



# INDEPENDENT INVESTIGATION REPORT INTO THE CARE AND TREATMENT OF MS K

NOVEMBER 2018

## TABLE OF CONTENTS

1	INTRODUCTION .....	3
2	DARREN EDESON.....	5
3	EXECUTIVE SUMMARY .....	6
4	RECOMMENDATIONS.....	17
5	PREDICTABLE / PREVENTABLE .....	22
6	JUNCTURE ONE: GEOGRAPHICAL AND SERVICE BOUNDARIES .....	30
7	JUNCTURE TWO: ASPIRE (EARLY INTERVENTION IN PSYCHOSIS).....	40
8	IN-PATIENT ADMISSION - 31 DECEMBER 2010 .....	56
9	JUNCTURE THREE: SECTION 3 MENTAL HEALTH ACT 1983 ORDER.....	62
10	JUNCTURE FOUR: DIAGNOSTIC PROCESS APPLIED IN LEEDS .....	69
11	JUNCTURE FIVE: DIAGNOSIS OR LABEL – THE IMPACT OF LABELS .....	82
12	JUNCTURE SIX: ATTENDANCE AT ACCIDENT AND EMERGENCY IN LEEDS, 29 JULY 2011 .....	89
13	JUNCTURE SEVEN: FAILURE TO ADHERE TO THE ETHOS OF THE CARE PROGRAMME APPROACH.....	109
14	JUNCTURE EIGHT: CHOICE OF CARE CO-ORDINATOR.....	120
15	JUNCTURE NINE: OPPORTUNITY PRESENTED FOLLOWING RELEASE FROM CUSTODY.....	124
16	JUNCTURE TEN: REACTION TO INCIDENT BY HEALTHCARE PROVIDERS .....	135

# 1 INTRODUCTION

- 1.1 On 20 December 2012, a jury at Leeds Crown Court found that Ms K had inflicted stab wounds upon Mr Darren Edeson during the course of the evening of 31 October 2011. Mr Edeson died of these injuries.
- 1.2 Ms K was initially found to be unfit to plead at her trial because of a mental disorder. She was made the subject of a Hospital Order, in accordance with Section 37 of the Mental Health Act 1983, together with a Section 41 Restriction Order. It was ordered that she was to be detained in a high security service without limit of time. Ms K remains under the care of high secure healthcare services.
- 1.3 Little information is known about the incident which led to the death of Mr Edeson. However, it is known that Mr Edeson was the subject of eight different stab wounds. The fatal wound was a deep wound to his chest. There was no evidence of any defensive wounds on Mr Edeson's body. At the time of Ms K's arrest some days later, she was noted to have a cut to her hand with no other injury. There was no evidence of any other injuries sustained by Ms K.
- 1.4 At the time of the offence, Ms K was 20 years old. She had been involved with Mental Health Services since the age of 14. Ms K had been involved in sex work in the period leading up to the death of Mr Edeson. In the period between 31 December 2010 and 31 October 2011, Ms K received care from Leeds and York Partnership NHS Foundation Trust ('LYPFT'), Bradford District Care NHS Foundation Trust ('BDCT'), and Nottinghamshire Healthcare NHS Foundation Trust ('the Nottinghamshire Trust'). The dates upon which Ms K was in contact with each of the Trusts is set out within the Chronology to the Report.
- 1.5 As a result, NHS England have commissioned an Independent Investigation Report in order to maximise the learning for the NHS from the tragic death of Mr Edeson. This report sets out the findings of the Independent Investigation Team.
- 1.6 The Terms of Reference of the Investigation, Team Membership, Methodology and the Chronology prepared during the course of the investigation can be found at appendices 1 to 4.
- 1.7 This report will seek to demonstrate;
  1. Ms K is an individual with complex needs who had been subject to childhood adversity and had an established pattern of chaotic interaction with services.
  2. Services were unable to respond to Ms K's needs and there was insufficient collaboration across service and geographical boundaries in order to provide continuity of care.
  3. Changes in her presentation were not recognised and Ms K's needs were largely unaddressed as her illness deteriorated.
  4. Ms K was unable to access an Early Intervention in Psychosis Service which could have addressed her complex needs and the chaotic manner in which she presented.

- 1.8 The report is divided into a series of 'junctions', at which care could have been delivered differently. At the end of each junction, the key points of the section are highlighted, together with a section setting out 'reflective practice' for clinicians.

## 2 DARREN EDESON

2.1 Whilst this report will focus on the care received by Ms K, it is important to highlight that Darren Edeson lost his life as a result of Ms K's actions on 31 October 2011. Mr Edeson was a son, and a father of two.

2.2 Darren Edeson was an individual who was loved and valued by those who knew him. His death has caused ongoing, deeply felt pain and suffering to his family and friends. The Independent Investigation Team appreciates that the traumatic grief which follows a homicide is intense, long-lasting, and affects a wide range of individuals connected with the event. The necessity of dealing with an Independent Investigation is an additional source of stress for those bereaved by a homicide.

2.3 Mr Edeson's mother, a dignified and hardworking lady, told the Independent Investigation Team of her feelings and concerns:

*'I want Darren to be remembered and it to be recognised that he lost his life. I worry that Darren's name is going to be forgotten and feel that my son has been murdered but there's no recognition of that fact. I feel that when I go to Court for the Hearings relating to Darren's case, it often seems like I'm there for something minor, such as a burglary charge that doesn't take into account the gravity of the situation.'*

*'I want to point out that I am not the victim, Darren is. My life has changed forever and, this young woman has invaded my life and taken my son from me. I feel as though the focus is now on Ms K, as if she is the victim, not Darren. However, Darren was the one who lost his life.'*

*'I do not see my grandchildren as much since Darren's death. I feel like they are slipping away, that they'll forget Darren, that they'll forget their dad. This is a great source of pain for me.'*

*'There have been failings all round. This girl's family have probably been failed. However, the system has also failed Darren. This is a no win situation. Nothing can bring Darren back and I'm sure that if it wasn't my son, it would have been someone else's.'*

### **3 EXECUTIVE SUMMARY**

#### **3.1 Introduction:**

**3.2** Ms K was found responsible for the death of Mr Edeson on 31 October 2011.

**3.3** Ms K's presentation is very complex. In sentencing Ms K, in relation to Mr Edeson's death on 20 December 2012, the Honourable Mr Justice Openshaw described Ms K's history in the following terms:

*'The defendant is now aged 20. She was brought up here in Leeds. As a child she lived in a violent and unstable and dysfunctional family where acute deprivation, domestic violence and substance abuse were rife. Her own increasingly chaotic lifestyle of abuse of drink and all manner of addictive drugs made her vulnerable to sexual exploitation. This led to frequent removals to children's homes from which she frequently absconded. She claims, very probably correctly, that this led to periodic homelessness and prostitution. She has almost inevitably a long psychiatric history with frequently diagnosed psychotic episodes'.*

**3.4** During the course of the criminal proceedings brought against Ms K, psychiatrists gave evidence to the Court that Ms K *'probably also has a personality disorder'*.

#### **3.5 Failure to treat Ms K's psychotic illness by specialist Early Intervention in Psychosis services:**

**3.6** Evidence given at Ms K's trial confirmed that Ms K suffers from a psychotic illness. The possibility that Ms K might have been experiencing a psychotic illness was considered on a number of occasions throughout her adolescence and early adulthood.

**3.7** Aspire is an organisation that provides an Early Intervention in Psychosis service in Leeds. This is a service which provides specialist treatment and support for young people who are suspected of experiencing symptoms of psychosis.

**3.8** Ms K was referred to Aspire on a number of occasions by a variety of sources, including a clinician who knew her relatively well (see Paragraph 7.21). However, she was turned down by the service on a number of occasions despite her presentation meeting Aspire's service criteria. Her emerging psychotic illness remained unrecognised and, accordingly, untreated.

**3.9** As this report hopes to demonstrate, the impact upon Ms K's care of her being denied access to an effective Early Intervention in Psychosis service cannot be overstated. Had Aspire adhered to its own service criteria regarding acceptance of referrals, there would have been a far greater chance that Ms K's complex needs would have been addressed.

**3.10** Whilst the detail of a potential alternative outcome would fall within the realm of speculation, an Early Intervention in Psychosis service would be

expected to address many of the deficiencies identified within Ms K's subsequent care, such as the failure to recognise and respond to diagnostic uncertainty, which her presentation gave rise to; the inability to accommodate complex comorbidity, including substance misuse; the application of narrow pathways of care which failed to address all of Ms K's needs; and the inability to operate assertively and across boundaries. Furthermore, involvement with an Early Intervention in Psychosis service would have been sustained over a three-year period of care within the same service.

- 3.11** The services which subsequently came into contact with Ms K struggled to provide either the appropriate level of care, or its delivery through assertive engagement, which Aspire, as an Early Intervention in Psychosis service, could have provided.
- 3.12** In-patient admission on 28 December 2010:
- 3.13** On 28 December 2010, Ms K was admitted to hospital in Keighley for assessment, following concerns being raised about her mental health. The Police exercised their powers under Section 136 of the Mental Health Act 1983 to remove her to a '*place of safety*'.
- 3.14** Whilst Ms K was in the Police station in Bradford, prior to her transfer to hospital, she was assessed by Aspire. Aspire determined that, due to Ms K's mental health problems having been present for more than two years, she did not meet their criteria for care. This interpretation of Aspire's eligibility criteria does not comply with the criteria set out within Aspire's clinical governance regime. Had Ms K been assessed as meeting Aspire's service criteria, she should have been accepted into the service where she would have received assertive care (see Section 7).
- 3.15** Ms K's connection with Leeds was quickly recognised whilst she was in hospital in Keighley, and she was transferred to Leeds on 29 December 2010, where she was made the subject of an Order under Section 2 of the Mental Health Act 1983, detaining her in hospital for an assessment of her mental health.
- 3.16** Ms K's condition deteriorated following her transfer to Leeds, and she was placed in a Psychiatric Intensive Care Unit.
- 3.17** Prior to this transfer, a Manager from Leeds CMHT 1 had questioned her level of motivation to engage with a Community Mental Health Team, and suggested that, due to some evidence of psychosis being present, a discussion with Aspire might be required.
- 3.18** Ms K remained in the Psychiatric Intensive Care Unit in Leeds until 19 January 2011. She was placed on anti-psychotic medication. A provisional diagnosis of '*probable bi polar affective disorder*' was made.

**3.19** Diagnosis of emotionally unstable personality disorder:

**3.20** During an application by an Approved Mental Health Professional to detain Ms K for a further period of treatment in hospital in Leeds in accordance with Section 3 of the Mental Health Act 1983, which was completed on 25 January 2011, two clinicians involved in the process provided medical recommendations which offered divergent clinical opinions regarding the nature of Ms K's mental disorder. The content of the application did not address the divergence of the recommendations. The grounds for Ms K's detention were based on a diagnosis that appeared in neither medical recommendation, namely '*emotional(ly) unstable personality disorder*'.

**3.21** There are several distinct forms of personality disorder and, whilst there is some overlap, the blanket term '*personality disorder*' encompasses a number of different conditions.

**3.22** The Independent Investigation Team is concerned that, in reaching a diagnosis of emotionally unstable personality disorder, and in implementing a management plan that was orientated around emotionally unstable personality disorder, little account appears to have been taken of what had occurred prior in terms of psychosis, other than to call it a drug-induced psychosis.

**3.23** The Approved Mental Health Professional referred in the application for detention for treatment under the Mental Health Act 1983 to '*emotional(ly) unstable personality disorder*' as the sole condition giving grounds for detention. This was the first time that this term had been documented in relation to Ms K, and was the first time it was suggested that her treatment needs related solely to this or any other personality disorder.

**3.24** In addition, personality disorder is a diagnosis which is broken down into a number of sub-types, each of which has an individual diagnostic framework and management pathway.

**3.25** In a forensic report dated 22 June 2010 which was prepared on behalf of the Court in relation to criminal proceedings which were being taken against Ms K, a diagnosis of emotionally unstable personality disorder is not mentioned. The report compiled by a Consultant Clinical & Forensic Psychologist, although drawing attention to the author's restricted ability to provide a useful formulation, makes a number of recommendations that suggest a potential direction for care that those working with Ms K could have taken. The suggestions include finding a professional with experience of engaging clients who are reluctant or ambivalent, substance misuse services and the 'Personality Disorder Network'.

**3.26** Geographical and service boundaries:

**3.27** Ms K had family connections in the Leeds area. She was known to travel regularly (albeit randomly) between Leeds and Bradford. As a result, her social and healthcare needs frequently crossed a number of service and geographical boundaries.

- 3.28** By frequently moving between Bradford and Leeds throughout the period considered by the Independent Investigation Team, barriers were encountered by Ms K in obtaining continuous service provision as she ‘*bounced*’ between services operated by different NHS Trusts. This impacted adversely upon the continuity of her care.
- 3.29** Whilst no one could have predicted precisely when or how frequently Ms K would ‘*migrate*’ between Leeds and Bradford, it is the finding of the Independent Investigation Team that, on the evidence, there was a sufficiently high likelihood that Ms K would nonetheless migrate between these two cities, a distance of approximately 12 miles, and in so doing, she would not notify services.
- 3.30** It is the opinion of the Independent Investigation Team that effective continuity of care provides a greater ‘*clinical awareness*’ of the patient with an increased knowledge about them and their specific needs.
- 3.31** Clinicians and services involved in Ms K’s care did not work collaboratively in order to accommodate Ms K’s random but frequent movement between Leeds and Bradford. By not doing so, they were not in a position to mitigate its impact upon the continuity of her care. This also made it more difficult to detect changes in Ms K’s presentation which might have been clinically relevant.
- 3.32** Collaborative working could have been secured by services working within the Care Programme Approach and convening meetings at points of transition for Ms K when her care was transferred between services. However, such meetings did not take place at key points in her care.
- 3.33** A longitudinal view of Ms K’s care was not obtained and, accordingly, the development of her emerging psychotic illness was missed.
- 3.34** Diagnostic process employed by LYPFT:
- 3.35** The diagnostic process for considering Ms K to have emotionally unstable personality disorder is not recorded in Ms K’s records. Indeed, it remains unclear as to the sub-type of personality disorder that Ms K has.
- 3.36** If it is accepted that Ms K indeed had emotionally unstable personality disorder, it was still necessary to consider the possibility based upon her presentation that she was suffering from a mental illness.
- 3.37** A mental illness should be considered first. Caution would normally be applied when diagnosing personality disorder in an individual who has mental illness at the time. It is established practice to wait and then review the diagnosis.
- 3.38** The reason for this is that, if a psychosis is treated, the underlying pre-morbid character of the person is able to come out. The person who behaves in a grossly erratic, chaotic, and anti-social way may be doing so because of an underlying illness, as opposed to being as a result of aspects of their personality.

- 3.39** Ms K was discharged from inpatient care with two diagnoses: a diagnosis of 'borderline personality disorder' and a diagnosis of 'drug induced psychosis'. Neither is an ICD-10 category of diagnosis and there are recognised difficulties with the reliability of these terms. Usage of the ICD-10 terminology and demonstration that the requirements set out in the ICD-10 definition had been met, would have added clarity and demonstrated diagnostic rigor.
- 3.40** Rather than diagnosis being regarded as part of a reflective process, subject to ongoing review and refinement over time, the application of diagnosis was treated as a single event that was, in essence, fixed. This acted to narrow the clinical perspective of clinicians who later came into contact with Ms K.
- 3.41** Impact of diagnosis of personality disorder:
- 3.42** The Independent Investigation Team considers the use of '*personality disorder*' to be a '*label*' in this context because it resulted in clinicians' views of Ms K being based on their expectations of people to whom this term applied, rather than considering Ms K as an individual, and considering whether her presentation remained consistent with diagnostic criteria or whether different or additional diagnoses might apply.
- 3.43** This diagnostic term as applied to Ms K was subsequently allowed to dominate thinking by clinicians about her overall presentation and stopped consideration of alternative reasons for her behaviours outside the label of '*personality disorder*'. As a result, behaviours which could have been suggestive of an emerging psychotic illness in a young person were not explored and were, in fact, referenced back to the personality disorder label.
- 3.44** Had a more sophisticated and reflective diagnostic process and bio-psychosocial formulation been applied to Ms K then there may have been acknowledgement of diagnostic uncertainty and more impetus to take an enquiring approach to understanding Ms K's behaviours. The Independent Investigation Team holds the view that by doing so, different conclusions could have been drawn and accordingly, different decisions taken regarding care and treatment pathways.
- 3.45** Choice of care co-ordinator in Leeds:
- 3.46** In mental health, interpersonal elements play a significant part in whether engagement is successful or not. The appointment of an experienced female care co-ordinator was appropriate.
- 3.47** Ms K was a complex individual with complex needs. Her needs and presentation required an assertive approach towards securing Ms K's engagement, which is different to the model of engagement employed by many Community Mental Health Teams. Assertive working can be provided by a Community Mental Health Team. However, to do so would require a degree of flexibility from a care co-ordinator, as it would impact upon the capacity and resources of that care co-ordinator and other members of the team.
- 3.48** The Independent Investigation Team could not see any elements of reflective practice in relation to the planning of Ms K's care co-ordination.

**3.49** Consequently, whilst Care Programme Approach requirements were adhered to, the ethos was not. The level of care which was given was inappropriate to the degree of complexity and risk as it focused upon standards concerning documentation rather than the recognition that those standards should be embedded into an appropriate care plan.

**3.50** Attendance at Accident and Emergency in Leeds – 29 July 2011:

- 3.51** Ms K was assessed by Psychiatric Trainee 1 on 29 July 2011 in Accident and Emergency. Psychiatric Trainee 1 then discussed his concerns with his more senior colleague, Psychiatric Trainee 2. During this process, new and clinically relevant information came to light about Ms K. This information included: a description of seeing shadows in the corner of her vision for a week (persistent visual hallucinations); stating that whenever she heard sounds they were turning into voices, that when she hears a bang she hears an Asian man and a woman, they tell her to be violent to her social workers (functional hallucinations); and stating she was hearing ‘voices every day “all the time”’.
- 3.52** It was acknowledged that her presentation required a proper assessment. Ms K herself was seeking admission to hospital. The option of referral to a day centre (Acute Community Service) the next day was given to Ms K by the trainee doctors. She refused this.
- 3.53** As a result of her presentation, the trainee doctors considered admission to hospital to be warranted. Accordingly, her care was passed to the Crisis Resolution and Home Treatment team.
- 3.54** During the course of the assessment with Trainee Psychiatrist 1, clinical information which was suggestive of an emerging psychotic illness (as opposed to ‘*personality disorder*’) was obtained.
- 3.55** Despite a thorough assessment having already been undertaken, members of the Crisis Resolution and Home Treatment team sought to conduct a further assessment of Ms K. Their conclusion was that Ms K would not benefit from admission.
- 3.56** Instead, Ms K was offered the option of care by the Acute Community Service, an option which she had already rejected, and one which would have relied upon Ms K’s engagement, which was known to be poor.
- 3.57** Ms K left the hospital and failed to re-engage with NHS community services.
- 3.58** The Independent Investigation Team is of the view that the Crisis Resolution and Home Treatment team accepted the earlier diagnosis of borderline personality disorder without further analysis of Ms K’s presentation, or investigation into other potential diagnoses which had been considered given Ms K’s age and presentation.
- 3.59** The Crisis Resolution and Home Treatment team were presented with the challenge of being restricted to a limited face to face assessment. In the view of the Independent Investigation Team, the conclusions reached placed too much emphasis on the earlier diagnosis of borderline personality disorder without taking into account recent new information from other clinicians or the impact of delay on engagement. This prevented a comprehensive analysis of Ms K’s presentation, or investigation into other potential diagnoses. As a result, the decisions which were made did not appear to members of the Independent Investigation Team to be based upon all of the information which was available about Ms K at that time.

**3.60** As a result, the judgements which were reached did not appear to members of the Independent Investigation Team to be based upon all of the information which was available about Ms K at that time. This is shown in section 12 below.

**3.61** Detention and release from custody:

**3.62** On 2 August 2011, Ms K set fire to a Drug Rehabilitation Clinic in Bradford. She was arrested and remanded in custody.

**3.63** During the period in which Ms K was in custody, three Trusts were involved in her care. It is clear upon analysis following contact on 8 August 2011, with a Court Liaison Nurse employed by BDCT, that Care Co-ordinator 1 attempted to transfer Ms K to BDCT services at the commencement of Ms K's remand in custody. This decision was made unilaterally without the involvement of any other organisation and without any discussion with Ms K.

**3.64** The manner in which care was transferred (whether to Bradford or, indeed, to the Prison In-reach Team) was not completed in accordance with LYPFT's own discharge policy. It is significant, in the opinion of the Independent Investigation Team that, had a Care Programme Approach meeting been convened on or around 9 August 2011 when CMHT 1 advised Nottingham that Ms K's care had been transferred, then a number of issues could have been addressed in order to better facilitate the transfer of care.

**3.65** Most importantly, it would have been clear that Ms K did not have accommodation in Bradford, that it was her intention to return to live with her mother (at least in the short term) and that, as a result, it could have been discussed whether a transfer to BDCT services would have been appropriate and, if so, which service would best address Ms K's needs.

**3.66** In addition, clinically relevant information which came to light about Ms K during her time in prison and, indeed, following her discharge from hospital in Leeds, could have been used to contribute towards a more informed risk assessment, and patient-centred care plan.

**3.67** Failure to adhere to the ethos of the Care Programme Approach:

**3.68** The Care Programme Approach was intended to provide a way of supporting individuals with severe mental illness to ensure that their assessment needs and care plans remain central in what can be complex systems of care. Put simply, the Care Programme Approach is a term for describing the process of how mental health services assess users' needs (including assessment of risk), plan ways to meet those needs, and review whether the identified needs are being met.

**3.69** Its primary function is to minimise the possibility of service-users losing contact with services and maximise the effect of any therapeutic intervention.

**3.70** During key transition points in Ms K's care, where transfer of care was taking place between services, and where the Care Programme Approach should have ensured that professionals gathered together to review Ms K's care and treatment, a Care Programme Approach review did not take place.

- 3.71** The benefit of such a meeting would include a sharing of information of new and potentially relevant clinical information relating to Ms K, including the threats which Ms K made '*to kill*' on 30 July 2011 in Accident and Emergency and later whilst she was on remand in HMP New Hall.
- 3.72** Internal Investigation:
- 3.73** There were three NHS organisations involved in Ms K's care at the time of Mr Edeson's death.
- 3.74** One organisation, LYPFT, took the lead in conducting an investigation, and initially involved BDCT to some degree. However, it is the view of the Independent Investigation Team that, on the evidence provided to it, LYPFT subsequently failed to work collaboratively with BDCT in undertaking an investigation into its own care of Ms K, which was based around the diagnosis of personality disorder.
- 3.75** The issue of Ms K's emerging psychotic illness was not given any consideration in the LYPFT Internal Investigation despite being present in her medical records prior to the death of Mr Edeson.
- 3.76** Attempts were not made to involve the families of Ms K or Mr Edeson in the Internal Investigation. Aspire remained unaware of the death of Mr Edeson until they were advised by the Independent Investigation Team.
- 3.77** As a result, the opportunity for learning which was presented by Ms K's care was lost.

### **3.78** GOOD PRACTICE

- 3.79** As part of the Terms of Reference relating to the Independent Investigation, the Independent Investigation Team is required to highlight elements of good or, indeed, best practice arising from the care of Ms K, and the learning which could be used to benefit the delivery of care across the NHS community.
- 3.80** The Independent Investigation Team has been critical of the decision made by Aspire not to accept Ms K into its care. However, as has been stated earlier in this report Aspire, as a service, was easily accessible to referrals, and was able to take referrals from a number of sources. This is an element of good practice.
- 3.81** A further element of good practice previously discussed in this Report was the care and treatment which Ms K received in the Psychiatric Intensive Care Unit in Leeds. Arrangements for handing information over during Ms K's transfer to the Becklin Centre were effective. In addition, as is more fully set out in Chapter 8, the Independent Investigation Team gained the impression that there was a cohesive consultant group within the in-patient units in Leeds, who supported one another, and there was evidence of peer support.
- 3.82** The Independent Investigation Team considered that the collaborative approach adopted by Psychiatric Trainee 1 and 2 in reviewing Ms K and amending their opinion based on the information that came to light demonstrates good practice.
- 3.83** When Ms K was discharged from hospital in Leeds, she was discharged into the care of a Community Mental Health Team. She was allocated a care co-ordinator from that team who had already become familiar with her care whilst she was in hospital which is an element of good practice.
- 3.84** The Independent Investigation Team was very concerned throughout the course of its investigation about the barriers which Ms K faced in relation to accessing care, whether as a result of organisational challenges, or because of discrimination arising from labels which were applied to her.
- 3.85** The Bradford Working Women's Service was consistently able to support Ms K when she was in Bradford. This is an organisation tailored to meet the needs of women involved in sex work. They can help facilitate access to drug treatment, housing, and diversionary activities. Their aim is to support women develop a route out of prostitution.
- 3.86** The approach which was adopted by this service was 'blind' to Ms K's labels and was able to adapt its response to accommodate Ms K's pattern of engagement and management.

## **4 RECOMMENDATIONS**

### **4.1 Recommendation one - Encouraging collaborative working between services:**

**4.2** There are significant challenges for services in providing care for complex individuals who move between services and service criteria. This is particularly so when patients use services in more than one Trust.

**4.3** Given that some patients may do this with some degree of predictability, the Independent Investigation Team recommends that the Trusts and commissioning groups involved in Ms K's care at the time<sup>1</sup> develop robust, collaborative, patient-centred plans, to guide staff who care for individuals presenting with complex needs and who move between geographical, commissioning, or service boundaries on a regular basis, with a view to ensuring continuity of care, and which minimise disruption of therapeutic relationships.

**4.4** It is anticipated that this will be a small number of patients, and that such an approach would be clinically more effective, and make more efficient use of resources, by avoiding multiple re-assessments and handovers. Early Intervention in Psychosis services and primary care already employ this model for university students, who are moving between two locations, albeit on a more predictable time schedule. The funding should follow the patient as per models used for people with complex social care needs

**4.5** Accordingly, the Independent Investigation Team recommends that;

**4.6** The Trusts and commissioning groups involved in Ms K's care at the time develop robust, collaborative, patient-centred plans, to guide staff who care for individuals presenting with complex needs and who move between geographical, commissioning, or service boundaries on a regular basis, with a view to ensuring continuity of care, and which minimise disruption of therapeutic relationships.

### **4.7 Recommendation two – Aspire Early Intervention in Psychosis service:**

**4.8** The Independent Investigation Team understands that a number of changes have been made by NHS England to the commissioning and evaluation of Early Intervention in Psychosis services. This has included significant extra funding for Early Intervention in Psychosis services. It has also involved an endorsement of the model of service delivery adopted within NHS Early Intervention in Psychosis services.

**4.9** The new standard requires that, from 1 April 2016, more than 50% of people experiencing a first episode of psychosis start a National Institute of Health and Care Excellence concordant care package within a maximum of two weeks of

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<sup>1</sup> In 2017 HMP New Hall ceased to be operated by Nottinghamshire Healthcare NHS Foundation Trust and is now under the control of a healthcare service provider known as 'Care UK'.

referral. Both elements of this new standard are critical, as the key aims of its introduction are to ensure that:

1. Duration of untreated psychosis is reduced, and people with an emerging psychosis, and their families, and key supporters, can have timely access to specialist early intervention services.
2. Early Intervention in Psychosis services provide the full range of psychological, psychosocial, pharmacological and other interventions shown to be effective in NICE guidelines and quality standards, including support for families and carers. Effective and integrated approaches are needed to address the social and wider needs of people with psychosis to help them live full, hopeful and productive lives.

**4.10** Early Intervention in Psychosis services also need the capacity to triage, assess and treat people with an at risk mental state, as well as to help those not triaged to access appropriate treatment and support.

**4.11** The Independent Investigation Team wishes to highlight to those commissioning Early Intervention in Psychosis services in Leeds that the Aspire model may face additional challenges in operating its service to the new standards, as a result of the differences in its current structure and ethos. Accordingly, it is recommended that Aspire produce an action plan for commissioners, which addresses how Aspire will implement the new standards

with a view to ensuring that complex individuals such as Ms K can access their service.

**4.12** Accordingly, it is recommended that:

Aspire produce an action plan for commissioners showing how they have implemented and monitored the Early Intervention in Psychosis Access and Waiting Time Standard.

**4.13** Recommendation three – Prescription of sodium valproate by LYPFT:

**4.14** The Independent Investigation Team recommends that:

1. The prescription of sodium valproate by clinicians should follow the recommendations within the British National Formulary, and the guidance from the Medicines and Healthcare Products Regulatory Agency, with respect to women of childbearing age.
2. In the event of the exceptional circumstances arising in which sodium valproate may be an appropriate treatment in such patients, those patients should be fully informed, both verbally and in writing, and must have the capacity to provide informed consent. This should include information regarding the expectation of the duration of treatment, and the risks associated with discontinuation of treatment once it is established.
3. In the event that a patient lacks capacity prior to using sodium valproate, or loses capacity during treatment with sodium valproate, it should be established that this is, or remains, in the patient's best interests with reference to the Mental Health Act 1983 and the Mental Capacity Act 2005.
4. The Trust should perform an audit to confirm compliance with this recommendation.

**4.15** Recommendation four – Multi-disciplinary Discussion regarding disagreements to admit:

**4.16** Crisis Resolution and Home Treatment teams have had a positive impact upon the numbers of individuals admitted to hospital. However, a key challenge faced by the Crisis Resolution and Home Treatment model of care is the potential for it to achieve close integration with other services involved with the patient in order to deliver continuity of care from a multidisciplinary perspective and not in isolation from other services or agencies in which the patient might be involved. In order to ensure that, in cases where there is a difference of opinion in relation to the decision to admit, a mechanism is developed and implemented by the Trusts involved in Ms K's care to ensure a multi-disciplinary team

discussion takes place to review the individual patient's options for care. It is recommended that the mechanism includes the following criteria:

1. If no admission is to occur, and home-based treatment is indicated, then all clinicians need to have collaboratively reached this conclusion.

However,

2. If one assessing clinician diagnoses a mental disorder and feels admission is needed, then admission should occur, in order to assess more fully the risk.

#### **4.17** Recommendation five – Review of engagement strategies:

**4.18** Ms K was a complex individual who posed a challenge for services to engage with. In addition, Ms K may have attracted some unhelpful '*labels*'. '*Labelling*' in a clinical context always opens the possibility of the clinical significance of some of her behaviours, particularly in relation to engagement, being missed.

**4.19** Strategies to secure her engagement were not always reviewed, and, as a result, the ethos of the Care Programme Approach was not always adhered to in relation to her care.

**4.20** Accordingly, the Independent Investigation Team recommends that:

1. LYPFT and BDCT review their engagement strategies with complex individuals to ensure that a properly formulated analysis and action plan is included when the issue of non-engagement is recognised, particularly in relation to safeguarding.

**4.21** The Independent Investigation Team also recommends that:

2. LYPFT and BDCT review their Care Programme Approach and training programmes in order to highlight the philosophical purpose behind Care Programme Approach, rather than focusing on adherence to administrative policies and procedures, important though this is, to ensure that care co-ordination is approached in a reflective manner.

#### **4.22** Recommendation six – Review of internal investigation processes

**4.23** In recognising that Mr Edeson's death occurred prior to the introduction of the legal duty of candour, the Independent Investigation Team is concerned that neither the family of Ms K or Mr Edeson were advised of the learning which resulted from the internal investigation, or the outcome from it.

**4.24** Throughout the course of the Independent Investigation, there was an expression of frustration on the part of the families about their lack of knowledge

about what had gone wrong in Ms K's care. This concern was exacerbated by the lengthy criminal proceedings which followed Mr Edeson's death.

**4.25** Accordingly, it is recommended that:

1. The Independent Investigation Team would encourage the Trusts involved in Ms K's care at the time to consider reviewing the approach which they adopt in providing the families of those involved in incidents such as the death of Mr Edeson with information and support.

**4.26** A significant issue in the care of Ms K was lack of communication between the various agencies involved in her care including social services who continued to have contact with Ms K following her arrest. The concern of the Independent Investigation Team is that if organisations are focussed on who is 'responsible' for an investigation (i.e. whose team saw an individual most or, indeed, last) then there is a danger that the bigger picture will be missed as organisations fail to come together.

**4.27** Accordingly, it is recommended that:

2. The Trusts review their approach to undertaking investigation when more than one organisation is involved to ensure that a collaborative approach is considered and if appropriate adopted with a view to maximising the learning for each individual organisation.

## 5 PREDICTABLE / PREVENTABLE

5.1 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to determine whether Mr Edeson's death was predictable or preventable. Many Independent Investigations identify failings, missed opportunities, or gaps in the care which was provided to an individual. However, this does not mean that a homicide could have been either predicted or prevented. The following tests are commonly applied to determine whether a homicide could have been predicted or prevented.

### 5.2 Predictable:

5.3 A homicide is '*predictable*' if there was evidence from the perpetrator's words, actions, or behaviour that should have alerted professionals that there was a real risk of significant violence, even if this evidence had been un-noticed or misunderstood at the time it occurred.

### 5.4 Preventable:

5.5 A homicide could have been '*prevented*' if there were actions that healthcare professionals should have taken, which they did not take, that could, in all probability, have made a difference to the outcome. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done better.

## **5.6** Predictability:

- 5.7** The medical evidence submitted to the Court during the course of Ms K's trial suggested that, at the time of Mr Edeson's death, she was suffering from a serious mental illness; namely schizophrenia, which was characterised by paranoid delusions of persecutory content, auditory hallucinations, disorganised thinking and behaviour, and lack of insight.
- 5.8** Media depictions often portray mentally ill individuals as violent or out of control, potentially promoting the common, widespread, and misconceived belief that people who suffer from schizophrenia are inevitably dangerous, which encourages stigmatisation. However, the statistical reality is that most violent crime is committed by people who do not suffer from a diagnosable mental illness<sup>2</sup>.
- 5.9** The Independent Investigation Team recognises that particular significance is attached to a past history of violence and aggression, because past behaviour is a guide to future presentation, and individuals who have a criminal history are generally at a greater risk of future violent behaviour. This is the case whether they are mentally ill or not.
- 5.10** However, it is also recognised by the Independent Investigation team that prediction of risk of violence involves the consideration of a number of factors which have the potential to interact and increase risk. This is the basis of well-validated structured risk assessment tools such as the '*Historical Clinical Risk-20 Scale*' in which previous violence, social adversity, substance use problems, personality disorder, impulsivity and major mental illness, amongst others, are identified as relevant.
- 5.11** It is the view of the Independent Investigation Team that the medical evidence submitted to the Court during the course of Ms K's trial highlighted how Ms K's behaviour is sudden and unpredictable. A Consultant Forensic Psychiatrist was instructed on behalf of Ms K to provide evidence about her mental state. A report submitted to the Court dated 10 December 2012 stated:
- 'Ms K is suffering from a mental disorder. In my view this is a mental illness, namely schizophrenia. She has the typical features of this condition including paranoid delusional beliefs, auditory hallucinations, incoherence of thoughts, being a thought disorder, incongruous affect and sudden unpredictable behaviour'*.
- 5.12** Certain types of personality disorder can also cause an individual's behaviour to be more unpredictable. Emotionally unstable personality disorder borderline type is, by definition, associated with a marked tendency to act impulsively, without consideration of the consequences, together with affective instability. This means that individuals experience rapid changes in their mood.
- 5.13** In addition, Ms K had an extensive history of drug and illicit substance misuse. Prison In-reach medical records indicate that several urine drug tests conducted upon her reception into custody during 2010 and 2011 were positive

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<sup>2</sup> NICE Guideline NG10, *Violence and Aggression: Short-term management in mental health, health and community settings* (2015), pp.21, 24, 32, 58-59.

for several illicit substances including benzodiazepines, cocaine, and opiates. Substance misuse alters people's judgement and, as a result, increases their level of unpredictability due to rapid and variable changes in their mood, thoughts, and perceptions. The impact is variable dependent on the amount and type of substances used.

- 5.14** Ms K had significant problems which could be attributed to a developing psychotic illness and personality disorder. In addition, she had a significant and destabilising substance misuse problem. The outcome of this combination would have been to make her behaviour even more difficult to predict.
- 5.15** It has become increasingly clear since the death of Mr Edeson and Ms K's reception into custody that Ms K's psychotic illness has continued to follow a relentless progression, notwithstanding the absence of illicit substances. A feature of her illness remains the unpredictability of her behaviour, despite her lack of access to those substances.
- 5.16** The Independent Investigation Team's focus, in relation to the issue of predictability, has concentrated on the pattern of Ms K's aggressive and potentially violent behaviour towards other individuals. Further focus is placed on the implications, if any, in relation to foreseeing an increase in risk to a given individual (specifically, Mr Edeson) in the months leading up to Mr Edeson's death.
- 5.17** As has been stated, the Independent Investigation Team recognises that particular significance is attached to a past history of violence and aggression. This is because past behaviour is a guide to future presentation, and if a person has a criminal history, then they are more likely to commit a violent act in the future than someone who does not.
- 5.18** There are numerous reports of Ms K expressing threats of violence towards members of her family, individuals responsible for delivering her care and members of the public. She is known to have assaulted members of her family. The incident which led to her imprisonment in August 2011 resulted from her setting fire to a Drug Drop-In Clinic where she was receiving care.
- 5.19** An experienced Psychiatric Nurse who worked at HMP New Hall made a statement dated 6 December 2011, which was considered by the Court in connection with the death of Mr Edeson. (see also Paragraph 15.13) In the statement, she said:
- 'On Thursday 4 August 2011, I met with Ms K. I began asking Ms K questions for our initial assessment. Ms K stated, after one of the questions, that she had thoughts to arrange to meet a punter, kill him, and put him in the boot of his car. She then went on to say she wondered how many she could kill before she got caught'.*
- 5.20** It is not necessarily unusual for people to make threats of violence towards others. Therefore, care has to be taken to ensure that hindsight does not ascribe an increased level of significance to the threats which were made. The threats made by Ms K (albeit on a regular basis) were expressed in general terms. The reported threat by Ms K was not made in relation to a specific

individual, but rather to a sub-set of individuals with whom she might have had contact. However, it must be recognised that aspects of the threat are present in the attack which was made upon Mr Edeson.

- 5.21** The clinical assessment of risk involves weighing up multiple factors in order to form a considered view of the likelihood, or otherwise, of future risk events occurring. Clinicians utilise professional skills, experience, and evidence in order to do so. The difficulty of the task, inherent to all assessment or screening tools, is that high risk and low risk individuals stand out clearly and can be managed accordingly. However, there is a middle group for whom prediction is more difficult. Ms K would have fallen into this group at the time.
- 5.22** It is important to note that, at the time, the task was to attempt to identify risk factors in advance. However, the information which was being evaluated can appear very different in retrospect when a serious incident has occurred. This is something the Independent Investigation Team is mindful of. Many people, whether in contact with mental health services or not, make non-specific threats in the context of emotional distress. In the majority of cases, no actions arise. The task for a risk assessment is to attempt to distinguish the minority who will act from the majority who will not.
- 5.23** The most reliable predictor of future risk events is the pattern of past behaviour in relation to risk. In Ms K's case, the features that stood out were Ms K's impulsive patterns of behaviour, and lack of regard for consequences for herself, or for others. This would have led a risk assessment to conclude that a premeditated and planned act would be far less likely than an impulsive one.
- 5.24** Further, the patterns of previous acts did not point towards a particular propensity for interpersonal violence, or a pattern over time of mounting levels of interpersonal aggression. When interpersonal aggression had occurred, it was in the context of acute disturbance and distress and presented a relatively low level of potential harm. It was reasonable, in the view of the Independent Investigation Team, to have taken Ms K's threats in this context, and to conclude that the most likely risk to others would be an unpredictable impulsive act of low level aggression in the context of acute anger or distress.

**5.25** Ms K had developed a substantial forensic history prior to the death of Mr Edeson:

<b>2005</b>	<ul style="list-style-type: none"> <li>• 2 Offences against property</li> </ul>
<b>2005-2007</b>	<ul style="list-style-type: none"> <li>• 8 Convictions for offences against the person</li> </ul>
<b>2006-2007</b>	<ul style="list-style-type: none"> <li>• 1 Drug offence</li> <li>• 7 Miscellaneous offences</li> </ul>
<b>2007-2008</b>	<ul style="list-style-type: none"> <li>• 13 Offences relating to Police/Court/Prison</li> </ul>
<b>Prior to 24 June 2010</b>	<ul style="list-style-type: none"> <li>• 9 Non-conviction disposals for offences including robbery and assault occasioning actual bodily harm</li> </ul>

**5.26** Whilst this is a significant history, and includes a number of assaults, the Independent Investigation Team has noted that the level of violence exhibited by Ms K was at a level substantially less than that directed at Mr Edeson, and that all of these incidents appear to involve a degree of impulsivity and unpredictability. The Independent Investigation Team was not provided with any evidence that suggested that Ms K had planned any of these events. Indeed, a feature of the acts of violence committed by Ms K was, in fact, their unpredictability.

**5.27** In addition, no evidence was produced to the Independent Investigation Team which confirmed that Ms K would carry out the activities which she threatened at a later date or time. Given the level of thought disorder experienced by Ms K (which was reported by the psychiatrists in the legal proceedings arising from the death of Mr Edeson) the planning of such an attack, and the subsequent execution of such an attack, would have been very difficult for her.

**5.28** For example, in a report prepared in relation to criminal proceedings held in June 2012 it was said:

*'Her thinking is disorganised, her speech lacks focus and she is unable to maintain a conversation or train of thought without repeatedly diverting to unrelated matter. She is profoundly paranoid and has a tendency to misinterpret neutral events as persecutory. Her accounts are characterised by a loss of continuity and irrelevant associations which suggest an inability to preserve conceptual boundaries and maintain causal links'.*

**5.29** The table below exhibits the reported pattern of Ms K's violence in the period between her release from the Becklin Centre on 8 February 2011 and the period

up until Mr Edeson's death on 31 October 2011. The Independent Investigation Team believes that it is important to note that, when an act of aggression has occurred, it appears to have occurred spontaneously, using any implement or tool which was close to hand in response to a specific event. Equally, the triggers for her acts of aggression are not altogether clear from the medical records.

<b>8 February 2011</b>	<ul style="list-style-type: none"> <li>• Release from Becklin Centre</li> </ul>
<b>15 March 2011</b>	<ul style="list-style-type: none"> <li>• Smashed a window</li> </ul>
<b>14 July 2011</b>	<ul style="list-style-type: none"> <li>• Violent outburst at Bradford Substance Misuse Service. Threatened staff when told service was closed</li> </ul>
<b>25 July 2011</b>	<ul style="list-style-type: none"> <li>• Left a note at Bradford Working Women's Service stating if she did not get help she would throw boiling water at staff and threaten to 'kill' her social worker</li> </ul>
<b>30 July 2011</b>	<ul style="list-style-type: none"> <li>• Became angry and walked out of CRHT assessment. Expressed thoughts of wanting to kill her social worker</li> </ul>
<b>2 August 2011</b>	<ul style="list-style-type: none"> <li>• Locked herself in a toilet cubicle at The Bridge Project and created a fire</li> </ul>
<b>10 August 2011</b>	<ul style="list-style-type: none"> <li>• Aggressive behaviour. Threatened to do harm to anyone involved in mental health services in her care</li> </ul>
<b>31 October 2011</b>	<ul style="list-style-type: none"> <li>• Death of Mr Edeson</li> </ul>

**5.30** Whilst the Independent Investigation Team believes that it was predictable that Ms K could act in a violent manner towards others whose actions she might have misinterpreted, and could do so with little or no provocation, the escalation of violence which she exhibited towards Mr Edeson was not predictable.

**5.31** Preventable:

The Independent Investigation Team's view is that the homicide could only have been prevented if Ms K could have been detained in accordance with the terms of the Mental Health Act 1983. It is the view of the Independent

Investigation Team that as Ms K had disengaged from services following her release from HMP Newhall, the homicide of Mr Edeson could not have been prevented.

The risks which were present and predictable were non-concordance, disengagement, substance misuse, self-neglect, exploitation, and deterioration of health. All are sufficient to detain someone with a mental illness, and a Mental Health Act 1983 assessment could have been triggered by non-concordance.

In order to do this, services would have had to have been engaged with Ms K to understand her presentation in the period immediately prior to the death of Mr Edeson. There is a considerable lack of information about this period, which has meant that the Independent Investigation Team was not afforded a clear view of the relationship between Ms K's offence and her illness.

Consequently, the Independent Investigation Team can only make general observations about the expected course of untreated or inadequately treated psychosis, for which the overwhelming evidence is of increased suicide risk, not homicide. Therefore, the basis of the Team's opinion is that, had she been detained in hospital based on the nature or degree of her mental disorder, she could not have committed that particular offence.

- 5.32** It is the view of the Independent Investigation Team that a significant feature of Ms K's care is that she did not have continuity of care. Her illness remained largely unrecognised, and therefore untreated. Had Ms K been actively engaged by a supportive and suitably designed community care team, which was capable of delivering care across geographical and service boundaries, then a careful evaluation of Ms K's history and presentation could have been undertaken. The result of this could have been a more favourable clinical outcome for Ms K and, simultaneously, the potential for her presenting in a violent manner could also have been properly assessed and understood.
- 5.33** It is the view of the Independent Investigation Team that a number of services involved with Ms K recognised her complexity, and her potential for violence. However, in the Independent Investigation Team's opinion, few were prepared to retain responsibility for her care. In applying a label of '*personality disorder*' to Ms K, services effectively determined that '*responsibility*' for engagement remained with Ms K. As such, services were able to state that, as Ms K was difficult to engage with, the onus was on her to change.
- 5.34** In fact, the Independent Investigation Team considers that it was the services which were difficult to engage with, as individuals struggled to find reasons why Ms K should receive care, given the manner in which she interacted with services. This is not true of some services, such as the Working Women's service in Bradford, who made strenuous efforts on Ms K's behalf.
- 5.35** It is the view of the Independent Investigation Team that had the term '*personality disorder*' formed part of a reflective and evolving diagnostic process, rather than being applied as a label, it is more likely that Ms K would have been recognised as developing schizophrenia. Such a diagnosis could

have changed the way in which services engaged with Ms K, and could have meant that she was assisted with engagement via an assertive approach.

**5.36** The risk is that a false dichotomy can operate, in which personality disorder is assumed to confer upon an individual total responsibility for their engagement with their care. However, the opposite appears to apply to severe mental illness. This dichotomy is based on an assumption that individuals with personality disorders are capable of retaining responsibility for all the actions and choices they make even at times of crisis. However, an inverse assumption is applied to severe mental illness. Such a false dichotomy inhibits personalised needs-based care and treatment.

**5.37** A more flexible, needs-based approach to engagement would have been better for Ms K. Engagement occurs in the context of an individual's unique personality, social and life circumstances, and symptom burden. It can be viewed as an interactive process in which rather than referring to an individual as difficult to engage the experience of service users categorised in this way is often that services are difficult to engage. The only service that appeared to have such a mandate was the Working Women's Service in Bradford, demonstrating that this was possible. It is not possible to know whether this would have altered the quality of engagement or impacted upon the outcome. However, it could have had a positive impact upon Ms K's care.

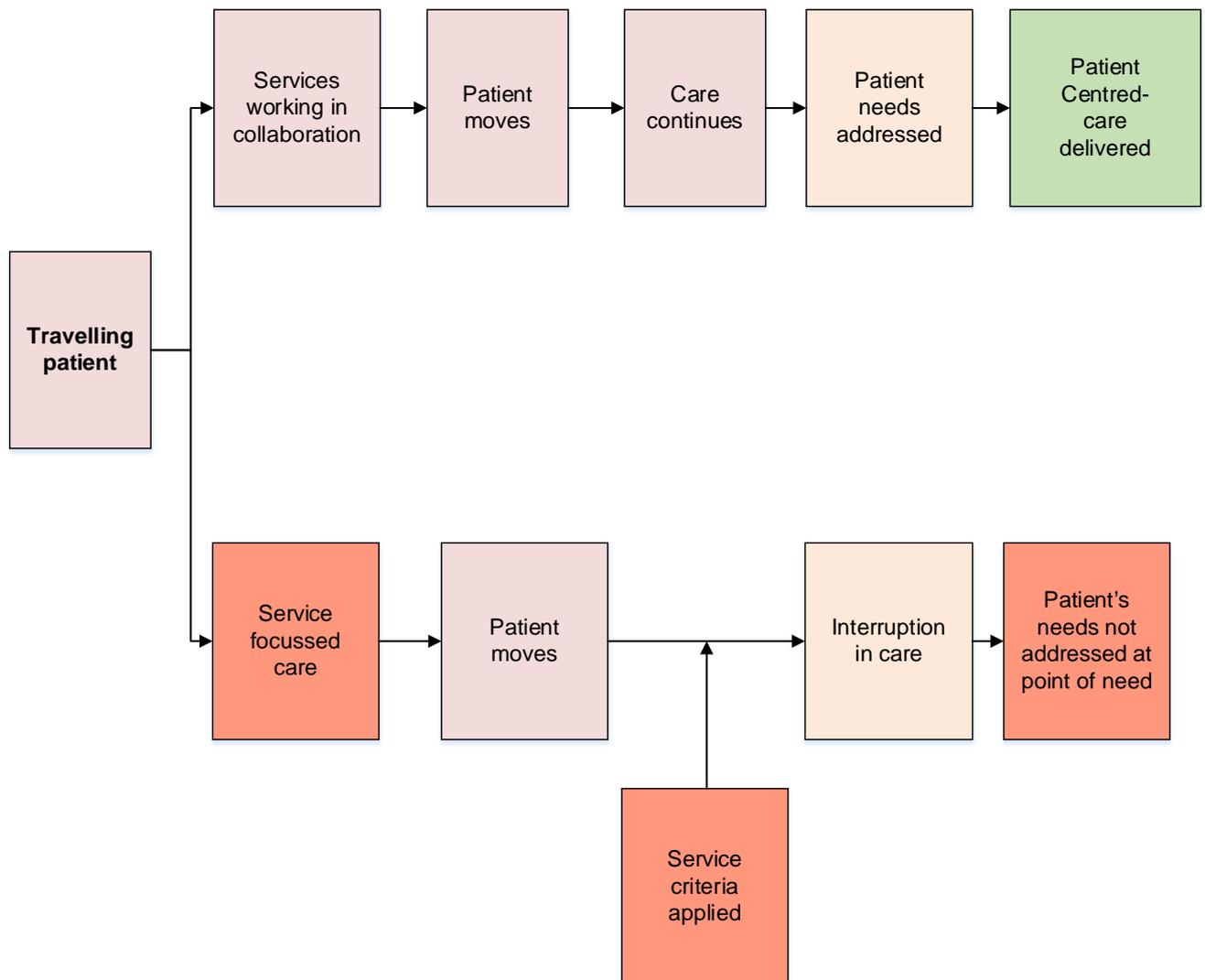
**Key points:**

The Independent Investigation Team believes that it was not predictable prior to 31 October 2011 that Ms K would commit a significant act of violence such as the attack on Mr Edeson which led to Mr Edeson's death.

The homicide could only have been prevented if Ms K could have been detained in accordance with the terms of the Mental Health Act 1983. As Ms K had disengaged from services following her release from HMP Newhall, the homicide of Mr Edeson could not have been prevented.

## 6 JUNCTURE ONE: GEOGRAPHICAL AND SERVICE BOUNDARIES

This is a juncture because Ms K *'bounced'* between cities. She presented to multiple services (from multiple Trusts) in different geographical areas. This constituted a juncture in her care because the services involved in her care were, as a result of this *'bouncing'*, presented with a choice as to whether to adopt a collaborative approach, or to apply strict service criteria.



**6.1** Ms K was a young woman who had a strong family connection in Leeds, as her mother lived in the city, and had done so for many years. Ms K's mother was in contact with her daughter and was engaged, to some degree, in her care. Social services in Leeds had a significant involvement with Ms K and her family for many years. Indeed, at the time of the incident, Ms K was receiving support from Leeds City Council through their programme for young people who had left local authority care.

**6.2** However, Ms K frequently moved between Leeds and Bradford. As has already been mentioned, when Ms K transitioned from adolescent mental health services, it was clear that she was already an individual of some complexity, who would face a number of ongoing challenges. This made it more likely that she would require input from a number of services as a young adult. It was also apparent that there were a number of characteristics in relation to her mental health needs, patterns of substance use and social circumstances that could impede standard engagement strategies for reason of utility (people do not believe treatment is working or is helpful), attitude (people feel mistrustful, or coerced), or practical reasons (treatment may be difficult to get to, difficult to schedule). In such circumstances unless these factors are addressed by services the interactive effect is that services are experienced by the patient as “difficult to engage” and therefore become of limited value. When considering whether disengagement means that a patient is exercising capacity to refuse a service, this context is vital.

**6.3** It was known that Ms K was involved in the sex industry. During the course of the interviews conducted by the Independent Investigation Team, members of the Independent Investigation Team were provided with information concerning the ‘*movement*’ of participants in the sex industry in the area at that time. In particular, the Bradford Working Women’s service provided the Independent Investigation Team with the following information about the pattern of movement of sex workers in the area and the reason for it:

*‘... [A] lot of the women that we work with will go to work on the Leeds beat, and Huddersfield, as well.’*

**6.4** When asked why this was, the explanation for this was said to be because:

*‘[The] men can take them to a different area. That’s what we tend to find. Or the women are conscious that there’s a lot more Police presence because things have been stepped up because things have happened in the community... So they do move from Leeds to Bradford to Huddersfield.’*

**6.5** Further:

*‘... If there’s some friction with another woman on the beat or if they’re trying to avoid a drug dealer that they owe money to – there’s lots of reasons. They may go and work in Leeds for a couple of weeks and then come back again.’*

*‘We may not be aware of that until they come back; she may say, ‘You haven’t seen me for a while because I’ve been in Leeds for a couple of weeks, because I owe so-and-so some money’.*

**6.6** Consequently, there was a significant possibility that Ms K would continue to move between Leeds and Bradford if she remained involved in the sex industry in the area. Ms K’s pattern of movement was recognised by those who were involved in her care. For example, during the course of an interview with Care Co-ordinator 1, it was said that:

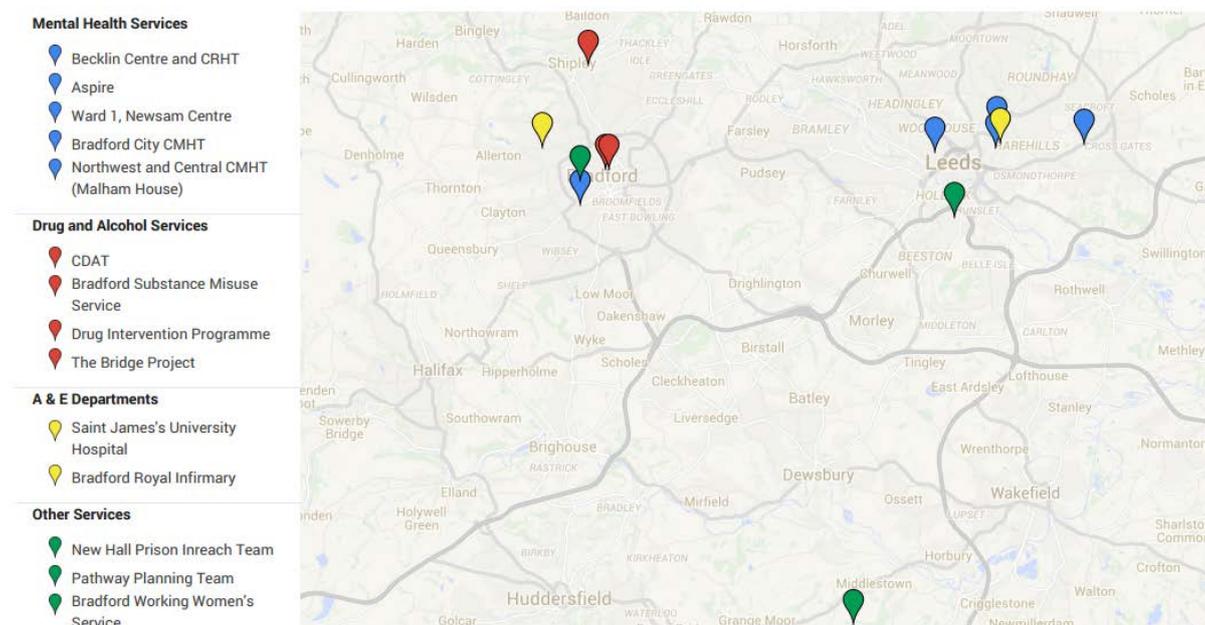
*‘I could see it was a vicious circle in that, because she had no benefits, no money, and no incoming money. She was going to Bradford to make money’*

and because she'd made money, the temptation for heroin was there. It was a huge bad cycle really.

'She wasn't taking any medication. She wasn't getting any money. All these things fed into the fact that she ended up going back to Bradford'.

**6.7** As a result, if services were to deliver patient-centred care which addressed Ms K's individual needs, it stands to reason that there would likely need to be an element of flexibility across a number of services accommodating of Ms K's movement between Leeds and Bradford, a distance of approximately 12 miles. Whilst no one could have ever predicted precisely when or how frequently Ms K would 'migrate' between these two cities, it is the finding of the Independent Investigation Team that, on the evidence, there was a sufficiently high likelihood that Ms K would nonetheless 'migrate' between these two cities and, that in so doing, she did not notify services.

**6.8** The following map provides an overview of the geographical distances between these services, with the services grouped according to their general category:



**6.9** Registration with a GP is the usual requirement for patients to access secondary mental health services within a defined local area. For the majority of patients, this does not present a problem, because their needs can be met within a single geographical area. Special provision can be made for certain groups (for example, those who are homeless). However, Ms K moved between Leeds and Bradford on a frequent, albeit apparently random, basis. To access services in each area, she had to be registered with a local GP, or be a resident in a specific area. Equally, if Ms K was not registered with a GP in that area, she would have been excluded from services in that area

**6.10** This requirement for registration in both Leeds and Bradford had a significant impact upon the continuity of Ms K's care (see for example, the difficulties outlined in Chapter 15). The Independent Investigation Team identified a number of interruptions in the delivery of care to Ms K, which occurred as she moved between the cities of Bradford and Leeds. Instead of recognising the

frequent (albeit random) pattern of movement which Ms K had, and adjusting the service's approach to that movement, interruptions in the delivery of care occurred while the arrangements attached to accessing care in a different city or service took place.

- 6.11** This applied to several NHS services and, indeed, those working outside the NHS. What was particularly striking for the Independent Investigation Team was the disproportionate impact upon the continuity of Ms K's care which was caused by her movement, when the solution to this problem was for the various services involved in Ms K's care to collaborate and work flexibly with each other across service and geographical boundaries.
- 6.12** Whilst teams were, at times, happy to provide assistance to Ms K to allow her to travel between the two areas, those involved in her care did not work with her across the service or geographical boundaries in order to ensure her continuity of care. Ms K did not signal her intention to move to services, which presented services with an additional challenge.
- 6.13** Services cannot be expected to keep track of every service user. However, Ms K was chaotic, and had complex needs. She was a vulnerable young person, who potentially had an incipient psychosis, and there were doubts about her diagnosis. As a result, her presentation represented a risk to herself, and potentially others. There was, therefore, a need for services to think '*outside their boundaries*' in order to construct a tailored care plan around her.
- 6.14** The Care Programme Approach was introduced as a form of case management to improve community care for people with severe mental illness. It is intended to assist services to maintain contact with users. The Care Programme Approach was introduced partly in response to the care of Christopher Clunis, who was a similarly chaotic individual who moved across service boundaries (see further Paragraph 16.31 – 16.32).
- 6.15** Ms K moved between services in a chaotic manner. Ms K did not notify services that she was moving. As a result, by the time Service A became aware that Ms K had moved within Service B's geographical remit, Ms K was often already on her way back to the service area of Service A. However, in this particular case, although the exact time of Ms K's relocation was unpredictable, her location was predictable to the extent that she did not leave the Leeds/Bradford conurbation. The map at Paragraph 6.9 illustrates the relatively narrow geographical area in which she moved.
- 6.16** The Care Programme Approach is intended to encourage services to think about the person, rather than focussing on service boundaries. This is intended to ensure that the care which is delivered is meaningful to the specific individuals concerned. In this case, in the opinion of the Independent Investigation Team, there was an expectation that conversations would need to take place between the services to determine a nimbler way of responding to Ms K's movement.
- 6.17** Ms K's actions exacerbated the difficulties which services faced in relation to her receiving continuity of care.

- 6.18** Whilst it was acknowledged in interviews that collaborative working could have been achieved using communication methods, such as the telephone, such an approach was not adopted.
- 6.19** This was not true of all teams involved in Ms K's care. Indeed, the Bradford Working Women's Service which is a non-mental health service demonstrated an ability to view Ms K '*holistically*' and was able to accommodate the fact that Ms K randomly but frequently travelled between Leeds and Bradford. The Bradford Working Women's Service is a service for working women aged 18 years and over, who are working on the street or off the street, selling sex or being coerced and/or trafficked and sexually exploited. It is not a specialist mental health service. However, this service advocated for Ms K, and, as a result, delivered a service that was flexible and inclusive, because it was designed around the needs of its service-users. This service assisted Ms K to obtain registration with a GP in Bradford, attempted to facilitate her access to Bradford Drug and Bradford CDAT (Community Drug and Alcohol Team) and later obtain access to services in Bradford. This is a demonstration of good practice.
- 6.20** By way of contrast, CMHT 1 became aware of the fact that Ms K had registered with a Bradford GP on 9 August 2011. This came to light during a conversation between the Court Diversion Service and Ms K's care co-ordinator when CMHT 1 was alerted to the fact that Ms K was on remand in HMP New Hall. A unilateral decision to transfer Ms K to BCMHT 1 was made later that day.
- 6.21** An entry in Ms K's records dated 9 August 2011, which was made by Care Co-ordinator 1 includes the following:
- 'She had been charged with arson, reckless behaviour and endangering life. She was due again in court on 17 August and they required a discussion regarding a package of care.'*
- 'On further investigation discovered that ...her housing support officer had terminated her tenancy on 25th July she was homeless. I then discovered she had moved her G.P to (Bradford). Explained all this to the in reach team at Newhall prison who are to liaise with the appropriate team. I will make a referral.'*
- 6.22** Ms K's care co-ordinator wrote to BCMHT 1 on 11 August 2011 about Ms K's care. This letter stated:
- 'As she has now moved over to [Redacted] Surgery I am now transferring her care over to your Team'*.
- 6.23** BCMHT 1 had no prior knowledge of Ms K. Ms K was discharged from the Leeds Community Health Team whilst she was on remand in HMP New Hall.
- 6.24** During the course of the Independent Investigation, BDCT made the following observation concerning Ms K's transfer of care at this time:
- 'Leeds Community Mental Health Team should have discussed the possibility of transfer of care from Leeds with the Trust before discharging her. These discussions may well have led to a meeting to plan the transfer and share*

information. In failing to do this the Leeds Community Mental Health Team worked outside the principles of the CPA process. ... Bradford/ the Trust were unable to take planning care forward following receipt of this letter because

*'(a) by this time, Ms K had been remanded in custody and*

*'(b) on her release from custody on 7 September 2011 reflecting comments that she had made to the prison health services she did not wish to engage with health services in Bradford but rather those in Leeds and therefore the prison health services should have taken account of this'.*

**6.25** No plans are mentioned in CMHT 1 letter dated 11 August 2011 to allow Ms K to be 'held onto' in Leeds while arrangements to allow a smooth transition to Bradford were made. Indeed, it may have been that, as a result of her repeated pattern of movement, her transfer to Bradford was premature.

**6.26** LYPFT has also responded to the issue of Ms K's discharge from the Community Mental Health Team in the following terms:

*'The Panel refers to the 'immediate' transfer of Ms K as a negative but LYPFT considers a prompt transfer to be a positive, service user focused, approach. A prompt transfer between services means that the local team, who is best placed to support the service user, is able to ensure a continuity of care. The Panel appears to suggest that there should have been a delay in the transfer of care, LYPFT would consider that approach to be potentially detrimental to a service user, as it would lead to a gap in care, when the service user's local mental health team did not know that she was in their area and possibly needing their support'.*

**6.27** BDCT have responded to LYPFT's comments set out at Paragraph 6.26 above in the following terms:

*'if such a transfer is to take place, it must be undertaken in a structured way rather than simply writing a letter to a new Community Mental Health Team in an adjacent area who had no previous knowledge of Ms K and without discussing the proposed transfer of care with Ms K. Furthermore, the position as suggested by LYPFT overlooks the fact that the Care Coordinator at LYPFT knew from at the latest 9 August 2011 that Ms K was in Newhall Prison and therefore would be in a position to access any healthcare services that she may require from within the prison health system. As such there would have been no detriment to Ms K by delaying the transfer'.*

**6.28** These responses illustrate the differences of opinions which can occur when a number of organisations are involved in an individual's care, with each taking a different view as to how, and in what circumstances, care should be transferred or retained in a manner which promotes the delivery of service- user-focussed care. However, in order to maintain continuity of care to deliver patient-centred care, organisations are required to consider working collaboratively, particularly in relation to an individual such as Ms K who required support from a number of services.

**6.29** Collaborative working does not necessitate members of teams travelling outside geographical service boundaries in order to provide care. The

Independent Investigation Team accepts that it would not be in the best interests of service users for clinicians to be required to travel outside their geographical or other service boundaries in order to provide service users with support. Collaborative care does, however, require organisations to recognise the fact that service boundaries may act as barriers to the continuity of an individual's care, and that steps may be required to mitigate the impact of this problem in order to ensure continuity of care. Early Intervention in Psychosis services and primary care already employ this model for university students, who are moving between two locations, albeit on a more predictable time schedule. The funding should follow the patient as per models used for people with complex social care needs.

- 6.30** Commissioning guidance should be used to ensure that services commissioned are encouraged to develop and implement models for delivering care to harder to reach individuals with complex needs. Access policies should include reduced, removed or different performance targets and indicators for harder-to-reach groups including those experiencing homelessness, drawing on existing best practice.
- 6.31** An element of collaborative working could have been achieved by arranging a Care Programme Approach meeting or, indeed, any gathering of professionals to discuss this complex individual at that time, in order to reach a decision as to where and how it would be best to deliver care to Ms K given her stated wish to receive care in Leeds, and the fact that she did in fact return to Leeds following her release from prison. Advances in communication methods, such as telephone conferencing, could have allowed for such a '*meeting*' to have been arranged quickly and economically. Any such discussions could have dealt with the practical organisational challenges which arose in providing Ms K with patient-centred care.

#### Key points – Choice of care co-ordinator

In mental health, interpersonal elements play a significant part in whether engagement is successful or not. The appointment of an experienced female care co-ordinator was appropriate. The disappointment for the Independent Investigation Team was in the way the role was performed.

Ms K was a complex individual with complex needs. Her needs and presentation required an assertive approach towards securing Ms K's engagement, which is different to the model of engagement employed by many Community Mental Health Teams. Assertive working can be provided by a Community Mental Health Team. However, to do so would require a degree of flexibility from a care co-ordinator, as it would impact upon the capacity and resources of that care co-ordinator and other members of the team.

The Independent Investigation could not see any elements of reflective practice in relation to the planning of Ms K's care co-ordination.

Consequently, whilst Care Programme Approach requirements were adhered to, the ethos was not. The level of care which was given was inappropriate to the degree of complexity and risk as it focused upon standards concerning documentation rather than the recognition that those standards should be embedded into an appropriate care plan.

Key points – Geographical and service boundaries:

Ms K had family connections in the Leeds area. She was known to travel regularly (albeit randomly) between Leeds and Bradford. As a result, her social and healthcare needs frequently crossed a number of service and geographical boundaries.

By frequently moving between Bradford and Leeds throughout the period considered by the Independent Investigation Team, barriers were encountered by Ms K in obtaining continuous service provision as she '*bounced*' between services operated by different NHS Trusts. This impacted adversely upon the continuity of her care.

Whilst no one could have predicted precisely when or how frequently Ms K would '*migrate*' between Leeds and Bradford, it is the finding of the independent investigation team that, on the evidence, there was a sufficiently high likelihood that Ms K would nonetheless migrate between these two cities, a distance of approximately 12 miles, and in so doing, she may not notify services.

It is the opinion of the Independent Investigation Team that continuity of care provides a greater '*clinical awareness*' of the patient with an increased knowledge about them and their specific needs.

Clinicians and services involved in Ms K's care did not work collaboratively in order to accommodate Ms K's random but frequent movement between Leeds and Bradford. By not doing so, they were not in a position to mitigate its impact upon the continuity of her care. This also made it more difficult to detect changes in Ms K's presentation which might have been clinically relevant.

Collaborative working could have been secured by services working within the Care Programme Approach and convening meetings at points of transition for Ms K when her care was transferred between services. However, such meetings did not take place at key points in her care.

A longitudinal view of Ms K's care was not obtained and, accordingly, the development of her emerging psychotic illness was missed.

Observation to encourage reflective practice:

Ms K randomly but frequently moved between Leeds and Bradford. This was a pattern which she had followed throughout her engagement with services over a number of years. The individual patient and their needs do not change despite their movement between services. Despite advances in communication methods, Ms K did not receive patient-centred care from a number of, (but not all) services that were involved with her.

Difficulties appear to arise as a result of differences in care, service ethos, models of engagement, and level of resources between services themselves. This is a long-standing challenge within mental health services, as many individuals with complex needs such as those exhibited by Ms K, 'bounce' between specialist services.

The strength of a collaborative approach is that it accommodates service-users' individual requirements, and promotes a degree of flexibility towards that patient, which allows care to be delivered across boundaries. Encouraging services to work collaboratively is a significant challenge but there are services such as Early Intervention in Psychosis which employ this approach and, indeed, in the case of Ms K, it was the Bradford Working Woman's service which was able to do this.

It is acknowledged that mental health services do not all benefit from the same level of resource. A Community Mental Health Team professional will have a significantly larger caseload than a colleague in an Early Intervention in Psychosis service, which may impede the ability to work assertively. However, it is still possible for elements of collaborative working to be developed by services if the focus is moved towards delivering patient-centred care, rather than the service criteria dictating the delivery of care.

**Recommendation one - Encouraging collaborative working between services:**

There are significant challenges for services in providing care for complex individuals who move between services and service criteria. This is particularly so when patients use services in more than one Trust.

Given that some patients may do this with some degree of predictability, the Independent Investigation Team recommends that the three Trusts and commissioning groups involved in Ms K's care develop robust, collaborative, patient-centred plans, to guide staff who care for individuals presenting with complex needs and who move between geographical, commissioning, or service boundaries on a regular basis, with a view to ensuring continuity of care, and which minimise disruption of therapeutic relationships.

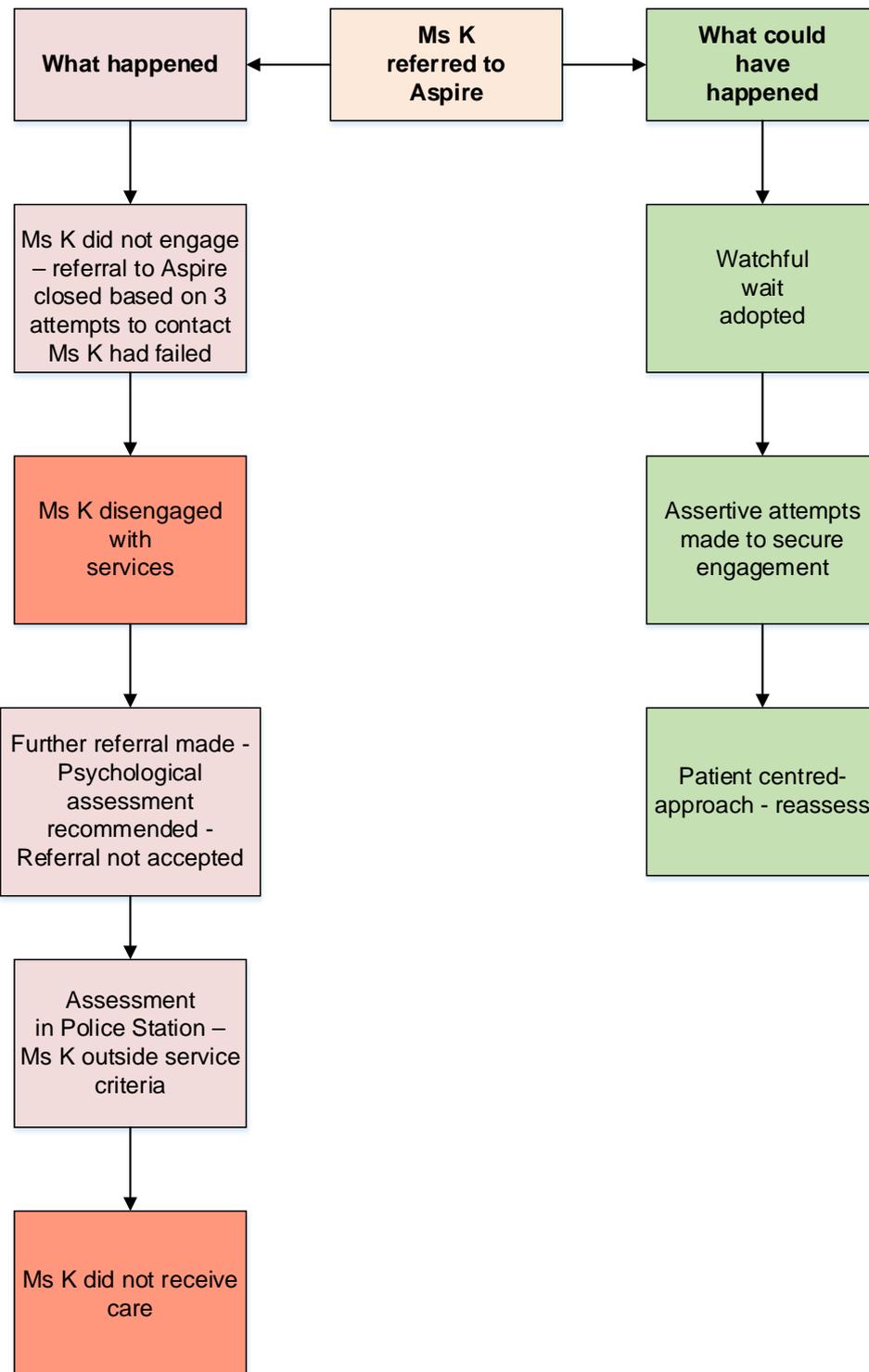
It is anticipated that this will be a small number of patients, and that such an approach would be clinically more effective, and make more efficient use of resources, by avoiding multiple re-assessments and handovers. Early Intervention in Psychosis services and primary care already employ this model for university students, who are moving between two locations, albeit on a more predictable time schedule. The funding should follow the patient as per models used for people with complex social care needs.

Accordingly, the Independent Investigation Team recommends that;

The three Trusts and commissioning groups involved in Ms K's care develop robust, collaborative, patient-centred plans, to guide staff who care for individuals presenting with complex needs and who move between geographical, commissioning, or service boundaries on a regular basis, with a view to ensuring continuity of care, and which minimise disruption of therapeutic relationships.

## 7 JUNCTURE TWO: ASPIRE (EARLY INTERVENTION IN PSYCHOSIS)

This is a juncture because Ms K failed to gain access to a service which was designed to accommodate the diagnostic uncertainty with which she presented, and which could work with her assertively.



- 7.1** Evidence given by a number of psychiatrists at Ms K's trial confirmed that Ms K suffers from a psychotic illness. A review of Ms K's medical records by the Independent Investigation Team shows that the possibility that Ms K might be experiencing a psychotic illness was considered on a number of occasions throughout her adolescence and early adulthood.
- 7.2** Early Intervention in Psychosis services are specialist services that were set up to provide treatment and support for young people who are suspected of experiencing symptoms of psychosis for the first time, and during the first three years following a first episode of psychosis.
- 7.3** Research shows that early treatment of psychosis improves outcomes for young people. Equally, delays in treatment can impact upon their overall recovery. This has been recognised and addressed recently through the application of a 14-day access and waiting time target for people with a first episode of psychosis. The first three years of an individual experiencing symptoms of psychosis carry the highest risk of relapse, suicide, and social disability. In addition, in this period, individuals may exhibit a higher degree of reluctance to engage with services and treatment plans.
- 7.4** Aspire:
- 7.5** Community Links is a third-sector organisation which provides the Leeds Early Intervention in Psychosis service through an organisation called Aspire. Aspire has been providing an Early Intervention in Psychosis service in Leeds since 2005. Although Aspire was established as a third-sector provider service, it was commissioned to deliver the same service level as other NHS models of Early Intervention care. However, the Aspire model of service provision did not replicate that adopted by other Early Intervention in Psychosis services which operated within the NHS at the time of Ms K's care.
- 7.6** In particular, the skill-mix found within Aspire did not replicate that found within NHS provided Early Intervention in Psychosis services. The Aspire team included a mixture of people from different backgrounds. They provide valuable experience of providing mental health services in voluntary and third-sector settings, rather than coming from a clinical background in the NHS.
- 7.7** At the time of the incident, LYPFT provided two part-time adult psychiatrists to Aspire, which was roughly equivalent to approximately one full-time post. The Independent Investigation Team understands that Aspire was not responsible for the employment or governance of these individuals. In a service dealing with diagnostic complexity, it would be more common for Psychiatrists to be a part of Aspire's Early Intervention in Psychosis service. A further liaison agreement with the Trust allowed Aspire access to a Child and Adolescent Mental Health Services psychiatrist to work with individuals under 18. Aspire also had access to a team psychologist.
- 7.8** Aspire had two team leaders at the time of Ms K's care. One was a registered mental health nurse, and the other an occupational therapist. In addition, there were eight early intervention practitioners, only three of whom were registered mental health nurses at the time Ms K was referred to Aspire.

**7.9** Aspire have experienced stability at management level. At the time of Mr Edeson's death, the Service Manager had managed the service since its inception. The Service Manager was originally a mental health nurse and had experience of managing a number of services which are aimed at individuals who experience mental health problems.

**7.10** Caseloads:

**7.11** Aspire has the capacity to work with 320 cases. At the time when Ms K was referred to the service, they worked with individuals in the age range from 14 to 25. Each case worker was allocated 13 to 14 cases, although this has now risen to 15. This is within National Guidelines. However, this size of caseload is considerably smaller than an average caseload size for a care co-ordinator working in a Community Mental Health Team. The smaller case load is designed to allow Early Intervention in Psychosis case workers to work assertively with individuals to support them with difficulties which they might have in relation to the social aspects of their lives.

**7.12** An Early Intervention in Psychosis care co-ordinator has the resources available to make sure that the young person has appropriate support in relation to their day-to-day needs. They will work with the young person to make sure they have a roof over their head, and make sure they have sufficient food and financial resources. They may also ensure that the young person attends key appointments with other services and will advocate with other services on the young person's behalf. Potentially, this could have had a significant benefit for Ms K, as an advocate could have put forward her views when her care was transferred to Bradford on 9 August 2011 (see Paragraphs 15.38 – 15.60).

**7.13** The rationale behind this is that most mental health problems, including psychotic symptoms, are known to be affected by stress. First proposed by Zubin in 1977<sup>3</sup> as the '*stress vulnerability model*', this has been validated in a number of research papers since (as set out in the literature review conducted by Goh and Agius in 2010<sup>4</sup>). It follows that, if current stress factors are minimised or eliminated, clinicians will be afforded a better opportunity to assess the individual in terms of their pre-existing vulnerability in order to determine the nature and degree of any underlying illness process or, indeed, the impact of personality on the young person's presentation.

**7.14** Service criteria:

**7.15** Aspire set out their acceptance criteria at the time of Ms K's care in a document entitled '*Aspire Acceptance Criteria*'. This stated:

*'Individuals presenting with symptoms of psychosis previously untreated (within the critical period) or treated (with anti-psychotic medication) no longer than 12 months prior to referral.'*

*'Where symptoms are clearly indicative of a psychotic episode*

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<sup>3</sup> Zubin J and Spring B, '*Vulnerability; a New View of Schizophrenia*', Journal of Abnormal Psychology, 1977, 86; 103-126.

<sup>4</sup> Cindy Goh & Mark Agius, '*The Stress-Vulnerability Model How Does Stress Impact on Mental Illness at the Level of the Brain and What are the Consequences?*', Psychiatria Danubina, 2010; Vol. 22, No. 2, pp 198–202.

- *'Acute and transient psychotic disorder (no prodrome and short duration of psychotic symptoms for less than 2 weeks with a clear stressful precipitant)*
- *'Schizophrenia*
- *'Other non-affective psychoses such as delusional disorder (without hallucinatory phenomena or negative symptoms)*
- *'Drug induced psychosis*
- *'Major alterations in mood including bipolar, schizoaffective and depressive disorders where psychotic symptoms are present*
- *'Puerperal psychosis'.*

**7.16** The Aspire Acceptance Criteria also state:

*'The following can cause diagnostic difficulties for identifying FEP (first episode of psychosis). If Psychosis is suspected we will undertake an assessment [...] Borderline personality disorder where transient psychotic symptoms are present [...] At Risk Mental State (ARMS) – evidence of mental distress coupled with fleeting or low intensity psychotic experiences not sufficient to meet current diagnostic criteria'.*

**7.17** Further in a document entitled *'Aspire EIP Operational Policy May 2007'* states:

*'WHAT ABOUT PEOPLE WHO HAVE BEEN DISCHARGED BY THE TEAM BUT THEN GO ON TO DEVELOP PSYCHOSIS?'*

*'Just because somebody has not been observed to be experiencing psychosis does not mean that this may not develop in the future.'*

*'Any professional working with an individual who notices signs of psychosis can re-refer to Aspire if they feel it is appropriate even if they have been previously assessed and declined by the team.'*

*'Likewise we have an open referral criteria so anybody who is concerned about somebody that they know can refer to the team, they do not have to be a health professional although seeking advice from a GP may be useful for them'.*

**7.18** In addition, Aspire operated a *'Duty Worker System'* which operated as follows:

*'The team will operate a duty worker system whereby one member of the team is available at the office base at specifically identified times.'*

*'They provide a point of contact for advice both in regard to new referrals and advice regarding psychosis for referrers, service users and carers. The duty system will ensure someone is always available between the hours of 12-2pm and 5-6pm Monday to Friday'.*

**7.19** Ms K's contact with Aspire:

**7.20** The following table shows the contact which Ms K had with Aspire. The table illustrates the fact that Aspire, as a service, was easily accessible for referrals, and was able to take referrals from a number of sources. This is an element of good practice.

**7.21** However, notwithstanding the referral of Ms K from a variety of sources, including a clinician who knew her relatively well, she was turned down by the service on a number of occasions for reasons which are not at all clear. This is a matter of significant concern for the Independent Investigation Team.

<b>Date</b>	<b>Contact with Aspire</b>	<b>Action</b>	<b>Outcome</b>
13 June 2008	Letter to Aspire from Leeds social services.	Ms K was referred to Aspire.	Aspire liaised with social services to establish an understanding of Ms K.
25 June 2008	Social services acting on advice from Child and Adolescent Mental Health Services Consultant.	Aspire agreed to visit Ms K.	Two failed visits undertaken. Ms K noted to have absconded.
11 July 2008	Aspire Client Notes.	Entry made in notes concerning potential arrangements to make contact with Ms K.	Ms K was missing since 8 July 2008. social services were to make contact with Aspire when they made contact with Ms K.
16 July 2008	Letter from Aspire to social services.	Further offer of assistance was given, should social services find Ms K.	Ms K was still missing.
23 September 2008	Police.	Police rang requesting advice, as Ms K was perceived to be increasingly distressed. Aspire agreed to assess.	Before an assessment was undertaken, Ms K absconded. Aspire planned to contact social services to discuss.
(continuation on clinical notes)	Social services telephone call.	Social services advised Ms K had returned. They had ongoing concerns around Ms K's mental state. A planning meeting was arranged to discuss options for a secure placement.	Aspire agreed not to make any further decisions on referral of Ms K until the outcome of the planning meeting.
25 September 2008	Social services telephone call.	Social services had a Secure Order in place but were	Aspire closed the referral on basis that psychological assessment of Ms

		unable to locate Ms K.	K's behaviour and emotional state may be more beneficial than psychiatric understanding but agreed to be available for consultation if required.
26 September 2008	Social services.	Child and Adolescent Mental Health Services report on Ms K to Aspire.	Aspire responded on 6 October 2008, confirming that Aspire would not be continuing the referral, as there were no indicators of psychosis, but offered their assistance in the future. They reiterated that a psychological assessment would help to understand Ms K's choices and behaviours.
24 November 2008	Child and Adolescent Mental Health Services Psychiatrist.	Child and Adolescent Mental Health Services Consultant enclosed most recent summary/psychiatric opinion to an Aspire Consultant, recommending Ms K be assessed.	

22 December 2008	Social services.	Arranged to meet Ms K.	Ms K did not attend as she was missing.
6 February 2009	Bradford Royal Infirmary Accident and Emergency Department.	Senior House Officer in Bradford assessed Ms K. No overt psychotic symptoms displayed. Outcome of assessment to be fed back to Aspire. Ms K to be assessed by Section 12 clinician.	Aspire faxed background reports to Crisis Resolution and Home Treatment team. Outcome to be fed back to Aspire. Aspire were to follow up by 9 February.  No follow up by Aspire recorded in notes.
19 January 2010	Community Mental Health Team.	Aspire referral form following Ms K presenting at St James's Hospital, where a Functional Analysis of Care Environment Risk Profile was completed.	Referral notes and information passed on to Aspire.
27 January 2010	Social services.	Aspire visit Ms K's flat. Ms K not present.	Aspire to flag Ms K up with Crisis Team for future reference. This was Ms K's third referral to Aspire. Team believe Ms K will not return to Leeds in the near future. Adult Protection meeting scheduled 23 February 2010.
2 March 2010	Aspire phone call to social services.		Aspire closed referral on the basis that three referrals had been made to Aspire, but no contact made. Agreed that social services could contact Aspire if Ms K located.

21 December 2010	GP Referral to Community Mental Health Team (16 December 2010) Community Mental Health Team referral to Aspire.		
28 December 2010	Bradford Police Station.	Assessment in Bradford Police Station.	Following assessment and consideration of notes, Aspire conclude that as mental health problems had been present for a number of years and therefore Ms K did not meet Aspire criteria around the Early Intervention Model.

**7.22** Previous care for psychosis:

**7.23** The issue of the diagnostic process which was applied to Ms K is dealt with more fully in Chapter 10 of this report and, in particular, Paragraph 10.6. However, records indicate that throughout the period between 13 June 2008 and 28 December 2010, there are reports from a number of sources including a Consultant specialising in Child and Adolescent Psychiatry that Ms K had exhibited patterns of behaviour and had reported thoughts and experiences that may have been the result of psychotic symptoms.

**7.24** Early symptoms of psychosis can be non-specific (i.e. can occur in other disorders) such as agitation or withdrawal. There are other early symptoms that are more specific and indicate an increased propensity to develop psychosis. In current practice these are termed '*At Risk Mental State*' ('ARMS') and there are specific tools for rating the risk of psychosis. At the time of the assessment in 2008, the concept of '*Basic Symptoms*', first coined in 1989, would have been well established, and symptoms within this definition were elicited and referred to.

**7.25** The diagnostic criteria that distinguish a pre-psychotic state from a '*First Episode of Psychosis*' ('FEP') use symptom type, symptom number, symptom intensity and duration of symptoms to delineate a range of ways in which a pre-psychotic state may present. Psychotic symptoms may, therefore, transiently arise, resolve, and never recur, or may recur periodically without meeting criteria for a psychotic episode.

**7.26** However symptom severity may develop in successive recurrences to comprise a psychotic episode or may simply persist from the initial onset. Furthermore, there are distinctions drawn between brief psychotic episodes and longer ones

that are indicative of schizophrenia. Once again, symptom type, number, and duration are relevant. By definition, those psychoses associated with substance use fall into the group of brief psychoses.

- 7.27** The Independent Investigation Team recognises that Ms K could have been rejected from an Early Intervention in Psychosis service if she previously had the equivalent of Early Intervention in Psychosis care elsewhere. However, the Independent Investigation Team found no evidence in Ms K's records that she had received previous care in respect of psychosis.
- 7.28** The Independent Investigation Team does not consider the previous treatment in Child and Adolescent Mental Health Services to have justified exclusion from Early Intervention in Psychosis services.
- 7.29** Despite a number of referrals being made to the service, no assessment of Ms K's presentation was carried out by the Aspire Team. The failure to assess Ms K was due, in part, to Ms K's failure to engage with services. However, instead of adopting an assertive response to Ms K's non-engagement, which should be a key feature of an Early Intervention Service response, Aspire did not take the type of persistent, proactive steps such as visiting places where she was known to be (such as her mother's home, for example), in order to develop a pattern of frequent, 'low key' contacts, and build trust by being available to provide practical help when the opportunity arose. This would have increased the chance of Aspire being able to build a relationship with her.
- 7.30** This strategy is recognised as effective in order to undertake an assessment as part of a structured diagnostic process by a service which specialises in the care of young people who may be experiencing an emerging psychotic illness.
- 7.31** It was decided by Aspire on 28 December 2010 that, as Ms K's mental health problems had been present for a number of years, she did not meet Aspire's service criteria, despite the fact that she had not been assessed or treated for a psychotic illness. This is a matter of significant concern for the Independent Investigation Team, because this appears at odds with Aspire's own service criteria and lacked internal consistency.
- 7.32** Given that a first episode of psychosis may emerge over a variable period of time and take a variety of patterns, Early Intervention in Psychosis services, including Aspire, would include in their criteria any period of psychosis, even one of considerable duration if, for its duration, the psychosis had remained untreated. It is also a significant concern for the Independent Investigation Team that Aspire did not recognise her admission to the Psychiatric Intensive Care Unit on 31 December 2010 as representing her first episode of treatment for psychosis (see also Chapter 8).
- 7.33** Ms K was commenced on olanzapine (which is an anti-psychotic medication) in response to a provisional diagnosis of bi-polar disorder. Later during her admission, Ms K was diagnosed as having a '*drug induced psychosis*'. Both conditions are listed in Aspire's '*Service Acceptance Criteria*', and neither of these diagnoses appeared in Ms K's records previously. This should have been recognised by Aspire as falling within their service criteria, indicating the possibility of a '*first episode of psychosis*'.

**7.34** At the commencement of her inpatient stay on 30 December 2010, members of CMHT 1 contacted Aspire again, seeking their input whilst Ms K was a patient in hospital. This request for assistance was rejected. In a letter dated 10 January 2011 addressed to Ms K, her GP, and CMHT 1, it was stated that:

*'It is clear from the meeting as well as the notes forwarded by the referrer that your mental health problems have been present for a number of years although we would like to acknowledge that these are serious and need further follow up work. This therefore means that Aspire cannot work with you due to our criteria around the Early Intervention model.*

*'At the point of writing up the assessment, we are aware you are currently on the Acute Ward at the Becklin Centre, St James Hospital for a period of Assessment and Treatment under S.2 of the Mental Health Act. This period will allow the staff to further assess your mental health difficulties as well as determining the best service for you'.*

**7.35** It appears that Aspire was unfamiliar with, or did not understand, its own service criteria. This is a concern, as it raises issues about clinical governance. The table at Paragraph 7.21 illustrates how its interpretation of its service criteria was contradictory and, as a result, there were missed opportunities to assess Ms K, or to provide specialist advice in relation to her care.

**7.36** In addition, the table at Paragraph 7.21 illustrates the fact that an approach which accommodates diagnostic uncertainty was not adopted. This is a key feature of the Early Intervention in Psychosis approach. However, it was not applied in relation to Ms K's contact with Aspire. Early Intervention services should be able to work with, and follow, people who are developing a psychosis, or who are suspected of developing a psychosis. Ms K was one such individual. However, she was not able to access Aspire's Service.

**7.37** Multi-Disciplinary Team meeting:

**7.38** The Independent Investigation Team found no evidence of any multi-disciplinary team working in relation to Ms K's case by Aspire.

**7.39** Ms K was an individual who had been referred to the service on three occasions by different routes. Her presentation included a degree of complexity due to her chaotic lifestyle, substance abuse, and social challenges. Ms K was proving difficult to engage with. However, there is no evidence that any discussions about Ms K's presentation was presented to Aspire's multi-disciplinary team to consider this important information.

**7.40** Aspire should have given consideration to the next possible steps for Ms K before decisions were taken about whether or not she could access care provided by Aspire. There is no evidence that her care was discussed in a supervision forum with a clinical supervisor or peer group. This is a particular concern, as one of the referrals made to Aspire about Ms K was made by a Consultant Psychiatrist who was aware of her previous history.

**7.41** The Independent Investigation Team is concerned that the failure to review Ms K's presentation in a multi-disciplinary manner at any stage prior to her

exclusion from the Early Intervention in Psychosis service indicates a significant failure in Aspire's clinical governance regime.

**7.42** Aspire did not appear to have a multi-disciplinary team that was working to consistent standards. Whilst the Independent Investigation Team recognises that this is not necessarily attributable to Aspire being a third-sector organisation, there are features inherent in its configuration which may have contributed to this issue.

**7.43** Other services and individuals involved with Ms K:

**7.44** The Independent Investigation Team acknowledges that Ms K was not an easy individual to engage with, due to her reluctance to consistently keep appointments, her suspension of services, and issues with substance misuse. However, there were a number of factors which could have helped Aspire, which they do not appear to have considered.

**7.45** For example, Ms K had a diligent key worker: Social Services Key Worker 1 was undertaking assertive work throughout the period of Ms K's involvement with Aspire. There were numerous occasions which were brought to the Independent Investigation Team's attention during the course of the interviews which were conducted, and in Ms K's medical records where Social Services Key Worker 1 would track Ms K down in order to reach out to her to advocate for her and connect with her.

**7.46** Social Services Key Worker 1 was concerned about Ms K, and was actively trying to get help for her. However, her concerns were not given sufficient priority by a number of health care professionals involved with Ms K. Additionally, Ms K maintained contact with her mother, who could have been approached for help in contacting Mental Health Services in order to support her daughter.

**7.47** For the Independent Investigation Team, the most striking feature of Aspire's approach to Ms K was the failure to assertively engage with her, and how difficult it was for her to access the service which intended to deliver the following to those aged 18 – 35:

- A mental health service that is active and assertive.
- A service which can cross boundaries and deal with individuals who may also have issues surrounding substance misuse.
- A service which can accommodate diagnostic uncertainty.

**7.48** Failure to exploit opportunities to assess Ms K in a safe place:

**7.49** A significant concern for the Independent Investigation Team is the failure by Aspire, when Ms K was in a safe place (such as an Accident and Emergency Department) to take the opportunity to assess or review her. This is despite the request made by a Consultant Psychiatrist for review, which, at the time, was outstanding, and had not been actioned by members of the Aspire team.

**7.50** Ms K was finally seen in a 'safe' place by Aspire in Bradford on 28 December 2010, when the Aspire Team incorrectly interpreted their own service criteria

and rejected Ms K's referral, despite her never having been actually seen by the service, and despite noting the presence of serious mental health problems which required follow-up. The Independent Investigation Team regards this as an important issue.

**7.51** Impact of substance misuse:

**7.52** It was noted in a letter dated 10 January 2011 from Aspire to Ms K, her GP and CMHT 1, following the consultation with Ms K which took place in a Police station, that it was evident that Ms K was under the influence of illicit substances.

**7.53** In an Early Intervention in Psychosis service, the diagnostic uncertainty and complexity that comes with comorbid substance misuse or personality disorder can be managed in order to provide a comprehensive treatment package for an individual experiencing psychosis. It is the view of the Independent Investigation Team, that the failure to do so in this case may indicate that Aspire were not properly equipped to evaluate and assess potentially complex cases.

**7.54** What is striking about Ms K's care is that in Aspire, there was a service which was designed to address the complexities which can arise in relation to the emergence of a psychotic illness in a young person.

**7.55** Changes in early intervention in psychosis provision:

**7.56** A strength of the Early Intervention in Psychosis approach is its ability to tolerate diagnostic uncertainty, which allows people to be followed over a period of time as their illness develops, or, indeed, does not develop. This flexibility allows clinicians to reach a diagnostic formulation that is appropriate. A further key feature of Early Intervention in Psychosis services is that they are active and assertive and can and do track people across service boundaries.

**7.57** A further strength of Early Intervention in Psychosis is that it is one of the first mental health services to have been set up and developed in a climate of evaluation and research into its effectiveness.

**7.58** This has led to robust data about outcomes such as lowered suicide rates and has also allowed research to inform further development of the service. Specifically, in relation to Ms K, it is now accepted that dilutions and modifications to the original model of Early Intervention in Psychosis are less effective. A copy of the Policy Implementation Guide is attached at Appendix D. The Aspire approach is one such modification. This was not known at the time Ms K had contact with Aspire.

**7.59** Further, it is now recognised that Early Intervention in Psychosis should be expanded to cover those who are most at risk of developing first episode psychosis, as well as those who have presented with a first episode of psychosis. This change has been commissioned and funded. This would have brought Ms K unequivocally within the service criteria for Early Intervention in Psychosis. Again, this was not policy at the time and was not part of commissions of Early Intervention in Psychosis. These factors have been taken

into account by the Independent Investigation Team when evaluating the quality of service provided by Aspire.

- 7.60** In order to promote learning, and perhaps address a concern voiced by Mrs Edeson that this type of event should not happen again, the Independent Investigation Team has given careful consideration to the changes which will be made to Early Intervention in Psychosis services following the injection of additional funding in 2016.
- 7.61** The new model of care, if properly applied, provides for two safeguards which could potentially have stopped this.
- 7.62** Firstly, following a referral, there is now a waiting time target which, in a team which is configured and resourced to work assertively, will result in frequent intensive attempts to pro-actively contact the person referred, and to utilise opportunities for engagement that arise through contact with other services. A discharge would not simply take place as a result of non-attendance.
- 7.63** Secondly, it has been recognised that the onset of psychosis is usually preceded by the appearance of initial symptoms before the development of the full illness. This is termed an '*At Risk Mental State*'. This comprises brief psychotic experiences and symptoms which might include depression, anxiety, loss of personal function, and subtle cognitive impairments. The new Early Intervention in Psychosis model provides for a specialised At Risk Mental State assessment to be conducted in these circumstances. These are important safeguards.
- 7.64** The Independent Investigation Team is of the view that these safeguards could have impacted on the care which Ms K received had they been in place prior to 2011.

Key points – Aspire (Early Intervention in Psychosis service):

Evidence given at Ms K's trial confirmed that Ms K suffers from a psychotic illness. The possibility that Ms K might have been experiencing a psychotic illness was considered on a number of occasions throughout her adolescence and early adulthood.

Aspire is an organisation that provides an Early Intervention in Psychosis service in Leeds. This is a service which provides specialist treatment and support for young people who are suspected of experiencing symptoms of psychosis.

Ms K was referred to Aspire on a number of occasions by a variety of sources, including a clinician who knew her relatively well. However, she was turned down by the service on a number of occasions despite her presentation meeting Aspire's service criteria. Her emerging psychotic illness remained unrecognised and, accordingly, untreated.

The impact upon Ms K's care of her being denied access to an effective Early Intervention in Psychosis service cannot be overstated. Had Aspire adhered to its own service criteria regarding acceptance of referrals, there would have been a far greater chance that Ms K's complex needs would have been addressed.

Whilst the detail of a potential alternative outcome would fall within the realm of speculation, an Early Intervention in Psychosis service would be expected to address many of the deficiencies identified within Ms K's subsequent care, such as the failure to recognise and respond to diagnostic uncertainty, which her presentation gave rise to; the inability to accommodate complex comorbidity, including substance misuse; the application of narrow pathways of care which failed to address all of Ms K's needs; and the inability to operate assertively and across boundaries. Furthermore, involvement with an Early Intervention in Psychosis service would have been sustained over a three-year period of care within the same service.

The services which subsequently came into contact with Ms K struggled to provide either the appropriate level of care, or its delivery through assertive engagement, which Aspire, as an Early Intervention in Psychosis service, could have provided.

#### Observation to encourage reflective practice – Two:

The Independent Investigation Team identified a number of significant concerns about the difficulties which Ms K experienced in accessing care through Aspire in 2011.

The impact of Ms K's failure to be provided with effective access to Aspire cannot be overstated. An Early Intervention in Psychosis service which is working effectively can supply the '*cross-boundary*' assertive working which an individual like Ms K requires. However, despite a significant amount of concern expressed across a number of '*agencies*' involved in her care, Ms K was not able to access Aspire's service. The reasons given for her ineligibility appear to the Independent Investigation Team to lack a secure foundation.

The lack of a properly formulated diagnostic explanation to support Ms K's exclusion from Aspire's service is a matter of significant concern and in fact may indicate that Aspire were not properly equipped to evaluate and assess potentially complex cases.

Aspire, as a third-sector organisation, had an unusual service design compared to other NHS provided Early Intervention in Psychosis services. High-level clinical expertise was '*bought in*'; in particular, access to a Consultant Psychiatrist. This is probably an efficient model for cases of low complexity, but the lack of embedded multi-disciplinary working is felt to have been a factor in the decision-making surrounding Ms K relating to her non-engagement and subsequent failure to obtain care.

At the time that Aspire were operating this model, most NHS Early Intervention in Psychosis services operated to a model of care with more significant emphasis on the inclusion of psychiatrists and psychologists within a multi-disciplinary team that had '*in house*' access to staff to deliver interventions such as Cognitive Behavioural Therapy and Family interventions.

### **Recommendation two – Aspire Early Intervention in Psychosis service:**

The Independent Investigation Team understands that a number of changes have been made by NHS England to the commissioning and evaluation of Early Intervention in Psychosis services. This has included significant extra funding for Early Intervention in Psychosis services. It has also involved an endorsement of the model of service delivery adopted within NHS Early Intervention in Psychosis services.

The new standard requires that, from 1 April 2016, more than 50% of people experiencing a first episode of psychosis start a National Institute of Health and Care Excellence concordant care package within a maximum of two weeks of referral. Both elements of this new standard are critical, as the key aims of its introduction are to ensure that:

- 1 Duration of untreated psychosis is reduced, and people with an emerging psychosis, and their families, and key supporters, can have timely access to specialist early intervention services.
2. Early Intervention in Psychosis services provide the full range of psychological, psychosocial, pharmacological and other interventions shown to be effective in NICE guidelines and quality standards, including support for families and carers. Effective and integrated approaches are needed to address the social and wider needs of people with psychosis to help them live full, hopeful and productive lives.

Early Intervention in Psychosis services also need the capacity to triage, assess and treat people with an at risk mental state, as well as to help those not triaged to access appropriate treatment and support.

The Independent Investigation Team wishes to highlight to those commissioning Early Intervention in Psychosis services in Leeds that the Aspire model may face additional challenges in operating its service to the new standards, as a result of the differences in its current structure and ethos. Accordingly, it is recommended that Aspire produce an action plan for commissioners, which addresses how Aspire will implement the new standards with a view to ensuring that complex individuals such as Ms K can access their service.

Accordingly, it is recommended that:

Aspire produce an action plan for commissioners showing how they can implement and monitor the Early Intervention in Psychosis Access and Waiting Time Standard.

## 8 IN-PATIENT ADMISSION - 31 DECEMBER 2010

- 8.1 On 28 December 2010, Ms K presented at Bradford Royal Infirmary because of a lump under her tongue. Ms K told clinicians that she had taken heroin, consumed alcohol, and had been sexually assaulted by a male who had financially and emotionally abused her. She was tearful, agitated, and hostile, with superficial cuts and bruises to her legs and wrists. She was responding to unknown stimuli and expressing delusional ideas.
- 8.2 Ms K absconded from the hospital and was later detained by the Police under Section 136 of the Mental Health Act 1983. Ms K was taken to a Police station in Bradford, as it appeared that she was in need of care. Her removal to a Police station would have ensured that she was in a designated '*place of safety*', as she had been found to be behaving '*bizarrely*' in a public space. It is reported that she was wandering the streets in a confused and agitated state. During the Section 136 assessment process, Ms K expressed delusional ideas and thoughts of self-harm and suicide. She described being the victim of an '*attack*' and being used for sex working in Leeds.
- 8.3 Whilst in the Police station, Ms K was assessed by Aspire (see also Section 7). Due to Ms K's mental health problems having been present for more than two years, it was decided that Ms K did not meet Aspire's service criteria with regard to early intervention.
- 8.4 Ms K was initially taken to Airedale Centre for Mental Health in Keighley for further assessment on 28 December 2010. She was then transferred to the Becklin Centre in Leeds on 29 December 2010. However, due to concerns developing about the risks which Ms K posed towards herself should she leave the hospital, she was initially detained in hospital under Section 5(2) of the Mental Health Act 1983 on 30 December 2010, and later under Section 2 of the Mental Health Act 1983.
- 8.5 Under Section 2 of the Mental Health Act 1983, a patient who meets the statutory criteria may be detained in hospital for assessment of their mental health needs and receive any treatment which they might need. An individual can be kept in hospital for up to 28 days under Section 2.
- 8.6 On 30 December 2010, a manager from CMHT 1 contacted the Ward in Leeds at which Ms K was being cared for. An entry in Ms K's records made in respect of this interaction states:

*'I expressed my concerns about her past history and if we allocated a care coordinator this would need to be a female worker given the accusations she has made in the past about male workers sexually abusing her.'*

*'I suggested that given her alcohol and illicit drug history that a referral be made to Leeds Addiction Unit who I think had a major role to play supporting her and perhaps coordinating her care. I asked the clinical team on the ward to question*

*her level of motivation to engage with LAU or the CMHT. This discussion needed to take place when appropriate.*

*'...They report that there maybe some evidence of psychosis in evidence and her behaviour on the ward has been challenging. A discussion with Aspire might be required it (sic) it is felt she meets their criteria'.*

- 8.7** Due to Ms K becoming verbally and physically aggressive with staff, she was transferred to the Psychiatric Intensive Care Unit on 31 December 2010. Psychiatric Intensive Care Units are designed to look after patients who cannot be managed on open (unlocked) psychiatric wards, due to the level of risk the patient poses to themselves or others. The patient's length of stay is normally short (a few weeks) rather than prolonged, as the patient should be treated and returned to an open ward as soon as their mental state is stable.
- 8.8** Ms K remained on the Psychiatric Intensive Care Unit until 19 January 2011. It is clear that the staff on Psychiatric Intensive Care Unit worked hard to obtain and share information about Ms K's background, including talking to her mother.
- 8.9** At times, Ms K's behaviour in the Psychiatric Intensive Care Unit was aggressive and unpredictable, which presented difficulties for those responsible for her care and management. She would spit at members of staff, which caused significant concern to those, given their knowledge that Ms K had given a self-reported history of lifestyle factors that would present a concern about transmission of blood-borne viruses such as Hepatitis B, C and HIV. Her status with regard to risk of transmission of blood-borne viruses was unknown at the time.
- 8.10** In addition, during her stay on the Psychiatric Intensive Care Unit, Ms K absconded during a period of unescorted leave. She was returned to the ward by the Police, having been located wandering around the red-light area in Bradford under the influence of illicit substances.
- 8.11** During her stay on the Psychiatric Intensive Care Unit, Ms K was commenced on medication, including haloperidol and semi sodium valproate. She made progress on this regime, but developed side-effects from the haloperidol, which was stopped as a result and replaced with olanzapine.
- 8.12** Sodium valproate is a mood stabiliser. It is, however, a drug with teratogenic properties. Teratogenic drugs have the ability to cause developmental anomalies in a foetus.
- 8.13** The National Institute for Health Care Excellence Clinical Guideline 38 (2006) states:
- 'Valproate should not be prescribed routinely for women of childbearing potential. If no effective alternative can be identified, adequate contraception should be used, and the risks of taking valproate during pregnancy should be explained'.*
- 8.14** Sodium valproate is an appropriate choice of medication if a diagnosis of acute mania or bipolar disorder is being considered. However, standard practice

would have been to prescribe an antipsychotic such as haloperidol or olanzapine, amongst others. Recording in relation to the decision to prescribe sodium valproate was very poor, and does not provide evidence of informed consent from Ms K. Furthermore, the sustained use of an oral mood stabiliser in someone with Ms K's pattern of engagement would only be appropriate if she remained in a setting where it could be supervised, because suddenly stopping a mood stabiliser can potentiate a relapse

- 8.15** Since its introduction in 1974, the product information for doctors concerning sodium valproate has included a warning about the possible risk of birth defects. As the risks to unborn children have been increasingly understood, the warnings have been strengthened such that in the latest iteration of the British National Formulary it is advised that it should not normally be used in women with childbearing potential.
- 8.16** The guidance from the Medicines and Healthcare Products Regulatory Agency is that in the circumstances that there are no other suitable alternatives, patients should be fully informed verbally and in writing and have the capacity to provide informed consent. It follows that, in the event of a lack of capacity then, prior to using valproate, it needs to be established that doing so would be in the patient's best interests. Although this guidance was not in place at the time that Ms K was prescribed valproate, the risk of teratogenicity was well established.
- 8.17** Ms K made progress on the Psychiatric Intensive Care Unit, and her mood began to stabilise. A decision was made on 19 January 2011 to transfer Ms K back to the Becklin Centre.
- 8.18** In-Patient Consultant 1 was of the view that Ms K would require further treatment in hospital. Accordingly, at the end of her stay in Psychiatric Intensive Care Unit on 19 January 2011, as well as providing Ms K with advice about contraception, In-Patient Consultant 1 made a recommendation for Ms K to be further detained in accordance with Section 3 of the Mental Health Act 1983.
- 8.19** Under Section 3 of the Mental Health Act 1983, patients are detained in hospital for treatment. Treatment might be necessary for their health, safety, or for the protection of other people.
- 8.20** Under Section 3 of the Mental Health Act 1983 a patient can be detained for up to 6 months but can be discharged prior to the expiry of the authority for detention. The detention can also be extended through further renewal of section 3 detention via appropriate legal processes.
- 8.21** Ms K's medical records appear to show that In-Patient Consultant 1 was considering Ms K's presentation in the context of a manic episode, which could have been part of a bipolar disorder, and the treatment which she was given at this time would support this view.
- 8.22** Accordingly, In-Patient Consultant 1's Section 3 recommendation was as follows:

*'She had contact with mental health services for approximately 3 years with symptoms suggestive of mania. Assessment and treatment has proved difficult due to non-compliance with medication and absconding behaviour from care*

*settings. This has been complicated by illicit substance misuse. Currently she is on a manic phase of a probable bipolar affective disorder, with symptoms of elation, pressured speech, aggression, violence to others and abnormal beliefs.....She lacks full insight into her mental disorder and has absconded when on leave from the ward. If not detained it is likely that her mental health will deteriorate and result in increased vulnerability, aggression and violence for herself and others. She does not accept treatment for her mental disorder which she requires’.*

- 8.23** During the course of the interviews conducted by the Independent Investigation Team, it became clear that the Consultants in the Psychiatric Intensive Care Unit and those working in the Becklin Centre enjoyed a close and supportive working relationship. Informal but effective information sharing arrangements had been developed partly as a result of strong professional relationships.

Key points – In-patient admission:

On 28 December 2010, Ms K was admitted to hospital in Keighley for assessment, following concerns being raised about her mental health. The Police exercised their powers under Section 136 of the Mental Health Act 1983 to remove her to a place of safety.

Whilst Ms K was in the Police station in Bradford, prior to her transfer to hospital, she was assessed by Aspire. Aspire determined that, due to Ms K’s mental health problems having been present for more than two years, she did not meet their criteria for care. The Independent Investigation Team disagrees with this interpretation of Aspire’s service criteria.

Ms K’s connection with Leeds was quickly recognised whilst she was in hospital in Keighley, and she was transferred to Leeds on 29 December 2010, where she was made the subject of an Order under Section 2 of the Mental Health Act 1983, detaining her in hospital for an assessment of her mental health.

Ms K’s condition deteriorated following her transfer to Leeds, and she was placed in a Psychiatric Intensive Care Unit.

Prior to this transfer, a Manager from Leeds CMHT 1 had questioned her level of motivation to engage with a Community Mental Health Team, and suggested that, due to some evidence of psychosis being present, a discussion with Aspire might be required.

Ms K remained in the Psychiatric Intensive Care Unit until 19 January 2011. She was placed on anti-psychotic medication. A provisional diagnosis of ‘*probable bi polar affective disorder*’ was made.

### Observation to encourage reflective practice – Three:

Overall, the care and treatment which Ms K received in the Psychiatric Intensive Care Unit was good.

The Independent Investigation Team gained the impression that there was a cohesive consultant group within the in-patient units, who supported one another, and there was evidence of peer support. This is an element of good practice. Arrangements for handing information over during Ms K's transfer to the Becklin Centre were effective.

An appropriate plan of care and treatment for Ms K had been developed, given that In-Patient Consultant 1 was of the view that Ms K would remain in hospital under a Section 3 in accordance with the recommendation he made. However, In-Patient Consultant 1 was not in a position to ensure that this was an integrated plan which his colleague was comfortable with, as the consultant in the Becklin Centre was on annual leave when Ms K was transferred out of the Psychiatric Intensive Care Unit.

The choice of sodium valproate was not appropriate for the management of Ms K's acute manic episode, due to its teratogenicity. It was not appropriate for Ms K's long-term treatment (prophylaxis of bipolar disorder) on three counts. Firstly, because of its teratogenicity, secondly due to the lack of certainty about her diagnosis, and thirdly because the level of Ms K's engagement and agreement to take the drug required for its prescription to be a success was unlikely to be achieved.

The guidance on capacity and consent to treatment outlined by the Mental Health Act Commission in 2009 (this body was later superseded by the Care Quality Commission) is clear that responsible clinicians should routinely assess capacity and consent of patients detained under the Mental Health Act 1983 prior to the statutory requirement to do so 3 months from the date of admission and, in the case of any patient for whom the presumption of mental capacity to take treatment decisions is in doubt, a full mental capacity assessment is carried out and kept under review.

The view of the Independent Investigation Team is that Ms K clearly fell into this category, and the expectation is that such an assessment should have been undertaken and documented in relation to her treatment. This is particularly so with regard to the concerns set out in this chapter about valproate

### **Recommendation three – Prescription of sodium valproate by LYPFT:**

The Independent Investigation Team recommends that:

1 The prescription of sodium valproate by clinicians should follow the recommendations within the British National Formulary, and the guidance from the Medicines and Healthcare Products Regulatory Agency, with respect to women of childbearing age.

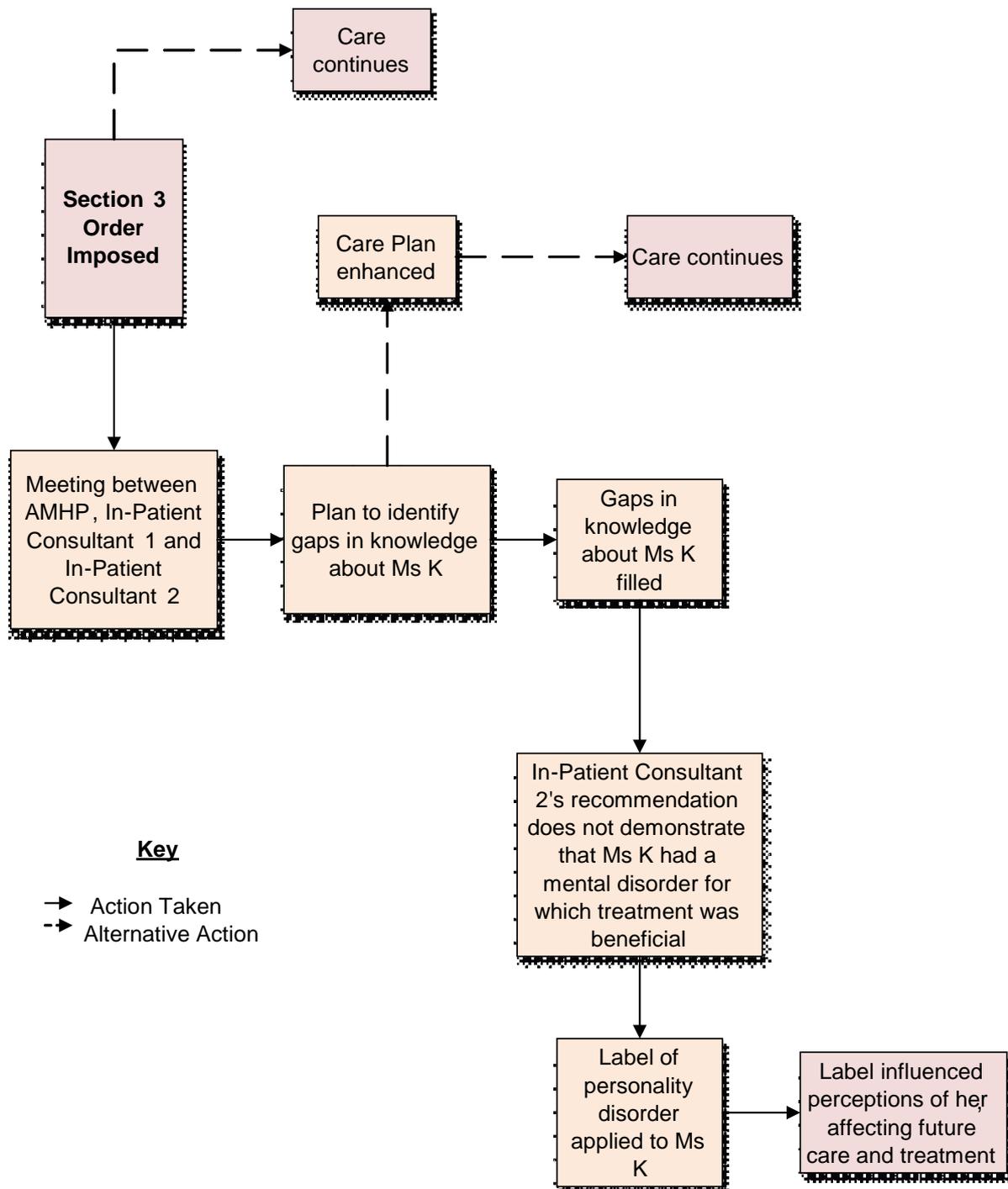
2. In the event of the exceptional circumstances arising in which sodium valproate may be an appropriate treatment in such patients, those patients should be fully informed, both verbally and in writing, and must have the capacity to provide informed consent. This should include information regarding the expectation of the duration of treatment, and the risks associated with discontinuation of treatment once it is established.

3. In the event that a patient lacks capacity prior to using sodium valproate, or loses capacity during treatment with sodium valproate, it should be established that this is, or remains, in the patient's best interests with reference to the Mental Health Act 1983 and the Mental Capacity Act 2005.

4. The Trust should perform an audit to confirm compliance with this recommendation.

## 9 JUNCTURE THREE: SECTION 3 MENTAL HEALTH ACT 1983 ORDER

This is a juncture, because it allowed clinicians an opportunity to acknowledge Ms K's complexity and formulate an appropriate plan whilst she was in a 'safe' environment.



- 9.1** Ms K was transferred back to Becklin Centre where she was under the care of In-Patient Consultant 2 on 19 January 2011. At this time, it appears that In-Patient Consultant 2 was on annual leave.
- 9.2** Following her return to the Becklin Ward, Ms K initially appeared settled. She disclosed the possibility that she might have been pregnant and as a result the sodium valproate was stopped. Following this, Ms K stated that she had only said this to 'wind staff up'.
- 9.3** Ms K absconded from the ward once more and upon her return was noted to be intoxicated. It is documented that her behaviour on the ward became difficult to manage once again, and she was aggressive and intimidating towards staff. It is clear that staff found her difficult to manage as a result of her behaviour. The recent discontinuation of valproate from the documentation which was made available to the Independent Investigation Team does not appear to have been considered as a contributory factor in this deterioration
- 9.4** LYPFT have responded to this concern in the following terms:  
*'Consultant 2 has confirmed that the Valproate was stopped after a long discussion with Ms K about risks in pregnancy particularly in relation to her chaotic lifestyle and sex working. She was deemed to have the necessary capacity at that time to engage in discussions about the use of valproate. The dose of Olanzapine was increased, which would have treated her symptoms yet offered an advantage in having much less risks if she were to become pregnant. There are several references in case records of junior doctors documenting her biological functions like sleep and appetite. She had ongoing assessments of manic and psychotic symptoms; she did not have manic symptoms but had intermittent psychotic symptoms after absconding from hospital. Overall her presentation remained unchanged apart from this, after she returned from PICU. Consultant 2 was satisfied that stopping the Valproate did not worsen her mental health in any way.'*
- 9.5** Recording in relation to the discussions which were had with Ms K regarding the risks attached to sodium valproate is poor, and as has already been stated (at Paragraph 8.14) does not provide evidence of Ms K's informed consent to the use of sodium valproate.
- 9.6** At this time, Ms K was being detained under Section 2 MHA 1983 under the Mental Health Act 1983. That Order was due to expire on 27 January 2011. Ms K had previously indicated that she was not happy being admitted to hospital under section as she had appealed the Section 2 MHA 1983 which had previously been made.
- 9.7** In the absence of Ms K's consent to remain in hospital following the expiry of the Section 2 MHA 1983, it was necessary that clinicians obtain an Order under Section 3 of Mental Health Act 1983 if they felt that she required further treatment and care in hospital.
- 9.8** An application to obtain an Order under Section 3 of the Mental Health Act 1983 must be made by an Approved Mental Health Professional. An Approved Mental Health Professional is an individual who is independent of the

healthcare environment and can take a fresh look at the patient's situation. The Approved Mental Health Professional will draw on all the information available on that individual; not just the medical and clinical factors. This includes the patient's individual, social, and cultural circumstances. The Approved Mental Health Professional will interview the individuals involved in the patient's care and must talk to the patient's nearest relative.

**9.9** The Approved Mental Health Professional must be satisfied that detention in hospital is, given all the circumstances, the most appropriate way of providing the care and medical treatment needed. They must then make the application for admission within 14 days of the interview.

**9.10** An application must be supported by two medical recommendations given in accordance with the Mental Health Act 1983. The dates of the medical 'examinations' of the patient by the two doctors who gave the recommendations must not be more than five clear days apart. The reason for the 5-day limit is to permit enough time for a second doctor to arrange to see the patient without introducing a level of delay that would present ethical or clinical difficulties. There is a further interval allowed between the receipt by the Approved Mental Health Professional of two medical recommendations and the time limit for making an application.

**9.11** It is this second interval that is for the purpose of gathering more information in the interview.

**9.12** In Ms K's case, the Approved Mental Health Professional applied the following timetable:

<b>19 January 2011</b>	<ul style="list-style-type: none"> <li>In-Patient Consultant 1 completed a Section 3 Medical recommendation for admission for treatment.</li> </ul>
<b>19 January 2011</b>	<ul style="list-style-type: none"> <li>The Approved Mental Health Practitioner was given the referral.</li> </ul>
<b>24 January 2011</b>	<ul style="list-style-type: none"> <li>Discussion between In-Patient Consultant 2, the Approved Mental Health Practitioner, and others involved in Ms K's care about the need for a Section 3 Order.</li> <li>In-Patient Consultant 2 had spoken to Ms K's mother, and people involved in her care.</li> </ul>
<b>25 January 2011</b>	<ul style="list-style-type: none"> <li>In-Patient Consultant 2 had spoken to Ms K's mother, who regarded this as a longstanding problem.</li> </ul>
<b>25 January 2011</b>	<ul style="list-style-type: none"> <li>In-Patient Consultant 2 completed a Section 3 medical recommendation for admission for treatment.</li> </ul>

- 9.13** The Mental Health Act 1983 Code of Practice helps professionals carry out their roles and responsibilities under the Mental Health Act 1983, to ensure that all patients receive high quality and safe care. The code has been revised since the time of Ms K's care.
- 9.14** The timetable which has been applied in Ms K's case is unusual in that, at Paragraph 4.44, the Code of Practice recommends that:
- 'Unless there is good reason, patients should be seen jointly by the Approved Mental Health Professional and at least one of the doctors making the Section 3 recommendation'.*
- 9.15** In addition, Paragraph 4.45 of the Code suggests that both doctors should discuss the patient with the Approved Mental Health Professional. It is the Approved Mental Health Professional's responsibility to co-ordinate the Mental Health Act assessments.
- 9.16** The Code of Practice offers guidance only. However, if departing from the code, Practitioners are required to record the reason for a departure from the code. This is a departure from the code, and consequently should have been recorded.
- 9.17** In-Patient Consultant 1's Section 3 recommendation is set out in Paragraph 8.20 of this report.
- 9.18** In-Patient Consultant 2's Section 3 recommendation was as follows:
- 'This young lady has a long history of chaotic and risk taking lifestyle with taking illicit drugs and prostitution. Recently she was (illegible) and observed to have psychotic and manic symptoms. She remains hostile, agitated and threatening. She had earlier assaulted staff. She has a long history of deliberate self-harm. She needs 24 hours nursing care, she is unwilling to have this informally'.*
- 9.19** The Independent Investigation Team notes that In-Patient Consultant 2's recommendation does not demonstrate that Ms K had a mental disorder for which treatment was beneficial. A Section 3 recommendation should refer to the criteria set out in the Mental Health Act 1983; namely that the individual has a mental disorder of a nature or degree that makes it appropriate for them to receive treatment in hospital, that it is necessary for the patient's health and safety, or the safety of others that they receive treatment. This cannot be provided if they are not detained.
- 9.20** The Independent Investigation Team is therefore concerned that in In-Patient Consultant 2's recommendation, the only mention of mental disorder is of an historic observation, the remainder of the *'recommendation'* a description of risk behaviour. This therefore begs the question whether the first criterion has been met.
- 9.21** The Approved Mental Health Professional's assessment conclusion is set out as follows:
- 'I detained Ms K under MHA S3 on the grounds that she has a mental illness; namely emotional (sic) unstable personality disorder'.*

- 9.22** This is significant in that this is the first time that '*[emotionally] unstable personality disorder*' is referred to in any documentation and is the first time that the term '*personality disorder*' is applied with certainty. It is the view of the Independent Investigation Team that the use of this statement as grounds for detention for treatment under the Mental Health Act 1983 implies a degree of certainty about this diagnosis which is not supported by the clinical records, including the medical recommendations for detention and forensic report.
- 9.23** It is also the view of the Independent Investigation Team that, by exclusively referring to this diagnosis, the impression is given that this is the sole condition requiring treatment, and that this is pertinent to subsequent decisions made in relation to Ms K's care.
- 9.24** During the course of the Independent Investigation, the following information was submitted by LYPFT:
- 'The inpatient Consultants (1 and 2) had extensive discussion about Ms K at the time of transfer between the wards. There was also an extensive discussion between the two Consultants about the Section 3 recommendations and the need for further treatment. Inpatient Consultant 2 had extensively discussed the case with the Approved Mental Health Professional (who had obtained a lot of information from social care and other sources) and spoke with Ms K's mother and nearest relative to obtain collateral information. The assessment for Section 3 was indeed utilised by the 3 professionals to acknowledge Ms K's complexity, what would be helpful for Ms K and what could be the limitations when formulating a treatment plan. All of the 3 assessing professionals acknowledged both the degree as well as the nature of Ms K's mental disorder.'*
- 9.25** Unfortunately, the content of the conversations between those involved in this aspect of Ms K's care is not recorded in Ms K's records. Therefore, it remains unclear as to the reason why the two medical recommendations differ to such a significant degree in their opinion of Ms K's mental disorder, nor is the reason clear as to why a diagnosis that is not recorded previously in the medical records, nor features in either medical recommendation should appear as the grounds for detention in the report recording the assessment in relation to the application for detention.
- 9.26** Further, the Approved Mental Health Professional involved in Ms K's care does not appear to have identified this and asked for a further assessment. This could have provided an opportunity for Ms K to have been re assessed.

Key points – Section 3 MHA 1983:

During an application by an Approved Mental Health Professional to detain Ms K for a further period of treatment in hospital in accordance with Section 3 of the Mental Health Act 1983, which was made on 25 January 2011, two clinicians involved in the process provided medical recommendations which offered divergent clinical opinions regarding the nature of Ms K's mental disorder. The content of the application did not address the divergence of the recommendations. The grounds for Ms K's detention were based on a diagnosis that appeared in neither medical recommendation, namely '*emotional(ly) unstable personality disorder*'.

There are several distinct forms of personality disorder and, whilst there is some overlap, the blanket term '*personality disorder*' encompasses a number of different conditions each of which has an individual diagnostic framework and management pathway.

The Approved Mental Health Professional referred in the application for detention for treatment under the Mental Health Act 1983 to '*emotional(ly) unstable personality disorder*' as the sole condition giving grounds for detention. This was the first time that this term had been documented in relation to Ms K, and was the first time it was suggested that her treatment needs relate solely to this or any other personality disorder.

The Independent Investigation Team is concerned that there was no evidence of any co-ordinated thinking in relation to the rationale supporting each professional's reason for considering detention for Ms K under Section 3 of the Mental Health Act 1983.

An Approved Mental Health Professional is a professional who is not trained in diagnosis, nor should one be expected to undertake this as part of their role. Given that the Approved Mental Health Professional recorded a *de facto* diagnosis that is at odds with In-Patient Consultant 1's medical recommendation, it is difficult to understand what the nature or degree of Ms K's disorder was felt to be, and therefore what appropriate treatment might be available for her.

Each professional was essentially saying something different. Indeed, it is not clear to the Independent Investigation Team whether In-Patient Consultant 2's recommendation addressed the criteria establishing a mental disorder.

Observation to encourage reflective practice – Four:

The Independent Investigation Team believes that there was a degree of unclear thinking attaching to the imposition of Section 3 MHA 1983 which could, in part, have been addressed by bringing In-Patient Consultant 1 and In-Patient Consultant 2 together, or, indeed, by the Approved Mental Health Professional consulting more widely with other people involved with Ms K's care, including statutory voluntary or independent providers. The Independent Investigation Team does, however, recognise that the Approved Mental Health Professional did consult with a number of individuals who were closely connected with Ms K.

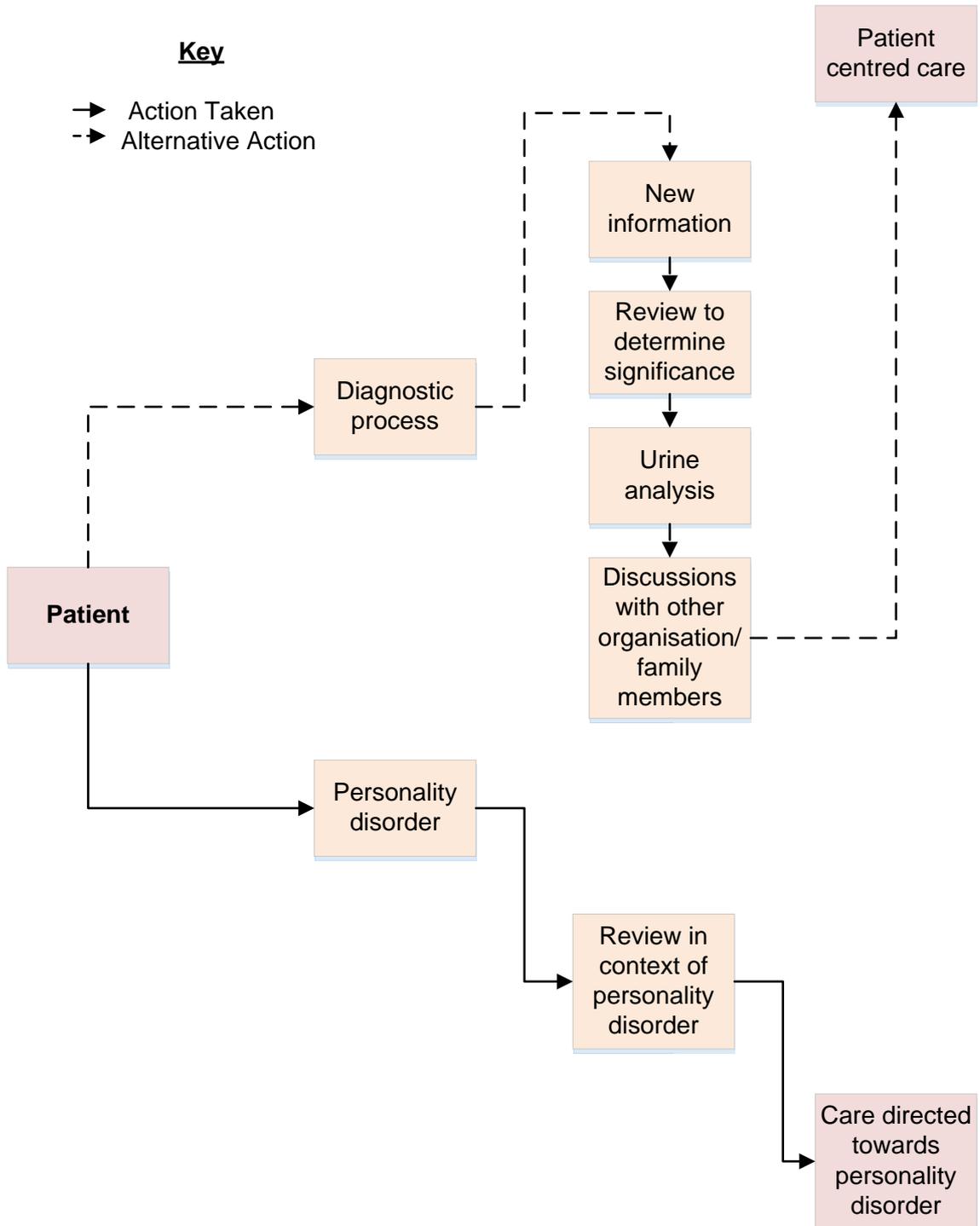
What is of concern is that the differences in opinion regarding Ms K at this stage were not viewed by clinicians as an opportunity to acknowledge this young woman's complexity, and the fact that there was much occurring which was not fully understood about her and her presentation. This could have been an opportunity for those involved with Ms K, including those contributing to Ms K's care outside the health service, to try to formulate a plan as to how the gaps in knowledge about Ms K could be identified and filled, and the limitations of what might be achieved for her to be recognised.

In doing so, this would have shifted the focus from the acuity or degree of the mental disorder to the severity or nature of any such mental disorder. This is made explicit in the Mental Health Act 1983 referring to the '*nature or degree*' (emphasis added) of a mental disorder within the criteria for detention. It is the view of the Independent Investigation Team that too little emphasis was placed on establishing the '*nature*' of Ms K's mental disorder (as applicable to the Mental Health Act 1983) as opposed to the degree of that illness.

The imposition of Section 3 MHA 1983 might still have been considered the correct course of action for Ms K at this time, but it could have been arrived at using a much more structured process which complied with the ethos of the Code of Practice.

## 10 JUNCTURE FOUR: DIAGNOSTIC PROCESS APPLIED IN LEEDS

This was a juncture because the diagnosis was reached without a structured diagnostic process being implemented, which, in the opinion of the Independent Investigation Team, resulted in exclusion of Ms K by other services from which she could have benefited.



- 10.1** Following the imposition of the Section 3 MHA 1983 on 25 January 2011, Ms K remained on Ward 5 in the Becklin Centre.
- 10.2** This provided those responsible for Ms K's care with an opportunity to review her case whilst she was on the ward, particularly in light of the differences of opinion which had been articulated in relation to Section 3 MHA 1983.
- 10.3** As has been stated at Paragraph 7.35, CMHT 1 had contacted Aspire earlier in Ms K's admission to hospital. Aspire declined Ms K's referral on the basis of the longstanding nature of her mental health problems. A table summarising Aspire's previous contact with Ms K as a result of concerns which had been raised about her is set out at Paragraph 7.21. Ms K's presentation had raised concerns about the possibility of an emerging psychotic illness on a number of occasions in Ms K's past.
- 10.4** For example, CAMHS Psychiatrist 1, a Consultant in Child and Adolescent Mental Health Services within LYPFT had become involved with Ms K's care in 2006. As she approached the age of 17 in 2008, the point which her care in child services would come to an end, CAMHS Psychiatrist 1 took steps to facilitate Ms K's ongoing care and referral to Aspire.
- 10.5** On 14 November 2008, CAMHS Psychiatrist 1 wrote to the Pathway Planning Team concerning Ms K. The letter explained that Ms K had recently had abnormal thoughts and persecutory feelings during a recent stay at a secure unit. Ms K had felt oppressed by staff and '*laughed at*' by the young people there. Her presentation was noted to be very unpredictable. At no point did she take responsibility for her behaviour. She kept a diary and made frequent well written complaints. She complained about having a sore wrist and asked to see a doctor. However, she was happy to play tennis using the wrist. Ms K had expressed an interest in websites dealing with suicide and bombing. CAMHS Psychiatrist 1 believed that there was evidence that Ms K was experiencing abnormal thoughts and persecutory feelings at this time.
- 10.6** CAMHS Psychiatrist 1 formed the impression that the history of Ms K's stay in the secure unit was suggestive of a possible onset of early psychosis but that this had not been apparent at his interview with her. He discussed the case with Aspire, who indicated that they would accept a referral (see also Paragraphs 7.22 – 7.37 of this report).
- 10.7** The diagnostic criteria that distinguish a pre-psychotic state from a First Episode of Psychosis is the use of symptom type, symptom number, symptom intensity and duration of symptoms to delineate a range of ways in which a pre-psychotic state may present. Psychotic symptoms may transiently arise, resolve, and never recur, or may recur periodically without meeting criteria for a psychotic episode. However, symptom severity may progress in successive recurrences to comprise a psychotic episode or may simply persist from the initial onset.
- 10.8** Furthermore, there are distinctions drawn between brief psychotic episodes and longer ones that are indicative of schizophrenia. Once again symptom type, number, and duration are relevant. By definition, those psychoses associated with substance use fall into the group of '*brief psychoses*'.

- 10.9** Psychosis and emergence of a schizophrenic illness may follow a number of patterns the most common being a relapsing remitting course. The evidence from Ms K's clinical records suggests that this was the pattern of her psychotic illness. Whilst this was ascribed by clinicians to her substance use, the Independent Investigation Team notes that this is the course followed by the majority of people with schizophrenia and substance use is recognised as one of the variables that might affect the presentation and outcome of schizophrenia (NICE: Psychosis and schizophrenia in adults: prevention and management – 2014).
- 10.10** Ms K had undisputable psychotic symptoms which were following a pattern of increasing impact on her ability to function. Whilst these were within the definition of At Risk Mental State in 2008, by the time of her admission to a Psychiatric Intensive Care Unit there were unequivocal acute psychotic symptoms evident. It is accepted that, at this stage, there was a need to be mindful of several diagnoses and not closing off by focusing on one diagnostic arm.
- 10.11** Progression of a psychotic disorder is rarely a smooth incremental worsening but is usually more disorganised reflecting fluctuations in symptom level together with the impact of external factors which can also fluctuate. Symptom characteristics, such as paranoia, and individual patient characteristics, such as social engagement, can affect functional impairment, patterns of behaviour and willingness to seek or accept help.
- 10.12** Ms K had presented with psychotic symptoms that persisted beyond the period of (presumed) intoxication with substances, and at a level and duration that necessitated treatment with antipsychotic medication. This would take her presentation within the definition of '*Brief Limited Intermittent Psychotic Symptoms*' ('*BLIPS*') which includes substance induced psychoses. The data on BLIPS indicates that 20% will progress to a diagnosis of schizophrenia within a 2-year period. Other relevant diagnoses include '*Acute and Transient Psychotic Disorder*' ('*ATPD*') (which requires no recent intoxication) and '*Bipolar Disorder*'. These also carry a risk of recurrence and progression<sup>5</sup>.
- 10.13** The Independent Investigation Team is of the view that Ms K was already in a high-risk group for developing a severe mental illness. Consequently, despite Aspire's failure to become involved in Ms K's care, there should have been a strategy in place to actively identify whether Ms K was exhibiting symptoms of an emerging psychosis and to consider intervention at this point. Based upon Aspire's service criteria, advice could have been sought from this specialised team, notwithstanding Aspire's failure to accept the referral into the service.
- 10.14** During this time, Ms K was difficult to manage on the ward. She was abusive and aggressive towards staff, who found her difficult to engage. She was disruptive and continued to abscond and engage in other risky behaviours, such as misusing substances on her time away from the ward. These types of behaviours understandably invoked anxiety on the part of staff.

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<sup>5</sup> Paolo Fusar-Poli et al, '*Prognosis of Brief Psychotic Episodes – A Meta-analysis*', JAMA Psychiatry, 2016;73(3):211-220.

- 10.15** Those responsible for her care recognised Ms K as a young person with limited financial and social resources. They knew she had been abused and did not trust people. Indeed, it was clear that she was being actively taken advantage of, particularly in relation to financial matters. Ms K's support mechanisms were neither extensive nor robust. Many of Ms K's challenges had been present since she was a teenager.
- 10.16** The Independent Investigation Team believes that those caring for Ms K recognised her as an individual who had experienced deprivation, adversity and trauma over her entire developmental period.
- 10.17** Ms K was correctly identified as having a background associated with increased risk of developing a personality disorder, and increased risk of substance misuse. Many of her behaviours, particularly those which gave rise to her difficulty in management on the ward, could properly have indicated the existence of a personality disorder. However, had Ms K also been conceptualised as somebody who had an emerging chronic, severe, and enduring mental health problem, complicated by drug use, trauma history, and adversity, then the same behaviours could have been framed in a more sophisticated way. Doing so would have led to a more holistic consideration of destabilising factors such as the recent change of ward and the recent change of medication.
- 10.18** During the course of the Independent Investigation, the Independent Investigation Team were provided with the following opinion concerning whether there had been adequate recognition by the clinicians in Leeds of an established association between early adversity and risk of other mental disorders including psychosis.

*'It is the evidence of the LYPFT clinicians that they always acknowledge the association between early adversity and all forms of mental disorders. In relation to Ms K it is recorded as part of the assessment that:*

*'[She] had a disturbed childhood'.*

*'She was said to have been exposed to cannabis via the inhalation of passive smoking from an early age.*

*'Her school years were disrupted due to her being placed within a children's home and her choosing not to attend.*

*'She is said to have commenced use of cannabis from at least the age of 14 and was deemed to have a 'risky lifestyle'. She absconded from the units that she was placed within and used illegal drugs. Her placements were characterised by disruptive behaviour, altercations with others and impulsive sexual relationships with male residents.*

*'This suggested a pervasive history of emotional dysregulation coupled with impulsive behaviour on the background of a chaotic, disruptive childhood. The clinicians noted that Ms K had intermittently shown some psychotic symptoms but the final nature of the disorder, as described within the Forensic report (dated 10 December 2012) prepared for Ms K's criminal defence, cannot be seen as having been present during this admission (two years earlier)'.*

**10.19** This opinion expressed by LYPFT also conflicts with evidence submitted to the Court by Ms K's defence team. In particular, it was stated by a Consultant Forensic Psychiatrist instructed on Ms K's behalf to the Court that:

*'Although her diagnosis may not have been clear in the past because of a very extensive use of illicit drugs it is very likely that she has been abstinent from such substance use for many months and her psychotic symptoms have persisted. The continuation of her symptoms has also been in the context of her receiving therapeutic doses of anti-psychotic medication over a prolonged period. In my opinion therefore it is very likely that she is suffering from a long-term psychotic mental illness such as schizophrenia'.*

**10.20** Ms K's presence on the ward presented clinicians with an opportunity to look at her more closely, and to observe her in order to gain a greater understanding of her presentation. This was particularly important given that she presented a significant challenge for those working with her in the community to secure her engagement. Section 3 MHA 1983 would have allowed for Ms K to have remained in hospital for a substantially longer period, had this been thought necessary.

**10.21** Consequently, the Independent Investigation Team takes the view that a systematic diagnostic process would have been of assistance in gaining a greater insight into Ms K's difficulties. Whilst this might ultimately have led to the same conclusions, the approach to diagnosis which appears to have been adopted was less than rigorous, and crystallised legitimate diagnostic uncertainty into spurious certainty which was potentially very damaging for Ms K.

**10.22** In relation to the drug-induced component, ideally the patient should be placed in a situation where it was possible to verify that she was not using drugs.

**10.23** Drug-induced psychosis is a term which is interpreted by healthcare professionals in a number of ways. Some professionals choose to interpret it as drug intoxication, whereas those responsible for Ms K's care were in fact very clear and said that it related to a psychotic episode which was caused by the use of illicit substances. One of the difficulties which Ms K presented was that her chaotic lifestyle meant that it was difficult to establish the connection between her drug taking and her psychotic symptoms.

**10.24** However, it is recognised that those who have a drug-induced psychotic episode, even as an intoxication phenomenon, are a group more vulnerable to subsequently developing a psychotic disorder. Whereas this should have pointed towards the need for more vigilance for the possibility of psychosis in future interactions with services, the reverse appears to have been the case.

**10.25** Furthermore, it could be suggested that her drug use should have been responded to with a harm minimisation approach that acknowledged the risk of psychosis. This is a recognised strategy to work with people who misuse substances and are not at a point where they are seeking interventions to achieve abstinence. The aim is to help them make better and safer choices about the type of substance and mode of administration. In the case of people at risk of psychosis this would include the propensity for certain substances to

induce or worsen psychosis such as stimulants and cannabis and discussion of the quantities or modes of use that are associated with psychotic symptoms in that individual. In general terms, psychotic symptoms emerging during intoxication are a risk indicator for more persistent psychosis.

- 10.26** Mental illness is very stigma laden, particularly where young people are concerned. As a result, some individuals may prefer to be regarded as a drug user, rather than as someone experiencing mental illness. An understanding of which drugs Ms K was using would also have been helpful. Reports in Ms K's diaries and other records suggest that she preferred to use opiates, which are not usually involved in triggering a drug-induced psychosis.
- 10.27** It is known that the purity of illicitly acquired substances can vary considerably and substances may be misrepresented in terms of their active content. Additionally, some individuals are unclear about recalling what they may have taken, or can, in fact, misreport what quantity of drugs has been taken. Therefore, urine analysis can be very beneficial. The relevance of a negative urine screen is that the presence of on-going psychosis in the absence of intoxication calls into question the notion of a substance induced psychosis and could point much more clearly to there being an underlying psychosis *complicated* by substance use.
- 10.28** A urine test had previously been conducted in Bradford, the results of that test, which was conducted on 26 February 2009, were negative and, therefore, could have raised questions about the causation of psychotic symptoms at a time when there were no substances present.
- 10.29** In an entry dated 29 December 2010, the results of a drug screen which was taken in Bradford during the course of a very brief admission to hospital prior to her transfer to the Becklin Unit in Leeds the following day, were negative for all drugs despite Ms K advising clinicians that she had taken '*a wrap of heroin*'.
- 10.30** Urine analysis was not conducted at any stage in Leeds. The Independent Investigation Team acknowledges that Ms K's failure to consent to urine analysis is documented on at least one occasion, for example, following an episode when she absconded from the Unit on 21 January 2011. On this occasion, despite her denial that she had taken any illicit substances, the Police reported their suspicions that she had.
- 10.31** However, there is no record of Ms K being offered a drug test or her refusal of such testing during her admission to hospital at other key points during this admission to hospital in Leeds. For example, following a further period when she absconded on 3 February 2011 and returned clearly intoxicated due to alcohol and reporting that she had taken heroin, the records do not contain any reference to drug screening being considered. In light of Ms K's refusal to undergo drug screening in Leeds, it would have been open to clinicians in Leeds to confirm with colleagues in Bradford as to whether any testing had been carried out during her brief stay. There is no record of this having happened.
- 10.32** Ms K was not the subject of any positive drug tests and accordingly her drug use was only self-reported. The majority of her self-reporting relating to drugs

was of heroin. The use of heroin does not characteristically result in psychosis. In the opinion of the Independent Investigation Team, this indicates a gap in the diagnostic process. The relevance of the earlier negative urine screen is that the presence of ongoing psychosis in the absence of intoxication calls into question the notion of a substance induced psychosis and points much more clearly to there being an underlying psychosis *complicated* by substance use. This is a difficult distinction to make, but one that should have been at the forefront of the minds of the clinicians.

- 10.33** ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems, a medical classification list by the World Health Organization. It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.
- 10.34** ‘*Drug induced psychosis*’ is not an ICD-10 category of diagnosis; the nearest ICD-10 category, ‘F1x.5’, requires a statement of the substance implicated, and allows specification of the subtype of psychosis, neither of which were stated.
- 10.35** Drug induced psychosis is an ill-defined term which can be too broad to be helpful in terms of ongoing management. It is, however, appropriate to use broad criteria such as this in Early Intervention in Psychosis service criteria in order to avoid missing an underlying psychotic disorder. It should be noted that in this context Drug Induced Psychosis is included in Aspire’s Service Criteria (see Paragraph 7.14 – 7.18).
- 10.36** ‘Borderline personality disorder’ is accepted by ICD-10 as being included in the definition of ‘*Emotionally Unstable Personality Disorder*’ (EUPD) with two subtypes of ‘*Impulsive*’ and ‘*Borderline*’, the latter is regarded as the closest equivalent to “Borderline Personality Disorder” although there are some differences in criteria. Prior to the discharge summary only the overall category of EUPD had been referred to and the process of having refined this diagnosis to one of the sub groups is not clear in the clinical documentation. Usage of the ICD-10 terminology and demonstration that the requirements set out in the ICD-10 definition had been met would have added clarity and demonstrated diagnostic rigor.

- 10.37** Personality disorder is a diagnosis which is broken down into a number of sub-types, each of which has an individual diagnostic framework and management pathway. In a forensic report dated 22 June 2010 which was prepared on behalf of the Court in relation to criminal proceedings which were being taken against Ms K, the diagnosis of emotionally unstable personality disorder is not mentioned.
- 10.38** The report compiled by a Consultant Clinical & Forensic Psychologist, although drawing attention to the author's restricted ability to provide a useful formulation, makes a number of recommendations that suggest a potential direction for care that those working with Ms K could have taken. The suggestions include finding a professional with experience of engaging clients who are reluctant or ambivalent, substance misuse services and the 'Personality Disorder Network'.
- 10.39** Ms K was, therefore, released from the Becklin Centre with diagnoses that were not ICD coded. The diagnoses which were given were not precise. Sometimes, that can arise from genuine uncertainty, particularly in the case of short admissions. However, in Ms K's case clinicians appeared to be very certain about what was in fact an uncertain diagnostic picture.
- 10.40** In the Independent Investigation Teams opinion, what appears to have occurred is that a reverse slant was applied. Rather than seeing drug-induced psychosis as an indicator that clinicians could be looking at an individual who was predisposed to psychosis, or indeed that Ms K was in a group of people within whom there was a high percentile chance of having a psychotic illness, clinicians appeared to have disregarded the psychotic symptoms, which they then attributed to Ms K's lifestyle. This appears to then have been used to reinforce the diagnosis of personality disorder.
- 10.41** The diagnosis of emotionally unstable personality disorder:
- 10.42** Initially in the Psychiatric Intensive Care Unit, the diagnosis that clinicians reached was one of psychosis and they began to treat it with anti-psychotic medication.
- 10.43** Ms K was transitioned from Adolescent Mental Health Services, which makes her case more complicated. This in itself could have put clinicians on notice that they could have been dealing with an individual who was potentially complex. However, what was lacking was an analysis of discussions with those who were close to Ms K, to gain an understanding of how her presentation might be changing in order to gain a better understanding of what might be occurring, and whether any changes could have diagnostic relevance.
- 10.44** During the course of the investigation, the Independent Investigation Team was provided with the following information by LYPFT, that there were:
- '[Multiple] conversations between LYPFT and Ms K's mother whilst Ms K was an inpatient. Further, there was contact with the Child and Adolescent Mental Health Services (CAMHS) about Ms K's presentation prior to her transfer to adult services in Leeds. This information was collated in the form of a Tribunal report and her eventual discharge summary from PICU.'*

[...]

*'LYPFT staff also discussed her case with other social workers and housing support workers. Simple questions mentioned in the report like 'is she always like this?' were specifically asked of her mother and support workers. The overwhelming evidence from these discussions was that Ms K was predominately engaging in behaviours of chaotic lifestyle, drug taking, interpersonal difficulties, history of self-harming and emotional instability'.*

- 10.45** The conversations between Ms K's mother and clinicians are not recorded in sufficient detail in Ms K's records to substantiate this comment. Equally, there was a concern raised by professionals involved with Ms K at the point of her discharge from the Becklin Centre that they *'had serious concerns regards her level of risk including safe guarding issues'*.
- 10.46** Focussed questioning of carers, family members, and other professionals involved with Ms K may have been able to give those caring for Ms K more of an insight into her internal world and assist with the subtle task of distinguishing stable patterns of relating to the world from a fluctuant or deteriorating pattern. If a clinician was told that the individual had recently seen new elements or a pattern of more instability, more fluctuation and/or poorer function, then this could be a flag to suggest additional possible psychopathology.
- 10.47** The Independent Investigation Team is concerned that in reaching a diagnosis of emotionally unstable personality disorder, and in implementing a management plan that is orientated around emotionally unstable personality disorder, little account appears to have been taken of what has occurred prior in terms of psychosis, other than to call it a drug-induced psychosis.
- 10.48** Personality Disorder is a diagnosis which is broken down into a number of sub-types, each of which has an individual diagnostic framework and management pathway.
- 10.49** In a report dated 22 June 2010, which was prepared on behalf of the Court in relation to criminal proceedings which were being taken against Ms K at that time, the diagnosis of emotionally unstable personality disorder is not mentioned. However, the report, which was completed by a Consultant Clinical and Forensic Psychologist with experience and expertise in personality disorders, did conclude that Ms K's mental health difficulties could be seen within a framework of personality disorder. The report, which was not prepared as part of a diagnostic process, makes a number of recommendations that suggest a potential direction for care that those working with Ms K peripatetically could have taken.
- 10.50** The diagnostic process which concluded that Ms K had emotionally unstable personality disorder is not recorded in Ms K's records. It also remains unclear as to the sub-type of personality disorder that Ms K was thought to have had. Caution would normally be applied when diagnosing personality disorder in an individual who has a psychotic illness. It is established practice to wait until the psychosis has settled and then review the diagnosis in light of any residual symptoms.

- 10.51** If regard is given to ICD categorisation, it is clear that in terms of both diagnosis and in terms of approach to management, a psychotic illness should have been considered and the evidence within Ms K's records be reviewed. The reason for this is that if a psychosis is treated, an individual who may be exhibiting erratic and chaotic behaviour may be found to be doing so because of that psychotic illness, rather than issues relating to their personality.
- 10.52** One of the challenges for services providing care for people with emotionally unstable personality disorder is that the engagement ethos is very different and is almost a polar opposite from the ethos which would apply to psychosis. Typically, people with emotionally unstable personality disorder over-engage with services, but in an unhelpful way. One of the notable things about Ms K was that she did not do this. This issue was not explored with her.
- 10.53** LYPFT make the point that a model of engagement and of care for someone with schizophrenia would be very different from one for a person with emotionally unstable personality disorder. This is a key point raised by the Independent Investigation Team because of course the inverse is true. However, the likelihood is that the situation was more complex even than this dichotomy in that it appears likely that complex comorbidity was present, and the predominant need and engagement model may shift back and forth. By remaining wed to a single model of engagement and care, the ability to intervene effectively was compromised and clinicians were blinkered to the need to review presentation, prevailing need and diagnosis at each contact.
- 10.54** In a more responsive and flexible approach to models of care, the psychosis would be addressed and stabilised, then a management plan that protects the individual against the psychosis (but which then addresses issues relating to personality) can be formulated.
- 10.55** If it is accepted that Ms K did indeed have emotionally unstable personality disorder borderline type, it is the opinion of the Independent Investigation Team that it was still necessary to consider the possibility, based upon Ms K's presentation and history, that she could also have been suffering from a psychotic illness. Recurrence of psychoses can be precipitated by stress and this needs to be addressed in any management plan
- 10.56** It is the opinion of the Investigation Team that the focus which was placed upon personality disorder obscured consideration of Ms K's symptoms which were suggestive of an emerging psychotic illness. Whilst personality disorder was relevant to Ms K's presentation, it was necessary to have in mind an emerging psychotic illness at the same time, and for clinicians involved in her care to work out which informed the approach to care and treatment at any one time.

Key points – Diagnostic process applied in Leeds:

In the period leading up to her first admission to hospital, and throughout that admission in Leeds on 30 December 2010, Ms K was noted to have been paranoid and suspicious, including ideas and behaviour which were rightly identified as emerging psychotic symptoms.

However, the Independent Investigation Team is of the view that, subsequently, these symptoms were too readily attributed to a combination of illicit substance use and personality disorder.

The Independent Investigation Team was unable to determine a structured diagnostic process which led clinicians to conclude that Ms K was experiencing a drug-induced psychosis and met the diagnostic criteria for emotionally unstable personality disorder borderline type.

Clinicians recognised that Ms K was an individual who had faced very significant challenges throughout her childhood, with behavioural disturbance indicative of trauma over her entire developmental period. In addition, clinicians identified correctly that, as a result, she was at increased risk of experiencing a personality disorder and may have also been predisposed to drug abuse.

However, it is the view of the Independent Investigation Team that there was no indication that there had been adequate recognition by clinicians of the association between early adversity and risk of other mental health problems, including psychosis.

It appeared to the Independent Investigation Team that the level of rigor that went into the thinking about personality disorder was minimal. Ms K's records do not provide evidence of a multi-disciplinary assessment.

It is the view of the Independent Investigation Team that instead there appeared to have been an over-reliance on symptom profile as inferred from Ms K's observed behaviours, an under emphasis on the pattern of her difficulties over time, and an under-emphasis on information from Ms K herself as well as collateral sources.

If it is accepted that Ms K did indeed have emotionally unstable personality disorder, borderline type, it was still necessary to consider the possibility based upon her presentation, that she was suffering from a mental illness.

Clinicians did not appear to factor the uncertainties about Ms K into their thought processes, and, as a result, what should have been legitimate and thoughtful diagnostic uncertainty crystallised into a misplaced narrowing of the diagnostic range that resulted in the application of inappropriate models of care, particularly approaches to dealing with poor concordance and poor engagement, and ultimately reduced Ms K's level of access to services.

### Observation to encourage reflective practice - Five

Personality disorder is defined in ICD-10 as a pattern of deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations<sup>6</sup>. They are developmental conditions, which appear in childhood or adolescence and continue into adulthood. They are not secondary to another mental disorder or brain disease, although they may precede and coexist with other disorders.

Furthermore, ICD-10 states that if a personality condition precedes or follows a time-limited or chronic psychiatric disorder, both should be diagnosed. Professionals often use the term '*personality disorder*' as shorthand for '*emotionally unstable personality disorder, borderline type*' because this is the most prevalent in mental health settings but, in diagnostic terms, there should be consideration of the criteria for personality disorder generally, and then consideration of its subtypes.

The presentation of emotionally unstable personality disorder, borderline type overlaps with, and can be confused with, other disorders but, crucially, it predisposes to comorbidity rather than excluding it - i.e. someone with emotionally unstable personality disorder (borderline type) is more likely to have a mood disorder, psychosis, or substance misuse problem than other members of the general population. Snapshot views of patients can lead to both under and over-diagnosis and are more vulnerable to prejudice.

In determining whether someone has a personality disorder, ICD-10 states that the assessment should be based on as many sources of information as possible. Although it is sometimes possible to evaluate a personality condition in a single interview with the patient, it is often necessary to have more than one interview, and to collect history data from informants.

If regard is given to the ICD-10 categorisation, it is clear that in terms of both diagnosis and approach to management, a mental illness should be considered first. Caution would normally be applied when diagnosing personality disorder in an individual who has mental illness at the time. It is established practice to wait and then review the diagnosis.

The reason for this is that, if a psychosis is treated, the underlying pre-morbid character of the person is able to come out. The person who behaves in a grossly erratic, chaotic, and anti-social way may be doing so because of an underlying illness, as opposed to as a result of aspects of their personality.

It is recommended that there is application of the recommendations made in the existing NICE guidelines (dating from 2009, updated in 2015) for people with borderline personality disorder. It is recommended that there is particular attention to guidance on the management of comorbidities:

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<sup>6</sup> World Health Organisation, *International Statistical Classification of Diseases and Related Health Problems 10th Revision* (2016), Chapter V, F60.

“Before starting treatment for a comorbid condition in people with borderline personality disorder, review: the diagnosis of borderline personality disorder and that of the comorbid condition, especially if either diagnosis has been made during a crisis or emergency presentation; the effectiveness and tolerability of previous and current treatments; discontinue ineffective treatments.

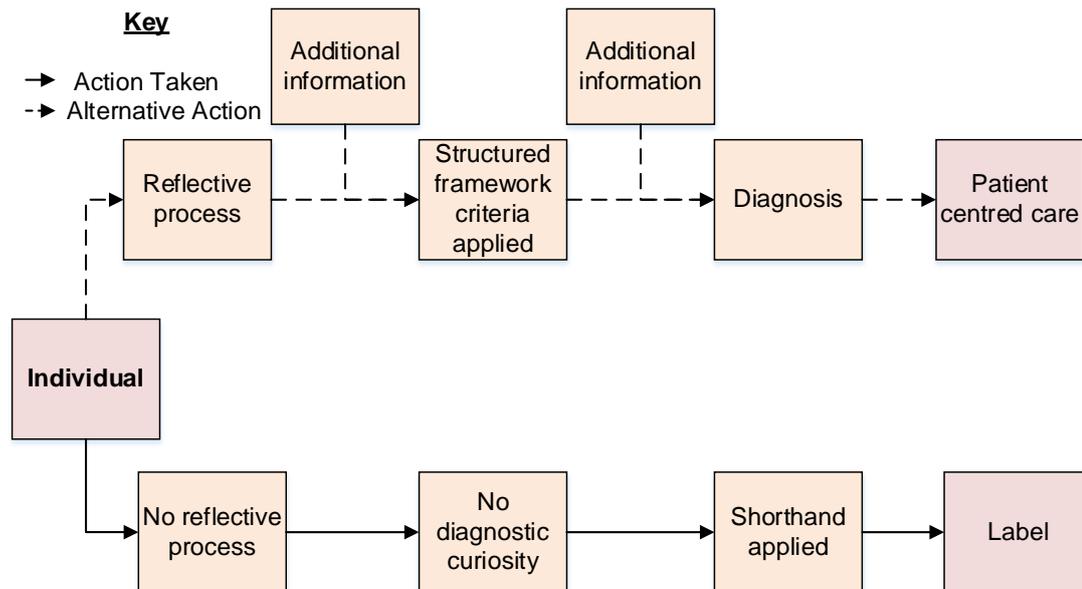
Treat comorbid depression, post-traumatic stress disorder or anxiety within a well-structured treatment programme for borderline personality disorder.

Refer people with borderline personality disorder who also have major psychosis, dependence on alcohol or Class A drugs, or a severe eating disorder to an appropriate service. The care coordinator should keep in contact with people being treated for the comorbid condition so that they can continue with treatment for borderline personality disorder when appropriate.

When treating a comorbid condition in people with borderline personality disorder, follow the NICE clinical guideline for the comorbid condition”.

## 11 JUNCTURE FIVE: DIAGNOSIS OR LABEL – THE IMPACT OF LABELS

This is a juncture because, in not applying a diagnostic process or criteria, an overreliance upon symptoms arising out of behaviour resulted in care not being delivered in relation to all Ms K's needs.



- 11.1** A striking feature of Ms K's presentation is the number of 'labels' which can be applied to her. A significant number of these 'labels' have negative connotations.
- 11.2** Mental health professionals diagnose mental illness by following a reflective process within a structured framework of criteria. During this process, active assessments are conducted of how the individual looks and behaves. The professionals listen to the way the individual speaks, and what they might say. Questions may be asked about how the individual is feeling, and what they are thinking. As more information is gathered, the diagnosis is reflected upon and refined. Some potential diagnoses may be abandoned, and other possible diagnoses may emerge.
- 11.3** Diagnosis is, therefore, a dynamic structured process. In contrast, labels do not derive from an underpinning process. The danger is that the label is allowed to narrow the range of thinking, and exclude a reflective process concerning an individual, or aspects of their presentation, leading to the loss of important diagnostic information.
- 11.4** The problem is that once a label has been applied, the 'why' behind the label may not be questioned. The clinical significance of behaviour can then become

lost or misinterpreted. Treatments may or may not be offered in response to the label, without fully taking into account an individual's specific needs.

- 11.5** Whilst little is known about the circumstances surrounding Mr Edeson's death, it is known that Ms K was engaging in sex work at around this time. Ms K was 20 at the time of Mr Edeson's death. Indeed, one of the labels which had been applied to Ms K in her records is that of '*sex worker*'.
- 11.6** As a child, Ms K had been in care and during this time she had been noted to be difficult to engage due to her repeat absconding. A feature of Ms K's absconding was drug misuse and sexual exploitation. For example:

**June 2006- October 2006**

Ms K received a secure placement order at a secure unit in Merseyside, as there were concerns arising from her use of cannabis, other drugs, and alcohol whenever she absconded. In addition, she was placing herself at risk of sexual exploitation by those supplying her with drugs.



**October 2006- March 2007**

Ms K returned to a children's home in Leeds, but ran away repeatedly.



**March 2007 – July 2007**

Ms K was formally placed at her mother's house in March 2007. In July 2007 she was placed in another children's home in Leeds following an altercation at home which led to a charge of assault against her sibling.



**July 2007- November 2007**

During Ms K's time at a children's home in Leeds, she frequently absconded for days at a time. It was known that, during this time, she was using drugs and alcohol, as well as being harboured by older male individuals who had sexual relations with her, and at other times she slept rough. In November 2007, she was found collapsed with visible needle marks. On her way back from hospital, she tried to run away, resulting in her being placed in a secure children's home in Devon.

- 11.7** At repeated points in her life, Ms K presented to services with a number of these potential indicators, which were suggestive of exploitation. Whilst it was recognised that she was vulnerable, a judgement that Ms K was controlling her behaviour was made, and the clinical significance of her behaviours was therefore not explored. For example, one of the features of individuals with emotionally unstable personality disorder is that they actively seek out and make demands of services. The help seeking pattern of individuals with psychosis is very different and more closely reflects the manner in which Ms K sought assistance from services.
- 11.8** Professionals involved in her care appear to have regarded Ms K as being in control of her absconding, anti-social, and sexual behaviours, and that these behaviours were, in fact, a matter of choice. This could have been viewed differently if the label of '*sex worker*' was recognised as having limitations, and her involvement in the sex industry was made the subject of a reflective process.

**11.9** During the course of the Independent Investigation, LYPFT provided the Independent Investigation Team with the following information:

*'Ms K was considered to be vulnerable but she was also an adult with the capacity to make her own decisions. She had been assessed as having a borderline personality disorder and drug-induced psychosis. Professionals spoke with Ms K about her involvement in sex working, she understood what she was doing, she understood the risks, but she was largely funding her drug use by sex working. Ms K engaged with support services involved in sex working. It was the view of the clinicians who met and assessed Ms K that she was able to make lifestyle choices, however unsafe or unwise they might have been'.*

*'The treating team are clear that the Panel's comments do not fit with the clinical picture or Ms K's presentation, at the time. Ms K was clear that sex working was her choice, the team concluded that she was able to make this choice and all they could do was warn her of the risks and ensure she was engaged with support services (which she was)'.*

**11.10** A further label which has been applied to Ms K is that of *'personality disorder'*. Individuals with personality disorders can face discrimination within healthcare settings<sup>7</sup>. Whilst attitudes are changing, personality disorder has previously been used as a blanket term to define a group of service-users who do not seem to fit elsewhere and are unresponsive to treatment or therapy. There is a mistaken perception that the diagnosis is dispensed as a last resort.

**11.11** As is set out throughout this report, in Ms K's case, the label of personality disorder denied her full access to services, including EIP and in-patient services, impacted upon her transfer out of CMHT 1, and inhibited further consideration of her presentation as her mental health deteriorated.

**11.12** The Independent Investigation Team acknowledges that LYPFT have developed a Personality Disorder Service, and that the Internal Investigation into the care of Ms K made a number of valuable recommendations in this regard. However, whilst this may improve care for individuals with an appropriately diagnosed personality disorder, it may not address the impact which a diagnosis of personality disorder can potentially have upon clinicians.

**11.13** The difficulty which the Independent Investigation Team observed during the course of its investigation was that if a *'label'* of personality disorder was applied, subsequent clinical perspective immediately narrowed and diagnostic curiosity ceased. Following the diagnosis of personality disorder, clinicians did not appear to give any further consideration to why Ms K was behaving in the way she did. When the diagnostic term was applied to Ms K, it appeared to obscure everything else in her presentation which perhaps did not fit this diagnosis. Consequently, the diagnosis of personality disorder which was relevant to Ms K obscured an emerging psychotic illness which was also relevant. Essentially, there were two *'conditions'* which were happening at the

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<sup>7</sup> Graham Thornicroft, Diana Rose, Nisha Mehta, *'Discrimination against people with mental illness: What can psychiatrists do?'* Advances in psychiatric treatment (2010), vol 16, 53-59, p55; National Institute for Mental Health in England, *'Personality disorder: No longer a diagnosis of exclusion'* (2003), p5; Department of Health, *'Recognising complexity: Commissioning guidance for personality disorder services'* (2009), p9.

same time. However, one was obscured by a premature narrowing of clinical thinking.

**11.14** For example, during the course of interviews conducted by the Independent Investigation Team, the diagnostic formulation applied at the time of Ms K's discharge from hospital was discussed with professionals who subsequently came into contact with her and in particular whether it was felt that there was an emerging personality disorder.

**11.15** In interview, Care Co-ordinator 1 stated:

*'I wouldn't have been involved at that point in any kind of diagnostic formulation because I only saw her extremely briefly. It was more down to the ward staff to look at her behaviour, look at her illness. I wouldn't be involved in that. I mean I could see that she was emotionally unstable, visually you could see, but it was hard to tell whether it was because of the ongoing drug use, because she was frequently going AWOL and taking drugs at the time. It could have been either. It was hard to establish at that time which was the prevalent disorder.'*

**11.16** When asked about the response which was made to the difficulties which were encountered in trying to get Ms K to engage with services and whether, in particular, she considered Ms K could have been referred elsewhere as a result of these difficulties, it was said in interview by Care Co-ordinator 1 that:

*'I guess I know that I was struggling to engage with her. I don't know what team would have been able to engage with her. Okay, there might be more appropriate teams, maybe the Dual Diagnosis Team, maybe the Personality Disorder Team. Even seeing Ms K just the once was virtually impossible, so how the Dual Diagnosis Team would be able to see her or how a Personality Disorder Team, who are office based, who don't go out into the community at all, would meet with Ms K. It just wouldn't happen.'*

*'I could have made a referral but it would have been a waste of time because she would never have engaged with a service that didn't – well she was never in anyway. If it was a Leeds-based service, she was never at home, she was always in Bradford. She had the Bridge Project already which was to do with alcohol and drugs. She had the Women's Refuge. From my side she already had two good services that she was engaging with. Sadly she set fire to one of them.'*

**11.17** Other clinical professionals involved in Ms K's care reached conclusions which were potentially based upon the application of a label rather than by following a reflective diagnostic process in relation to, for example, Ms K's failure to engage with services.

**11.18** For example, an entry in Ms K's records made by the Criminal Justice Team on 17 August 2011 states:

*'I contacted HMP Newhall Inreach who informed me that Ms K had shown no signs of psychotic phenomena nor evidence of a schizophrenic illness since she was remanded a fortnight ago. They discharged her from healthcare to normal location yesterday whereupon Ms K hurled abuse and was resistant to being moved. She also refused to see the prison psychiatrist yesterday...'*

*'My observations are of a personality disorder (of mixed type) with a presentation complicated by her chaotic lifestyle and social/financial instability. She has benefited from her remand period in regards to her general health presentation and demeanour.*

*'Discussed with (Ms K's) solicitor... Concern expressed that nobody is engaging with her client. I suggested that many 'dislocated' services had previously offered support but that Ms K had been reluctant and/or failed to engage. I suggested also that her client might have to contribute to the process by agreeing to be assessed'.*

- 11.19** When clarification was sought with regard to the use of the word “observations”, the following response was given:

*“when I say, “My observations are...” That is the wrong word to use. I should have said, “My impression...” perhaps.*

- 11.20** Further, when asked for clarification of whether that impression was gained from Ms K's records or from direct observation of her, the following response was given:

*“Talking to different people who have been with her at New Hall, from what I have heard from ..., the probation officer, from having looked back at those notes, from reading of the absconson and the drug mis-use, I think I came to those conclusions and supported the earlier diagnoses as it were, of a personality disorder”.*

*I don't even understand why I have put, “Of mixed type.” Because I certainly would not use that expression now”.*

- 11.21** It is the Independent Investigation Team's opinion that these examples illustrate how the application of a 'label' can impact upon the rigor of a diagnostic process and the use of diagnosis as a way of considering alternatives and informing therapeutic processes. Ms K's pattern of non-engagement was not the subject of a reflective process. The assumption was that Ms K was choosing not to engage, which closed down the possibility of an ongoing review of her diagnosis and potentially placed an undue emphasis on a specific aspect of her presentation i.e. a personality disorders to the detriment of the whole clinical picture which she presented.

Key points – The impact of labels:

Ms K was discharged from inpatient care with two diagnoses: a diagnosis of 'borderline personality disorder' which is taken to be shorthand for the ICD-10 category 'Emotionally Unstable Personality Disorder, Borderline Type'; and a diagnosis of 'drug induced psychosis'. This is not an ICD-10 category of diagnosis and there are therefore difficulties with its reliability as a concept.

The Independent Investigation Team considers the use of '*personality disorder*' to be a '*label*' in this context because it resulted in clinicians' view of Ms K to be based on their expectations of people to whom this term applied rather than to consider the individual and consider whether her presentation remained consistent with diagnostic criteria or whether different or additional diagnoses might apply.

Rather than the use of this diagnosis being regarded as part of a reflective process, subject to ongoing review and refinement over time, the application of the diagnosis of emotionally unstable personality disorder was treated as a single event that was, in essence, fixed.

This acted to narrow the clinical perspective of clinicians who later came into contact with Ms K.

As a result, behaviours which could in actual fact have been suggestive of an emerging psychotic illness in a young person were not explored and were in fact referenced back to the personality disorder label.

#### Observation to encourage reflective practice – Six:

Psychiatric diagnosis is an active process in which symptoms and behaviour are evaluated against standardised criteria to arrive at a 'best match'. In complex cases, the information needed to make a diagnosis is often incomplete or requires a period of longitudinal evaluation. Further, a patient's symptoms or presentation may change over time. Diagnosis, therefore, should be dynamic and be regularly reflected upon, reviewed, and refined. Particular difficulties arise when diagnostic terms are misused in the form of labels due to the misplaced assumptions that derive from them.

Had a more sophisticated and reflective diagnostic process and bio-psychosocial formulation been applied to Ms K then there may have been acknowledgement of diagnostic uncertainty and more impetus to take an enquiring approach to understanding Ms K's behaviours.

Labelling goes beyond diagnostic terms and represents a shorthand way of categorising an individual without properly formulating their personal circumstances, personal history, and need. This approach, therefore, fails to see the person, as the stigma from labelling is about the blanket application of assumptions about a group of people, rather than exploration of the individual. As well as adversely influencing decision-making with regard to health and social interventions, labelling also acts as a smokescreen to changes in the pattern of a person's difficulties. This was a significant factor in relation to Ms K.

The label of sex worker was applied to Ms K. Professionals involved in her care appear to have regarded Ms K as being in control of her absconding, anti-social, and sexual behaviours and that these behaviours were, in fact, a matter of choice connected to her role as a '*sex worker*'.

This could have been viewed differently if the label of '*sex worker*' was recognised as having limitations and was instead made the subject of a reflective process, which potentially could have led to a greater understanding of the reasons for some of Ms K's behaviours.

A further label which has been applied to Ms K is that of personality disorder. Individuals with personality disorders can face discrimination and exclusion within healthcare settings.

The issue, with regard to these particular labels, is that they appear to have been associated with assumptions of capacity, and models of engagement that were inappropriate to Ms K as an individual. In looking to see to what extent, and to what level of detail this was explored by services, it is the view of the Independent Investigation Team that this was not done in anything more than a cursory way.

This links back to earlier observations about the way in which models are developed and used, and that are appropriate for one broad clinical or social group, but in complex individuals there can be conflict between models, as commented on in relation to the assertive engagement issue.

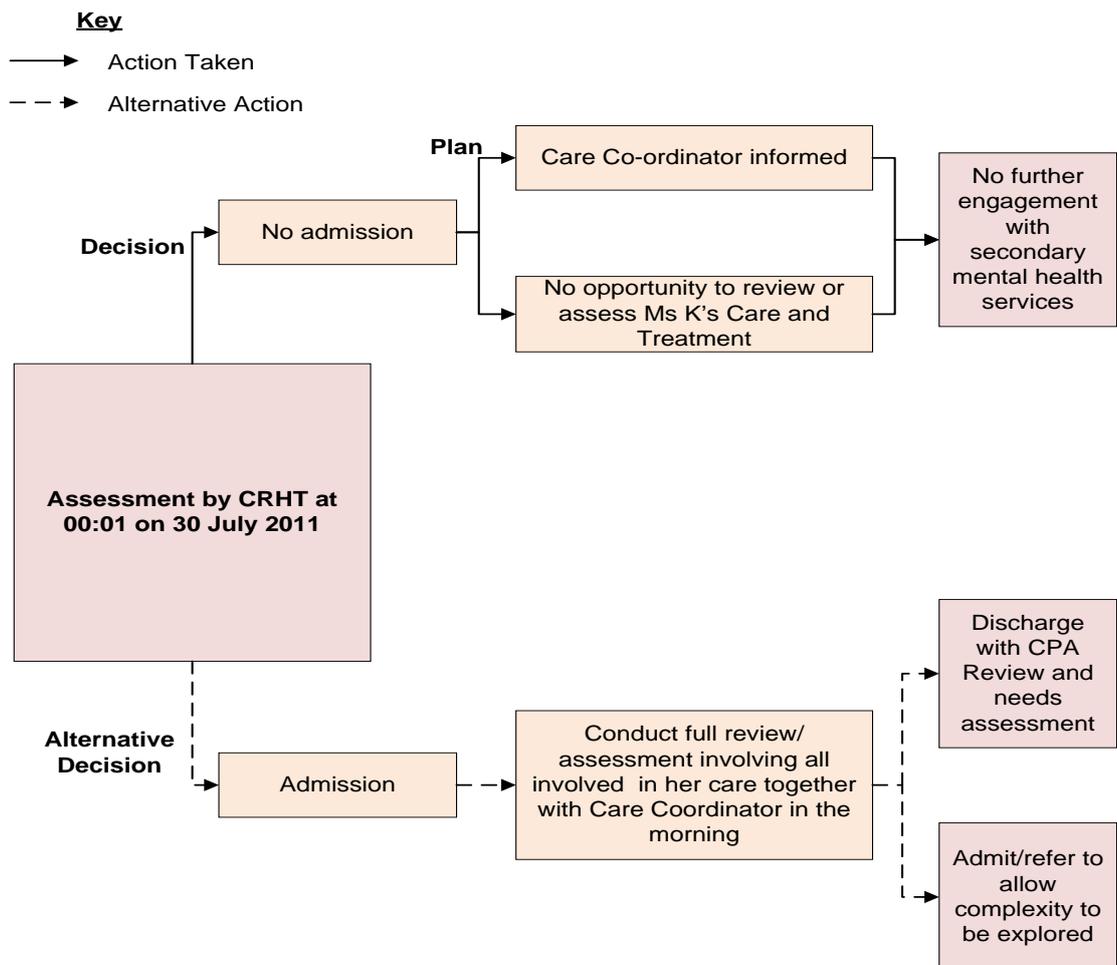
Whilst the context of this investigation is the use of diagnoses and labels in relation to mental health, the same observations apply to blanket assumptions made about physical diagnoses or disabilities. However, considerable advances have been made in this respect. For there to be parity of esteem, similar progress should be sought with regard to mental health.

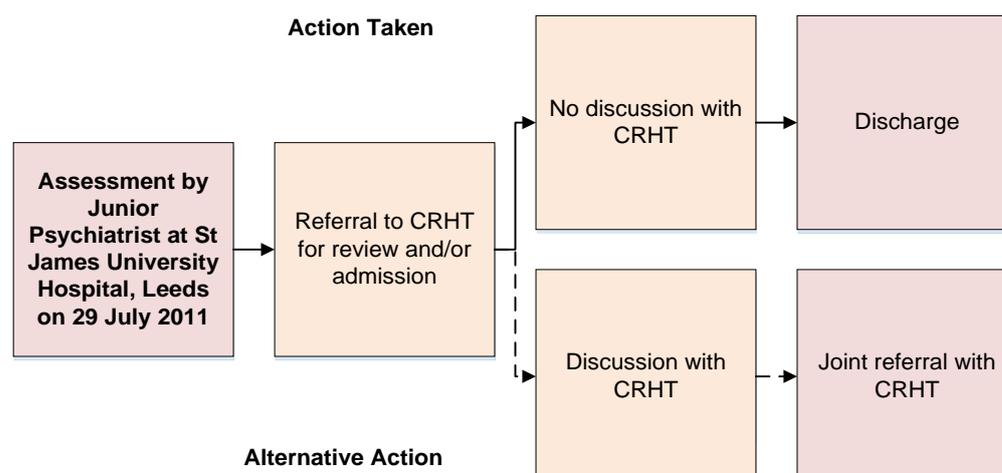
The use of diagnostic terms can only be effective if a level of diagnostic curiosity is retained. There is a significant danger that the application of a label can inhibit a structured diagnostic process, which recognises the individual patient, and restricts the care and treatment options which may be open to them.

## 12 JUNCTURE SIX: ATTENDANCE AT ACCIDENT AND EMERGENCY IN LEEDS, 29 JULY 2011

This is a juncture because:

- New clinically relevant information came to light.
- Ms K was seeking help/admission, was compliant and of engaged presentation.
- Ms K was assessed by Psychiatric Trainee 1. Psychiatric Trainee 1 then discussed his concerns with his more senior colleague, Psychiatric Trainee 2. Both felt Ms K should be admitted to allow a proper assessment to take place, which would be beneficial. This recommendation was passed to a Crisis Resolution and Home Treatment team.
- The Crisis Resolution and Home Treatment team did not consider admission to be necessary, and asked Ms K to return to be seen by the Acute Community Services.





**12.1** Both doctors who were involved in Ms K's care in Accident and Emergency on 29 July 2011 were trainees and could be referred to as '*junior doctors*'. However, this broad term covers a number of levels of training and experience. Psychiatric Trainee 1 was a '*Senior House Officer*', in modern terms a '*Core Trainee*', meaning a fully registered medical practitioner who has completed up to three years of core specialist training. Psychiatric Trainee 2 was a '*Registrar*', in modern terms a '*Specialist Trainee*' a fully registered medical practitioner who has completed three years of core specialist training, passed professional examinations to become a Member of the Royal College of Psychiatrists, is approved under Section 12(2) of the Mental Health Act 1983 as having specific expertise in mental disorder and has additionally received training in the application of the Act, and has completed up to six years in total of specialist training. Beyond this six-year point, a trainee is eligible to become a Consultant Psychiatrist.

**12.2** Assessment performed by Psychiatric Trainee 1:

**12.3** Psychiatric Trainee 1 first became aware of Ms K as a result of his attendance at ward rounds conducted in the Becklin Centre in February 2011. He saw Ms K once again on 29 July 2011 in the Accident and Emergency Department at St James's University Hospital Leeds, having been asked to perform an on-call assessment. In-Patient Consultant 2 was responsible for his educational supervision throughout this time. Psychiatric Trainee 1 was in the first year of his specialised psychiatry training when he first met Ms K. Psychiatric Trainee 1 was complimentary about the quality of training which he received, and described the Consultants, and team in which he worked, as being supportive.

- 12.4** Psychiatric Trainee 1 performed a very thorough assessment of Ms K. During the course of this assessment Ms K felt able to disclose information which she had not previously told clinicians, some of which could have been clinically significant. His main focus of concern was the psychotic symptoms which she revealed, the reported carrying of knives, and thoughts of harm to herself and others (including a threat to kill her social worker), together with details of drug and alcohol abuse. In addition, Ms K provided a description of seeing shadows in the corner of her vision for a week (persistent visual hallucinations). She also stated that whenever she heard sounds they were turning into voices. She also reported that when she heard a bang she heard an Asian man and a woman, who told her to be violent to her social workers (functional hallucinations). She also stated that she was hearing 'voices every day "all the time"".
- 12.5** Psychiatric Trainee 1 was concerned about Ms K, and offered her admission to the Acute Community Service, which is a day hospital, for further assessment. Acute Community Service is open from 8.30am to 9pm each weekday, and from 10am to 6pm at weekends, every day of the year. In doing this, Psychiatric Trainee 1 advised the Independent Investigation Team that his focus was on Ms K's long-term management, which he felt should be in the community.
- 12.6** The Acute Community Service is intended to provide an effective and extended alternative to in-patient care for people who need treatment for acute mental health problems. The Acute Community Service takes referrals from the Crisis Resolution and Home Treatment team, from Community Mental Health Teams, and from in-patient wards. Malham House Community Mental Health Team was an Acute Community Service, at that time.
- 12.7** When Ms K refused the option of Acute Community Services, Psychiatric Trainee 1 did not feel able to send her home, as he believed that in light of her refusal, Ms K's presentation warranted in-patient admission.
- 12.8** Supervision of Psychiatric Trainee 1:
- 12.9** Psychiatric Trainee 1 discussed Ms K with the Psychiatric Trainee supervising his work, who provided him with clinical supervision. Psychiatric Trainee 1's clinical supervisor agreed with the view that Ms K should be admitted to hospital and, therefore, Psychiatric Trainee 1 approached the Crisis Resolution and Home Treatment team
- 12.10** Psychiatric Trainee 1 was a junior doctor at training level. Accordingly, this individual who would be registered with the General Medical Council as a doctor and who was employed as such by the LYPFT, was in the early stages of specialist training.
- 12.11** The level of experience of Psychiatric Trainee 2 is not known. However, in order to supervise another trainee, an individual in this position would need to have completed at least 3 years of training in psychiatry, have completed their membership with the Royal College, and would be in the process of doing their specialist training to be a consultant.
- 12.12** Supervising both trainees would be a consultant psychiatrist on call, who is a specialist. The trainee doctors would not be supervised by nursing staff within

the Crisis Resolution and Home Treatment team. Consequently, the level of supervision in this case was coming from somebody who has the same professional knowledge as a consultant, because they will have done their membership examination, but they will not have all of the experience that a consultant would have. However, they would be able to work autonomously, and they should be expected to know when they would take things to a consultant or not.

**12.13** Each trainee doctor was an autonomous practitioner. However, having recognised that they need assistance with the decision making in Ms K's case, Psychiatric Trainee 1 has taken it to their next line of seniority and a decision was taken. They felt it was within their competency to make a decision without recourse to the on-call Consultant Psychiatrist and the decision they arrived at was to admit

**12.14** Psychiatric Trainee 1's views in decision to admit Ms K:

**12.15** A concern for the Independent Investigation Team highlighted by this consultation is the role of the junior doctor and his part in the assessment and, when necessary, admission of patients.

**12.16** As somebody who was a junior member of the team, Psychiatric Trainee 1 carried sufficient responsibility to discharge patients from the 'safety' of hospital care. This decision is complex and requires knowledge of what could happen to that individual when discharged. However, that same doctor did not have the authority to admit Ms K to a place of safety. That authority lies within the Crisis Resolution and Home Treatment team.

**12.17** The decision not to admit is equally complex but can be made by the Crisis Resolution and Home Treatment team in isolation from clinicians who have had prior knowledge of the patient, which is what happened in this case. This can, and did, occur without full knowledge of the patient, and therefore carries the risks attached to discharge from the relative safety of an Accident and Emergency Department.

**12.18** LYPFT have put forward a different opinion to that of the Independent Investigation Team of the role of mental health professionals in Accident and Emergency and the process for an admission to a mental health unit from this setting:

*'If a junior doctor has no cause for concern then a decision to 'not admit' is straightforward. However, if the junior doctor feels that a patient may benefit from an admission he will seek the input of the Crisis Resolution and Home Treatment team, who will have much more experience of making admission decisions. The Crisis Resolution and Home Treatment team will review the patient if there is not a clear need for an admission.'*

*'The Panel might not be aware that the large majority of mental health presentations to the emergency department do not require any further involvement from secondary care mental health services'.*

- 12.19** Once she had been referred to the Crisis Resolution and Home Treatment team, Psychiatric Trainee 1 had no further contact with Ms K. His views were not sought by members of the Crisis Resolution and Home Treatment team.
- 12.20** During the course of the interview conducted with Psychiatric Trainee 1, he made it clear that working relationships with the Crisis Resolution and Home Treatment team were good, and, if necessary, a joint assessment could have been conducted. However, despite the later assessment conducted by the Crisis Resolution and Home Treatment team being incomplete, Psychiatric Trainee 1 was not approached by the Crisis Resolution and Home Treatment team in relation to Ms K's care.
- 12.21** Evidence given to the Independent Investigation Team during the course of the investigation suggested that the information which Psychiatric Trainee 1 would have had available to him when he saw Ms K in Accident and Emergency was restricted to information recorded on the PARIS computer system maintained by the Leeds Teaching Hospitals NHS Trust. Ms K's medical and nursing notes from previous admissions to the Becklin Centre, for example, would not have been available to clinicians in Accident and Emergency, because Accident and Emergency was not part of the Trust.
- 12.22** When patients were seen at that time in Accident and Emergency, an Accident and Emergency Liaison pro forma would be used to record hand-written details of the consultation and assessment. The completed hand-written pro forma would be provided to the Accident and Emergency Administrative Team, who would then insert an edited version of the pro forma into the electronic record system. The data entered into Ms K's records is not, therefore, an exact transcription of the original completed pro forma, nor is the typed version checked or reviewed by the clinician who completes the pro forma.
- 12.23** There is a danger inherent in this system of key information (such as the discussions between Psychiatric Trainee 1 and his clinical supervisor) being omitted from the information which is entered electronically into the patient's records, which could then subsequently be taken into account as part of the decision-making process employed by the Crisis Resolution and Home Treatment team.
- 12.24** The Independent Investigation Team is concerned that a system which appears to rely upon a non-clinician to summarise (as opposed to transcribe) a clinical record does not include any process for the clinician to check and validate clinical entries. The non-clinician does not have the clinical training or expertise to know whether information is significant or not. This constitutes a significant clinical governance issue.
- 12.25** Threshold for admission:
- 12.26** The system which operated at the time of Ms K's care would have allowed Psychiatric Trainee 1 to have performed a joint assessment with the Crisis Resolution and Home Treatment team (Leeds Liaison Psychiatry Service Operational Systems 2010). However, this option was not taken. This is a matter for concern.

**12.27** The Independent Investigation Team understands that a verbal handover would normally take place. It was Psychiatric Trainee 1's understanding that the responsibility for recording the content of the verbal handover in the records lies with the Crisis Resolution and Home Treatment team. No details of any verbal handover given to the Crisis Resolution and Home Treatment team appear in Ms K's records. Psychiatric Trainee 1 did not recall any such discussion taking place

**12.28** Psychiatric Trainee 1's description of the conclusion of his consultation with Ms K in interview was as follows:

*'At that point, you know you can't send someone home that seems sort of psychotic and is saying they're having ideas of harming people. You can't do that, so from what I can see there, I offered an admission to the ACS, which is the day hospital, for further assessment.'*

*'...She's agreed to go home, and keep herself safe – so what had happened is, if she agreed to ACS, which is the day hospital, they open at 8:00 or 9:00 in the morning. I think she knows – from what I've seen in the notes, she was from CMHT 1, which was an ACS then, at that time. The Crisis Team could have agreed to support her, overnight, and she could have gone to the ACS, which is an alternative to an inpatient admission during the day.'*

*'That was with a view to a long-term – to make more of a long-term management plan with her, to continue her care in the community. Obviously, she refused that; she didn't want that. I wasn't – you think, 'Well, I can't send you home if you're saying this sort of thing, because I am quite worried.' This probably warrants some sort of inpatient admission.'*

*'At that point – I don't know if it's changed now, but at that point, if you wanted anything extra, like Crisis Team, or inpatient admission, you had to go through the Crisis Team. They were the sort of gatekeepers, so then you refer with the registrar, or you discuss with the registrar on call, and even they're powerless. They can't say, 'Well, yes, I'll admit them,' and admit them straightaway. You still have to go through the Crisis Team'.*

**12.29** The issue of concern which this raises for the Independent Investigation Team is that the threshold for admission was met in the view of two clinicians but that they were unable to enact this when they had a consenting patient who was seeking such an admission. There was, in the view of the Independent Investigation Team, no compelling reason to reassess this decision to admit and an opportunity was missed to undertake a more detailed assessment in a safer and controlled setting.

**12.30** LYPFT have referred to the initial opinion of Psychiatric Trainee 1 as being not to admit to hospital and that therefore the conclusion arrived at by the crisis assessors was consistent. However, the Independent Investigation Team heard from psychiatric trainee 1 that his initial management plan was predicated on the willingness of Ms K to engage and follow the plan to manage the risks identified and in light of an indication to the contrary he discussed the situation with his clinical supervisor and they jointly arrived at a different plan.

- 12.31** The Independent Investigation Team considered that Psychiatric Trainee 1 amending their opinion based on the information that came to light and the subsequent discussion with a senior trainee is a good practice point showing an ability to avoid being rigidly attached to a particular plan when the information changes.
- 12.32** The Independent Investigation Team understands that the Trust has now introduced a single point of access to make it easier for referrals to be made, and to allow the number of repeat assessments to be reduced and information to be shared more easily.
- 12.33** In addition, Acute Community Services, Mental Health Intermediate Care and Home-Based Treatment have been integrated and are now known as the Intensive Community Service.
- 12.34** The role of Crisis Resolution and Home Treatment teams:
- 12.35** Crisis Resolution and Home Treatment teams were set up to help people avoid admission to mental health hospitals or, indeed, to return home more quickly following a situation which for them amounts to a mental health crisis. Crisis Resolution and Home Treatment teams are now the first point of access to secondary mental health services for the majority of adults.
- 12.36** A key part of the role of Crisis Resolution and Home Treatment teams is to 'gatekeep' access to in-patient care. 'Gatekeeping' is where patients are assessed to consider whether home treatment is a safe and clinically beneficial alternative to in-patient care. Consequently, an individual cannot be admitted for in-patient care unless the Crisis Resolution and Home Treatment team has agreed that there is no other alternative.
- 12.37** Assessment of Ms K by the Crisis Resolution and Home Treatment team:
- 12.38** Despite the level of detail, and breadth of the assessment carried out by Psychiatric Trainee 1, a decision was taken by the Crisis Resolution and Home Treatment team to conduct a second face-to-face assessment of Ms K, late at night with a reduced data set compared to that which was available to Psychiatric Trainee 1.
- 12.39** The assessment of Ms K was undertaken by Crisis Team Assessor 1 and Crisis Team Assessor 2 at around midnight on 30 July 2011. The consultation which the Crisis Resolution and Home Treatment team practitioners had with Ms K was a difficult one. Ms K was not co-operative, and her responses were abusive at times.
- 12.40** The Crisis Resolution and Home Treatment team made no attempt to contact Psychiatric Trainee 1 or his clinical supervisor to discuss Ms K's presentation. However, they would have had access to Psychiatric Trainee 1's hand-written notes, which would more accurately have reflected Psychiatric Trainee 1's consultation with Ms K than the electronic records.

**12.41** The Crisis Resolution and Home Treatment team practitioners also reviewed a number of Ms K's records and reached the view that Ms K's previous in-patient admission had not been advantageous for her and had provided no benefit.

**12.42** The entry made in Ms K's records of this consultation states:

*'20 year old girl with a diagnosis of borderline personality disorder and drug-induced psychosis. Experiencing some symptoms of psychosis properly (sic) related to drug usage.'... 'No evidence of want to change her chaotic lifestyle*

*'Had refused ACS and no evidence that admission would help her condition. In circumstances feel longer term support from cmht and referall (sic) to drug agencies may be more beneficial'.*

**12.43** Whilst typing errors in that extract have been preserved for the sake of accuracy, the Independent Investigation Team is placing no emphasis upon those errors, nor drawing any inferences from them.

**12.44** The Crisis Resolution and Home Treatment team assessment could not be completed, because Ms K abruptly terminated the assessment by leaving the hospital. At this point, it should be noted that Ms K had been in hospital for over eight hours. The Crisis Resolution and Home Treatment team recognised Ms K as being vulnerable and, indeed, sought to address this by providing her with a taxi fare.

**12.45** Response to Ms K's presentation by the Crisis Resolution and Home Treatment team:

**12.46** The Independent Investigation Team is of the view that the Crisis Resolution and Home Treatment team did not undertake further analysis or review of the information which Psychiatric Trainee 1 had been able to obtain about Ms K earlier that day

**12.47** Psychiatric Trainee 1 makes a number of key observations consistent with psychosis and hallucinations in his assessment. The Independent Investigation Team are aware from his evidence that he did not write the entry that records his consultation. With regard to hallucinatory phenomena there are three distinct perceptual abnormalities referred to in Ms K's history: visual hallucinations; auditory pseudo-hallucinations and auditory hallucinations (functional auditory hallucinations i.e. triggered by a non-vocal sound).

**12.48** The last are referred to twice and with some detail that suggests a prominence and also indicates that command hallucinations were present at this time. The pseudo-hallucinations are noted as being in the third person, which is unusual in emotionally unstable personality disorder.

**12.49** Pseudo-hallucinations are not pathognomonic of personality disorder nor do they exclude psychosis as they can occur in psychosis. Unfortunately, the mental state examination records these phenomena ambiguously and the hallucinatory component is missing from the formulation. This may reflect the level of training of Psychiatric Trainee 1.

- 12.50** However, the same information was made available to the Crisis Resolution and Home Treatment team assessors to evaluate and formulate. In the limited interview conducted by the Crisis Resolution and Home Treatment team, Ms K did confirm that she heard a voice and saw shadows in the corner of her vision, but the voices were assumed to be pseudo-hallucinations.
- 12.51** These symptoms were not addressed by the Crisis Resolution and Home Treatment team. Instead, a number of assumptions appear to have been made about her presentation which could have been based on her previous diagnosis of personality disorder, a diagnosis which, as has been mentioned, often excludes individuals from care.
- 12.52** It appears to the Independent Investigation Team that Ms K as an individual became less significant in comparison to a generic interpretation of the diagnosis of '*personality disorder*' which had previously been applied to her. In doing this, clinical focus was diverted from the individual characteristics of Ms K's presentation. In addition, labels applied to aspect of Ms K's presentation such as '*chaotic*', '*drug user*', or '*prostitute*', may have clouded objective clinical decision-making of some of the individuals involved in her care. As a result, judgements reached did not appear to members of the Independent Investigation Team to be based upon all of the information which was available about Ms K at that time.
- 12.53** The Independent Investigation Team believes that this is illustrated by the use of the clustering tool by the Crisis Resolution and Home Treatment team. Mental Health Care Clusters are 21 groupings of mental health patients based upon the patient's characteristics and are a way of classifying individuals utilising mental health services.
- 12.54** Following the Crisis Resolution and Home Treatment team consultation, Ms K was clustered into the non-psychotic superclass. Her mental health problems were considered to be in the category of '*common mental health problems, low severity*'. This is a category that does not reflect the level of severity and complexity elicited in the first assessment by Psychiatric Trainee 1 in terms of her presenting features, or the conclusions drawn by Psychiatric Trainee 1.
- 12.55** Indeed, during the course of an interview conducted with Crisis Team Assessor 1, it was stated in answer to the following question concerning the clustering applied:

Question: '*[Where] it talks about the superclass allocation being non-psychotic and the cluster allocation being zero one, current mental health problems low. Looking back at those notes now, is that something that makes sense to you, could you comment on that?*

Response: '*Yes. I think this lady was a lady who had incredible vulnerability and led an incredibly chaotic life. However, I do not feel that, from looking at it, that these were particularly caused by a mental illness. They are much more sort of due to developmental problems, due to the life that she was experiencing*'.

**12.56** Admission to hospital:

**12.57** Ms K was not admitted to hospital by the Crisis Resolution and Home Treatment team, despite the views of two trainee doctors that she should be, one of whom was a Section 12 approved junior trainee. The decision left Ms K without support from mental health services until the next morning. It is the view of the Independent Investigation Team that this led to her disengaging with mental health services whilst in the community.

**12.58** During the course of the Independent Investigation, LYPFT have provided an opinion upon whether Ms K should have been admitted to hospital at this time. They have stated;

*'The Draft Report indicates to a reader that Ms K should have been admitted because she wanted to be admitted and may have benefitted from an admission. A private patient might be admitted on that basis but, in respect of NHS care, whether for mental or physical problems, the treating teams must care for the patient in accordance with the most clinically appropriate care pathway. [...] Ms K's presentation on 29/07/11 did not warrant her admission to an inpatient unit.'*

**12.59** The Independent Investigation Team has struggled to understand how the Crisis Resolution and Home Treatment team, as a service, addressed Ms K's individual needs on 30 July 2011. What appears to have happened is that the Crisis Resolution and Home Treatment team responded to a previous diagnosis which they had not fully explored following the assessment conducted by Psychiatric Trainee 1.

**12.60** During the course of an interview conducted with members of the Independent Investigation Team, Crisis Team Assessor 1 provided the following recollection of the consultation with Ms K:

*'I do remember asking her why she felt she should be admitted, and she pulled off her shoes and said, 'Look I've got these trainers. Look at the state of them.' They were sort of rotten old trainers and that was the reason why she should be admitted to hospital.'*

*'Which was quite a poor reasoning, and it struck me that she was somebody who was obviously struggling and obviously quite impulsive and quite vulnerable. But unfortunately she did not strike me as being someone who was acutely mentally ill, at the time.'*

*'On top of that, again, having reviewed the notes, looking back on the notes, there is no evidence that admission had helped her in the past, and I think that was a big factor in the decision that Crisis Team Assessor 2 and I made, was that, admission in the past had led to going to PICU, which is psychiatric intensive care, and aggression and absconding and those sort of behaviours'*

*'Very little evidence that it had brought around any type of change in presentation, or any type of advantage for her'*

**12.61** The Independent Investigation Team disagrees with this conclusion. There were, in fact, considerable benefits to be gained by admitting Ms K (at very

least, on an overnight basis) in order to properly assess her in an environment which was more likely to allow a therapeutic relationship to develop, as opposed to doing so in the highly charged surroundings of a busy Accident and Emergency Department late at night.

**12.62** LYPFT have provided the following response to the view expressed by the Independent Investigation Team:

*'Deciding what care may be of 'benefit' to a patient is only one part of a determination regarding is (sic) clinically appropriate. The Crisis Resolution and Home Treatment team assessors' decision to not admit Ms K was based upon all of the information, including the information obtained by Psychiatric Trainee 1, and was not solely based upon her personality disorder diagnosis.*

*'The case notes demonstrate that the assessors thought Ms K had diagnoses of both personality disorder and psychosis, and indeed considered that she was experiencing some symptoms of psychosis at the time'.*

**12.63** There is a wide-spread reluctance on the part of mental health practitioners to admit individuals with a personality disorder to hospital. The evidence for treatment of emotionally unstable personality disorder, borderline type is that long admissions are unhelpful, and there should be a degree of therapeutic risk-taking by not admitting an individual with a personality disorder to hospital on a long-term basis. However, this can get translated into a blanket denial of admission and desensitisation to risk. This may inhibit consideration of circumstances when short-term admissions can, in fact, be helpful such as when there is a change of presentation suggestive of significant comorbidity.

**12.64** Gate keeping:

**12.65** As stated above, Crisis Resolution and Home Treatment teams were set up to help people avoid admission to mental health hospitals or, indeed, to return home more quickly following a situation which for them amounts to a mental health crisis. Crisis Resolution and Home Treatment teams are now the first point of access to secondary mental health services for the majority of adults.

**12.66** A key part of the role of Crisis Resolution and Home Treatment teams is to 'gatekeep' access to in-patient care. 'Gatekeeping' is where patients are assessed to consider whether home treatment is a safe and clinically beneficial alternative to in-patient care. Consequently, an individual cannot be admitted for in-patient care unless the Crisis Resolution and Home Treatment team agreed that there is no other alternative.

**12.67** An assessment of Ms K was undertaken by Crisis Team Assessor 1 and Crisis Team Assessor 2 at around midnight on 30 July 2011. The assessment could not be completed because Ms K abruptly terminated the assessment by leaving the hospital. At this point it should be noted that Ms K had been in hospital for over 8 hours.

**12.68** There is evidence which suggests that, nationally, Crisis Resolution and Home Treatment teams are successful in their role as gatekeeper if viewed from the

perspective of reducing bed usage<sup>8</sup>. However, a reduction in bed usage should not be the only mark of success for a Crisis Resolution and Home Treatment team.

**12.69** A Crisis Resolution and Home Treatment team does not have the longitudinal responsibility for individuals who they have seen. Their frame of reference is specific with stringent access criteria and thresholds, which could impact adversely upon an individual whose presentation is complex and may require the input of a number of multi-disciplinary team members<sup>9</sup>.

**12.70** This can lead to a Crisis Resolution and Home Treatment team acting in isolation from other services, particularly community services. The Government's '*No health without mental health strategy for England*' advocates comprehensive use of Crisis Resolution and Home Treatment team services to improve the acute care pathway. It is open to commissioners and trusts to organise services as they choose, including the relationship between Crisis Resolution and Home Treatment teams and other community services<sup>10</sup>.

**12.71** Improvements in service:

**12.72** The Trust has now introduced a single point of access to make it easier for referrals to be made, allow the number of repeat assessments to be reduced, and information to be shared more easily.

**12.73** The Independent Investigation Team considered whether the proposals for parity of access to a four-hour waiting time standard for emergency mental health assessments would have addressed these deficiencies. The conclusion was that without a collaborative approach to care, the standard, in itself, would not have addressed these deficiencies. However, timely access to a multi-disciplinary assessment process would have done so.

**12.74** Ms K's consultation with the Crisis Resolution and Home Treatment team was the last point at which mental health services in the community had an opportunity to assess and deliver care to Ms K prior to the death of Mr Edeson.

**12.75** The Independent Investigation Team did not see any evidence that Ms K was seen as an individual by the Crisis Resolution and Home Treatment team. The Crisis Resolution and Home Treatment team made no attempt at the time to contact In-Patient Consultant 2, or Psychiatric Trainee 1, to discuss Ms K's presentation.

**12.76** However, as stated, they would have had access to Psychiatric Trainee 1's hand-written notes. Despite the level of detail and breadth of the assessment carried out by Psychiatric Trainee 1, a decision was taken to conduct a second face-to-face assessment of Ms K late at night with a reduced data set than was

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<sup>8</sup> Gyles Glover, Gerda Arts, Kannan Suresh Babu, *Crisis resolution/home treatment teams and psychiatric admission rates in England* (2006) *British Journal of Psychiatry*, 189, 441-445, p.445

<sup>9</sup> Lyons C., Hopley P., Burton C. R., Horrocks J. Mental health crisis and respite services: service user and carer aspirations. *Journal of Psychiatric and Mental Health Nursing* 2009;16(5):424-33

<sup>10</sup> Allen D. CRHT teams do exactly what it says on the tin... Crisis resolution home treatment. *Mental Health Practice* 2008;11(6)

available to Psychiatric Trainee 1 with a patient who had, by that stage, become uncooperative.

**12.77** Drug induced psychosis:

**12.78** There is a second issue, particularly in relation to the Crisis Resolution and Home Treatment Team assessment, about the treatment of drug-induced psychosis (as opposed to simple intoxication). NICE guidelines on coexisting severe mental illness (psychosis) and substance misuse recommend that assessment and treatment should focus on the psychosis and the substance misuse and neither element should be used as a justification for exclusion from services. Comprehensive assessment is recommended in an appropriate setting. Particular attention is drawn to be aware that low levels of substance use that would not usually be considered harmful or problematic in people without psychosis, can have a significant impact on the mental health of people with psychosis. It is a very different model of care from the appropriate intervention for intoxication (supportive to prevent immediate harm until the effects of the substance subside) and harmful or dependent use (demonstration by the patient of a motivation to engage and make change<sup>11</sup>).

**12.79** Had Ms K been given a bed overnight, in the morning, any intoxication effects would have worn off. The issue could have been revisited the following day. There would also be a consultant review the following day, so somebody with next level of seniority could have reviewed and if appropriate have discharged her if there was no psychosis the following morning

**12.80** A number of assumptions appear to have been made about Ms K, based on her previous diagnosis of personality disorder, a diagnosis which, as has been mentioned, often excludes individuals from care. In addition, features of Ms K's lifestyle and other labels which could have been attached to her, such as '*drug user*', or '*sex worker*', may have clouded clinical judgement, and denied her access to care which could have supported her on a path leading to recovery. It appeared to the Independent Investigation Team that Ms K, as an individual, became less significant in comparison to the label of '*personality disorder*' which had been applied to her. In doing this, clinical focus was diverted from Ms K towards her label.

**12.81** Review of the Crisis Resolution and Home Treatment team decision to discharge Ms K on 30 July 2011:

**12.82** The Independent Investigation Team is of the view that the Crisis Resolution and Home Treatment team accepted the earlier diagnosis of borderline personality disorder without further analysis of Ms K's presentation, or investigation into other potential diagnoses which had been considered given Ms K's age and presentation. As a result, the judgements which were reached did not appear to members of the Independent Investigation Team to be based upon all of the information which was available about Ms K at that time.

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<sup>11</sup> Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings: NICE 2011.

- 12.83** As stated above, the Independent Investigation Team believes that this is illustrated by the use of the clustering tool by the Crisis Resolution and Home Treatment team. Ms K was clustered into the non-psychotic superclass. In addition, her mental health problems were considered to be in the category of '*common mental health problems, low severity*'. This may represent an attempt to '*fit*' Ms K into the category of borderline personality disorder or drug-induced Psychosis rather than being recognition of her presenting features or the presentation noted by Psychiatric Trainee 1.
- 12.84** The Crisis Resolution and Home Treatment team recognised Ms K as being vulnerable and, indeed, sought to address this by providing her with a taxi fare. However, without support being available to Ms K from mental health services until the next morning, the Independent Investigation Team has struggled to understand how the Crisis Resolution and Home Treatment team reverted to a plan that had previously been considered and rejected by other clinicians who had the benefit of a more detailed assessment. In contrast the Independent Investigation Team views as good practice Psychiatric Trainee 1 amending their opinion based on the information that came to light and the subsequent discussion with a senior trainee meaning they did not get rigidly attached to a particular plan when the information changed.
- 12.85** The result was that Ms K was excluded from services at a point when she had presented seeking help and following which she disengaged from mental health services in the community.
- 12.86** As will be discussed in the following chapters, care planning in relation to Ms K was weak. There was no crisis plan for her. This problem was worsened by the fact that Ms K presented out of hours to a service which did not exhibit a commitment to providing Ms K with an appropriate juncture in her longitudinal care.
- 12.87** The Independent Investigation Team is aware that this is a problem faced by a number of Crisis Resolution and Home Treatment teams throughout the country and believe that the way to tackle this barrier is by improved communication. If Community Mental Health Teams and Crisis Resolution and Home Treatment teams adopted an element of joint work (for example, by a Crisis Resolution and Home Treatment team representative attending Community Mental Health Team multi-disciplinary meetings) it is likely that they would have a better understanding of the needs of the individuals who might seek care from them. This would have a significant impact upon the quality of care which could be delivered.
- 12.88** It was stated during interviews that there was no evidence that any benefit had been achieved for Ms K in the past by admitting her to hospital. The Independent Investigation Team disagrees with this conclusion. There was incomplete assessment and insufficient weight placed on the information gathered in earlier assessments compared to the historic information. There were, in fact, considerable benefits to be gained by admitting Ms K, at least on an overnight basis in order to properly assess her in an environment which was more likely to allow a therapeutic relationship to develop, as opposed to doing

so in the highly charged surroundings of a busy Accident and Emergency department late at night.

**12.89** NICE guidelines suggest that short crisis admissions may be beneficial for individuals with borderline personality disorder in certain well-defined circumstances.

**12.90** It is important to ensure that admissions are properly managed, to ensure that short admissions do not become long-term admissions. The risk that patients with a personality disorder may engage in self-harm whilst on a ward must be addressed at the outset, including plans put in place to determine at what point the continuation of an admission is more harmful than discharge. This can create anxiety for clinicians. However, a degree of therapeutic risk taking is appropriate as part of a properly formulated multi-disciplinary care plan.

Feature	Comment	Learning
<p>Consultation took place in Accident and Emergency at around midnight. Ms K had been in the hospital for over 8 hours at this point</p>	<p>Delays in receiving assessment and care are often the result of a number of unavoidable factors</p>	<p>Recognition of the feelings that delays in assessment and the conditions in which an assessment is made upon the presentation of a person in crisis should not be underestimated by those responsible for their care</p>
<p>Assessment undertaken by Crisis Resolution and Home Treatment Team was the third that had been conducted that day</p>	<p>In this case, the initial assessment conducted by Psychiatric Registrar 1 was thorough and could have been used by the Crisis Resolution and Home Treatment Team rather than conduct a further assessment which was less comprehensive and failed to illicit any additional information which was clinically significant</p>	<p>Multiple assessments are particularly disadvantageous to an individual in crisis who has to keep demonstrating a need for help. They can also waste time</p>
<p>Assessment was incomplete as Ms K would not divulge information nor engage with the assessment</p>	<p>The interpretation of Ms K's actions in refusing to engage or cooperate was that it confirmed that she did not need admission. Ms K's lack of cooperation could have been due to a number of other factors related to the assessment process, duplication of assessments, time of day, etc.</p>	<p>Individuals in crisis should be treated in a warm, caring, respectful way irrespective of the circumstances in which they come into contact with services. A failure to recognise this does not produce a productive clinical relationship nor engender the conditions that help people take steps to recover</p>
<p>A detailed assessment by Psychiatric Registrar 1 was comprehensive and elicited information not previously disclosed by Ms K. Both Psychiatric Registrar and a Registrar with whom he discussed the case believed that admission was necessary</p>	<p>Two doctors felt it was appropriate to admit Ms K. Their views were disregarded by Crisis Resolution and Home Treatment Team on the basis of their own incomplete assessment</p>	<p>Multi-disciplinary decision making was not applied. The value of multidisciplinary team working in problem solving and addressing issues to improve service delivery was lost</p>

### Key points – Crisis Resolution and Home Treatment team

Ms K was assessed by Psychiatric Trainee 1 on 29 July 2011 in Accident and Emergency. She was seen by a junior doctor who she had met before and, in the opinion of the Independent Investigation Team, trusted sufficiently to disclose information that she found hard to discuss.

During this process, new and clinically relevant information came to light about Ms K. This information included: a description of seeing shadows in the corner of her vision for a week (persistent visual hallucinations); stating that whenever she heard sounds they were turning into voices, that when she hears a bang she hears an Asian man and a woman, they tell her to be violent to her social workers (functional hallucinations); and stating she was hearing 'voices every day "all the time"".

During the course of the assessment with Trainee Psychiatrist 1, clinical information which was suggestive of an emerging psychotic illness (as opposed to 'personality disorder') was obtained. It was acknowledged that her presentation required a proper assessment. Ms K herself was seeking admission to hospital. The option of referral to a day centre (Acute Community Service) the next day was given to Ms K by the trainee doctors. She refused this.

As a result of her presentation, the trainee doctors considered admission to hospital to be necessary.

Accordingly, her care was passed to the Crisis Resolution and Home Treatment team. Psychiatric Trainee 1, in conjunction with his supervisor (who will have been a more senior Section 12 approved specialist trainee), formulated a plan, but were prevented from implementing it by a process that required 'approval' by a different clinician, who is not part of the same profession, or supervision structure.

Despite a thorough assessment having already been undertaken, members of the Crisis Resolution and Home Treatment team sought to conduct a further assessment of Ms K. Their conclusion was that Ms K would not benefit from admission.

This significant change in plan was not found to have been the result of considered and balanced clinical decision-making. The psychiatrists, although providing psychiatric emergency cover out of hours, were not embedded with the crisis service as part of a true multi-disciplinary team.

This had the following consequences:

- The decision to admit made by the psychiatrists could not be enacted without being reviewed, whereas, paradoxically, a decision to 'not admit' would not have been subject to the same review – a 'fail-unsafe' mechanism.
- The need to review the decision was interpreted by other clinicians as a need to conduct another assessment.

- The need to conduct another assessment introduced unacceptable delay, and the opportunity to engage the patient was lost.
- The clinical assessment made by the psychiatrists was not accorded the weight it deserved when set against the very limited second assessment.

Instead, Ms K was offered the option of care by the Acute Community Service, an option which she had already rejected, and one which would have relied upon Ms K's engagement, which was known to be poor.

Ms K left the hospital and failed to re-engage with NHS community services.

The Independent Investigation Team is of the view that the Crisis Resolution and Home Treatment team accepted the earlier diagnosis of borderline personality disorder without further analysis of Ms K's presentation, or investigation into other potential diagnoses which had been considered given Ms K's age and presentation. As a result, the judgements which were reached did not appear to members of the Independent Investigation Team to be based upon all of the information which was available about Ms K at that time.

The Crisis Resolution and Home Treatment team accepted the earlier diagnosis of borderline personality disorder and drug induced psychosis without further analysis of Ms K's presentation.

#### Observation to encourage reflective practice – Seven:

This is a significant juncture in Ms K's care and represents a significant missed opportunity to direct her care.

Different parts of the same emergency provision did not work together to cross the professional and team boundaries between them to discuss the case, and their respective views upon the direction of Ms K's care.

The purpose of multi-disciplinary working is to enhance clinical quality, by integrating a range of professional perspectives. In this case, a different clinician reaches an independent (and flawed) decision about the weight to place on the earlier assessment, relative to his own interview, and takes no account of the impact of the time spent waiting, the previous disclosure of distressing information, and her presentation as a distressed and vulnerable young adult, on the degree of co-operation, thereby drawing the incorrect conclusions.

In Ms K's case, there was a sharing of information, but there was no integration of information. As a result, new clinically significant information was not factored in to her care, as the label of 'personality disorder' was instead allowed to direct a response towards care.

Ms K's assessments took place as entirely separate exercises. They should have been conducted as part of the same process, despite the organisational structure which was in place.

The NHS is structured to allow individuals with complex health issues to be managed across multiple services throughout entire episodes of care. The involvement of multiple teams in the provision of mental health care has increased greatly in recent years with the development of functional teams (e.g. Crisis Resolution and Home Treatment teams, acute in-patient care teams, and different types of community mental health teams, such as Early Intervention in Psychosis) that focus on a particular part of the patient's care and treatment. Whilst this has led to advantages (for example it allows a greater number of patients to receive the appropriate level of specialised care to meet their needs) there is a danger that it can lead to a loss of a long-term perspective in care delivery, with each team concentrating on the particular function of its part of the service, and not considering the overall course of care over time of the patient's illness.

Patients look at care differently than care providers. Patients see in terms of '*my care*' rather than as a series of separate encounters. Care is organised around one or more health concerns that leads to intervention. The point of treatment is to address specific problems which the patient feels that they are having. Care may extend across multiple sites with multiple providers, but for every patient it has a start, middle, and end, and is directed towards their perception of their problems.

The difference between the focus of patients on the solution of their problems, and that of the teams which are structured from an organisational perspective, creates a significant challenge for services such as Crisis Resolution and Home Treatment teams. A key part of the role of Crisis Resolution and Home Treatment teams is to '*gatekeep*' access to in-patient care, as an individual cannot be admitted for in-patient care unless the Crisis Resolution and Home Treatment team has agreed that there is no other alternative.

There is evidence which suggests that Crisis Resolution and Home Treatment teams are successful in their role as gatekeepers if viewed from the perspective of reducing bed usage. However, there is a potential problem attached to this.

If Crisis Resolution and Home Treatment teams regard their primary role as being a '*gatekeeper*' to in-patient services, then this can become the focus of attention for team members, rather than the needs of the individuals who approach a Crisis Resolution and Home Treatment team seeking care as part of what may indeed be a long-term illness. The risk is that the function of the service promotes a culture which sets thresholds for admission at too high a level, with team members becoming reluctant to admit patients.

Crisis Resolution and Home Treatment teams do not have the longitudinal responsibility for individuals who they have seen. This can lead to a Crisis Resolution and Home Treatment team acting in isolation from other services, particularly community services. They are not required to consider what the patient's overall needs or long-term needs are. In relation to the care of Ms K, different parts of the same emergency provision did not work together to cross the professional and team boundaries to discuss her case and their respective views upon the direction of care.

Their frame of reference is relatively narrow, which could impact adversely upon an individual whose presentation is complex, with a long-term element. This problem was worsened by the fact that Ms K presented out of hours to a service which did not exhibit a commitment to providing Ms K with an appropriate juncture in her longitudinal care.

**Recommendation four – Multi-disciplinary Discussion regarding disagreements to admit:**

Crisis Resolution and Home Treatment teams have had a positive impact upon the numbers of individuals admitted to hospital. However, a key challenge faced by the Crisis Resolution and Home Treatment model of care is the potential for it to achieve close integration with other services involved with the patient in order to deliver continuity of care from a multidisciplinary perspective and not in isolation from other services or agencies in which the patient might be involved. In order to ensure that, in such cases where there is a difference of opinion in relation to the decision to admit, a mechanism is developed and implemented by the Trusts involved in Ms K's care to ensure a multi-disciplinary team discussion takes place to review the individual patient's options for care. It is recommended that the mechanism includes the following criteria:

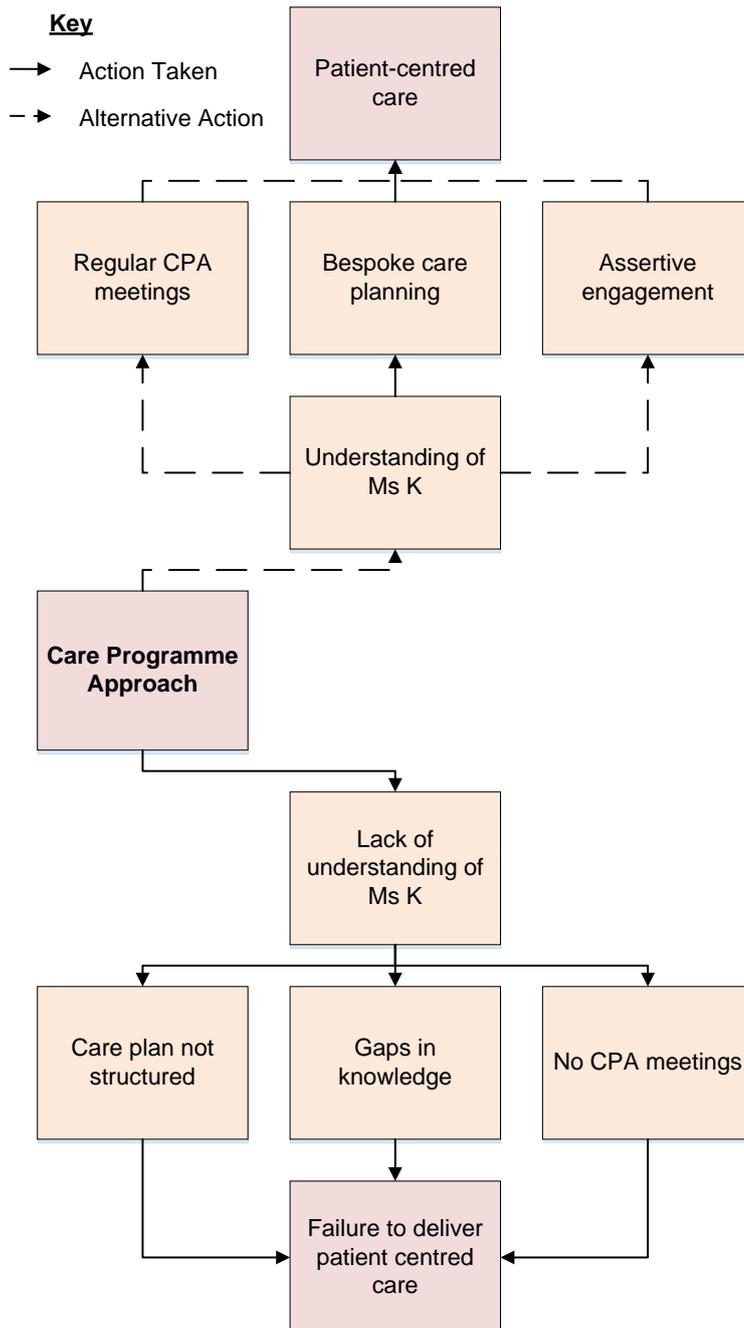
1. If no admission is to occur, and home-based treatment is indicated, then all clinicians need to have collaboratively reached this conclusion.

However,

2. If one assessing clinician diagnoses a mental disorder and feels admission is needed, then admission should occur, in order to assess more fully the risk.

### 13 JUNCTURE SEVEN: FAILURE TO ADHERE TO THE ETHOS OF THE CARE PROGRAMME APPROACH

This is a juncture because adherence to the ethos of the Care Programme Approach would have provided care across service and geographical boundaries and would have identified information to assist the diagnostic process.



- 13.1** The Ritchie report into the care of Christopher Clunis underlined the need for clarity about who has overall responsibility for co-ordination and review of the progress of care<sup>12</sup>. The message of the Ritchie report was about the needs of the individual being assessed to be understood and then used to construct a template for services to work to in a co-ordinated fashion with someone working with the service-user to oversee the template and the delivery of interventions.
- 13.2** The Care Programme Approach is a vehicle which was adopted to address some of the concerns in the Ritchie report. The Care Programme Approach was intended to provide a way of supporting individuals with severe mental illness to ensure that their assessment needs and care plans remain central in what can be complex systems of care. Put simply, the Care Programme Approach is a term for describing the process of how mental health services assess users' needs (including assessment of risk), plan ways to meet those needs, and determine whether the identified needs are being met.
- 13.3** The Care Programme Approach is intended as both a management tool and a system for engaging with people. Its primary function is to minimise the possibility of service-users losing contact with services and maximise the effect of any therapeutic intervention. However, a concern with the Care Programme Approach is that it can be used as a means of service evaluation, and performance management, with a focus on the administration of the process, rather than the appropriateness and quality of the interventions.
- 13.4** In the space of three weeks during her first admission to hospital, Ms K's diagnosis had changed from that of emerging bipolar disorder to possibly an emotionally unstable personality disorder borderline type. In addition, a decision to discharge her into the community with an outpatient care plan and an allocated care co-ordinator had been made. In practical terms, this is a significant amount of work to have completed in a comparatively short-term whilst maintaining a focus on the quality of this process.
- 13.5** Given the pressure on services, this is not an uncommon situation. However, given Ms K's complex presentation, the speed at which these '*milestones*' may have been achieved may have been at the cost of a number of steps which would have been present had more opportunity and time for reflective practice been involved. In addition, in reaching a diagnosis of personality disorder, clinicians had arrived at a diagnosis which, unless questioned and reviewed carefully, potentially excluded Ms K from in-patient care

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<sup>12</sup> Jean Ritchie, Donald Dick, Richard Lingham, *The Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994).

- 13.6** LYPFT have responded to the Independent Investigation Team with the following submission:

*'The average length of stay for the vast majority of patients (approximately 80% of the patients are detained under the Mental Health Act sections) on the acute wards is about 2-3 weeks. Ms K was admitted to hospital for 6 weeks hence it is factually incorrect to suggest that the diagnosis, treatment and aftercare were planned within a short space of time.'*

*'Mental health services (wards and community teams) work collaboratively to make assessments and all teams are therefore clear of the need to keep a diagnosis under constant review, whilst ensuring a service user focus''.*

- 13.7** This is not accepted by the Independent Investigation Team, which would refer to the following statement made by Ms K's care co-ordinator during an interview with members of the team:

*'I wouldn't have been involved at that point in any kind of diagnostic formulation because I only saw her extremely briefly. It was more down to the ward staff to look at her behaviour, look at her illness. I wouldn't be involved in that. I mean I could see that she was emotionally unstable, visually you could see, but it was hard to tell whether it was because of the ongoing drug use, because she was frequently going AWOL and taking drugs at the time. It could have been either. It was hard to establish at that time which was the prevalent disorder'.*

- 13.8** Prior to Ms K's discharge from hospital, a Care Programme Approach meeting was held to discuss her care, and, it seems, to prepare for her discharge from hospital. This meeting was attended by Ms K's care co-ordinator, In-Patient Consultant 2, Psychiatric Trainee 1 and Ms K's mother.

- 13.9** Ms K's social worker was not present at this meeting. She had been very involved with Ms K and had attempted to obtain help and indeed had advocated for her in the past. She was also able to cross boundaries between organisations involved with Ms K and therefore was a very valuable source of information. She was not at the meeting because Ms K had declined to consent to her attendance. However, notwithstanding Ms K's lack of consent, it would have been open for Ms K's clinical team to contact her to seek information. In these circumstances, whilst information could be obtained about Ms K, the clinical team would not have been able to provide any information about Ms K.

- 13.10** There were no other professionals from 'outside agencies' present to provide collateral information about Ms K. This could have afforded clinicians an opportunity to become more acquainted with her complicated social circumstances or consider any risks which she posed to herself or, indeed, others.

- 13.11** LYPFT responded in the following terms:

*'LYPFT staff involved in Ms K's care were of the opinion that Ms K had the capacity to make decisions relating to her own behaviour but unfortunately she made some very unwise decisions which significantly impacted on her ability to keep herself and others safe. There was significant concern within her clinical team (both community and inpatient) regarding the potential risks to Ms K in*

*particular. The issue was not about 'control' of her behaviour but whether she could make specific decisions based on capacity. It is inaccurate for the Panel to state that Ms K was denied access to safeguarding due to a lack of 'control' of her behaviour but rather that she would not engage with LYPFT staff in order to make safeguarding meaningful. This decision was made with the support of safeguarding services so was not solely the decision of the clinical team at the time'.*

**13.12** However, the Independent Investigation Team would highlight the following passage from the Internal Investigation performed by LYPFT:

*'Whilst Ms K had the right to make informed decisions, including the taking of risks and have maximum control over her own life wherever possible, there have been concerns expressed by professionals during the investigation regarding concerns whether Ms K did have the capacity to make informed decisions. Dr H, RC held a reasonable view that Ms K had capacity to make decisions about her lifestyle, even though such decisions increased her own vulnerability. She appeared aware of her risky lifestyle but had also grown accustomed to the social contact and stimulation of alcohol and other substances. Unfortunately such views were not systematically recorded in the relevant documentation including any formal assessment of capacity. There appeared to be a lack of evidence to suggest that safe guarding issues had been a high priority for the clinical team'.*

**13.13** A further aspect of this approach which is of significant concern to the Independent Investigation Team is, despite a member of the Community Mental Health Team considering that there might have been merit in Aspire reviewing Ms K whilst she was on the ward, it was taken without question that Aspire would not assess Ms K because they had previously felt that she failed to meet their service criteria, and a further referral to Aspire was not pursued. The Independent Investigation Team is of the view that this was a significant missed opportunity, and advocacy by the in-patient team or Community Mental Health Team challenging Aspire would have been warranted (see Chapter 7 for further discussion).

**13.14** LYPFT's Management Report Summary Sheet (SUI REF NUMBER:2011/21879) explored this issue. It states in relation to this meeting:

*'The discharge CPA meeting held on the 08/02/2011 was only attended by medical and nursing staff. There is some confusion as to whether invitations to attend were actually forwarded to key professional colleagues. It has also been suggested that Ms K did not want her community workers represented at the meeting. Whatever the case it is clear from the evidence of several e-mail communications that colleagues from the Pathway Planning Team in particular were perplexed and concerned that Ms K had been discharged on the day of the CPA meeting and had serious concerns regards her level of risk including safe guarding issues'.*

**13.15** It is the view of the Independent Investigation Team that the failure to pursue the individuals involved in Ms K's care from other agencies was most likely caused by the resource demand of organising such a meeting coupled with time constraints. However, without their presence, the Care Programme Approach

was not being applied as a mechanism for delivering patient-centred care as, in some respects, the Care Programme Approach Review meeting had become a procedural step rather than a vehicle for the multi-disciplinary care of a complex individual during an important transition. Indeed, a number of the community care services involved in Ms K's care were very concerned about her rapid discharge to the community and their failure to be involved in this process.

- 13.16** In addition, the Independent Investigation Team is concerned about the lack of curiosity about what the community follow-up would be for Ms K. Ms K was known to be vulnerable and, indeed, was known to be difficult to manage on the ward. She was also known to be difficult to engage. However, the issue of the risk which she posed to herself and others was not approached systematically to address these concerns. Furthermore, no were plans made to address these issues.
- 13.17** The Independent Investigation Team believes that this is best illustrated by a failure to conduct a multi-agency meeting to talk about issues facing Ms K including safeguarding until after she had left the hospital.
- 13.18** One of the key objectives of safeguarding is set out in a policy which was adopted by LYPFT in June 2009. It is described in the following terms:
- 'Safeguarding encompasses a pro-active approach to identifying vulnerability and providing those people with the skills to protect themselves from harm. When this has not been possible, it is necessary for agencies to respond to concerns that someone may have been abused'*.
- 13.19** A safeguarding meeting involves a discussion between a number of individuals involved with, or concerned about, the vulnerable individual. That discussion could again have resulted in information which could have led to additional information about Ms K which was useful from a diagnostic perspective.
- 13.20** A safeguarding meeting was not arranged until after Ms K had left hospital. The conclusion of this meeting was that it was felt that without Ms K's engagement there was little that could be done to protect her.
- 13.21** Ms K is a complex individual. She could have been viewed as having been sexually exploited and was involved in the sex working throughout her care as an adult. Indeed, it is that involvement which may have given rise to some of the practical issues surrounding her care, such as her movement between cities, for example.
- 13.22** These events took place prior to the publication of the Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013). These events have led to greater awareness of exploitation and its impact upon the lives of those young people who were involved. Part of the learning from the various inquiries is the lack of support which the young victims of a crime had from mental health services.
- 13.23** It is interesting to note, therefore, that Ms K (whose medical records contain references to abuse which she had suffered, and potentially on-going sexual exploitation) appears to the Independent Investigation Team to have been

deemed to be in sufficient control of her behaviour to be denied access to safeguarding support until she 'chose' to engage with services, without any recognition of the impact that the abuse or exploitation had upon her ability to engage.

**13.24** LYPFT provided the following response to the preceding paragraph:

*'There was a Multi-Disciplinary Meeting with the Safeguarding Lead Co-ordinator on 7 March 2011. Ms K's mum was invited to the meeting but did not attend. It was noted that Ms K did not want to engage with staff. Safeguarding were satisfied that the team was doing all that could be done and safeguarding support would have been available to Ms K if she had wanted that support, but her presentation and understanding was such that she did not require this support to be forced upon her.'*

**13.25** With regard to this, the Independent Investigation Team would note that the issue of Ms K's capacity was not the subject of a formal recorded process.

**13.26** As a result of Ms K's complexity, which had led to her involvement with a number of social and NHS services, she could be expected to be (and indeed was) placed on an enhanced level of Care Programme Approach care when she left hospital. Standard models of engagement and working for people with substance misuse, personality disorder, and those experiencing psychotic symptoms, are in conflict. In addition, no single model of engagement would have been able to address all of Ms K's needs because of her complexity.

**13.27** Consequently, in order to deliver Care Programme Approach effectively at a level which would address Ms K's needs and allow for a comprehensive understanding of the risks which she posed, a bespoke approach to the delivery of her care, which recognised her needs arising from her youth and early trauma, was needed. This would have had to have involved assertive engagement which was not necessarily available from each of these services. However, the assertive outreach approach should not be restricted only to so-called specialist Early Intervention in Psychosis & Assertive Outreach teams. To an extent, this should be available within a community mental health team.

**13.28** The alternative model to assertive engagement in the context of the Care Programme Approach is an approach in which there is expected to be capacitous decision by the patient to participate and engage (or not) in a treatment plan.

**13.29** This appears to have been the approach adopted in relation to Ms K, with significant emphasis being placed upon it being Ms K's choice not to engage with services to direct availability and planning of her care. However, the requirement that she 'opt in' effectively deprived Ms K of the benefits of enhanced Care Programme Approach which would more closely have addressed her needs.

**13.30** It appears to the Independent Investigation Team that consideration could have been given to whether the manner in which services were attempting to engage Ms K was, in fact, the best method to secure that engagement. It did not appear to the Independent Investigation Team that there was any flexibility applied in

terms of switching approach when the chosen approach did not work, and Ms K's engagement could not be secured.

**13.31** The Care Programme Approach which was adopted in relation to Ms K across a number of services had the following features:

- Regarded distance as an issue and did not accommodate cross-boundary working – as a result clinically relevant information did not come to light.
- Relied upon the service-user to attend and engage rather than recognising the difficulties which the service-user had in engaging.
- Lack of Care Programme Approach reviews.
- No crisis planning.
- No reviews of risk, or needs assessments, or comprehensive assessment of need appropriately reviewed.
- Lack of involvement of carers and other interested parties such as social services, who were working assertively with Ms K.

**13.32** Consequently, the Care Programme Approach which was adopted by a number of services became something of a bureaucratic exercise, which did not uphold the ethos of the Care Programme Approach (i.e. placing the patient's needs at the centre of the care which is delivered and reviewing this care to evaluate its effectiveness).

**13.33** A bespoke approach which involves assertive engagement has significant resource implications for services. However, this could have been flagged as an issue as part of a Care Programme Approach Review, and the issue could have been fully explored with appropriate plans being put in place.

**13.34** There were a number of opportunities for a Care Programme Approach Review to take place, which could have brought professionals from a number of services together to talk about Ms K, and construct strategies which could work within each service, and which would deliver a more effective approach towards Ms K. This would include:

- When Ms K's care was transferred from Leeds Community Mental Health Team to BCMHT 1 on 9 August 2011.
- When Ms K set fire to a Drug Drop-In Clinic on 2 August 2011 and was remanded in custody.
- When Ms K attended Accident and Emergency in Leeds on 30 July 2011.
- When Ms K was discharged from Psychiatric care in Bradford on 4 October 2011.

**13.35** These opportunities were not exploited.

**13.36** During the course of the Independent Investigation, it was said by LYPFT in relation to the concerns raised relating to the transfer of Ms K's care following her remand in custody to HMP New Hall following the incident at the Drop-in centre:

*'Ms K's care was transferred from LYPFT to the Bradford District Care Trust on 15 August 2011, whilst she was under the care of Nottinghamshire Healthcare NHS Foundation Trust at HMP Newhall. LYPFT was advised that Ms K was*

*living in Bradford, where she was registered with a GP. In those circumstances it was entirely appropriate for LYPFT to assume that Nottinghamshire Healthcare NHS Foundation Trust would liaise with the Bradford District Care Trust regarding Ms K's care in prison and the handover of her care back to the community team'.*

**13.37** BCDDT have responded to this issue as follows:

*'LYPFT knew that Ms K was on remand. Therefore the possibility existed that she may not remain at Newhall Prison for any substantial length of time. .... It is unclear who advised LYPFT that Ms K was living in Bradford. Whilst the Trust accept that she was registered with a GP, LYPFT and Care Coordinator 1 had knowledge that Ms K 'bounced' between Leeds and Bradford and therefore it was not entirely appropriate for LYPFT to assume that she would remain living in Bradford and therefore that it was appropriate for care to be transferred to Bradford Services or (b) that she would remain living in Bradford and therefore that it was appropriate for care to be transferred to Bradford Services or (b) on the basis of what would appear to be a telephone conversation or other very limited information that Nottinghamshire Healthcare would liaise regarding any transfer of care to the Trust. In any event, ... no such communication took place. ... it seems evident that in the course of communication between LYPFT and Newhall Prison, no such clear arrangements or understanding was made'.*

**13.38** The above paragraphs clearly set out the divergent views of the Bradford and Leeds Trusts. In addition, BCDDT have also stated:

*'the precise circumstances regarding the transfer from LYPFT to the Trust is that this was affected under cover of a letter dated 11 August 2011 and received at the Trust on 18 August 2011.*

**13.39** It appears to the Independent Investigation Team that whichever version is accepted as being accurate, neither version accords with the ethos of the Care Programme Approach which is understood by the Independent Investigation Team and which is embodied in LYPFT's Policy entitled '*City-wide Care Programme Approach Policy (Including arrangements for Care Plan)*'. This policy became effective on 4 July 2011 and which was therefore in place on 9 August 2011 when Care Coordinator 1 stated that Ms K 'will be under the C/O Bradford services'.

**13.40** In '*City-wide Care Programme Approach Policy (Including arrangements for Care Plan)*' LYPFT sets out its approach to the Care Programme Approach to be delivered throughout the Trust. The Introduction to the Policy states:

*'Refocusing the Care Programme Approach Policy and Positive Practice Guidance' published by the Department of Health in March 2008 set the framework for the future development of care co-ordination and care management.*

*'The term Care Programme Approach describes the approach used to assess, plan, review and co-ordinate the range of treatment, care and support needs*

*for people in contact with secondary mental health services who have complex characteristics.*

*'Active service user involvement and engagement will continue to be at the heart of the approach, with a focus on promoting social inclusion and recovery in its broadest sense'.*

**13.41** The Policy is comprehensive and deals specifically with the situation where an individual's care is transferred to a service outside the Trust. Paragraph 5.20.3 states:

*'Any decision to transfer the care of a service-user to another area must be agreed at a CPA or Care Plan review meeting. Until transfer arrangements are agreed, the current care co-ordinator or lead professional retains responsibility.*

*'Prior to an out of area transfer, the care co-ordinator or lead professional must ensure the following has been agreed:*

- *'The receiving team/agency have taken responsibility/has taken responsibility for assessing the service user and, if appropriate appointing a care co-ordinator or lead professional.*
- *'The service user has been advised and where necessary supported in changing GP registration.*
- *'Agreed to set up service within the receiving team/service to meet the service users assessed needs.*
- *'All relevant information has been effectively communicated to the receiving team including any entitlement to Section 117 aftercare services (see Section 117 aftercare guidelines in appendix D).*
- *'All risk information has been shared with the receiving team/service*

*'All decisions, throughout the process, must be agreed and communicated in writing to the service-user, their carer (where appropriate) and all members of the care team'.*

**13.42** No Care Programme Approach meeting was convened in relation to the transfer of Ms K's care from LYPFT either to Bradford or indeed Nottingham.

**13.43** Transfer appears to have taken place without the involvement of or discussion with Ms K or indeed the Bradford or Nottingham Trusts. Whilst ultimately, the Bradford CMHT assumed responsibility for Ms K's care, they did so without being given an opportunity to assess Ms K or develop a plan which was formulated to address her needs. Equally, they were provided with very limited clinical information concerning this complex individual.

**13.44** Whilst this was a very responsive action which was aimed at achieving continuity of care in difficult circumstances, a properly convened Care Programme Approach meeting might actually have been more successful in achieving this result.

Key points – Failure to adhere to the ethos of the Care Programme Approach:

The Care Programme Approach was intended to provide a way of supporting individuals with severe mental illness to ensure that their assessment needs and care plans remain central in what can be complex systems of care. Put simply, the Care Programme Approach is a term for describing the process of how mental health services assess users' needs (including assessment of risk), plan ways to meet those needs, and review whether the identified needs are being met.

Its primary function is to minimise the possibility of service-users losing contact with services and maximise the effect of any therapeutic intervention.

The ethos of the Care Programme Approach was not adhered to in Ms K's care by the NHS Trusts involved in Ms K's care. The Care Programme Approach became something of a bureaucratic exercise, which did not place the patient's needs at the centre of the care which was delivered.

Ms K's care plan was not properly structured. It is not clear how it was envisaged care would be delivered or, indeed, its success measured. Whilst issues such as Ms K's vulnerability were highlighted, a plan to address that vulnerability was not constructed whilst she was an in-patient. There were no effective crisis plans, and scant attention was paid to the issue of compliance with prescribed medicines.

Ms K's care appears to have been planned by one group of health professionals, excluding a number of other professionals who were closely connected to Ms K's care, which does not adhere to the ethos of the Care Programme Approach.

Ms K's care was not planned or delivered with the close collaboration of Ms K's family, for example, or other professionals who had knowledge of Ms K. This meant that there was a lack of a coherent narrative or thread that considered a patient's pathway or journey through services and anticipates or considers the previous and subsequent elements of such a pathway.

Risk reviews and needs assessments were not devised with knowledge gained from those who knew Ms K outside NHS services.

During key transition points in Ms K's care, where transfer of care was taking place between services, and where the Care Programme Approach should have ensured that professionals gathered together to review Ms K's care and treatment, a Care Programme Approach review did not take place.

The benefit of such a meeting would include a sharing of information of new and potentially relevant clinical information relating to Ms K, including the threats which Ms K made '*to kill*' on 30 July 2011 in Accident and Emergency and later whilst she was on remand in HMP New Hall.

Observation to encourage reflective practice – Eight:

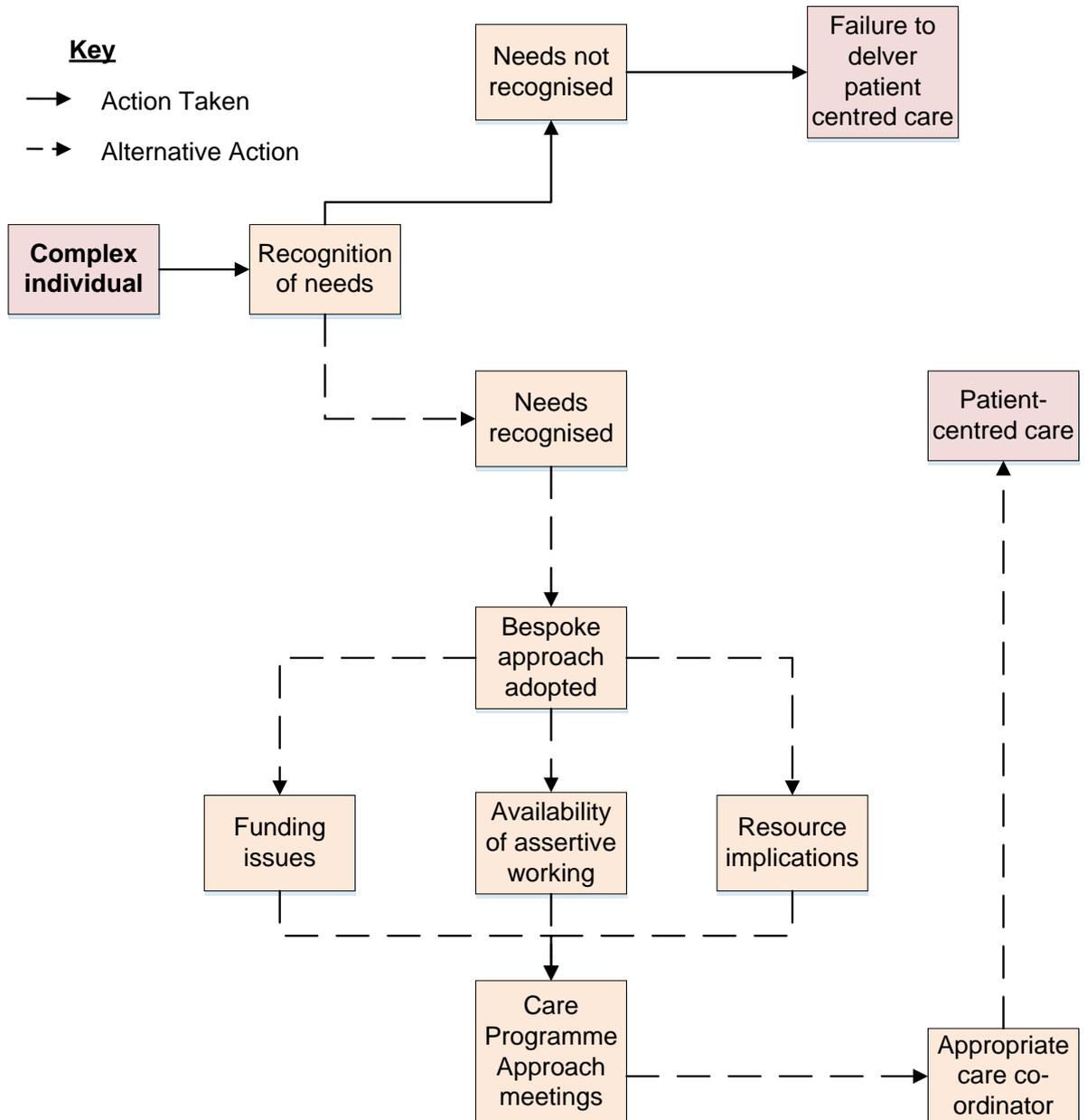
In order to deliver Care Programme Approach effectively at a level which would address Ms K's needs and allow for a comprehensive understanding of the risks which she posed, a bespoke approach to the delivery of her care was needed. This would have had to have involved assertive engagement.

A bespoke approach which involves assertive engagement has significant resource implications for services. However, this could have been flagged as an issue as part of a Care Programme Approach Review, and the issue could have been fully explored with appropriate plans being put in place.

There were a number of opportunities for a Care Programme Approach Review to take place, which could have brought professionals from a number of services together to talk about Ms K, and construct strategies, which could work within each service, but which would deliver a more effective approach towards Ms K. These opportunities were not exploited.

## 14 JUNCTURE EIGHT: CARE CO-ORDINATION

This is a juncture because a care co-ordinator could have used the Care Programme Approach to assertively engage with Ms K to deliver care which was tailored to suit the complexity of her needs.



**14.1** When Ms K was discharged from hospital, she was discharged into the care of a Community Mental Health Team. When she was discharged, she was to take oral olanzapine. She was allocated a care co-ordinator from that team who had already become familiar with her care whilst she was in hospital which is an element of good practice. However, even when she was visited in hospital by her care co-ordinator, Ms K did not want to engage with this individual.

- 14.2** In mental health, interpersonal elements play a significant part in whether engagement is successful or not. Reflective teams allow an opening for this when it may be relevant.
- 14.3** As has been mentioned, Ms K was a complex individual with complex needs. Her needs and presentation required an assertive approach in order to achieve engagement, which is different to the model of engagement employed by many Community Mental Health Teams, but which is in line with the approach applied by EIP teams such as Aspire. Assertive working can be provided by a Community Mental Health Team. However, to do so would require a degree of flexibility from a care co-ordinator, as it would impact upon the capacity of that care co-ordinator and other members of the team. Evidence provided to the Independent Investigation Team suggested that Ms K's care co-ordinator had a significant caseload at the time that she was responsible for Ms K.
- 14.4** Care Co-ordinator 1 was only able to see Ms K on three occasions with appointments being spread out. It is accepted by the Independent Investigation Team that Care Co-ordinator 1 had a significant caseload, and therefore would have found it challenging to provide the required level of intensity towards her attempts to engage with Ms K.
- 14.5** In order to operate an assertive model of care for an individual such as Ms K, funding and resources would have to be considered and allocated. These may have been available: Ms K was also a Section 117 Mental Health Act 1983 aftercare patient and still subject to aftercare following her discharge from hospital. Furthermore, it needed time, effort, communication, perseverance, and determination to effectively operate the assertive model.
- 14.6** During the course of the Independent Investigation, it became clear that the CMHT 1 was facing resourcing challenges. Care co-ordinator caseloads were large, and practitioners were under pressure. It appears to the Independent Investigation Team that Ms K was allocated an experienced care co-ordinator who, it was felt, would be in a good position to respond to Ms K's needs. Experience was seen as a crucial factor in dealing with Ms K's known degree of complexity. Ms K was also provided with a female care co-ordinator, which displays an element of responsiveness.
- 14.7** However, the Independent Investigation Team could not find any evidence that Ms K's care co-ordinator recognised the impact of Ms K's complexity upon her own resources and responded to this systemically. It would have been open for Care Co-ordinator 1 to have flagged the need for '*an assertive engagement strategy*' in order to meet Ms K's unmet need. This would have required Care Co-ordinator 1 to recognise that Ms K's needs were not only complex but of a nature that would be likely to respond to assertive engagement. Typically, this is recognised as being the presence of psychosis with co-morbid substance use and/or co-morbid personality disorder plus significant risk to self and/or others. The Independent Investigation Team holds the view that Ms K met these criteria. The Independent Investigation Team holds the view that this should have been apparent to an experienced Care Co-ordinator and implicit in this recognition would be the likely failure of a '*standard*' approach to engagement.

- 14.8** Ms K's care co-ordinator's supervision records indicate a focus on training needs and other clinical responsibilities, and Ms K was not flagged as being of any significant concern. The quality of the care co-ordinator's input was questionable, in that it did not reflect the complexity and vulnerability of Ms K, nor recognise the potential risks. Instead, an approach was adopted which covered some of the basic tasks of care co-ordination, but which left areas unaccounted for.
- 14.9** At best, Ms K required a bespoke approach to care co-ordination or, at least, delivery of a level of truly enhanced care co-ordination. A fundamental aspect of this would be consideration of whether the model of engagement used by the care co-ordinator was the most appropriate, with regular reviews if it was noted to not be working. This would demand a degree of flexibility on the part of the care co-ordinator, as to their approach to the patient.
- 14.10** The Independent Investigation Team could not find any evidence that Ms K's care co-ordinator approached her care in a reflective manner. For example, in order to meet the care needs of an individual with emotionally unstable personality disorder borderline type, it is necessary to set increased boundaries around interventions, to contain demands and encourage a more consistent pattern of engagement with services. This requires careful consideration and supervision as it offsets a probable short-term increase in risk against a longer-term pattern of more appropriate engagement and lower risk.
- 14.11** The Independent Investigation Team could not see any evidence that this reflection took place. Furthermore, the Investigation Team holds the view that, as a result, Care Co-ordinator 1 was not in a position to reflect upon Ms K's pattern of engagement and identify that it was not typical of emotionally unstable personality disorder borderline type, and to be open to the possibility of an emergent psychotic illness.
- 14.12** Indeed, it appears to the Independent Investigation Team that as soon as an opportunity arose to remove Ms K from her caseload, the opportunity was accepted, notwithstanding the impact which the lack of a planned transfer of care upon Ms K could have had. Furthermore, it appears as though Ms K's expressed wishes or intentions were not considered, nor were her family involved in the process.
- 14.13** The Independent Investigation Team has considered Care Co-ordinator 1's failure to convene CPA meetings more fully at Chapters 13 and 15.
- 14.14** Consequently, whilst Care Programme Approach requirements were adhered to, the ethos was not. The level of care which was given was inappropriate to the degree of complexity and risk as it focused upon standards concerning documentation rather than the recognition that those standards should be embedded into an appropriate care plan.

#### **KEY POINTS – CARE CO-ORDINATION**

When Ms K was discharged from hospital, she was discharged into the care of a Community Mental Health Team.

Ms K was a complex individual with complex needs. Her needs and presentation required an assertive approach in order to achieve engagement, which is different to the model of engagement employed by many Community Mental Health Teams, but which is in line with the approach applied by EIP teams such as Aspire.

Evidence provided to the Independent Investigation Team suggested that Ms K's care co-ordinator had a significant caseload at the time that she was responsible for Ms K. and was only able to see Ms K on three occasions with appointments being spread out.

Assertive working can be provided by a Community Mental Health Team. However, to do so requires a degree of flexibility towards care co-ordination, as it impacts upon the capacity of the care co-ordinator and other members of the team.

It also includes consideration of whether the model of engagement used was the most appropriate, with regular reviews if it was noted to not be working.

The Independent Investigation Team could not find any evidence that Ms K's care co-ordination was approached in a reflective manner.

#### **Recommendation five – Review of engagement strategies:**

Ms K was a complex individual who posed a challenge for services to engage with. In addition, Ms K may have attracted some unhelpful 'labels'. 'Labelling' in a clinical context always opens the possibility of the clinical significance of some of her behaviours, particularly in relation to engagement, being missed.

Strategies to secure her engagement were not always reviewed, and, as a result, the ethos of the Care Programme Approach was not always adhered to in relation to her care.

Accordingly, the Independent Investigation Team recommends that:

1. LYPFT and BDCT review their engagement strategies with complex individuals to ensure that a properly formulated analysis and action plan is included when the issue of non-engagement is recognised, particularly in relation to safeguarding.

The Independent Investigation Team also recommends that:

2. LYPFT and BDCT review their Care Programme Approach and training programmes in order to highlight the philosophical purpose behind Care Programme Approach, rather than focusing on adherence to administrative policies and procedures, important though this is, care co-ordination was approached in a reflective manner.

## 15 JUNCTURE NINE: OPPORTUNITY PRESENTED FOLLOWING RELEASE FROM CUSTODY

The Independent Investigation Team considers the time which Ms K spent on remand in prison between 3 August 2011 and 7 September 2011 to be a critical juncture in her care.

- 15.1 Ms K was a '*remand*' prisoner. This had implications upon her care in prison. A remand prisoner does not have a release date which allows those involved with the prisoner an opportunity to structure and plan their time and eventual release from prison. This planning would include social and healthcare support. A challenge faced by prison services is the 'short' release whereby a prisoner attends a hearing at Court and is released without returning to prison to complete a period of treatment or care.
- 15.2 On 3 August 2011, Ms K was remanded in custody, following an incident during which she had set fire to a toilet cubicle at a Drop-in Service in Bradford. This was Ms K's third remand into HMP New Hall.
- 15.3 HMP New Hall is a closed women's local prison, holding around 360 women, including a small number of young adults.
- 15.4 Mental Health Services within the prison were provided by Nottinghamshire Healthcare NHS Foundation Trust, through a Prison Mental Health In-reach Team. Since 2017, HMP New Hall mental health services have been provided by an organisation known as 'Care UK'.
- 15.5 In keeping with HMP Inspector of Prisons' findings at similar women's prisons across the country, levels of need in the female prison population (including mental health issues) are high. For example, over a third of prisoners reported having depression, mental health issues, or suicidal feelings upon arrival, and a similar number reported having a disability.
- 15.6 In addition, nearly half of the women reported having a drug problem upon arrival, and 43% said they had problems with alcohol. Nearly two-thirds said they had experienced emotional wellbeing issues, and 78% were taking prescribed medication
- 15.7 On 3 August 2011, Bradford Forensic Services contacted the Prison In-reach Mental Health Team to inform them of Ms K's Court appearance that day and reported she may be headed to HMP New Hall where she may require mental health support.
- 15.8 Ms K was assessed by a mental health nurse working within Prison In-reach Services on 4 August 2011
- 15.9 An urgent triage assessment was carried out which highlighted Ms K's, previous involvement with services including her recent admission at the Becklin Centre in Leeds under Sections 2 and 3 of the Mental Health Act 1983. Ms K's Care Programme Approach care co-ordinator was identified, and diagnoses of

Borderline Personality Disorder and Drug induced psychosis were noted whilst prevailing symptoms of paranoia, auditory hallucinations, substance misuse and thoughts to kill '*punters*' were identified and reported to the prison.

- 15.10** This triage immediately recommended a comprehensive mental health assessment under the prison In-reach mental health team.
- 15.11** At this time, Ms K claimed to have been in contact with mental health services from the age of 15, that she had been diagnosed with borderline personality disorder, and drug-induced psychosis, and had previously been prescribed 15mg olanzapine, though she had never taken it.
- 15.12** Ms K expressed paranoid concerns that there were cameras in her room and claimed that she was hearing voices in her head when she moved. She spoke about '*working on the streets*' and disclosed that she had fantasised about killing '*punters*' and putting their bodies into the boots of their cars. She had speculated about how many she could kill before being caught.
- 15.13** The nurse considered Ms K's remarks about wanting to kill a '*punter*' to be a sufficiently significant event to report it as a security matter within the prison risk management system. A prison risk of self-harm or suicide review meeting (ACCT review) to support in the safe management of Ms K in relation to self-harm ideation was carried out. There is no information from Ms K regarding her symptoms or experiences at the time she made this threat. Therefore, it is not possible to state with certainty that this threat was related to her mental health. However, it is important to note that at this time she had been assessed as being mentally unwell based on her conduct and behaviour.
- 15.14** Later, on 4 August 2011, Ms K changed her mind about wanting to engage with mental health services. On 5 August 2011, Bradford Forensic Services rang the In-reach Team and left a voicemail message highlighting that all mental health concerns should be forwarded to Ms K's care co-ordinator in Leeds.
- 15.15** Ms K was assessed by a Spectrum Community Healthcare CIC on 8 August 2011 by a Substance Misuse Nurse who was concerned regarding her mental health as she appeared distracted, appeared to respond to unknown stimuli and was requesting Olanzapine medication. This nurse immediately contacted the Prison In-reach Service highlighting these observations. On 9 August 2011, Ms K was described as '*distracted*', and later '*abrupt*', though with no evidence of aggression at that time. Ms K was '*very difficult to establish any rapport with*' and '[continued] *to present with agitation and unsettled behaviour*'.
- 15.16** During the mental health review conducted by Prison In-reach Services on 9 August 2011, Ms K expressed the desire to try taking olanzapine, as she alleged that she had previously been prescribed it in the community. To seek clarification of this, Prison In-reach Services contacted Ms K's care co-ordinator in Leeds. A note of this conversation made by the Prison In-reach Team states:

*'Contacted Care co-ordinator 1 who informed me that Ms K will be under the C/O Bradford services as she has registered with GP in Bradford. I have contacted this GP who will call back this PM for discussion'*

- 15.17** There is no clinical information contained in the record of the discussion between the In-reach Team and Care Co-ordinator 1. Equally, details of the service in Bradford which would be responsible for Ms K's care were not recorded in Ms K's records.
- 15.18** At this point, Ms K had not been formally discharged from services operated by LYPFT as the letter dated 11 August 2011 which purported to transfer Ms K's care to services in Bradford had not been written.
- 15.19** There is no healthcare wing at HMP New Hall. The wing named Holly House where Ms K was located is a small residential wing catering for twelve prisoners which previously served as an in-patient unit before the In-reach Service was commissioned by Nottinghamshire. Holly House has a higher ratio of prisoners to prison staff ratio as five officers man the wing of twelve; this allows for increased observations, support and a low stimulus self-contained environment. This environment is suited to supporting individuals with the complexity Ms K presented. However, it is manned by prison staff who make decisions around who is located on or off this wing. It is by default rather than by design that patients requiring increased mental health support are located on this unit.
- 15.20** Psychiatrists at HMP New Hall are visiting Psychiatrists. At the time of Ms K's care a Psychiatrist attended the prison two days a week. This meant on the other three days where the mental health service was operational on site, there would be no Psychiatrist cover. The local GP who came in daily would thus support prescribing following confirmation of treatment plans.
- 15.21** During her stay in Holly House, Ms K did not have her condition reviewed by a psychiatrist. An entry in Ms K's records states that a referral had been made to see the visiting psychiatrist on 12 August 2011. However, Ms K refused to engage in this review appointment which had been scheduled to take place on 16 August 2011. This was the visiting psychiatrist's first working day at the Prison. Consequently, medical advice concerning the prescription of olanzapine was sought instead from Ms K's new GP in Bradford. Whilst this displays an element of collaborative working, it is important to remember that the GP who was contacted had never met Ms K and may not have had access to her full history as she had only recently been transferred to their care. A formal letter discharging Ms K from the care of CMHT 1 is dated 11 August 2011.
- 15.22** After a troublesome night on 10 August 2011, during which she was up all night making noise, Ms K was initially guarded, but eventually apologetic. Her thoughts were described as '*disjointed*'. She claimed to be hearing the voices of three males, who were threatening her and pressuring her to commit crimes, and '[continued] *to report thoughts of ending her life*'. She had banged on the door of her room all night, kicking and shouting. Her neighbour also complained that Ms K had been running her taps all night, and frequently boiling the kettle. Although she apologised for her behaviour, she denied repeatedly boiling her kettle and accused her neighbour of lying.
- 15.23** Ms K was prescribed 10mg olanzapine and admitted to Holly House, for assessment and stabilisation of symptoms and to ensure she took her

medication. Ms K remained in Holly house until 17 August 2011 when she was transferred back to the main prison. Following her refusal to engage with the visiting consultant on 16 August 2011, Ms K was allocated an appointment in his outpatient clinic. A further review was conducted on 24 August 2011. Before Ms K could attend this appointment, she was released from prison.

**15.24** It would have been open for Ms K to have refused to engage with the Prison Psychiatrist on 16 August 2011. At this point, her condition appeared to be improving. The same presumptions of capacity apply in a prison setting as in the community. Consequently, if an individual is not behaving in such a manner that would trigger a Mental Health Act assessment, then she would have been presumed to have capacity to be able to refuse consent.

**15.25** Ms K's release from prison was not a planned event. Ms K had attended Court on 7 September 2011 and had been released. It is clear from her In-reach records that she had been expected to return to the prison.

**15.26** Risk posed by Ms K:

**15.27** Ms K reported psychotic symptoms in the form of delusions and hallucinations whilst she was in HMP New Hall.

**15.28** In a community setting, the combination of Ms K's symptoms or signs of mental illness, together with the potential for significant risk to others, could have provoked consideration of her detention to hospital using the Mental Health Act 1983. However, before detention in hospital would have been actioned, consideration would have been given to whether the risks which she posed could be managed by other less restrictive means. In addition, consideration would also have been given to whether the patient would have accepted the less restrictive means available.

**15.29** In a prison setting, the risks which Ms K posed were contained. Despite the difficulties establishing a rapport, Ms K requested and accepted treatment with olanzapine. Her condition appeared to improve.

**15.30** At the point of her release from prison on 7 September 2011, Ms K's mental health had improved. She had not repeated the threats which she had made earlier during her remand in custody. Based on her presentation at that time and the pattern of risk which she had previously exhibited, the Independent Investigation Team is of the view that it was reasonable to have interpreted the threats which she had vocalised as being made in the context of agitation and paranoia arising from a deterioration in her mental health and did not represent a sustained plan or intent which Ms K would carry out upon her release from prison.

**15.31** Engagement:

**15.32** During Ms K's time at HMP New Hall, it is evident that she was not easy to engage with. From being reluctant to engage with assessments, to sporadic engagement in which she was evasive and contradictory, to claiming not to know members of staff with whom she had engaged only a few days earlier, Ms K was selective in when and with whom she would engage.

- 15.33** The Independent Investigation Team noted that a characteristic of Ms K's reluctance to engage was coupled with, or followed from, Ms K either disliking or disagreeing with suggested aspects of her treatment. For example, when Prison In-reach Services suggested that further mental health screening may be beneficial on 26 September 2010 during a prior period of imprisonment, she immediately expressed the view that she did not want to engage with mental health services. Again, on 9 August 2011, when questioned about her desire to take olanzapine, Ms K became agitated.
- 15.34** As mentioned above, Ms K was admitted to Holly House on 10 August 2011. Ms K spent five days at Holly House. During this time, she was aware that she was to be transferred internally again, although it was unclear as to where. Ms K expressed her views concerning the potential transfer by swearing at Prison In-reach Services, resulting in her transfer back into the main prison being postponed. On 16 August 2011 Ms K was due for discharge from Holly House. Upon learning this, Ms K refused to be reviewed by the mental health team.
- 15.35** The Independent Investigation Team is of the view that this demonstrates that Ms K's wishes clearly needed to be considered as part of her treatment plan, in order that she could be properly engaged.
- 15.36** Release from HMP New Hall:
- 15.37** Ms K was released from prison on 7 September 2011.
- 15.38** On 31 August 2011, Ms K had expressed the view that, upon release, she wished to return to her mother's house in Leeds. Additionally, she wished to return to her care co-ordinator in Leeds, as she felt that they had worked well together. Moreover, Ms K expressed that she did not wish to stay in Bradford and had no desire to return to the GP in Bradford.
- 15.39** The discharge process from the Prison In-reach Team itself at the time was not reliant upon the input of healthcare staff; the decision to release was taken by non-clinical prison staff. The Independent Investigation Team understands that this process has now been reviewed and, accordingly, healthcare staff are now involved in the discharge of patients. The Independent Investigation Team welcomes this change in process.
- 15.40** HMP New Hall was most recently inspected by HMP Chief Inspector of Prisons between 8 and 19 June 2015. The following are extracts from that report in relation to mental health provision:

*'Women were offered an appointment with a nurse before release, and a summary of clinical care received, including medication, was sent to their GP. Women released with no settled accommodation were given information about how to register with a GP. A week's supply of prescribed medication was provided. A release pack with relevant health information and condoms was being developed but had not yet been implemented.'*

*'Women with complex mental health needs were put in touch with their local community teams and mental health nurses addressed women's housing'*

*needs, linking them with local community women's services. Short notice releases were a regular challenge'.*

**15.41** Ms K was released from prison upon short notice, which itself presents a challenge for those involved in prison healthcare across the country, and, indeed, is an ongoing challenge for services in HMP New Hall. When Ms K attended Court on 7 September 2011, it had been expected that she would return to prison following the hearing. This potentially would have allowed for arrangements to be made regarding her ongoing care in the community. However, she was in fact released from prison.

**15.42** However, what was striking for the Independent Investigation Team was that, during her remand in custody, Ms K asked to be transferred back to her care co-ordinator in Leeds upon release. This is recorded in the Prison In-reach notes. Equally, it is known that she did indeed return to Leeds where the homicide of Mr Edeson took place. However, because she had been newly registered with a GP in Bradford as a means of obtaining access to services, Ms K's care co-ordinator had already made a referral to BCMHT 1.

**15.43** There is no record of any discussions with Ms K nor, indeed, BCMHT 1 concerning this decision to transfer Ms K's care to Bradford either on 9 August 2011 or indeed subsequently. Given that Ms K had previously found it difficult to engage with services, her opinions as to where she would prefer her care to be given were of particular importance as they would have had a direct impact upon the likelihood of securing successful engagement.

**15.44** The Independent Investigation Team understands that Ms K's request to remain in Leeds was not communicated to LYPFT following 31 August 2011.

**15.45** LYPFT have stated that:

*'Ms K's mental health care was the responsibility of the Nottinghamshire Healthcare NHS Foundation Trust whilst she was on remand at HMP New Hall (3 August 2011 – 7 September 2011), so the care transfer upon her release would be from Nottinghamshire Healthcare NHS Foundation Trust to the Bradford District Care NHS Foundation Trust [...] there was no CPA meeting to facilitate the transfer of Ms K's care from Nottinghamshire Healthcare NHS Foundation Trust to the Bradford District Care NHS Foundation Trust.*

*'In any event, Ms K did not follow through upon her intention to move back to Leeds and she remained under the care of the Bradford District Care Trust until the time of her index offence (2 months later). If she had moved back to Leeds (and registered with a Leeds GP) her care would have transferred back to the care of the Leeds Community Team and probably the Care Co-ordinator (who she stated she wanted, despite having previously refused to engage).*

*'Nottinghamshire Healthcare NHS Foundation Trust was responsible for Ms K's mental health care during her time in prison and had a responsibility to share relevant information with the appropriate community team. Nottinghamshire Healthcare NHS Foundation Trust did not share any information with LYPFT'.*

**15.46** The Independent Investigation Team has given consideration to the opinion expressed by LYPFT. As has been discussed in Paragraph 6.21, the decision

taken by Care Co-ordinator 1 on or around 9 August 2011, to transfer Ms K's care appears to have been a unilateral decision which did not accord with LYPFT's discharge Policy.

- 15.47** There is no evidence of any handover of care from LYPFT to Nottinghamshire Healthcare NHS Foundation Trust during Ms K's remand in custody. Further, in Care Co-ordinator 1's letter to Bradford CMHT dated 11 August 2011, there is no mention of the fact that Ms K was in HMP New Hall at the time the letter was written. In particular, there is no evidence that any clinical information concerning Ms K was provided by Care Co-ordinator 1 to the prison to assist in her care and to ensure its continuity. Indeed, In-reach staff who attempted to obtain information concerning the prescription of olanzapine to Ms K were referred by Care Co-ordinator 1 to a GP in Bradford who had not previously met her for assistance concerning the prescription of olanzapine.
- 15.48** In addition, when the In-reach Team spoke to Care Co-ordinator 1 concerning Ms K's onward care, no details of the service to which Ms K was being transferred were given to the prison, making it more difficult to ensure continuity of care.
- 15.49** Prison In-reach staff were asked whether they had an opportunity upon being told that Ms K's care was being transferred to Bradford but that Ms K herself had stated that she was to return to Leeds to revert to CMHT 1. Their response was as follows:
- 'I think because she was registered with the GP in Bradford and the Leeds services couldn't pick her back up, unless upon release she did go back to Leeds then she would have to register with a Leeds GP to continue her work with Care Co-ordinator 1'.*
- 15.50** When asked the question whether in her opinion Ms K would have been able to negotiate the challenges of finding a new GP in Leeds in order to register and then access care from CMHT 1, In-reach staff responded saying she would not. This appears to accord with a view shared by Care Co-ordinator 1 in her letter dated 11 August 2011 which provides further detail about Ms K's inability to interact with GP's;
- 'She has never been to pick up her medication and is unable to attend the GP surgery to get sick notes in order to receive Employment allowance. She therefore frequently has her benefits stopped'.*
- 15.51** Ms K's care co-ordinator in Leeds wrote to Ms K's GP surgery in Bradford to alert them of the difficulties they would face when trying to engage Ms K. However, no attempt was made to arrange a Care Programme Approach meeting to facilitate the transfer of her care.
- 15.52** Without any Care Programme Approach meeting being considered, opportunity to take a longitudinal view of Ms K's care was lost. Ms K did not attend any of the appointments offered to her by BCMHT 1.
- 15.53** During her time upon remand, Ms K would have had significantly reduced access to drugs which would have allowed her presentation to be reviewed. The Independent Investigation Team is of the view that the re-emergence of

psychotic symptoms in the context of reduced access to illicit substances is significant, and the diagnosis of a drug-induced psychosis should have been called into question.

- 15.54** This could have afforded those involved in Ms K's care an opportunity to review her diagnosis and plan her care from a longitudinal perspective in order to evaluate her to drive decisions about service direction. A care co-ordinator who was in receipt of the necessary background information could potentially have raised the question of a change in the pattern of symptoms exhibited by Ms K (highlighted by prison staff) in preparation for a Care Programme Approach review.
- 15.55** Following pro-active information gathering after Ms K's release from prison, there would have been an opportunity to arrive at a more complete formulation of Ms K as an individual, based upon a review of her historic presentation and the information which had come to light whilst she was in prison.
- 15.56** There are practical difficulties attached to holding CPA meetings in prison, including obtaining security clearance for participants. Notwithstanding this issue, a CPA meeting could have been arranged.
- 15.57** However, given the uncertainties that are attached to the release date of a prisoner who is 'on remand' in prison, the involvement of the In-reach Team was less certain. Once an individual is put on remand in prison, the community team which was responsible for their care is not able to provide care.
- 15.58** The community team is therefore reliant upon information being provided to them by the Prison In-reach Team. This would have allowed a robust care plan to have been developed on behalf of Ms K.
- 15.59** Had a collaborative approach to care been developed, then the clinically relevant information which came to light about Ms K during her time in prison

could have been used to contribute towards a more informed risk assessment, and patient-centred plan.

**15.60** Transfer of Ms K's care while she was in prison:

**15.61** On 9 August 2011, while Ms K was on remand at HMP New Hall, Ms K's care was transferred from LYPFT to BDCT. This was on the basis that Ms K was registered with a GP practice in Bradford at that point in time.

**15.62** A letter was sent to BCMHT 1 by Care Co-Ordinator 1 on 11 August 2011. This letter does not mention whether Ms K was subject to a standard or, indeed, enhanced Care Programme Approach. However, a copy of Ms K's discharge summary from the Becklin Centre, dated 8 February 2011, was attached. This indicated that Ms K was indeed subject to an enhanced Care Programme Approach.

**15.63** Following her release from prison on 7 September 2011, Ms K was offered an appointment with a psychiatrist in Bradford on 27 September 2011. Ms K did not attend this appointment. The psychiatrist in Bradford therefore wrote to Ms K's GP practice on 4 October 2011, explaining that:

**15.64** *'Looking through her notes, it appears that Ms K has a very strong dislike of Psychiatry, and it seems extremely unlikely that she will come and see me. I am therefore going to discharge her back to your care, but if she attends requesting psychiatry assessment, having changed her mind, I would be only too pleased to see her and think I am probably the most appropriate Psychiatrist for you to refer her to.'*

**15.65** Discharge from psychiatry is often sufficient to trigger a Care Programme Approach meeting. The responsibility for organising such a meeting would usually fall to a patient's care co-ordinator. The Independent Investigation Team has been unable to determine whether Ms K was under the care of a care co-ordinator in Bradford at this time.

**15.66** In addition, at the time of her discharge, Ms K would have been subject to the provisions of Section 117 aftercare. The requirements of Section 117 aftercare would have necessitated that a Care Programme Approach meeting took place prior to Ms K's discharge from services, if this is what occurred.

**KEY POINTS – OPPORTUNITY PRESENTED FOLLOWING RELEASE FROM CUSTODY:**

On 2 August 2011, Ms K set fire to a Drug Rehabilitation Clinic in Bradford. She was arrested and remanded in custody.

During the period in which Ms K was in custody, three Trusts were involved in her care.

Care Co-ordinator 1 attempted to transfer Ms K from Leeds to Bradford services on 9 August 2011.

This decision was made unilaterally without the involvement of any of the other organisations involved with Ms K and without any discussion with Ms K herself.

No discussions took place concerning which service would have been able to best address Ms K's needs at this time.

No Care Programme Approach meeting was convened.

Clinically relevant information which came to light about Ms K during her time in prison and, indeed, following her discharge from hospital in Leeds was not shared or used to contribute towards a more informed risk assessment and patient-centred care plan following her release from custody.

This resulted in a significant missed opportunity to diagnose a persistent psychotic illness. Had this opportunity been recognised, a different, more appropriate, assertive approach to care and treatment might have been taken towards Ms K's ongoing care.

Ms K did not engage with the Community Mental Health Team in Bradford.

#### Observation to encourage reflective practice – Nine

Ms K's care was transferred to BCMHT 1, who had not previously had an opportunity to review or assess Ms K.

The manner in which care was transferred (whether to Bradford or, indeed, to the Prison In-reach Team) was not completed in accordance with LYPFT's own discharge policy.

It is significant, in the opinion of the Independent Investigation Team that, had a Care Programme Approach meeting been convened on or around 9 August 2011 when CMHT 1 advised the Prison In-Reach Team that Ms K's care had been transferred, then a number of issues could have been addressed in order to better facilitate the transfer of her care.

The Independent Investigation Team views this as a further example of where service structures and protocols were not centred on individual need and were not able to reflect the needs of those who are most complex and most vulnerable.

In addition, there is inconsistency in the approach taken by health services towards Ms K. This is one of several examples in which services, and in particular mental health services, have operated a '*double bind*', in which Ms K has been deemed to have the capacity to refuse services without this being challenged, but, on the occasions she has requested a specified service, this has been denied.

In general terms, it is now recognised as desirable that there is integration between primary and secondary care provision of mental health care. However, inherent in the devolution of purchasing to Clinical Commissioning Groups, and the purchaser/provider split is the notion of patient choice. It is recognised that there can be a tension between these principles, but it is notable that this tension is less apparent with regard to physical health care, and therefore raises the issue of parity of esteem.

Patient-centred care requires that the wishes, and, indeed, needs of the patient to be taken in to account. In re-accessing services in Leeds, Ms K would have been able to obtain the possibility of continuity of care.

It is the view of the Independent Investigation Team that an appropriate response to the delivery of Ms K's care and the need to be responsive to the choices she expressed could have been to allow Ms K to exercise her preferred choice of provider which was the Leeds Trust through a purchaser in Bradford.

## **16 JUNCTURE TEN: REACTION TO INCIDENT BY HEALTHCARE PROVIDERS**

**16.1** As part of its Terms of Reference, the Independent Investigation Team is required to:

- Review the Internal Investigation Report (SUI 2011/21879) and assess the adequacy of its findings, recommendations, and action plan.
- Review the progress that has been made in implementing the action plan.

**16.2** Circumstances in which Mr Edeson's death came to light:

**16.3** Mr Edeson's body was discovered at his home by members of his family, including his mother, on 8 November 2011.

**16.4** On the 8 November 2011, Ms K spoke to a drug worker in Bradford and told her that she had stabbed a man. Her drug worker reported this statement to the Police.

**16.5** When Mr Edeson's body was discovered, the Police linked his death to what Ms K had reported to her drug worker. The following day, Ms K was arrested and remanded in custody.

**16.6** LYPFT was made aware of the incident through the STEIS Serious Incident process, and the Strategic Health Authority was informed. An Initial Service Management Review was completed for the Strategic Health Authority.

**16.7** Reaction of mental health services to the death of Mr Edeson:

**16.8** LYPFT became aware of the incident involving Ms K on 11 November 2011, when Ms K's care co-ordinator was contacted by social services. A Management Fact Finding Pro Forma was completed on 15 November 2011.

**16.9** Bradford Working Women's Service became aware that Ms K had been charged with the murder of Mr Edeson on 11 November 2011, following a telephone call from the Police. A Serious Untoward Incident report was submitted that day to BDCT by a Team Leader at the Bradford Working Women's Service. The Trust's Complaints Department and Communications Team were informed.

**16.10** Ms K was remanded in HMP New Hall, immediately following her arrest in connection with Mr Edeson's death.

**16.11** Involvement of services in investigations:

**16.12** Ms K had been seen by the Prison In-reach Team in HMP New Hall during the course of her sentence for arson, which commenced on 3 August 2011. This is an NHS secondary mental health service, which provides assessments, care, and treatment for those in prison experiencing mental health problems. Ms K had received care from LYPFT in the period between 31 December 2010 and 31 October 2011. Ms K's care was transferred to Bradford in August 2011. Accordingly, there were three NHS mental health services involved in Ms K's

care in the six-month period leading up to the death of Mr Edeson. Potentially, contact which Ms K had with any of these organisations should have triggered an Internal Investigation following the incident.

**16.13** The Independent Investigation Team was provided with copies of an exchange of emails between Leeds and Bradford concerning the homicide committed by Ms K.

**16.14** The emails show that, following the homicide, there was communication between LYPFT and BDCT concerning investigation of the care which Ms K received. It appears to the Independent Investigation Team following consideration of those emails that a decision was taken whereby Leeds would take the lead in co-ordinating an investigation into the homicide.

**16.15** On 18 November 2011, an email was sent to Bradford by LYPFT which stated:

*'Following discussion with the SHA with regards to the Homicide incident last week, it would be useful if Bradford Care Trust could undertake a seventy 72 (sic) hour review into the care provided to the patient prior to the incident occurring. This review will be submitted to the IIC along with LPFT's for consideration. The SHA are keen to ensure that the appropriate provider is identified as the lead investigator with support from the associated provider. Would you be able to request this, or alternatively if you have a contact I am more than happy to follow it up'.*

**16.16** Bradford subsequently undertook a 72-hour review.

**16.17** BDCT had no further contact from LYPFT following this email exchange in November 2011. Further, there was no further correspondence after 18 November 2011 from the commissioners of BDCT (NHS Bradford, Airedale and Leeds) to BDCT about this incident. Both Bradford and Leeds had the same commissioners at the time of the incident (NHS Bradford, Airedale and Leeds).

**16.18** However, there appeared to be some confusion as to the nature and extent of the collaboration. For example, on 29 April 2014, in an email from LYPFT to BDCT it was said:

*'Some weeks have passed since we met at Blenheim House re the above.*

*'I have asked [Redacted] to clarify what I had been told that your services had declined involvement (sic) with our origioanl (sic) review. Already there is indication that I may have been misinformed. If this is the case I will of course make this point with NHS England.*

*'In the meantime I wonder if it would be helpful for our organisations to stay in touch about the review?'*

**16.19** Further, during the course of the Independent Investigation, LYPFT submitted the following statement of opinion to the Independent Investigation Team:

*'It is factually inaccurate to state that LYPFT took the lead [on behalf of the three Trusts]. LYPFT carried out an internal investigation regarding the care provided by its staff, in accordance with its own policies. It was for the other*

*organisations to consider their contact with Ms K, and carry out an investigation if appropriate in accordance with their own policies.*

*[...] LYPFT carried out an internal investigation into the care provided by LYPFT staff but the organisations subsequently responsible for Ms K's mental health care, Nottinghamshire Healthcare NHS Foundation Trust and the Bradford District Care NHS Foundation Trust, did not undertake an investigation.*

*'The care provided by its staff, in accordance with its own policies. Contact would have been made with other services if it was felt that it was appropriate, for example if there were issues or learning which would have benefited other organisations. LYPFT expected any other services involved to consider their own contact with Ms K, carry out an investigation where appropriate and share any learning with LYPFT where relevant. It is not for LYPFT to undertake an investigation for other organisations, consider the care provided by other Trusts or to require them to undertake their own investigation'.*

- 16.20** BDCT have asked that their view that the information contained in paragraph 16.19 is inaccurate be expressly recorded in the report.
- 16.21** It appears that initially there were attempts at collaborative working between Leeds and Bradford. However, these were unsuccessful. As a result, a significant opportunity for learning was lost. As has been stated in Section 7 of this report, the role of Aspire was crucial. This organisation was unaware of the death of Mr Edeson, or that investigations into Ms K's care had commenced, until they were contacted by members of the Independent Investigation Team.
- 16.22** Given that three NHS organisations and one third sector organisation were involved in Ms K's care, the Independent Investigation Team is of the opinion that there would have been significant benefit in one joint investigation having been conducted across all the organisations, rather than one organisation conducting an internal investigation with a narrow scope confined to its own organisation.
- 16.23** Investigation carried out by LYPFT:
- 16.24** An Internal Investigation performed by the Trust began on 22 December 2011 and was completed on 14 February 2012. It was presented to Leeds and York Partnership NHS Foundation Trust Risk Forum on 17 February 2012. It was signed off by a Director of the Trust and was subsequently sent to Leeds Primary Care Trust and the Strategic Health Authority on 18 March 2012.
- 16.25** A meeting was subsequently held with the Risk Manager (Patient Safety) from Leeds Primary Care Trust and LYPFT to discuss the details of the report, and some of the findings and subsequent recommendations and actions. The report's author agreed to make some minor changes to the concluding remarks to make it clearer what the investigator had concluded. Neither Leeds Primary Care Trust nor the Strategic Health Authority asked LYPFT to share the report with other services, Ms K, or the victim's family. As a result, the findings of the

Internal Investigation were not conveyed to Ms K's family, nor to that of Mr Edeson.

**16.26** The Terms of Reference consisted of the following:

- Identify a chronology and timeline of events, including care received in relation to Ms K, and the time leading up to the alleged offence.
- Examine any possible causal or contributory factors relating to Ms K's alleged offence and identification of the risk, context, and suitability of clinical interventions and relevant systems of care.
- Provide relevant analysis and recommendations for future systems and practice.

**16.27** The Internal Investigation compiled by the Trust identified a number of key features of Ms K's presentation. In particular, the following was recognised:

- Ms K's presentation was complex.
- Little information was available about Ms K's history from her records.
- Ms K was difficult to engage with.

**16.28** It is the view of the Independent Investigation Team that the Internal Investigation concentrated on one aspect of Ms K's presentation: namely, the issue of personality disorder. This was the guiding approach taken post-hospital discharge by clinicians involved in her care. LYPFT have responded to this concern in the following terms:

*'[The] terms of reference required a review of the care provided by LYPFT staff, with a focus upon the suitability of clinical interventions. The report's author acknowledges Ms K's complexity (personality disorder) and describes other clinical aspects of her presentation and needs.'*

*'It is accepted that the only 'diagnosis' which was considered was 'Borderline Personality Disorder and Drug induced Psychosis'. However, at the time of LYPFT's care, that was the diagnosis, and there was no reason to doubt that diagnosis with regard to the evidence available at the time of Ms K's treatment. It is not accepted that a later diagnosis, further to a change in a service user's presentation or the development of new behaviours, means that the earlier diagnosis was wrong at the time it was made.'*

**16.29** When used effectively, Root Cause Analysis is a powerful investigative tool. In this case, aspects of Ms K's presentation have clearly been subjected to Root Cause Analysis. It remains the view of the Independent Investigation Team that the Internal Investigation which was carried out into Ms K's care concentrated on one aspect of Ms K's presentation which replicated the approach taken by clinicians involved in Ms K's care.

**16.30** For the reasons set out in Chapter 10 of this report, it is the opinion of the Independent Investigation Team that Ms K was exhibiting features that raised the possibility of an emerging psychotic illness whilst she was being cared for by LYPFT. Consequently, the conduct of an investigation into one aspect of Ms K's presentation represented a significant missed opportunity to identify

learning. This could, potentially, have been mitigated if the other organisations involved with Ms K had been involved in an investigation into her care.

**16.31** Previous investigations in the NHS:

**16.32** The Ritchie Inquiry identified a string of failures by the mental health professionals involved in the care of Mr Clunis. The landscape of mental health provision today is more complex than when the Ritchie Inquiry was written. Since 1992, significant changes have been made to the legal framework governing mental health, and there have also been changes in the manner services are delivered. However, analysis of mental health homicide reports since the Ritchie Inquiry into Mr Clunis' care, show that the issues highlighted in that report remain a persistent and common feature in the findings of Independent Homicide Investigation Teams.

**16.33** The Ritchie report led to a movement towards ensuring that processes are in place to address the type of failings which were noted to have occurred in the care of Christopher Clunis. This may not have been the intention of those who wrote the Ritchie report, but it is how that report's recommendations have been translated and implemented by some organisations.

**16.34** The Francis Inquiry report was published on 6 February 2013 and examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009<sup>13</sup>. The report made 290 recommendations. The report was significant, because it stated that the quality of patient care is central to service delivery and in doing so encouraged a move away from a systems-based culture which has evolved in some areas of the NHS.

**16.35** The Francis report requires NHS organisations to re-evaluate their approach to care. In essence, following the Francis report, it is not sufficient simply to have a system or process in place to deliver care; it is the quality of the care to be delivered that is important. Consequently, in order to develop a culture that places care at its heart, individuals are required to consider the quality of care which is being delivered rather than simply delivering and adhering to a policy which may not address the needs of an individual patient. In essence, professionals can operate a system which their organisation requires of them, but this may not be enough if that approach does not deliver patient-focused care.

**16.36** The Ritchie report and the Francis report both have direct relevance to the care of Ms K. The Independent Investigation Team recognises that the events which are the subject of this report took place prior to the conclusion of the Francis Inquiry. However, a core purpose of the Care Programme Approach (which was modified in response to the Ritchie report) is to provide a framework for care planning, which recognises the needs of the individual, and in that sense both reports place the needs of the individual at the heart of service delivery. As a result, the continuing relevance of the Care Programme Approach was recognised.

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<sup>13</sup> Robert Francis, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (2013).F

**16.37** Investigation of Ms K's care:

- 16.38** A number of organisations were involved in the care and treatment of Ms K. However, not all these organisations conducted internal investigations following the death of Mr Edeson to identify whether there were lessons which each individual organisation could learn.
- 16.39** Leeds and Yorkshire NHS Partnerships undertook an internal investigation. The investigation, and subsequent action points, concentrated largely upon the diagnosis of personality disorder.
- 16.40** The Independent Investigation Team is concerned about the failure to include a number of individuals involved in Ms K's care in the Internal Investigation, and also the extent of the subsequent dissemination of learning from that investigation. During the course of the interviews conducted by the Independent Investigation Team, it became clear that many key individuals who were involved in Ms K's care had not been interviewed as part of the Internal Investigation process.
- 16.41** The Independent Investigation Team is concerned that the Trust did not look more widely in relation to Ms K's care to identify learning. It appears that a collaborative approach, which operated across service boundaries, was not adopted towards the investigation of her care. In some respects, this reflects the manner in which care was delivered.
- 16.42** Since 27 November 2014, NHS bodies have been required to meet a Duty of Candour. This requires healthcare providers to be open and transparent when things go wrong.

Key points – Internal Investigations:

There were three NHS organisations involved in Ms K's care at the time of Mr Edeson's death.

One organisation, LYPFT, took the lead in conducting an investigation, and initially involved BDCT to some degree. However, LYPFT subsequently failed to work collaboratively with BDCT in undertaking an investigation into its own care of Ms K, which was based around the diagnosis of personality disorder. In addition, Aspire were not included in any investigations and only became aware of the death of Mr Edeson when they were contacted by the Independent Investigation Team.

The issue of Ms K's emerging psychotic illness was not given any consideration in the LYPFT Internal Investigation despite being present in her medical records prior to the death of Mr Edeson.

Attempts were not made to involve the families of Ms K or Mr Edeson in the Internal Investigation.

As a result, the opportunity for learning which was presented by Ms K's care was lost.

### Observation to encourage reflective practice – Ten

Despite the Internal Investigation recognising Ms K's presentation as being complex, there does not appear to have been an attempt to explore that complexity in her presentation with a view to unlocking the maximum learning from her case. This was a significant missed opportunity, as the recommendations and action points are focussed upon personality disorder, which is only one aspect of Ms K's complex presentation. The distinct possibility of an emerging psychotic illness that the Independent Investigation Team believes was apparent from the information presented in her medical records appears not to have been considered within the terms of the internal investigation. This is particularly concerning, as, once again, it appears that the label of '*personality disorder*' has precluded Ms K from a comprehensive assessment of her care.

In addition, it appears that the Internal Investigation did not talk to a wide group of individuals who were closely connected with Ms K's care, including external organisations, and also key clinicians involved in Ms K's care. Further, when asked in interview about the Internal Investigations and, indeed, the learning which had been unlocked from it, these individuals confirmed that they had not received any notification about the Internal Investigation or its results or recommendations.

A recommendation of the Internal Investigation was that Community Mental Health Team members were to access the '*Knowledge and Understanding Framework*' training when working with service-users who have a personality disorder. Ms K's care co-ordinator confirmed in interview with the Independent Investigation Team that, whilst she completed the first part of this training, she had been off sick when the second part of the course had been due to take place, and, subsequently, had been unable to access the second stage of the training.

With regard to the diagnoses of personality disorder, substance misuse, or psychosis, there are fundamental differences in terms of the models of engagement that are optimal for each. This is one of the main reasons that complex comorbidity is challenging for services to manage. Crucially, the Leeds Internal Investigation replicated the approach of the clinicians by focusing on one aspect of Ms K's presentation, and, therefore, the Trust's response was only tested against one model of engagement. In addition, other key issues which, in fact, are commonly occurring themes in homicide reports, and, indeed, were issues of concern, and which were highlighted in the Ritchie report, have been omitted from the investigation.

These included:

- A failure to achieve proper communication and liaison.
- A failure to manage provision of health and social services.
- A failure to note and act upon warning signs and symptoms to prevent relapse when a patient is living in the community.

- Discrimination based on labelling and around capacity.

### **Recommendation six – Review of internal investigation processes**

In recognising that Mr Edeson's death occurred prior to the introduction of the legal duty of candour, the Independent Investigation Team is concerned that neither the family of Ms K or Mr Edeson were advised of the learning which resulted from the internal investigation, or the outcome from it.

Throughout the course of the Independent Investigation, there was an expression of frustration on the part of the families about their lack of knowledge about what had gone wrong in Ms K's care. This concern was exacerbated by the lengthy criminal proceedings which followed Mr Edeson's death.

Accordingly, it is recommended that:

1. The Independent Investigation Team would encourage the three Trusts involved in Ms K's care to consider reviewing the approach which they adopt in providing the families of those involved in incidents such as the death of Mr Edeson with information and support.

A significant issue in the care of Ms K was lack of communication between the various agencies involved in her care including social services who continued to have contact with Ms K following her arrest. The concern of the Independent Investigation Team is that if organisations are focussed on who is 'responsible' for an investigation (i.e. whose team saw an individual most or, indeed, last) then there is a danger that the bigger picture will be missed as organisations fail to come together.

Accordingly, it is recommended that:

2. The Trust's review their approach to undertaking investigation when more than one organisation is involved to ensure that a collaborative approach is considered and if appropriate adopted with a view to maximising the learning for each individual organisation.