing throughout 2011/2012
	The Healthy Ambitions model envisages a transition to New Ways of Working across all CMHT's whereby the need for Outpatient Clinics				

⁵ The Healthy Ambitions Model consists of a number of components aimed at improving the pathways between primary care and non-urgent Adult Mental Health Services. It includes:

- development of a single point of access for referrals for Primary Care Mental Health Teams and CMHTs.
- establishment of joint triage arrangements between PCMHTs and CMHTs.
- establishment of 'link worker' arrangements between CMHTs and GP practices.
- development of 'easy in, easy out' arrangements and shared care protocols with primary care.

	<p>is reduced and consultants do not hold care co-ordination responsibility.</p> <p>A Project Implementation Group is in place with an implementation plan throughout 2011/2011. Early implementation will be in North Bradford and Airedale, followed by South & West, then City.</p> <p>Resource has been identified for an additional 10 Care Co-ordinators. This resource will be targeted on those cases, held by Doctors, where care co-ordination is required. [Updated 28.6.11]</p>				
Action Number	Requirement	Responsible Lead	Action taken/Progress made	EVIDENCE Assurance and outcome	Date for completion & RAG
9	<p>Requirement: Meeting to be arranged between Medical Director, Head of Operations and South & West CMHT consultants. This meeting will formulate and agree specific actions required to address caseload issues and to ensure that these are congruent with the wider pathway and capacity and demand work.</p>				
	See above	Medical Director	Meeting held: referred to memorandum and caseload review process pathway. This meeting took place on 9/2/11	Meeting minutes	28/2/2011
<p>Key area for action: the referral and allocation system within South & West CMHT.</p>					
10	Team Managers must be reminded that discussions and decisions in allocation meetings are part of the service user record and must be recorded on RiO	Head of Operations	See below	Team Manager Meeting minutes	12/2010
	<p>Team Managers were alerted to this requirement in regular meetings. This has been followed-up in writing by way of a memo to all Team Managers and Senior Managers for Community Teams.</p>				

11	Team Managers must be reminded that all allocation meetings must be properly minuted	Head of Operations	See below	Correspondence	January 2011
A formal memo has been issued by the Head of Operations, AMH, to all Team Managers and Senior Managers for Community Teams addressing this issue.					
Action Number	Requirement	Responsible Lead	Action taken/Progress made	EVIDENCE Assurance and outcome	Date for completion & RAG
12	A sample audit will be undertaken to ensure that interventions recorded on RiO reflect the agreed decisions recorded in the meeting minutes	Head of Operations	28 June 2011. Audit completed August 2011	Audit tool Audit report	June to August 2011
Recommendation 2: The CPA Policy should be revisited to ensure that Consultant Psychiatrists are not named Care Co-ordinators for service users who are high risk and subject to s.117 of the Mental Health Act.					
13	CPA Lead to review CPA Policy and recommend appropriate amendments	CPA Lead	Work has commenced	Revised policy presented to SGC on 28 March 2011	31/3/2011
14	Requirement: Memo to Consultant Psychiatrists (copy to CMHT Team Managers) to provide interim guidance regarding role and responsibilities in relation to: a) Service Users who meet the criteria for CPA and are high risk; b) Service users who meet the criteria for CPA who do not currently have allocated Care Co-ordinators; c) Service users who meet the criteria for Standard Care				
	See above	Medical Director	Memorandum issued, discussion taken place with key consultants	Correspondence	31/1/2011
15	Requirement: Memo to CMHT Team Managers to provide guidance regarding action to be taken when resources do not permit the				

allocation of Care Co-ordinators to service users who meet the criteria for CPA.				31/1/2011
See above	Head of Operations, AMH	See below	Correspondence	
Action: A formal memo has been issued by the Head of Operations, AMH, to all Team Managers and Senior Managers for Community Teams addressing this issue.				

In addition to the above actions, the Independent Team is aware that BDCT commissioned the current Deputy Director of Operations at the neighbouring Pennine Care Trust to work with it to conduct a review of the functionality and standards of Mr S's CMHT. The report of this review was written in March 2012.

A number of observations and recommendations were made as a consequence of this, some of which are detailed below.

Sample of observations:



- That the thorough 'root and branch' review of consultant psychiatrist caseloads has yet to be completed.
- That there did not appear to be a robust process for ensuring that the CMHT's caseload focused on the most vulnerable and risky people.
- That almost all qualified staff were at a band 6, and that this did not appear to be necessary given the expectations of the roles carried.
- A re-affirmation that there are insufficient staff to deliver the services within the required model.
- That the plans to address the service issues did not extend beyond gaining further investment.
- Early clustering data suggested that the CMHT is working with approximately 23% of its caseload who did not require secondary mental health services.
- That there are multiple points of access into the service, and there appeared to be a lack of reference to core eligibility criteria during the allocation process.
- There was a lack of clarity about how the role of the interim care co-ordinator worked within the team.
- Only a third of the files reviewed as part of a CPA audit could show assessed need and relevant care plans at the point of discharge from in-patient to community services.
- There was a lack of clarity regarding the review of and process for achieving discharge from s.117 aftercare.
- Communication and effective transfer of information between in-patient and CMHT services remained challenging at the point of discharge.
- Although risk assessments seemed to be performed to a good standard, it was less clear how risk formulation and care planning occurred.
- BDCT has a good 7-day follow-up check list and was meeting all of its targets.

Sample of recommendations:

- The conduct of a full clinical review of all service users who are clustered 1-3 with a view to transfer them out of the CMHT caseload.
- A review of the skills mix and consideration of using band 5 roles more.
- Developing a standardised approach (probably alongside CPA reviews) to reviewing ongoing s.117 requirements.
- The implementation of the integrated SPOE⁶ should give careful consideration to its role in relation to: clear guidelines for access, process for decision making, liaison, support for out of office hours which avoid the use of urgent care pathways, brief therapies, and an overall focus of using services at the lowest possible tier first.

Independent Team comment

The recommendations made by BDCT's investigation team and the subsequent actions implemented have been wide ranging and have targeted all of the areas of concern it identified in relation to the effective delivery of CPA for BDCT's service users. The action plans also address aspects of practice and system structure that the Independent Team was concerned about but which had not been sufficiently explored at interview. It is notable that the recommendations and action plans were implemented on a service-wide basis, which was appropriate.

The Independent Team marked a number of the actions implemented with . As already indicated, the  denotes those actions that, although appropriate, are of low reliability. Consequently, BDCT must ensure that it institutes appropriate audit mechanisms to determine the extent to which the actions taken have impacted on practice/management standards. Subsequent re-audit will also be required to determine the extent to which any improvements have been sustained.

Because of the wide-ranging recommendations made by BDCT at the time of their investigation and their reported progress against these as outlined in their updated action plan of January 2012, the Independent Team can see no value in re-interviewing those staff involved with Mr S regarding his CPA status in November/December 2009. The Independent Team cannot see added value would be achieved at this stage.

⁶ Single point of access entry.

BDCT 3: The discharge meeting held by the in-patient service did not result in a robust risk assessment and the care plan being developed prior to discharge

In parallel with the previous section on CPA, the times at which attention to Mr S's risk assessment was most important were:

- At the time of Mr S's initial assessment.
- During his first contact episode with the Intensive Home Treatment Team.
- During his second episode of contact with the Intensive Home Treatment Team.
- During the period of Mr S's admission to in-patient services in November 2009 through to his discharge from CPA to non-CPA on 7 December 2009 at the 7-day post-hospital discharge home visit.

Of these periods, the most significant was the discharge of Mr S by in-patient services and the discharge of Mr S to the sole care of his consultant psychiatrist by the interim care co-ordinator on 7 December 2009. The Independent Team agrees with the BDCT investigation team that the discharge risk assessment conducted by in-patient services was of greatest significance as it should have informed the interim care co-ordinator's subsequent decision-making process.

The in-patient risk assessment (19 November 2009 to 1 December 2009)

This assessment form was completed on 19 November 2009. The style of form was a combination of tick box and descriptive data, allowing the assessor to elaborate on each section of the form completed. The key headings on the form were:

- Harm to self
- Harm from others
- Harm to others
- Accidents
- Other risk behaviours
- Factors affecting risk.

The assessor was asked to identify the presence of a range of factors under each main heading, indicating whether the factor had been present in the last six months or at all. The form did not allow for a 'don't know' response. In this respect the form design was flawed and potentially unsafe.

The nurse who completed Mr S's assessment recorded the following:

Under 'Harm to Self':

"On 19/11/09 [Mr S] presented at the department saying that if he had to go home he would stab his wife and himself. Alternatively, Mr S said he would run into oncoming traffic."

Under 'Harm from Others':

"[Mr S] subjectively reports being at risk of bullying by his work colleagues. [Mr S] has reported he wanted to stab himself and has a poor dietary intake."

Under 'Harm to Others':

“[Mr S] has expressed wishes to harm his wife with a knife. Due to these risks [Mr S’s] children may be at risk as they share the same home.”

Under ‘Factors Affecting Risk’:

“Due to [Mr S’s] current thoughts towards his wife and colleagues it would appear that this could be affected by [Mr S’s] current mental state. As [Mr S’s] family have not reported his presentation it would appear that they are unaware of his risk.”

The HONOS score sheet also rated Mr S as level 4 (i.e. severe to very severe problem) for the following:

- problems with hallucinations and delusions;
- problems with depressed mood;
- problems with relationships; and
- problem with living conditions.

The risk assessment of 19 November and the HONOS scores were not repeated between the time of admission and Mr S’s discharge. The only difference between the handwritten document of 19 November 2009 and the RiO document dated 1 December 2009 was the addition of ‘aftercare arrangements’, which detailed the following:

- *“The [interim care co-ordinator] to do 7-day follow with [Mr S].*
- *[Specialist Registrar] will contact him to arrange this.*
- *[Community consultant psychiatrist] to follow-up in the community.*
- *Advised [Mr S] to go to his GP’s for advice regarding driving.”*

It would have been prudent if the risk assessment had been updated prior to or at the time of Mr S’s discharge to reflect the changes in Mr S’s presentation and actions requiring completion with regards to the team’s risk management plan. It is clear from reading the clinical progress notes and care plan that there were concerns about the potential risk Mr S posed to his wife and that a number of decisions were made to mitigate this.

Relevant aspects of Mr S’s admission between 19 November and 1 December with regards to the assessment of his risk

The core elements of Mr S’s care plan which were informed by his presentation and initial risk assessment were:

- To offer Mr S a minimum of three half-hour one-on-one engagements a week to enable assessment of his mental state with regards to his mood and levels of suspicion and levels of paranoia.
- To assess Mr S under s.5 of the Mental Health Act (1983) if he tried to leave the ward. Specifically to assess his thoughts towards his wife.
- For Mr S to be maintained on a general level of observation.

The day-to-day progress notes show that on admission to the in-patient ward:

- Mr S was engaging, calm and willing to give information.
- Mr S expressed thoughts that he was being victimised by colleagues and they were trying to kill him.

- Mr S considered that his wife was having an affair, and trying to poison him. He also reported that his wife did not get on with his family and provided a barrier between Mr S and his extended family.
- Mr S also reported that his wife swore at him.
- Mr S admitted to shouting at his wife, but reported never shouting at his children.

The impression recorded following Mr S's medical assessment on 19 November at 20.45hrs was as follows:

- ?? psychotic depression
- ?? relapse of psychotic illness – cause?
- ?? delusional disorder
- Risks to self and risk to wife?

The day after his admission, Mr S approached the Duty SHO and asked if he could go home to get some clean clothes. He was appropriately informed that he could not go home unaccompanied and there were no members of staff available to facilitate this. The Duty Doctor reiterated in his contemporaneous record that “[Mr S] *has not asked to go alone but if he does [try and leave] he should be assessed by medical staff with a view to detention under the Mental Health Act 1983 due to the threats he has made to himself and his wife.*”

On 21 November Mr S is noted to again ask to leave the ward to “*pay some bills, see his children, and get some clothes*”. The reviewing doctor recorded that Mr S “*still feels cameras follow him. Recognises yesterday's thoughts as 'thoughts', but says these come and go ... 'doesn't know' if wife is having an affair, denies ideation to harm himself or his wife at the moment.*”

The assessing doctor's impression was “*still having ? delusional and persecutory thoughts. I suggest he is masking some of these thoughts also.*”

Mr S was persuaded to remain in hospital informally and the assessing doctor reassured him that the staff would continue to try and contact his family to bring him in some clean clothes. It was again noted that should Mr S try to leave the ward he was to be detained under s.5(2) of the Mental Health Act 1983.

On 22 November a bank nurse spent approximately one hour with Mr S in a one-to-one session and explored in detail with him how he was feeling and a range of coping strategies that might assist him in responding more appropriately to life's stressors. The impression of this nurse was that Mr S was appropriate and engaged in the conversation. He also wrote: “*In terms of risk, no risk towards others. In relation to self, has negative self identity though not hopeless. No current active desire towards death or actual suicidal thoughts or plans. Did have wish to kill self at admission but this has now gone – would appear that risk has reduced.*”

On 23 November Mr S again asked to leave the ward and a registered mental health nurse explored with him his reasons for admission. Following Mr S's recount of these, the nurse asked Mr S directly if his thoughts had changed, to which he is

recorded as saying no. Furthermore, Mr S reported that he believed that someone on the ward *“had it in for him and was out to get him”*. However, he could not say who or why. Mr S was again persuaded to stay on the ward and wait for the consultant ward round the following day. On this day Mr S also managed to make contact with his wife. Mr S was noted to be distressed afterwards as his wife had reportedly said *“come home now”*.

At the consultant ward round Mr S reported feeling less stressed, and provided consent for the medical team to speak with his wife. With regards to his request to go home for Eid, the notes clearly stated that this issue was to be discussed later in the week.

The consultant also requested Mr S's complete BDCT clinical records.

On 25 November Mr S had another one-to-one session. At this session Mr S reportedly denied *“any current ideation of self harm or paranoia, and stated he no longer has thoughts of harming his wife. Keen to go on overnight leave for Eid. States otherwise being ‘fine’.”*

The assessing nurse contacted the Specialist Registrar regarding leave for the Eid period. However, she was informed that the Specialist Registrar had not yet managed to speak with the family and once she had been able to contact them then she would contact the ward and inform them about the possibility of leave.

Later that same day (17.20hrs) the Specialist Registrar is recorded as having contacted the ward after speaking with Mr S's wife. The registrar reported that:

- Mr S's wife had no understanding of her husband's illness.
- Mr S's wife wanted him home.

The Specialist Registrar also reported speaking with Mr S's brother regarding his willingness to escort Mr S to and from hospital.

The nurse who received this communication also spoke in detail with Mr S, who reported feeling *“a lot better after admission, could acknowledge the difference in his thought process now. He doesn't feel suicidal, no thoughts of harming anyone ... his wife thinks he is pretending, doesn't understand his illness ... now he feels much better, more relaxed, positive, no strange thoughts/experiences.”*

The ward staff discussed possible leave with the Specialist Registrar on 26 November. The registrar was noted to be reluctant about overnight leave for Mr S, but, in view of his informal status, she was noted to agree, provided that the duty doctor assessed Mr S immediately prior to going on leave, and if he was not detainable then to allow the leave to proceed. This plan was followed, including seeking the input of the duty social worker. Consequently, Mr S went on home leave for four days. The agreement was that he stayed with his brother over this time and not at his own home. He was also to speak with the ward on 27 November and attend for the ward review on 28 November. In the event, although the telephone communication occurred as planned on 27 November, on the 28th Mr S contacted

the ward advising that he could not get to the hospital and requested further overnight leave, reporting that all was going well and that his wife needed him at home. The nurse Mr S spoke with also spoke with Mr S's sister-in-law, who informed the staff nurse that "[Mr S] had told her that he felt much better". The sister-in-law was also noted as reporting that Mr S's behaviour had been appropriate, and that Mr S was needed at home to support his wife with their young children. The record also noted that Mr S was asking to be discharged.

On 30 November the in-patient ward tried to contact the interim care co-ordinator regarding the ward review that was to occur the following day. However, he was not available to speak with the ward staff.

On 1 December 2009 the Discharge Ward Round occurred.

At the time of Mr S's discharge, all the indicators were that the risk factors that he had presented with some twelve days previously had significantly reduced. However, bar the brief conversation with Mr S's sister-in-law while he was on home leave, none of Mr S's self-reports of improvement, or that his wife was happy to have him back home, were validated via collateral history-taking by the clinical team. Furthermore, the previous report by the Specialist Registrar regarding the lack of understanding Mr S's wife had about her husband's illness and thus the potential risks to her remained unaddressed. The discharge plan formulated did not address the need to achieve a detailed discussion with Mr S's wife, or the need to try and obtain collateral information from other family members. The issue of future possible risks to Mr S's children should Mr S relapse again were also unaddressed.

BDCT's investigation and its analysis of Mr S's risk assessments

The BDCT investigation team appropriately concentrated their exploration of the assessment and management of Mr S's risk on the final in-patient episode. They also sought perspectives from Mr S's community consultant and also the Intensive Home Treatment Team regarding Mr S's historical risks and also perceptions of his risks for the period July through to September 2009.

The interviews revealed the following:

From the in-patient team

That risk assessments are conducted on the ward "*every now and then*" to make sure the patient is safe and for the safety of others. Generally, the risk assessment would be completed by the team in meetings; the nurse would update the risk assessments and the consultant and thus the medical team would be made aware. Risk Plans were also reportedly reviewed at team meetings. The in-patient nurses articulated a clear understanding of the need for risk assessment.

With regards to the risks to Mr S's wife and the need to inform her, and/or assess her understanding of him, one of the Senior House Officers was noted as recalling that "*they did get a report from his previous care worker*" and that this showed that Mr S had a quick recovery once stressors at home had settled. The Senior House Officer also reported to the BDCT investigation team that it was her impression that Mr S usually sought help when unwell. She also told the BDCT investigation team that she did not believe that Mrs S was frightened of her husband, as when he was in hospital

she was ringing the ward and wanting him home. With the benefit of hindsight, however, she said, *“I wonder whether it would have been worth helping the family a little bit more, looking at the notes now a year later.”* It would, at the time, have been usual for them to have tried to have achieved an in-depth review with the partner of a service user presenting as Mr S did.

There is no evidence that the reasons why this did not occur for Mrs S were explored by the BDCT investigation team.

The BDCT investigation team did, however, gain confirmation from the senior house officer that *“yes, an adult needs to be informed and it is up to them what risks they are willing to take on. If there are limitations on their ability to understand the risks then we should look at that – in this case the language barrier proved a problem; maybe we should have looked at this better.”*

The consultant psychiatrist told the BDCT investigation team that he, like his junior doctor, believed that the information they received from the interim care co-ordinator was based on personal knowledge of Mr S and not simply his interpretation of what was in the clinical records. He underlined the fact that there is often a delay in obtaining access to BDCT records held on a different hospital site.

With regards to Mr S's wife, the consultant told the BDCT investigation team that *“he and the team were aware that [Mr S's] wife had difficulties in looking after the children and was unhappy at home. [The Specialist Registrar] had taken the lead in speaking with [Mrs S]; however, the brother took the lead in terms of speaking with the clinical team. That was how the family had arranged it and it made it much more difficult to gain access to [Mrs S].”* The consultant told the BDCT investigation team that, with hindsight, he wondered whether this was a cultural issue and something they need to be more aware of. Nevertheless, he also considered that at the time, with the efforts of his Specialist Registrar, they *“probably had about as much contact with the wife as [they] were likely to get”*. As a team they felt confidence in Mr S's brother; he came across as a *“fundamentally honest and reliable man. He didn't present as withholding information. We felt a degree of comfort regarding the contact we had with the family.”*

With regards to the need to have warned Mrs S about her husband's threat at the time of his admission, the consultant categorically reported: *“that should happen in all cases, always when there is a specific threat to a person and always when that person is accessible. I know that the specialist registrar had a conversation with the family and the wife. There is not full detail in the records ... the conversation should not be a surprise to the family, but the conversation should still happen. Where there is any risk to a specified person, the conversation should definitely happen.”*

It is clear that it was the impression of the consultant psychiatrist that the conversation about the threat to Mrs S did happen. When the BDCT investigation team asked the Specialist Registrar about the interaction with Mrs S, she told them that she recalled asking Mrs S if she felt at risk from her husband. Mrs S is reported to have told the Specialist Registrar that when her husband got depressed he got irritable, but that when he took his tablets and saw his community consultant he was

fine. The Specialist Registrar also told the BDCT investigation team that *“in this case my understanding of it was that it was a known risk and it wasn’t something new. The wife knew about it ... we knew he had been seen by the IHTT – everyone knew about the risk. The whole idea of him coming into hospital was to reduce the risk, and that happened.”* The registrar also recalled that throughout Mr S’s admission to hospital his family were encouraged to come in and meet with the team. However, this did not occur. The Specialist Registrar also told the BDCT investigation team that in the case of Mr S his risks were two-fold, to his wife and also to himself. There were from her perspective a number of risks for Mr S, but they all diminished during his in-patient stay. Essentially, in terms of the weight of risk the Specialist Registrar believed that for Mr S it could have gone either way: *“he could have killed himself; sadly he killed his wife”*.

The other key interview relevant to the risks posed to Mrs S was with the support worker who worked with the Intensive Home Treatment Team. This individual reported to the BDCT investigation team that he felt Mrs S did understand what was happening with her husband, as when they lived in Rochdale she was involved with the police because of her husband’s anger towards her. The support worker understood from his conversations with Mrs S that she monitored her husband’s behaviour. However, the support worker never had the opportunity to speak with Mrs S on her own, as he believed that would increase the risk, owing to Mr S’s levels of suspicion and paranoia. He didn’t want to create a risk. He did note that both Mr S and his wife spoke openly about their previous experience of domestic abuse; he also told the BDCT investigation team that Mrs S came across as upfront and appeared to have nothing to hide. Furthermore, the interview record clearly shows that the support worker did not perceive any risks for Mrs S at the time he met with her and her husband. He detected nothing that led him to believe that they were conspiring against each other. Initially, they did keep separate bedrooms, but by the end of the IHTT intervention they had reverted back to sharing a room together.

Finally, the IHTT support worker informed the BDCT investigation team that in his view Mrs S was a strong lady and quite forthright, instructing her husband to recount the details of their experiences, even when he did not want to, and if he did not then share the information, she did. The support worker believed, as a consequence of his time with Mrs S and her husband, that the main risks were to Mr S and not to Mrs S or his children. This perspective is underlined by the fact that Mr S’s brother-in-law became involved in providing support to his sister not because of his concerns about her, but because they were worried about Mr S and his risk to self. Mrs S initiated this additional family support. The support worker also informed the BDCT investigation team that, at the time of Mr S’s discharge from the IHTT, Mr S’s risks had considerably reduced, telling the BDCT investigation team that *“when you actually spoke with him, his thoughts and beliefs ... the black magic didn’t shift, but the poisoning and affairs, all that had gone”*. Importantly, at the time Mr S was receiving support from the IHTT, Mr S was not making any threats towards his wife. The issues were more to do with his inability to cope with what he (Mr S) described as his wife’s uncaring attitude towards him and this inability to cope resulted in low-level self-harm at the time. The support worker’s contemporaneous records and the

IHTT records of their contacts with Mr S fully support the information provided to the BDCT investigation team.

The Independent Team also considers it important to recognise that, at the point of discharge from the IHTT, the recommendation of the IHTT was that Mr S required long-term support in the community and referred him back to the CMHT for allocation of a care co-ordinator. However, the CMHT's perspective was that this was not required. (This issue has already been addressed in the previous section of this report.)

Independent Team comment

Having read the clinical records and the BDCT interview records, it is clear that between July 2009 and 1 December 2009 the IHTT staff and the in-patient staff were mindful of Mr S's risks of harm to self and from 19 November 2009 the potential for harm to his wife.

However, it appears that the in-patient team over-valued the reassurance provided by the interim care co-ordinator that Mr S normally recovered quickly from his relapses; they had incorrectly formed the impression that the interim care co-ordinator had previous contact with Mr S, whereas his knowledge and impression came solely from his interpretation of Mr S's existing BDCT clinical records; records that the in-patient team had not had access to.

Critically, the information that the pattern of relapse for Mr S was as it had been previously, and was normal for him, was a misrepresentation of the facts. In November 2009 there was a significant difference in Mr S's presentation; this was his direct threat to kill his wife or himself. This change, albeit subtle, should have alerted all involved to an escalation in Mr S's risk profile. The BDCT interview records do not demonstrate any exploration of this subtle change in risk profile with the in-patient consultant or the Specialist Registrar with regards to Mr S's ongoing management following his discharge from in-patient services, or of the information in-patient services needed to ensure Mr S's community consultant psychiatrist was made aware. Neither was the means by which in-patient and community consultants communicate with each other about service users explored.

Neither was this subtle change in presentation explored with the interim care co-ordinator. Furthermore, the BDCT team should have asked this practitioner if the information recorded in the clinical record regarding his communication with in-patient services accurately portrayed his interpretation and understanding at the time. It would have been useful had the BDCT investigation asked the interim care co-ordinator what difference to his perspective about Mr S and the need for care co-ordination had he appreciated the difference between this last presentation and those in July and September 2009. As previously articulated, it would have been good practice for the BDCT investigation team to have asked the interim care co-ordinator to recount how he normally conducted a 7-day discharge assessment visit and in particular how he assessed mental state and risk.

All of the above were essential components of the effective and searching investigation. The lack of detailed exploration around the practice of risk assessment generally and specifically in relation to Mr S detracts from the clear intention of the BDCT investigation to have thoroughly explored this aspect of Mr S's management. Nevertheless, the information gathered is sufficient to render further independent re-investigation of this particular aspect of Mr S's care and treatment unnecessary. It is clear that there was a lapse in practice standards both collectively and individually. It is also clear that at the time the systems and processes in place were insufficiently embedded to assure effective information exchange or the effective recording of all staff assessments leading to key clinical decisions, notably that of the interim care co-ordinator.

The recommendations made by the BDCT investigation team that are relevant to risk assessment practice are:

BDCT Recommendation 5

Action Number	Requirement	Responsible Lead	Action taken/ Progress made	EVIDENCE Assurance and outcome	Date for completion & RAG
Recommendation 5: <ol style="list-style-type: none"> The discharge process should ensure that: <ul style="list-style-type: none"> Discharge meetings are planned in advance A multi-disciplinary approach to discharge planning is taken, including representatives of both the discharging and admitting teams as per the BDCT Care Programme Approach Policy Robust discharge planning and risk assessment is in place on discharge. 					
23	An audit will be undertaken to ascertain the quality of discharge planning	Head of Operations, AMH	Added to the audit programme Audit completed August 2011	Audit tool Audit report	June to August 2011
24▲	Head of Operations, AMH, will re-issue the guidance on discharge planning arrangements across the care group	Head of Operations, AMH	A formal memo has been issued by the Head of Operations, AMH, to all Team Managers and Senior Managers for Community Teams addressing this issue	Correspondence	31/1/2011

Independent Team comment

Although laudable, the actions taken as a consequence of the recommendation made will not necessarily address the issues that arose in the case of Mr S. In his case the interim care co-ordinator was unable to attend for an unplanned discharge CPA meeting. This situation is one that will occur again. It would therefore be prudent for Adult Mental Health Services within BDCT to audit the frequency with which care co-ordinators are unable to attend at a CPA discharge meeting and the frequency with which these occasions coincide with an unplanned discharge.

With regards to the audit that was conducted, the following emerged:

Page 3 of the Service Governance Committee Report March 2012

“4.2 Evidence of the Care Co-ordinator’s involvement in the whole of the service user’s journey regardless of setting:

- For existing Service Users we found that 88% had evidence of a Care Co-ordinator’s continued involvement:
-

Oct 2010	Jan 2011	Oct 2011	Feb 2012
79%	75%	79%	88%

Comment

This question particularly asked auditors to focus on evidence on whether Care Co-ordinators had remained in contact, particularly when the Service User was in hospital. Evidence suggests that Care Co-ordinators are maintaining a high level of contact.”

In addition to the above comments, the Independent Team marked one aspect of the above action plan with ▲. This type of action constitutes an ‘administrative intervention’ and does not have high reliability characteristics for delivering sustainable improvements in standards and performance. It is important therefore that the Head of Operations implements measures to satisfy himself/herself that the desired effect when sending the memo has been achieved, and is sustained.

BDCT Recommendation 10

Action Number	Requirement	Responsible Lead	Action taken/ Progress made	EVIDENCE Assurance and outcome	Date for completion & RAG
Recommendation 10: Guidance must be devised which aids staff to undertake a robust 7-day follow-up assessment.					
33♦	Guidance on the evidence base and rationale for 7-day follow-up is to be reissued to all CMHTs	Head of Operations, AMH	Reissued in September 2010	Correspondence	September 2010
34♦	New and updated guidance to be issued to Care Co-ordinators	Head of Operations, AMH	A formal memo has been issued to all Team Managers and Senior Managers for Community Teams addressing this issue	Updated guidance Correspondence	28/2/2011
35	Development of a 'checklist' for staff to use to support consistency and quality of 7-day follow-up	Head of Operations, AMH	The checklist has been developed and issued to Care Co-ordinators [Updated 28 June 2011]	Checklist for 7-day follow-up	31/3/2011

Independent Team comment

BDCT has delivered what it set out to achieve, which is specific guidance to care co-ordinators regarding what is required at the 7-day follow-up assessment. However, two of the three interventions (♦) have weak reliability in terms of sustaining improvement in practice and quality standards. It is essential that the new guidance is subject to regular audit so that the head of operations and the relevant service managers are assured that improvements in practice are sustained in the medium and long term.

BDCT Recommendation 14

Action Number	Requirement	Responsible Lead	Action taken/ Progress made	EVIDENCE Assurance and outcome	Date for completion & RAG
Recommendation 14: Training on clinical risk assessment should be further rolled out; a further 18 people (making 36 in all) will be trained in a 5-day Critical Risk Assessment Course. All community staff within Adult Mental Health will be required to attend a 2-day training course on Clinical Risk Assessment.					
42	Commission further risk training from Nurse Consultant in Clinical Risk, Manchester University	Director of Nursing & Operations	Action completed; training commissioned with agreed provider	Correspondence	December 2010
43	Ensure delivery of the above training to an agreed audience	Head of Operations, AMH	Training planned	Training materials Training attendance	31/7/2011
44	A further 2-day bespoke training course is to be developed for all community staff	Director of Nursing & Operations	There will be slippage on this action due to the external trainer being part of the Mr S Investigation Panel	Training materials	31/3/2011 Propose new date September 2011
45	CMHT and IHTT Senior Managers to identify and ensure attendance of relevant community staff on 2-day training course	CMHT and IHTT Senior Managers	Dependent on the above	Attendance records	Nov 2011 New date due to above

Action Number	Requirement	Responsible Lead	Action taken/ Progress made	EVIDENCE Assurance and outcome	Date for completion & RAG
46	Develop a revised Risk Assessment Tool in conjunction with Manchester University	Director of Nursing & Operations	Following assessment by Nurse Consultant and discussion with the Director of Nursing & Operations and the Chief Executive, it has been agreed that the current risk assessment tool is appropriate and does not require change [December 2011]	Risk assessment tool	30/9/2011

Independent Team comment

BDCT has appropriately increased its investment in this essential aspect of practice. It now needs to ensure that there is a regular audit programme of the quality of risk assessment documentation including the formulation of risk management and contingency plans to monitor the impact of the training investment and also to assure that the detail of the risk assessments and risk management plans meet expected standards. This type of audit is quite different to that which can be conducted by the Trust's CPA lead, which generally constitutes a quantitative audit and does not provide an assessment of quality.

BDCT also needs to provide its commissioners with an update on when the community care co-ordinators are to receive their 2-day training programmes and what the plan is for the delivery of update/refresher training on a 3-yearly basis in keeping with the Safer Services Report of 1999 (Independent Inquiry Report into Homicides and Suicides).

BDCT 4: The interim care co-ordinator discharged Mr S back to the care of his consultant psychiatrist after a 7-day follow-up visit

This particular care management concern has already been addressed within the information contained in the Independent Team's commentary on care management concerns 'two' and 'three' (see pages 38-74 of this report).

BDCT 5: The process for outpatient appointments was flawed in that Mr S was not seen for nine months prior to the incident occurring

This particular care management concern is the least complicated of those set out by the BDCT investigation team. As they set out on page 52 of their report, the Trust's then policy on 'failure to attend' was straightforward and clear in its expectations. It said:

"3. Situations where a service user will be classified as 'failed to attend'

A service user will be classified as 'failed to attend' in the following circumstances:

- 1. The service user does not attend for an outpatient appointment.*
- 2. The service user is not at home when visited by a professional at a prearranged time.*
- 3. The service user has not attended day services on more than one occasion (or one if this is deemed to be significant).*
- 4. The service user has moved from their usual place of residence and has given no indication of their new address.*
- 5. In relation to a mental health service user, when the individual refuses to engage with any secondary community mental health service."*

It also said:

"4. Service users who are known to the service

Service users known to the service should have a contingency plan in their CPA care plan to outline action to be taken if they fail to attend an appointment. This should include those patients who are only seen by their Consultant Psychiatrist.

4.1 If there is assessed to be no risk, and therefore no contingency plan associated with non-attendance, the following action should be taken:

- a. Notification in writing to General Practitioner and CPA care co-ordinator.*
- b. The care co-ordinator should ask for a further appointment if required.*
- c. If there is no care co-ordinator, the Consultant Psychiatrist should decide the date and number of subsequent appointments to be offered.*
- d. If the service user fails to attend subsequent appointments, the General Practitioner and CPA care co-ordinator should be contacted to clarify whether the service user continues to require follow-up.*

4.2 Service users who fail to attend but who are deemed to be at possible risk and have no contingency plan on their CPA care plan:

- a. Should be telephoned at home **at least twice** by the duty worker/care co-ordinator
and/or
b. Should be visited at home **at least twice** by the care co-ordinator/duty worker.*

If no contact is made, the service user should be reviewed by the Multi-disciplinary team and the outcome be communicated in writing to the General Practitioner, asking him/her to contact the service user."

Mr S clearly met the criteria for having defaulted on an outpatient appointment in May 2010. As the BDCT report sets out, Mr S's care team (his consultant, the interim care co-ordinator, the community mental health team, and in-patient staff at the time of discharge) did not consider that Mr S posed a risk to himself or others. Consequently, the actions listed at 4.1 were taken. The BDCT investigation team in its report states that their perspective was that Mr S met the criteria listed at 4.2 owing to his relapse in November 2009 and the circumstances of this. The contributory factors to staff's non-appreciation of Mr S's potential risks permeate throughout the BDCT investigation report, and have their roots planted in:

- An insufficient number of care co-ordinators to deliver CPA to the service users who met CPA criteria;
- Ineffective communication pathways at the time of Mr S's discharge from hospital;
- The lack of an up-to-date and meaningful risk assessment, risk management plan and care plan at the time of discharge from in-patient services;
- An ineffective assessment at the 7-day post-hospital discharge visit in December 2009.

BDCT recommendations

There was no specific recommendation regarding the management of service users who fail to attend at a planned appointment. However, the BDCT action plan did address the subject of the 'did not attend' service user within a number of other recommendations, the key relevant features of which are presented below:

Action Number	Requirement	Responsible Lead	Action taken/ Progress made (escalation to risk register)	EVIDENCE Assurance and outcome	Date for completion & RAG
Recommendation 10: Guidance must be devised which aids staff to undertake a robust 7-day follow-up assessment.					
33	Guidance on the evidence base and rationale for 7-day follow-up is to be found in a variety of documents, including the DNA policy; this is to be reissued to all CMHTs	Head of Operations, AMH	Reissued in September 2010	Correspondence	September 2010
Key area for action: The capacity of consultants to provide supervision to Senior House Officers (regarding clinics), including: Administrative support in respect of consultant appointment systems and reviewing how clinics are arranged (ensuring that, in the early part of junior medical staff's rotation, clinics are not booked when the incoming juniors have already made commitments such as holidays).					
7	Explore the way clinics are structured and identify approaches to ensuring that appointment systems and supervision of clinics are more effective	Medical Director	Communication has taken place with consultants; progress is linked to the completion of actions 4 and 5. This work is ongoing. Reinforcement of the need to use the DNA Policy [Updated June 2011]	External Review Report	31/5/2011

Independent Team comment

The Independent Team is not satisfied that the Trust has explored the issues relevant to the lack of follow-up of Mr S when he defaulted from his planned outpatient appointment. It is the recommendation of the Independent Team that BDCT need to assure their commissioners that:

- It has a reliable system for ensuring that all 'DNAs on CPA' are flagged up at the next weekly CMHT team meeting.
- That the requirements of its 'Failure to Attend Policy' are consistently being met. (The production of audit data showing the volume of DNAs of service users on CPA, and evidence of what percentage of cases were tabled and

minuted at the next community team meeting, would constitute the type of information required to achieve assurance.)

Because of the extensive range of actions targeting an improvement in the allocation of care co-ordinators, the number of care co-ordinators and the systematic review of the CMHT involved with Mr S, the Independent Team is confident that the Trust will have identified the operational issues that needed to improve. Furthermore, the Independent Team is satisfied that, had Mr S's care management met all the required standards between 19 November 2009 and 7 December 2009, then it is unlikely that Mr S would have been discharged from CPA, and thus there would have been a more robust follow-up of him in May 2010.

BDCT 6: There was no discussion with or referral to the safeguarding adults or safeguarding children's leads within BDCT by any staff team involved with Mr S's care

As previously highlighted, the Independent Team considers that the formulation of this care management concern was too narrowly focused and would have benefited from being stated more broadly, or stated as a critical question to which the BDCT investigation responded. Furthermore, the issues of 'safeguarding children' and 'vulnerable adults' needed to be treated separately. The issue relating to vulnerable adults could have been incorporated into the care management problem that explored the extent to which Mrs S was informed of the threat made towards her by her husband on 19 November 2009.

The analysis presented in the BDCT investigation report, as a consequence of the narrowness of the problem statement, lacks illumination. However, when the Independent Team read the interview records there was considerable information relevant to staff's consideration of 'safeguarding children' and also relevant to staff's consideration of possible domestic abuse, and risk in relation to Mrs S.

Independent Team comment – Vulnerable Adults

The BDCT policy relating to vulnerable adults was issued in August 2009. The Independent Team is not aware of what training had been provided to Trust staff between this date and December 2009, or whether training had been provided in advance of the policy launch. The newness of the policy document is relevant to the articulation of how/why staff may not have responded to Mr S's potential risks to his wife.

The policy opens with the following statements:

"Abuse is the violation of an individual's human and civil rights by another person or persons.

DH (2000) 'No Secrets'

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.

BDCT’s policy at page 6 says:

“2.2 Summary of reporting and investigation process

All staff should be able to identify and report signs of abuse and take immediate action to protect the adults covered by this policy. Managers have a crucial role in deciding whether a situation needs to be referred for a multi-agency approach under the adult protection procedures.

If the adult concerned can be offered effective protection by a multi-disciplinary care planning process and she/he is happy with this, then a multi-agency process may not be needed.

However, many situations will require support and assistance from other organisations to assess and reduce risk.

Multi-agency adult protection referrals must be made if any of the following apply:

The concern relates to potential abuse by a staff member or volunteer or to institutional abuse.

The adult at risk wants a referral, or for an adult without capacity the best interest decision is for this to happen.

The co-operation of other agencies is needed to either:

- a) protect the adult immediately or in the near future or*
- b) help them recover from their experience of abuse.*

The risk has not been or cannot be managed by the Trust, e.g. pattern of recurring incidents. Trust protection plans not effective.

Abuse or neglect has led to death, significant harm or critical risk to the adult’s independence.

A crime has been committed against an adult without capacity to report this and the best interest decision is for this to be reported.

Anyone involved in the situation believes a referral is necessary.

There is potential risk to adults in other services.

Once a referral has been made an appropriate manager from the Trust will negotiate the role that BDCT will play in the adult protection process.”

The Independent Team does not consider that this policy directly applied to the situation for Mrs S. Neither does the Independent Team consider that Mrs S was a vulnerable adult in the intended meaning of a vulnerable adult’s policy. Independent validation of this perspective was sought through liaison with the lead of the public Protection Unit within the locality of one of the Independent Team.

Mrs S was an adult who had capacity. She was also an adult who had been asked if she felt at risk from her husband by staff at Pennine Care Trust, the Intensive Home Treatment Team (BDCT) and the Specialist Registrar in the in-patient unit. The Independent Team considers that, because of the language difficulties, the difficulty

in being able to speak with Mrs S in private, and the prevailing concern about Mr S's risks to his wife in November 2009, it would have been prudent for the clinicians involved, and/or the ward manager, to have sought advice on what measures, over and above those they had already taken, were needed to try and speak with Mrs S. Clearly, the vulnerable adult lead for the Trust would have been a logical person with which to have held such a discussion. However, the Independent Team does not consider that any BDCT professional lapsed in their duty to Mrs S in respect of any adherence or non-adherence to the Trust's vulnerable adults policy.

Independent Team comment – Safeguarding Children

As with the vulnerable adults policy, BDCT's policy in respect of safeguarding children was ratified in August 2009.

In the context of the policy document, safeguarding children was defined as:

- protecting children from maltreatment;
- preventing impairment to a child's health and development;
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.

This definition was taken from *The Children Act, 2004: Working Together to Safeguard Children, 2006*.

The Trust's policy also says:

Ward/Unit Managers/Community Team Leaders

"The above managers have a responsibility to ensure that team members within their practice follow the policy and procedure for safeguarding children. Managers will also support staff who are working on cases where there are safeguarding children issues and liaise with the Named Professionals accordingly. The above managers are responsible for identifying and managing training needs within their team, ensuring that all staff receive their required training, as well as staff receiving safeguarding children supervision."

Individual Members of Staff

"All members of staff have a responsibility to follow the Trust's safeguarding children policy and procedures in safeguarding children cases. The Trust's policy and procedures should be read and used in conjunction with those of the Local Safeguarding Children Boards of Bradford and North Yorkshire. Members of staff should ensure that, in cases of uncertainty or complexity, they seek out the relevant support, supervision and advice. ... Staff will be required to keep comprehensive and contemporaneous notes where there are concerns of or actual child abuse."

The Trust's policy document would benefit from the inclusion of some practical examples of situations BDCT staff might encounter which should result in a safeguarding concern, or at the very least the seeking of advice. The policy document as it stands, although compliant with the national requirements, talks strongly of abuse. In the case of Mr S, his behaviours may have posed a threat to the "health and development" of his children and a threat to his children receiving

safe and effective care from him and his wife. After 2005 and 2006, there is nothing in the information the Independent Team has read that suggests that Mr S's children were at risk of direct abuse from their parents. Furthermore, the Intensive Home Treatment Team did communicate appropriately with the health visitor to the children at the time and this individual reported no concern from a safeguarding perspective.

The Independent Team suggests that the ward staff should have included safeguarding children in the plan of care for Mr S because of the way in which he presented. This care plan should have included re-communication with the children's health visitor so that a home check could be made and the well-being of the children confirmed, or otherwise. As with the matter of 'safeguarding adults', it would have been prudent for staff to have sought the advice of the safeguarding lead for children under the circumstances. However, the Independent Team does not consider the fact that this did not happen to have been a serious lapse in quality standards. The lack of care plan or documentation about safeguarding children, the Independent Team considers, was more significant, as it demonstrated a complete lack of awareness of the importance of the children's safety.

One of the key contributory factors identified by the BDCT investigation to the lack of safeguarding performance related to the lack of knowledge of staff. Staff interviewed had not attended any safeguarding training.

BDCT's recommendations and action plan

BDCT have undertaken the following actions since their internal investigation:

Action Number	Requirement	Responsible Lead	Action taken/ Progress made	EVIDENCE Assurance and outcome	Date for completion & RAG
21	Repeat the Learning event held by the AMH Care Group, in conjunction with the safeguarding children lead regarding the findings of a Serious Case Review	Head of Operations, AMH	This event took place on 26 January 2011	Event programme and attendance	February 2011

Action Number	Requirement	Responsible Lead	Action taken/ Progress made	EVIDENCE Assurance and outcome	Date for completion & RAG
22	The Head of Operations, AMH, will issue further guidance consistent with existing protocols highlighting the lessons from this incident	Head of Operations, AMH	Further guidance has been issued. A Learning event occurred in May 2011. The revised caseload management guidelines also reference safeguarding	Correspondence	31/3/2011
38	Heads of Operations to be informed of requirement to improve attendance of existing staff on Safeguarding Adults & Children training	Director of Nursing & Operations	Email sent to Heads of Operations. Training report received in February highlighting some improvement	Reports to Service Improvement & Development Group Training report	December 2010
39	All new starters and staff changing posts within the Trust have an introduction to safeguarding adults and children on central induction. Non-attendees are followed up and rebooked and this must continue	Training department	The process for booking and following up non-attendance for new starters continues to be implemented This process remains in place. [Updated June 2011]	Reports to Service Improvement & Development Group	Review attendance data in June 2011

Action Number	Requirement	Responsible Lead	Action taken/ Progress made	EVIDENCE Assurance and outcome	Date for completion & RAG
41	Improved attendance on safeguarding adults and safeguarding children training to existing staff. Specific focus on ensuring that in-patient Ward staff are up to date with training	Heads of Operations in all Care Groups	There are ongoing reports on training attendance being provided within the Trust and support for staff to attend training – progress will be reviewed in June 2011. Agenda item for AMH Governance Group in July 2011 for further actions [Updated 28 June 2011]	Attendance data	To review attendance data in June 2011

The above initiatives will assist in ensuring that staff are more aware of the need to consider safeguarding issues as a core component of their everyday work. However, because of the nature of the interventions, i.e. training and alterations to policies, the interventions do not have strong reliability characteristics in terms of achieving sustainable improvement in practice. BDCT might therefore consider a range of additional measures to enhance the opportunity for sustainable improvements in practice and also reliable reminders to staff about the issues they need to consider as a component of safeguarding children or adults.

For example, the Independent Team reviewed the risk assessment tool used by the Trust at the time. This did and continues to ask staff to state whether there are known risks to children in the preceding six months, and 'ever'. However, it provides no prompts for staff about the range of issues they need to bear in mind when determining their answer to this question.

Because the assessment of risk to children is central to the contemporary assessment of risk and because it is a complex issue, BDCT could consider including a dedicated section in its risk assessment form for safeguarding children. This would enable the form to include more discrete questions about possible threats to child safety and well-being, and thus assist staff in delivering their professional accountabilities in this regard.

The following are examples of the types of questions that could be considered:

- Has there been any direct threat made towards the children by the service user?

- Are there any recorded instances of physical violence towards the children (including smacking)?
- Are there any known instances of neglect towards the children?
- Are there concerns about the service user's capability to discharge their parenting duties to the children when mentally unwell?
- Are you, the mental health professional, confident that the needs of the children are being adequately and safely met by the service user's spouse or partner?
- Is the service user a single parent?

The Independent Team does not suggest that these are the precise questions that could or should be used. Expert advice should be sought from the Trust's safeguarding lead and children and family services at the local authority if this suggestion is taken forward.

With regards to safeguarding adults, should a concern be raised that requires a specific risk assessment, then there may be merit in BDCT working with the relevant local authority to devise a specific set of questions that staff explore as part of the risk assessment process.

BDCT 7: There was no evidence that Mr S's wife was made aware of the threats made against her in November 2009 by either the in-patient services or the CMHT

As has already been identified by the Independent Team, the wording of this care management concern does not accurately reflect the issue of concern. It would have been better if the problem statement had said something along the lines of:

"On 19 November Mr S made a direct threat of harm against his wife.

Although

- *the clinical records show that staff were aware that Mr S posed a potential risk to his wife and took appropriate measures to prevent him leaving the in-patient unit until his risk had been assessed as reduced; and*
- *the specialist registrar did speak with Mrs S about her husband and attempt to explore her perception of his mental health illness and her own risk exposure;*

neither the clinical records, nor the information provided at interview, demonstrated that the in-patient or the community mental health service did all that it could have done, or should have done, to satisfy themselves that

- the risk was sufficiently reduced so that no medium-term assessment of Mr S in the community was required;*
- Mrs S was sufficiently informed about her husband's condition, his relapse indicators, and the future risk to herself should he relapse again in the future."*

Although less succinct, the formulation of the problem statement along the lines suggested above more accurately states the realities of the situation at the time.

Although the BDCT investigation team explored the issues of the potential risk to Mrs S with almost all staff working in the in-patient unit and also with the interim care co-ordinator, the BDCT investigation team did not accurately set out the information it gathered in its analysis of the stated care management concern.

The contributory factors analysis on page 55 of the Trust's investigation report says:

- *“Individual staff factors”* – That none of the staff interviewed stated that they had tried to inform Mrs S that her husband had said that he may kill her or himself in November 2009.
- *“Team and social factors”* – The threats that Mr S made to himself and his wife on admission were not reassessed throughout the admission or at the point of discharge.
- *“Equipment and resources”* – The telephone interpreting service was not utilised by the ward team to communicate with Mrs S, nor was an interpreter sought.
- *“Education and training”* – Staff failed to seek advice from safeguarding adults and safeguarding children's leads, and that attendance at safeguarding training was lower than it should have been on the ward.

The BDCT interview records and Mr S's clinical records as assessed by the Independent Team revealed that:

- Staff did undertake an assessment of Mr S's risks, and in particular sought information from him regarding thoughts of harm to himself and to his wife on a number of occasions during his in-patient stay and prior to agreeing home leave from 26 November. The assessment of Mr S's risks was predominantly undertaken by nursing staff and their progress records clearly show that risk to Mr S's wife was explored.
- The specialist registrar's records and nursing records made following communications with the registrar show that she was very mindful of the risks to Mrs S and that it was important that she was able to speak with Mrs S about her husband and the possible risks. The Independent Team agrees that the lack of documentation about the conversation she had with Mrs S was unacceptable.
- The ward round notes of 24 November clearly reference the need for Mrs S to speak with her husband's in-patient consultant psychiatrist. In the event, it was determined that the conversation would be with the specialist registrar, because she spoke the same language as Mrs S.
- The interview record with the specialist registrar said:
“Yes [I was able to communicate successfully with Mrs S]. I remember because I had to ring the ward and tell them what I had spoken about. It was a very short telephone call with the wife. I remember this because I offered to do it because I understood the language. He was a Bradford patient, but to find out what had happened, we had to start from the beginning. I remember trying to do the groundwork, me and the SHO. I remember offering to do it because we'd heard rumours that she couldn't speak English. That jogged my memory in the notes – her English was very poor. She just said that when he gets depressed, he gets like this. I'm trying to translate it in my head ... she said

he's got depression. We had read the notes that he had been aggressive, and the wife said that was only when he was depressed and now he is OK and we are happy to have him home. When I tried to explain to her that he is here on the ward, her understanding was very poor.

Did she understand she was at risk?

No. It was very vague – I wasn't getting anywhere with the conversation; there were kids in the background – lasted only 6-8 minutes. I told the ward that her understanding about the situation was very poor. The family called it depression; that was the problem. Mr A [believed to be Mr S's brother] described it as depression too – from an Asian background, I can understand them using that; they don't understand psychosis. Neither of them understood it.”

The registrar also told the BDCT investigation team:

“Was it explained to Mr A?

We queried that on the ward. No-one attended from the family. It was winter and the family were struggling to get to Airedale. The wife couldn't attend, which is why I rang her. The brother came and picked him up, but again there were questions about him being so far away.

Also, questions re whether he was the brother or not.

What was communication like?

Language difficulties, but I think she did understand me and I understood what she said. The difficulty was more about the understanding of the mental illness, or her refusal to understand. Looking at the notes, it is everywhere about going home to the children, and the wife also said frequently that the children needed him home. On the ward round, it was all about going back to the children and how he was good with the children and how they needed him back for Eid, as they would miss him. It was a kind of emotional blackmail, but at the time we were just trying to figure him out a bit better.”

The registrar also told the BDCT investigation team that:

“I did ask her if she felt at risk; she said when he gets depressed he gets irritable – the translation is difficult – she could have meant either irritable or aggressive. But when he takes his tablets and sees [the consultant], he is fine. I just didn't get anywhere with that conversation.”

When asked about the utilisation of interpreter services, the registrar also informed the BDCT investigation team that:

“language wasn't the problem. We could communicate OK and we could get the idea that she wasn't understanding the mental issues. It was round and round in circles – I was trying to explain to her, but she just kept replying that

he was just depressed and that he gets better and she wanted him home. I couldn't get past that – it wasn't a language issue."

The completeness of the information communicated to the BDCT investigation team during interview that was relevant to their analysis of this specific care management concern was not set out in the BDCT investigation report and neither did the analysis conducted by the BDCT investigation team result in a fair and balanced portrayal of the situation with regards to the consideration of Mrs S's risks and the need to inform her of the same.

The Independent Team considers that the BDCT investigation team should have explored with the specialist registrar, the in-patient consultant, Mr S's named nurse and the ward manager:

- how risk assessments are usually reviewed during an in-patient episode;
- how identified risks are re-assessed when discharge is being considered/occurring;
- how the in-patient unit usually communicates unresolved/outstanding issues of concern to the nominated care co-ordinator if they are not present at the discharge ward round; and
- how unresolved issues are communicated to a service user's regular community consultant.

In addition to the above, the Independent Team considers that the BDCT investigation team should have asked the in-patient team the following:

- What experience they had in dealing with a potentially high-risk domestic abuse situation?
- How feasible it would have been to have engaged the support of the Intensive Home Treatment Team to make a home visit to Mrs S because i) they had a worker who could speak her language; and ii) they had already visited her at home and established a rapport.
- What their assessment was of the immediate risk to Mrs S when her husband was discharged?
- What their assessment was of the risk to Mrs S should Mr S relapse again in the future?
- Whether there were any specific Asian women's support groups that BDCT could have worked in partnership with to have achieved a more satisfactory outcome to the discussion held with Mrs S.

The BDCT recommendations and action plans

BDCT made a range of recommendations already presented in this report in relation to risk assessment, risk management and safeguarding. However, the Independent Team is not confident that the measures taken can be expected to avoid the loss of focus with regards to the need for an ongoing risk management plan that addressed those issues of concern that had not been addressed to a satisfactory degree prior to discharge back into the community from in-patient services.

If BDCT accept the Independent Team's suggestion that the current design of the Trust's risk assessment form could be expanded to include specific sections with regard to safeguarding adults (including domestic abuse), this would go some way to mitigating against these factors being missed in the future. If a specific discharge risk document could be designed, so that staff had to specifically address each identified risk and state the position in relation to the risk at the time of discharge, that might mitigate against future loss of focus and also ensure that the professional undertaking the 7-day post-discharge assessment had a clear and up-to-date perspective about what risk issues remained current. (Note: this suggestion may need to be addressed through the RiO designers.)

Independent Team opinion

Although the Independent Team does not consider that:

- the Trust's presentation of their analysis of this care management problem properly reflected the information gathered; or
- that the in-house investigation asked the full range of questions that they should have;

the Independent Team is satisfied that the BDCT internal investigation team across the breadth of the investigation, and the Trust owing to the breadth of the actions taken, have rendered the need for re-investigation of this aspect of care and treatment unnecessary.

The attention of the senior management team at BDCT is, however, drawn to the Independent Team's recommendations set out in section eight (page 91) of this report.

BDCT 8: There was no evidence of referral for either psychological interventions or specific social support

As previously stated, the Independent Team considers that this issue could have been absorbed by the care concern relating to s.117 aftercare. However, the Independent Team notes that when the BDCT investigation team met with Mr S in prison, he informed them that he would have liked support in his day-to-day living and more support to discuss his feelings. When the Independent Team met with Mr S, he reported that the support he found most helpful was his regular outpatient appointments with his community consultant. He also reported that he felt isolated in the community and that he was unable to use his family for support owing to barriers he saw as created by his wife.

The Independent Team agrees with the BDCT investigation team that, had Mr S been subject to CPA from September 2009, and had there been consideration of his s.117 aftercare status, then it is possible that there would have been greater opportunity for his psychological needs to be addressed, particularly as Mr S did inform the mental health professionals that speaking with his family and seeking support from them was difficult because his wife objected to him being in contact with them.

This information, and other comments from Mr S about his wife, did raise for the Independent Team a consideration regarding whether or not he was a 'vulnerable adult' and also subject to domestic abuse. This appears not to have been considered by Mr S's care teams at any stage. At the time of writing, the Independent Team has not seen any information to confirm or refute any such situation.

6.0 OTHER ISSUES THE BDCT INVESTIGATION TEAM EXPLORED DURING ITS INVESTIGATION

In addition to its presentation of the eight identified care management concerns, the interview notes compiled by the BDCT investigation team showed that during the course of the investigation the BDCT team explored:

- The reasonableness of the in-patient service's decision to allow Mr S home for leave during the Eid period.
- Why Mrs S had not been offered a carer's assessment.

Both of these issues were appropriate to have been explored and the Trust's investigation team were particularly thorough regarding its exploration of the Eid leave.

7.0 CONCLUSIONS OF THE INDEPENDENT TEAM

As a consequence of its considerations, the Independent Team confirms its conclusion that:

- Although the quality of investigation could be much improved, the BDCT investigation was reasonable.
- The range of recommendations and subsequent actions taken by BDCT were appropriate and will contribute to the Trust's determination to reduce the risk of the care and treatment lapses identified with regards to Mr S and his wife from re-occurring.
- On the balance of probabilities, the incident that occurred was not predictable by BDCT staff. Although a constant feature of his paranoia, when unwell, were unhealthy thoughts about his wife, there is no evidence after 2006 that there was any domestic abuse between Mr S and his wife. His threat to harm her in November 2009 was made with an equal threat towards himself. Before going on home leave, Mr S had reported to staff that he no longer felt this way towards his wife or himself. There were independent family reports that the leave period went well and Mr S was appropriate in his behaviour. It is not reasonable to suggest that on the basis of Mr S's presentation in 2009, and his past history, that staff should or could have predicted that he would kill her.
- With regards to preventability there are three things that must be considered. Staff must have had:
 - Knowledge that an incident was both likely and imminent;
 - The legal means to prevent it; and
 - The opportunity to prevent it.

On all three counts the Independent Team is confident that the BDCT did not have any of the necessary means or knowledge to have prevented what occurred, even had they been in contact with him in May and August 2010. Mr S's history shows that when unwell on all previous occasions he had actively sought the input of primary care services, or the police, or A&E services. He made no approach to any of these services between December 2009 and September 2010. Importantly, neither did the local Family Protection Unit have the knowledge of means to prevent what occurred to Mrs S. At no time during the four years Mr and Mrs S were resident in Bradford did Mrs S or any family member raise any concern regarding domestic abuse with:

- the mental health services;
- Domestic abuse services;
- Health visiting services.

8.0 RECOMMENDATIONS OF THE INDEPENDENT TEAM

It is clear that BDCT have engaged in a wide-ranging spectrum of work since this incident occurred. However, based on its analysis and review, the Independent Team does have additional recommendations for BDCT to consider. These recommendations are intended to build upon and enhance the effectiveness of actions already taken by BDCT.

Recommendation 1: BDCT commissioned its own review of the CMHT under which Mr S was managed. The report of this review was published in March 2012. The Independent Team suggests that BDCT provides its commissioners with a detailed breakdown of its considerations of the recommendations made in this report and any actions that are being implemented as a consequence of this, with a timetable for completion.

In particular, the Independent Team would expect actions taken forward to include:

- The development of a robust and workable process for reviewing a service user's s.117 aftercare status and seeking discharge from this where appropriate.
- A clear statement of what the role and responsibilities of the interim care co-ordinator are and how this individual interfaces with the rest of the CMHT.

Recommendation 2: Safeguarding children

Because the assessment of risk to children is central to the contemporary assessment of risk and because it is a complex issue, BDCT and the provider of its electronic records system could consider including a dedicated section in its risk assessment form for safeguarding children. This would enable the form to include more discrete questions about possible threats to child safety and well-being, and thus assist staff in delivering their professional accountabilities in this regard.

The following are examples of the types of questions that could be considered:

- Has there been any direct threat made towards the children by the service user?
- Are there any recorded instances of physical violence towards the children (including smacking)?
- Are there any known instances of neglect towards the children?
- Are there concerns about the service user's capability to discharge their parenting duties to the children when mentally unwell?
- Are you, the mental health professional, confident that the needs of the children are being adequately and safely met by the service user's spouse or partner?
- Is the service user a single parent?

The Independent Team does not suggest that these are the precise questions that could or should be used. Expert advice should be sought from the Trust's safeguarding lead and children and family services at the local authority if this suggestion is taken forward.

Target Audience: The Deputy Chief Executive/Director of Nursing.

Timescales: Because this recommendation is not something BDCT can take forward without the active support and participation of their RiO provider, it is not appropriate to impose timescales on the implementation of this recommendation. However, the Independent Team considers that it is reasonable that the Trust should be able to update its commissioners on any communications the Trust has with its RiO provider within three months of the publication of this report.

Recommendation 3

Although the Trust's internal investigation report demonstrated a sincere commitment to the conduct of an effective investigation, there are a number of elements that the Trust needs to improve to ensure that future investigations:

- Are completely impartial;
- Deliver good practice standards in investigative interviewing technique;
- Demonstrate a good working understanding of how 'root-cause analysis' applies to mental health incidents such as homicide.

To achieve the above, the Independent Team recommends the following:

- That future investigation teams are considerably smaller than that convened for the Mr S investigation. It should be possible to deliver an effective investigation with a three-person team (one lead investigator, one medical advisor and one nursing/social care advisor). If other subject-matter advisors are required, these could be accessed on an 'as-required' basis.
- Staff identified as 'investigative leads' must know how to conduct a good investigative interview and appreciate the value of:
 - the 'tell all' instruction;
 - broad open questions;
 - closed questions for clarification purposes;
 - the funnelling technique;
 - avoiding leading and asking questions in such a way as to suggest the answer;
 - ;
 - avoiding expressing opinions during the interview.

Investigative leads must also:

- appreciate that the investigation is an 'enquiry' into what happened and, to ensure that the investigation team understands this from the perspective of the professionals involved, it is essential that there is sufficient depth of exploration, not simply a question and answer approach.

- have an appreciation of the need for the forensic exploration of pivotal aspects of practice, which is an essential competency for an investigative lead.
- Staff identified as investigative lead have a more complete understanding of how the National Patient Safety Agency's human factors framework is applied during the information analysis part of the investigation and how, from this process, root causes can be agreed on.

Appendix 1 MINI BIOGRAPHIES OF THE INDEPENDENT TEAM

Dr Mark Potter: **Consultant Psychiatrist**
Place of Work: **West Battersea CMHT**
 Garratt Court
 Furmage Street
 London SW18 4DF

Professional Protection Membership:
 Medical Defence Union
 Membership Number 170879

GMC Number: **2579823**

Dr Potter has been working as CMHT consultant psychiatrist since November 1991. He leads a Community Health Team serving a population of 45,000. The catchment area served is an inner city area with significant pockets of deprivation. The service has a clear focus on serving the needs of the long-term mentally ill. There are strong links with Social Services, and Social Workers are fully integrated into the CMHT. As the Consultant Psychiatrist within the Team, Dr Potter functions as the Clinical Team Leader. The responsibilities of his role include ensuring that the Team provides care which is safe, effective and efficient; and to ensure clear accountability arrangements, including supervision and appraisal for all staff within the Team and to be ultimately responsible for ensuring allocation of each individual service user's care and to direct the Team's overall resources accordingly.

In addition to his day-to-day clinical work, Dr Potter is the Head of Psychiatry in the adult services directorate, which requires him to provide professional leadership to the medical staff within the adult directorate and advise the Clinical Directors on medical issues. Other responsibilities include overseeing appraisal for consultant staff and non-training grade doctors. He has also published extensively in peer review journals.

His experience as a senior psychiatrist who continues to work in the community as well as his higher level management responsibilities makes him an ideal clinician to provide an independent assessment of the care and treatment of Mr S.

Mrs Joanne Lawrence

Place of work and current job role:

South London and Maudsley NHS Foundation Trust (SLaM) – Clinical Services Lead for Early Intervention in Psychosis services across the four SLaM Boroughs (Southwark, Lambeth, Lewisham and Croydon) since April 2011

Professional Registration: Nursing and Midwifery Council (NMC) PIN: 78A1325E

Qualifications:

RMN (1982) – Royal London Hospital

RGN (1982) – Royal London Hospital

BSc (Hons) (1997) – Specialist Practitioner in Community Mental Health Nursing (2:1) – University of East London

Joanne has nineteen years' experience in community mental health services. Her experience encompasses:

- Five years' practice as a CPN;
- Fourteen years' experience as a community manager spanning CMHT, Assertive Outreach, and early intervention services.

Her current role is as the clinical services lead for Early Intervention in Psychosis services across the four South London and Maudsley Boroughs (Southwark, Lambeth, Lewisham, and Croydon). Consequently, she is well versed in the complexities of working within a multi-cultural environment and families where English is not the first language, and/or is not spoken at all.

Her vast experience of delivering specialist mental health services in the community makes her the ideal nurse advisor for this case.

CUK has worked with Joanne previously, in her role as nurse advisor on HSG investigations within NHS London and NHS North West. In terms of her approach she is:

- grounded;
- pragmatic;
- evidence-based;
- practice focused; and
- credible.

Maria Dineen – Director of Consequence UK

Maria originally trained as a Midwife, and then developed her career in clinical risk management in 1994, developing one of the first clinical risk management and incident-reporting systems in England for the Women's Centre at the John Radcliffe in Oxford. This was part of a research project in conjunction with Oxford University. From here she developed her knowledge and expertise in the field as an assessor for the Clinical Negligence Scheme for Trusts, and then as a Research Fellow at the Health Services Management Centre, Birmingham.

In 2000 she was invited to work with the Organisation with a Memory Team at the Department of Health in the early set-up phase of the National Patient Safety Agency. This work led to her being retained by the National Patient Safety Agency between 2001 and 2003 to work with its in-house team to develop and road test the now national model of incident investigation and root-cause analysis.

With regards to independent investigation work, Maria has extensive experience in leading independent investigations for Strategic Health Authorities in England and also the Health and Safety Executive in the Republic of Ireland. These investigations have largely been focused on Homicide investigations, and Safeguarding – Adults investigations.

To date she has led over 35 independent investigations, of varying degrees of complexity.

Maria has published widely in the field of healthcare risk management and in 2002 published a book on how to conduct an effective investigation that targeted health and social care. This book, *Six Steps to RCA*, is now in its 3rd edition and has sold over 7,000 copies to date.

Related but separate to her investigation work, Maria has a long-standing interest in

- facilitating workshops for staff wishing to improve their investigative skills; and
- supporting organisations and teams in developing meaningful critical success factors and facilitating a dynamic risk assessment regarding the team or organisation's ability to deliver these.

She has led an extensive range of workshops over the last nine years to Safeguarding Boards, professional safeguarding leads, NHS Trusts (all disciplines) and the Private Sector. Notably she was engaged by the following organisations to deliver investigation training to their officers and to advise on how internal processes could be improved:

- The Nursing and Midwifery Council;
- The Royal College of Nursing;
- The Royal College of Midwives;
- The Mental Welfare Commission in Scotland; and
- King Faisal Specialist Hospital, Saudi Arabia.