



**An independent  
investigation into the  
care and treatment of  
a mental health  
service user (Tom) in  
Cambridgeshire**

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Author: **Carol Rooney, Head of Investigations**

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Niche Health & Social Care Consulting Ltd is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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Niche Health & Social Care Consulting Ltd  
1 City Approach  
Albert Street  
**Eccles**  
**MANCHESTER**  
**M30 0BG**

Telephone: 0161 785 1001  
Email: [enquiries@nicheconsult.co.uk](mailto:enquiries@nicheconsult.co.uk)  
Website: [www.nicheconsult.co.uk](http://www.nicheconsult.co.uk)

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# 1 Executive summary

- 1.1 NHS England, Midlands & East commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user 'Tom'. Niche is a consultancy company specialising in patient safety investigations and reviews.
- 1.2 The independent investigation follows the NHS England Serious Incident Framework<sup>1</sup> (March 2015) and Department of Health guidance<sup>2</sup> on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.
- 1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 1.4 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning. This investigation was commissioned to support the work of the independent lead reviewer of the Domestic Homicide Review (DHR) commissioned by Huntingdon Community Safety Partnership.
- 1.5 Tom killed his wife Sally at their home in Cambridgeshire on 29 August 2015. Tom initially started to cut his own throat, and attacked his wife after she called emergency services for help. He was found guilty of manslaughter by diminished responsibility in March 2016 and was detained indefinitely under the Mental Health Act.<sup>3</sup> Medical reports presented in court showed Tom had suffered a series of psychiatric problems, including paranoid schizophrenia, following a motorbike accident in 2004. Although there are some indications that Tom was somewhat withdrawn and had low self-esteem before the accident, family and friends have emphasised that this had a serious effect on his mental health.
- 1.6 We would like to express our condolences to Sally's family. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Tom.

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<sup>1</sup> NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

<sup>2</sup> Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

<sup>3</sup> Mental Health Act 1983, 2007. <http://www.legislation.gov.uk/ukpga/1983/20/contents>

## **Mental health history**

- 1.7 Tom received mental health services from Northamptonshire Healthcare NHS Foundation Trust (NHFT) from 2007 to 2013 and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) from 2014 to 2015. This investigation reviews his care and treatment from both Trusts, and the mental health care provided by Cedar House GP Surgery (Cambridgeshire).

## **Conclusions**

- 1.8 I consider that Tom's pattern of being non-compliant with medication and lack of engagement with ongoing care should have triggered a more detailed discussion by CPFT mental health services, where this could have been discussed and treatment options considered.
- 1.9 He had a clear history of a serious and enduring mental illness, which had previously been relatively well maintained by outpatient supervision by a community psychiatrist, although he had been discharged to the care of his GP in November 2013. He did not engage well with CPFT services, and did not comply with treatment offered, which suggests that CPFT should have taken a proactive longer term view, rather than focussing on short term management.
- 1.10 There was however no history of violence to others, and no suggestion of any violence towards his wife prior to the homicide.

## **Notable practice**

- 1.11 We wish to highlight these as examples of good practice:
- 1.12 Sally received consistent regular carer support during Tom's treatment by both NHFT and CPFT.
- 1.13 Tom was provided with extensive psychological input, including couples therapy, through NHFT early intervention in psychosis service (NSTEP).

## **Recommendations**

- 1.14 This independent investigation has made seven recommendations for the NHS services to address in order to further improve learning from this event.

### **Recommendation 1**

Northamptonshire Healthcare NHS Foundation Trust must provide assurance that the policies on handovers, transfers of care and discharges are implemented and standards maintained.

### **Recommendation 2**

Cambridgeshire and Peterborough Clinical Commissioning Group must provide explicit information about routes of access to mental health services provided by Cambridgeshire and Peterborough NHS Foundation Trust and there should be processes in place to ensure locums are aware of this, which must be monitored for assurance.

### **Recommendation 3**

Northamptonshire Healthcare NHS Foundation Trust health records policy must be adjusted to include the use of consultant outpatients letters as equivalent to a clinical record entry.

### **Recommendation 4**

Cambridgeshire and Peterborough Clinical Commissioning Group must implement a set of standards for reviewing the notes when a new patient with a secondary mental health history is accepted at a GP surgery.

### **Recommendation 5**

The process of discharge from Cambridgeshire and Peterborough NHS Foundation Trust services to primary care must be supported by specific delivery standards that are formally monitored.

### **Recommendation 6**

Northamptonshire Healthcare NHS Foundation Trust must provide assurance that the 'working with risk' policy is implemented consistently in NSTEP, and that there are standards in place for the communication of risk information to primary care, which are monitored.

### **Recommendation 7**

Cambridgeshire and Peterborough NHS Foundation Trust must ensure that an understanding and assessment of insight is included in its risk management training.

## 2 Independent investigation

### Approach to the investigation

- 2.1 The independent investigation follows the NHS England Serious Incident Framework (March 2015)<sup>4</sup> and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.<sup>5</sup> The terms of reference for this investigation are given in full in Appendix A.
- 2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 2.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning. This investigation was commissioned to support the work of the independent lead reviewer of the Domestic Homicide Review (DHR) commissioned by Huntingdon Community Safety Partnership.
- 2.4 The investigation was carried out by Carol Rooney, Head of Investigations for Niche. The investigator will be referred to in the first person in the report. The report was peer reviewed by Nick Moor, Partner, Niche.
- 2.5 The investigation comprised interviews and a review of documents, with reference to the National Patient Safety Agency (NPSA) guidance.<sup>6</sup>
- 2.6 NHE England wrote to Tom at the start of the investigation, explained the purpose of the investigation and asked to meet him. Tom wrote to clarify that he did not want to take part in the investigation or DHR. Clinical records were obtained through the relevant Caldicott Guardian.<sup>7</sup>
- 2.7 We used information from:

Northamptonshire Healthcare NHS Foundation Trust (NHFT)  
Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)  
Cedar House Surgery.

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<sup>4</sup> NHS England Serious Incident Framework (March 2015). <https://www.england.nhs.uk/patientsafety/serious-incident/>

<sup>5</sup> Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

<sup>6</sup> National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

<sup>7</sup> Caldicott Guardian – a senior person responsible for protecting the confidentiality of patient and service user information and enabling appropriate information sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated in 1999 by Health Service Circular HSC 1999/012. Caldicott Guardians were subsequently introduced into social care in 2002, mandated by Local Authority Circular LAC 2002/2.

2.8 As part of our investigation we discussed the case with/interviewed:

- Head of Speciality Services (report author) NHFT
- Consultant clinical psychologist, NHFT
- Associate Director of Performance Delivery (report author) CPFT
- Consultant psychiatrist (report author) CPFT
- Consultant psychiatrist and Clinical Director (Community Mental Health Team - CMHT) NHFT
- GPs from Cambridgeshire surgery
- Care coordinator, (Huntingdon Adult Locality Team - HALT - CPFT)
- Consultant psychiatrist (HALT, CPFT)

2.9 A full list of all documents we referenced is at Appendix B.

2.10 The draft report was shared with NHS England, both Trusts, and other stakeholders. This provided an opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

### **Contact with the victim's family**

2.11 Contact with the victim's family was arranged and carried out by the DHR independent lead reviewer. A draft of this report was offered to them but they did not take up the opportunity to give any feedback.

### **Contact with the perpetrator's family**

2.12 The perpetrator's family was contacted by both the DHR lead and NHS England, and they have not wanted to participate in the DHR or mental health independent investigation.

### **Contact with the perpetrator**

2.13 NHS England wrote to Tom at the start of the investigation, and received his written confirmation that he did not wish to participate in the investigation. I wrote to his current clinical team to ascertain whether he wished to see the draft report.

2.14 His current psychiatrist clarified that it would be appropriate to offer him the opportunity to read the draft report. This was offered but he declined.

## Structure of the report

- 2.15 Section 3 provides some background to Tom's personal history and access to health services. Section 4 sets out the details of the care and treatment provided to Tom. The terms of reference are at Appendix A, and a list of documents reviewed is at Appendix B.
- 2.16 We have included an anonymised summary of those staff involved in Tom's care for ease of reference for the reader at Appendix C and a medication history is at Appendix D.
- 2.17 Section 5 examines the issues arising from the care and treatment provided to Tom by both Trusts and includes comment and analysis. This includes a review of the individual management review (IMR) from NHFT and the serious incident report from CPFT. There was no IMR from the GP practice.
- 2.18 Section 6 sets out our overall analysis and recommendations.

## 3 Background

### Personal history

- 3.1 Tom was born and brought up in Rushden, Northamptonshire and is the middle of three children, attending local schools. He has described a happy childhood although he has also said his brother and sister were more outgoing and confident than him.
- 3.2 He graduated from university with a degree in biomedical sciences and later went on to complete a Master's degree in biological informatics.
- 3.3 After leaving university he worked in his family's engineering company for around eight years. He described this to the initial assessing consultant psychiatrist Dr A in February 2007 as a difficult time; he did not enjoy the work and was bullied by other workers for being the son of the 'boss'. He had many months off due to the injuries he sustained in a serious motorbike accident in May 2004.
- 3.4 He told Dr A that he finally left the family company in December 2006 because he could bear it no longer. His parents attended part of this meeting and said Tom had always lacked confidence and self-esteem, for instance at university he completed a Higher National Diploma initially because he did not think he could manage a degree.
- 3.5 Tom was unemployed initially in 2006, intending to do some DIY projects around the house and then apply for other jobs. He started a new job in early 2007, but gave it up within two weeks of starting. Tom had become convinced that co-workers were persecuting him, especially by whistling at him.
- 3.6 He took up a university course in late 2007 and completed a Master's degree in biological informatics. In 2009 he was working in London for a scientific journal for five months, finishing in October 2009. Between 2012 and 2015 Tom was employed as a practice liaison officer with a patient care company, his role involved managing the company's relationship with practices; visiting GP practices across the country to discuss the services that the company provided.

### Relationships

- 3.7 Tom met his wife Sally when they were both at university, and they remained a couple ever since. Sally's family are of Asian origin, and it is noted that she has said her family always assumed that she would marry someone from a similar background, and for this reason the relationship was concealed from her family for many years. This concealment caused tension in Tom's family also.
- 3.8 During and after the motorbike accident in 2004, Tom and Sally lived together in Rushden, and were married in 2010.

- 3.9 There were several periods of separation; in December 2006 he was living at his parents' house during the week until at least June 2007, starting to spend time at his home again in April 2007.
- 3.10 In May 2011 a private fertility clinic wrote to request information about his psychiatric treatment. His consultant psychiatrist noted in late 2013 that they had just tried fertility treatment but it had been unsuccessful. In the GP notes it is recorded on 23 July 2015 that tests were being carried out with regards to fertility treatment.
- 3.11 A decision was made to move closer to Sally's work, and they moved to Cambridgeshire in September 2013.
- 3.12 In September 2014 Sally told professionals that they had separated on a trial basis, and Tom went to live with his parents. According to neighbours he moved back in March or April 2015.

### Contact with criminal justice system

- 3.13 Tom had no contact with criminal justice systems, apart from an incident on 6 July 2009 when he attended Bedford police station to inform them that he believed he had sexually assaulted a five year old girl. He was arrested and interviewed during which time he said he had inappropriately touched a family friend in 1995, when he was 19, and touched her bottom over her clothing.
- 3.14 Police officers were concerned that he appeared to have mental health issues, and they interviewed Sally, who confirmed that Tom had a fixation for being punished for what he claimed to have done, but she did not believe it had occurred.
- 3.15 He was released from police custody with no further action, but a note on the police national computer recorded contact with him as a 'vulnerable adult' with a 'suspected mental disorder'. The police were made aware that he was under the care of mental health services and NHFT staff contacted the police to obtain more information about this incident.

### Physical health

- 3.16 Tom had no previous serious health issues and was described as an active young man, enjoying rugby, canoeing and other active outdoor sports. In 2007 he told NHFT staff that he had experienced severe migraines over the previous 12 years since he was 19, and had attended A&E several times because of severe pain. This is not noted in current electronic GP records, which start in 2004.
- 3.17 On 29 May 2004 Tom was involved in a serious motorbike accident. He sustained multiple injuries and burns to his right arm and face, after the motorbike caught fire. He was admitted to Oxford Radcliffe Hospitals NHS Trust (ORH). On 9 June 2004 whilst in intensive care, Tom became

very agitated with paranoid delusions that nurses were plotting to kill him and his family. He succeeded in ripping out the first venous bypass graft in his right thigh, with the aim of killing himself.

- 3.18 He was assessed by the ORH psychiatric consultation service who diagnosed delirium due to infection and pulmonary embolism, with secondary depression and anxiety. They recommended management with haloperidol<sup>8</sup> 4mg four times daily, and lorazepam<sup>9</sup> 2mg twice a day. The depression and anxiety were considered to be part of an 'acute stress reaction continuing to an adjustment reaction three to four days post injury'. It was noted he had experienced visual hallucinations and intense paranoia.
- 3.19 He was seen for follow up for scarring to his face and body by the department of plastic and reconstructive surgery at ORH until 2007. He had some restricted movement in his ankles and toes, and wore a pressure garment to prevent his right leg swelling, and to prevent 'lymph leak'<sup>10</sup> from the medial fasciotomy<sup>11</sup> scar.
- 3.20 In December 2005 Tom was referred to a consultant clinical neuropsychologist Dr B at Oxford Radcliffe hospital by the department of plastic and reconstructive surgery. The referral noted that although he was making a good recovery physically, he had residual psychological problems in relation to continuing paranoid ideation and marked loss of self-confidence. It was suggested that these problems were entirely related to the episode of delirium with altered mood state that he experienced after the accident in 2004. This was Tom's first referral for treatment of mental health issues.

## 4 Mental health care and treatment

### Oxford Radcliffe 2005- 2007

- 4.1 At an assessment in late 2005 by Dr B, Tom presented as having generalised anxiety with panic attacks and low mood, but no clear evidence of a posttraumatic stress disorder. He was seen for six sessions of cognitive behavioural therapy in relation to generalised anxiety, panic and occasional paranoid ideation.

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<sup>8</sup> Haloperidol is used to relieve the symptoms of schizophrenia and other problems which affect the way people think, feel or behave. <http://patient.info/medicine/haloperidol-haldol-serenace>

<sup>9</sup> Lorazepam is an anxiolytic which works by affecting the way certain substances in the brain (called neurotransmitters) pass messages to your brain cells. It has a calming effect on various functions of the brain. <http://patient.info/medicine/lorazepam-a-benzodiazepine>

<sup>10</sup> Burns, life-threatening infections, or other critical illnesses can cause a reaction that allows fluid to leak into tissues almost everywhere. <http://emedicine.medscape.com/article/192248-treatment>

<sup>11</sup> A fasciotomy is an incision to relieve pressure caused by Compartment syndrome; occurring due to increased pressure within a confined space, or compartment, in the body usually after an injury or burn. <http://patient.info/health/compartment-syndrome-leaflet>

- 4.2 He was discharged from the service in July 2006, and at this time it was reported that his panic and paranoid cognitions had essentially resolved, and there had been a significant reduction in his overall level of anxiety, becoming a mild degree of social anxiety. Some residual difficulties were noted, particularly in relation to self-confidence and motivation to make a career change, and also in assertiveness and self-esteem in relation to his family. However it was noted that these were long standing and not directly related to the trauma or problems during his hospital management, and the opinion was given that Tom had sufficient insight and skills to address these in his own time.
- 4.3 He was discharged with the proviso that Dr B would be happy to see him again if the need arose, and the discharge letter was sent to the consultant plastic surgeon, his GP and to Tom.
- 4.4 Tom emailed Dr B in late July 2006 after experiencing suspicious and paranoid feelings on a martial arts weekend away, but he responded well to emailed reassurance and reminders about skills and resources he could use.
- 4.5 He emailed again in October 2006 from overseas, where he was attending Sally's sister's wedding. He described feeling uncomfortable in a crowd of people (partly because he was the only person who didn't speak their native language), having panic attacks and feeling agitated and suspicious of people. He described having a resurgence of the feelings of paranoia, and that people were out to get him, similar to what he experienced in hospital. It was agreed he would attend for a further six sessions on his return to England.
- 4.6 Dr B wrote to his GP in December 2006 informing him that she had agreed to see Tom again for six sessions, but advising that the service remit is to support acute neurosciences, therefore if his problems were longer term she may recommend that he be referred to local mental health services.
- 4.7 Tom's presentation at this time was described by Dr B as a renewed preoccupation with the delusions and hallucinations he experienced in hospital, and a lower threshold for anxiety so that his pre-existing shyness had now led to a social phobia. His background anxiety which was related to long-standing workplace bullying was described as now leading to catastrophic thoughts. The treatment was described as focussed on cognitive behavioural strategies for improving his self-confidence and reducing the phobic element of his behaviour, and exploring the delusions to clarify their unreality.
- 4.8 An urgent referral to NHFT community mental health services was made by his GP on 9 February 2007, after Tom attend the GP surgery, complaining of feeling increasingly agitated and paranoid, with periods of deep depression. The GP's faxed referral was followed up with a more detailed letter dated 9 February 2007. Dr B had phoned the GP surgery

on 8 February expressing concern that Tom's mental health had deteriorated.

- 4.9 Tom was written to on 9 February and then seen for an initial appointment on 12 February at The Gables (East Northamptonshire community mental health team, Rushden Hospital).

## Northamptonshire 2007- 2013

### East Northants Community Mental Health Team

- 4.10 Tom was referred to East Northants Community Mental Health Team (CMHT, also called The Gables) on 9 February by his GP, after being seen by his GP for the first time on 8 February.
- 4.11 The GP had had a call from Dr B on 8 February, stating that Tom had called her the previous day, and expressing her concerns about Tom's mental health and her opinion that he was at considerable risk, without giving an opinion of the kind of risk. The GP made an urgent referral to the East Northants CMHT.
- 4.12 Tom told his GP he had episodes of depression, paranoid delusions and panic attacks. He reported being increasingly agitated and paranoid with periods of deep depression. The GP offered to refer him to East Northants CMHT, and prescribed an antidepressant and a short course of zopiclone.<sup>12</sup>
- 4.13 He was seen by a community mental health nurse for an Initial Screening Assessment (ISA) appointment on 12 February 2007. The main issues were difficulty sleeping and paranoid thoughts that people talk about him and are out to harm him. He said he cannot run or walk long distances since his accident so cannot do sports he used to enjoy. In the 'assessment of risk' structure three domains are noted; indicators of danger, support system and ability to cooperate. These are rated 1 to 5 with 1 as most serious. He was assessed as having no suicidal ideation or behaviour (indicators of danger: 5), interested family, friends or others willing to help (support system: 4), and actively seeks outpatient treatment, willing and able to accept support (ability to cooperate: 5). He was initially offered an outpatient appointment, but after a further deterioration a request for him to be seen urgently was made by his GP.
- 4.14 Dr B phoned the GP again on 14 February 2007 suggesting that atypical antipsychotic medication may be required. Tom and his mother came to see the GP on 14 February, both requesting help. Both were noted to feel desperate about Tom's mental health, and his thoughts of having abused a young girl were noted.

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<sup>12</sup> Zopiclone tablets are sleeping pills used for short term treatment of difficulties in falling asleep, waking up at night or early in the morning. <https://www.medicines.org.uk/emc/medicine/18157>

- 4.15 A further letter was faxed to the community mental health services by the GP on 14 February 2007. He was seen at The Gables on 14 February 2007.
- 4.16 Tom was seen initially by a social worker from the CMHT, but when it became evident that his medication would need to be reviewed, Dr A, the consultant psychiatrist, joined the meeting. In the past two weeks he had become convinced that he had sexually assaulted a young girl and had been telling his family this. He felt unmotivated and lacking energy since giving up the job in his family's firm.

### **Crisis Resolution Home Treatment Team (CRHTT)**

- 4.17 Further support was arranged through the CRHTT and Tom was prescribed quetiapine<sup>13</sup> 50mg twice daily, increasing to 200mg twice daily within four days. Dr A advised increasing his citalopram<sup>14</sup> to 20mg daily and to continue with zopiclone to help him sleep.
- 4.18 The Crisis Resolution Home Treatment Team (CRHTT) assessment tool was completed on 14 February 2007. Tom was described as feeling very low with some delusional thoughts, and had anxious thoughts of people talking about him and wanting to harm him. He reported finding it easier to sleep with zopiclone. At this assessment it was noted he had no suicidal ideation or behaviours, and no history of violent or impulsive behaviour, he had interested family and friends who were willing to help.
- 4.19 He was discharged by the CRHTT on 19 February 2007 with an up to date HoNOS<sup>15</sup> assessment, and he was noted to have shown some improvement (but does not say how). He was assessed as having no suicidal ideation or behaviour (indicators of danger: 5), interested family, friends or others willing to help (support system: 4), wants to get help but is ambivalent or motivation is not strong willing and able to accept support (ability to cooperate: 4). This assessment had changed in the 'ability to co-operate' section only, which noted he was not actively seeking out treatment.
- 4.20 His medication had been increased to quetiapine 200mg twice daily, citalopram 10mg at night and zopiclone at night. Tom was reported to be happy with the medication and felt it was helping, but was still preoccupied with ideas about harming a child in the past. He was to be

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<sup>13</sup> Quetiapine is used to treat the symptoms of schizophrenia or, alternatively, for a mood disorder such as mania or depression. <https://patient.info/medicine/quetiapine-seroquel>

<sup>14</sup> Citalopram is a selective serotonin reuptake inhibitors (SSRI) used in the treatment of depression. <http://patient.info/medicine/citalopram-cipramil-paxoran>

<sup>15</sup> Health of the Nation Outcome Scales. <http://www.rcpsych.ac.uk/crtu/healthofthenation.aspx>

allocated a key worker at The Gables while awaiting an assessment by the early intervention in psychosis service, called NSTEP.<sup>16</sup>

### **East Northants Community Mental Health Team (The Gables)**

- 4.21 A further outpatient appointment was arranged for 19 February 2007, and it was arranged for someone from NSTEP to be present as it was thought he may fulfil their criteria and they could offer a more intensive support than the CMHT. Dr A saw him initially alone then with his mother, and members of the CRHTT and NSTEP. In the week since the last appointment he reported that his sleep and appetite had improved and he was feeling less agitated, but still had no energy or motivation. He was still insisting that he had sexually assaulted a little girl, and described an “image” of being behind the sofa with the little girl and of two other people as well as his parents being in the room. He insisted this had really happened and was not a dream, and he had not mentioned it before because he had “blocked out” the memory. His mother reported that she did not think he had improved that much, and still required a lot of prompting, and was preoccupied that people were out to get him. At this time he was living at his parents’ house.
- 4.22 The plan agreed was that CRHTT would discharge him, CMHT staff would see him at home the following day, Dr A would see him the following week, current medication would be continued, and the ISA team would ‘hold’ him as keyworkers until it was clear whether NSTEP would accept him. A crisis plan was agreed, and it was noted that there were no immediate risk to self or others identified at this consultation.
- 4.23 At the next appointment with Dr A Tom was not tearful but reported feeling very depressed and sitting staring into space at home. His sleep had improved but he was now eating more and had put on weight, he was staying with his parents as he felt unsafe in his own home, worrying that neighbours believed him to be a paedophile and therefore a threat. He denied being sexually aroused by images of children and said he had never downloaded sexual images of children from the internet. He found reminders of children upsetting and actively avoided them or mention of them in the media, as he was frightened that he might pose a risk to children.
- 4.24 His diagnosis was ‘psychotic episode’, and Dr A stated that her impression was that the differential diagnosis was between a depression with psychotic features and a delusional disorder. His quetiapine and citalopram were increased to 500mg and 40 mg respectively, and he was seeing an NSTEP worker twice a week, and the outcome of NSTEP’s assessment was awaited. Dr A arranged to see him again in two weeks. No immediate risks to self or others were identified in this

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<sup>16</sup> Northamptonshire service for the treatment of early psychosis or NSTEP, for people aged between 14 and 35 who are experiencing their first episode of psychosis and have not had treatment before.  
<http://www.nht.nhs.uk/main.cfm?type=CONTENT3>

consultation, and Dr A also wrote 'in particular I do not believe that [Tom] poses a risk to children'.

- 4.25 Dr A noted an improvement on 12 March 2007, and he was sleeping and eating well, and taking part in more activities outside his parents' home, though still reluctant to return to his own home. No risk to others were identified and he specifically denied any suicidal ideation.
- 4.26 In early April Dr A noted that Tom was doing very well, his previous belief that he was a paedophile was receding, he was feeling more confident and had been socialising. His mood was much brighter and he reported that he and his girlfriend were thinking of moving nearer to Cambridge where she worked. Advice was given about splitting the dosage of quetiapine differently because he complained of sedation in the mornings. The formal outcome of the NSTEP assessment had still not been received by 11 April, although they were continuing to see him twice weekly.
- 4.27 He was seen by Dr A on 18 April 2007 urgently at his request, and said he had returned to his own home two weeks earlier as his parents were away on holiday. He heard a passer-by say "the lunatic" which he had taken as referring to himself, and since then his mood had dropped, and he experienced feelings of anxiety. He had increased support from NSTEP, but the preoccupation with ideas related to paedophilia had returned. He did not want to increase medication. Although there was a past history of self-harm, Dr A noted she did not feel there was an immediate risk of harm to self or others at this consultation.
- 4.28 On 25 April 2007 it was confirmed that Tom had been accepted onto the NSTEP caseload, and a key worker and consultant psychiatrist Dr C were allocated. A referral for carer support was made in April 2007 for Tom's mother.
- 4.29 Dr A saw Tom on 30 April 2007, and he was much brighter in mood, had been much more active and was continuing to take the medication (quetiapine 500mg and citalopram 40mg). Dr A noted she discussed his care with Dr C, and he had agreed to take over the consultant role. Dr A therefore discharged him from East Northants CMHT.

#### **NSTEP**

- 4.30 Tom was allocated a care coordinator and he was seen weekly individually, and was able to attend activity groups run through NSTEP. The focus of his care was on anxiety management and cognitive coping skills. He was seen in June 2007 for an assessment by the team psychologist. Tom was noted to say he felt he was recovering without the need for individual therapy, so it was agreed he would attend the recovery group initially and then assess if individual psychological work was needed.

- 4.31 There are no Epex<sup>17</sup> entries between 12 April 2007 and 12 July 2007. There are however paper notes from March to Sept 2007.
- 4.32 In May 2007 Tom's parents attended a 'friends and family' information group run by NSTEP.
- 4.33 By July 2007 Tom was living with Sally again, and 'high expressed emotion' was noted from Tom's mother, and 'obvious tension' was noted between Tom and his mother. On 2 August Tom reported feeling anxious but was noted to have a meeting with NSTEP psychologist PSY1 on 8 August.
- 4.34 Individual psychology sessions started in August 2007, and Tom identified his main goal as developing coping strategies when he hears comments which he perceives as derogatory in social situations. A formulation was developed of paranoid thoughts and how social situations can trigger a very emotional memory of being convinced that a group of people are going to harm him and his family. This memory was linked to his hospital stay following the motorbike accident in May 2004.
- 4.35 In September 2007 it was felt he would benefit from support from a male care coordinator, and CPN1 was allocated, who remained his care coordinator until discharge from NSTEP in September 2012.
- 4.36 Tom started a Masters course in October 2007 but had paranoid thoughts that people at the university knew about him abusing a child. He called the Samaritans on 30 October, and was seen at the NSTEP team base the following day, upset and tearful. At this time he said he would not kill himself because of the effect on his family, he felt very low but had no suicide plan. He was referred to Meadhurst<sup>18</sup> 24 hour support service.
- 4.37 In November 2007 his quetiapine was stopped because he was not tolerating the side effects of drowsiness, and had begun to reduce it himself. He was prescribed aripiprazole<sup>19</sup> 15mg to increase to 30 mg after one week, and the prescription of citalopram 20mg remained. He was noted to be struggling with university, and had started taking his quetiapine at the same time as aripiprazole, despite the junior psychiatrist's (Dr H) advice not to take two antipsychotics. Tom maintained that quetiapine helped him to sleep, and the aripiprazole helped his paranoia but left him feeling anxious.
- 4.38 He was reviewed by Dr H and PSY1 at the end of November 2007. Tom stated that attending the individual sessions meant his beliefs were

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<sup>17</sup> Epex was the electronic record keeping system used by NHFT at the time.

<sup>18</sup> Meadhurst was a local authority 24 hour crisis service in Kettering, no longer operating.

<sup>19</sup> Aripiprazole is an antipsychotic prescribed to relieve the symptoms of schizophrenia.  
<https://patient.info/medicine/aripiprazole-abilify>

explained by psychosis, which was difficult for him to accept because he was sure that his own explanations for his experiences was correct (i.e. that he had sexually assaulted a young girl, and everyone knew about it). He complained of poor sleep and agitation and anxiety since starting aripiprazole, and that the citalopram had no effect. He denied also taking quetiapine, Dr H noted his view to Tom and Sally that the agitation was a result of the combination of medications.

- 4.39 In November 2007 his partner Sally attended a 'friends and family' session run by NSTEP.
- 4.40 The prescription was changed to aripiprazole 15mg, and citalopram was changed to mirtazapine,<sup>20</sup> and a short term prescription of zopiclone to aid sleep was also given. His agitation settled and he was able to continue his college course, seeing CPN1 and PSY1 regularly. He was reviewed by Dr H in December 2007 and it was noted that he was tolerating the medication well, was not preoccupied with paranoid beliefs.
- 4.41 In January 2008, a carer's assessment was offered to Sally by NSTEP, which was started in March 2008.
- 4.42 Tom continued to see PSY1 monthly, and had regular face to face and telephone contact with CPN1 until March 2008. At the end of March Tom informed CPN1 that he had stopped taking aripiprazole because it interfered with his concentration on his coursework, he was advised against this, but said he would start again if paranoid feelings started. It was planned to work on identifying his early warning signs after his exams finish in May 2008.
- 4.43 At an individual session with PSY1 in April 2008 Tom said he was now completely recovered from his psychosis, and no longer believed that people were talking about him or conspiring against him. He told PSY1 that he had also stopped the antidepressants, but started taking them again because he started to feel low in mood, and they had helped. In May 2008 Tom was due to go on holiday to Bali where he was due to be best man at a friend's wedding. CPN1 discussed strategies to minimise stress with him, and reminded him he could call the Meadhurst 24 hour service number. Tom called from Bali, saying he was feeling paranoid, had dropped out of being best man and had started taking his medication again (aripiprazole and mirtazapine). He also called CPN1, said he had been very anxious and believed his paranoid feelings might return, he was advised to restart his medication and try to source some anxiolytics locally.
- 4.44 This appeared to have been effective and he later reported that he felt he had coped well. After the holiday he returned to live at his parents' house to work on his thesis. He agreed a further four individual sessions

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<sup>20</sup> Mirtazepine <https://patient.info/medicine/mirtazapine-for-depression-zisprin-soltab>

with PSY1, to work on his key beliefs that may have contributed to his underlying low mood and self-esteem. Tom said he felt he had not separated developmentally from his parents and wanted to be more independent and pursue his own goals. Tom saw PSY1 fortnightly through August and September, and in September he completed and handed in his Masters' thesis.

- 4.45 Tom started a temporary job in late September 2008, and paranoid ideas about workmates and beliefs that they were whistling started again, although he decided to work through this and carry on. Sally called NSTEP on 1 October to say she was concerned that Tom was very unwell and asking for him to be seen urgently. He was seen by Dr H and a CPN in CPN1's absence. Tom was very distressed and said he had lost the will to live but had no suicide plan. He experienced early morning waking and felt he was in the midst of a conspiracy against him, but he was assessed as of low risk of harm to children and low risk of suicide. He accepted an increase in mirtazapine to 30mg and continued taking the prescription of aripiprazole. He did say in a call a week later that the only reason he hadn't killed himself was because of the effect on his family.
- 4.46 A psychology appointment was brought forward, and Tom again said he had suicidal thoughts but would not act upon them because of the pain it would cause to his family and Sally. He was again preoccupied with the belief that he had molested a child and his co-workers were conspiring to get him to kill himself. The pattern of Tom wanting help when feeling distressed but distancing himself from treatment when he felt better was discussed with him.
- 4.47 He was reviewed by Dr H on 24 October 2008 with CPN1, and had no suicidal ideas, but the paranoid ideas remained. Tom said he tries to distract himself, he was taking aripiprazole and agreed to increase mirtazapine to 45mg.
- 4.48 By 11 November 2008 however Sally told CPN1 that Tom had stopped taking aripiprazole. He told PSY1 that he had stopped taking aripiprazole because of side effects. He requested extra psychology sessions to help prepare for a job interview, which was agreed. Tom told PSY1 that that he wanted people to believe that he had molested a young girl, and be appropriately punished, rather than have to accept that this was a facet of his psychosis. PSY1 explained that he did not feel it appropriate to activate child protection procedures because he did not believe Tom was a risk to children. Tom had an appointment planned with CPN1 for the following day.
- 4.49 The following day Tom turned up unexpectedly at the NSTEP team base stating he had suicidal thoughts of stabbing himself in the chest with a knife. He was seen for assessment by CPN1 and the CRHTT, and he was concerned that there was no move to place him on the sex offenders' register. Social stressors were noted, that is he was due to start a new job on Monday, he was concerned that his relationship with

Sally was deteriorating because of his ruminations, and there was recent media coverage of paedophile activity.

### **Crisis Resolution Home Treatment Team (CRHTT)**

- 4.50 It was agreed he would be seen daily from 27 November by the CRHTT, jointly with CPN1 where possible; and a medication review would take place with the CRHTT psychiatrist. He was due to start a new job the following week. He was seen over the weekend by CRHTT, and continued to ruminate on beliefs and appear low in mood but denied suicidal ideas. He was seen for review on 3 December 2008 by the CRHTT psychiatrist, diazepam was added short term and the plan to continue CRHTT input with gradual handover back to NSTEP was agreed. His mother asked for support with the strain that this has put on the family, and it was agreed to discuss with PSY1. Tom's mother refused a carer's assessment.
- 4.51 By 11 December Tom reported he was feeling a lot better, was managing the travel to work, and was no longer in crisis. He was discharged from CRHTT on 11 December 2008.

### **NSTEP**

- 4.52 CPN1 kept in touch over the next few months while Tom attended work and seemed more settled. PSY1 saw Tom and Sally together in April 2009, and they had been spending more time together. Tom talked openly about how his parents are critical and offer unsolicited advice, so he was starting to spend more time with Sally and less at his parents' house. Sally said she was hopeful of having children with Tom, and was committed to doing anything that prevented him relapsing. Later that month however he tried to make contact with the father of the girl he alleges he molested, and was strongly advised not to by NSTEP staff.
- 4.53 Sally and Tom were seen together in May 2009 by PSY1 and CPN1 to discuss possible couple's work, looking at their relationship and how it had changed since the onset of Tom's difficulties. Both had concerns about the future of the relationship, and agreed to have some initial sessions to assess the potential usefulness of these, to be carried out by PSY1 and a female psychologist, PSY2.
- 4.54 At the first of these they disclosed that they had planned to get married, and Tom had proposed after the motorbike accident. Sally had accepted but they had not got around to getting married. Sally was less concerned about getting married but would like to have children with Tom if this were possible. Six days after this session, on 6 July 2009 Tom presented at a police station in Bedford. Tom was arrested and interviewed under caution, and bailed until 21 August 2009. Tom's sister contacted an NSTEP social worker who called the police to find out more. The police officer informed NSTEP that Tom disclosed that he had not been taking his medication for the past week. The NSTEP social worker maintained contact until the next joint psychology session. Through this time Tom presented as calm and rational, he had told Sally

who regarded it as his decision to make. His sister remained very distressed however. At the joint psychology session Tom said he was glad he had gone to the police as it meant facing up to what he had done. They talked of planning to get married and moving nearer to Sally's work so she had less of a commute. By September 2009 they reported moving forward with plans to get married and were discussing practicalities. Both said they thought things were going well and did not see the need to meet further.

- 4.55 Tom was seen monthly by CPN1 during late 2009 and early 2010, and Tom reported he was well and had no mental health concerns. His mother called NSTEP in March 2010 expressing concern about what would happen if/when Tom was discharged from NSTEP, as she believed he still isolates himself socially and continues to need support from the family to motivate himself.
- 4.56 Sally and Tom were married in July 2010, and he was working from home for a friend on IT work. He was seen by CPN1 monthly, although there is an unexplained gap in the visits between December 2010 and March 2011. It was known that Tom's grandmother died in February 2011, to whom he was very close.
- 4.57 In May 2011 a private fertility clinic wrote to CPN1 to request details of any psychiatric treatment with regard to possible risks to any unborn child. It was noted in this letter that he had told the clinic he had had medication and had 'delusions that he had abused a child in the past, reported himself to the police, that this was fully investigated and found to be false'. The staff grade psychiatrist wrote to the clinic on 7 June 2011 after receiving permission to disclose from Tom, and it was confirmed he had received treatment for psychosis but was not taking any medication currently, and stating that there are 'no known current factors in [Tom's] mental health that would deem him at risk to the welfare of children, born or unborn. There is no reference to this correspondence in the Epex clinical records.
- 4.58 At midnight on 11 June 2011 Sally called the CRHTT to say that Tom had cut his wrists at home in their bathroom, and had been taken by ambulance to Leicester Royal Infirmary for treatment. He was seen at the hospital by CPN1, CRHTT and Leicester deliberate self-harm team.
- 4.59 Tom reported feeling depressed for the last month, his job had not worked out, and he heard a voice from the TV telling him to cut his wrists. This had occurred over the previous three weeks, increasing in intensity. It was noted that he had never disclosed command hallucinations to NSTEP. He had made cuts that severed tendons to his left arm, requiring surgery to repair tendons and nerve damage. His right arm was also cut but with less severe damage. Tom said he wanted to die and intended to kill himself, he went upstairs to the bathroom at midnight with a ceramic knife and started to cut. He had locked the door and his wife heard a noise and disturbed him, later it was noted that Tom showed no regrets.

- 4.60 He was admitted informally to Avocet Ward, St Mary's Hospital Kettering. He was assessed by a staff grade psychiatrist, and the triggers were noted as seeing the fertility clinic four weeks earlier, grandmother's death, and unemployment. He said he was used to hearing voices but says he has learnt to ignore them. Sally had been working in Germany the previous week, returning on the Thursday. They had stayed up late on the Saturday night and he had snapped at her, then went upstairs about 23.30. He said this was triggered by messages from the television saying 'you might as well end it all', 'you are walking around with your head in the clouds'. He had locked the bathroom door but fell and hit his head after cutting himself, Sally heard and came to find out, then she applied first aid. It was planned that he would be observed under 'general ward observations' to be increased at nurses' discretion, have ECG and routine bloods and drug screening, and plans would be reviewed at the team meeting.
- 4.61 On 18 June 2011 he completed a Beck Depression Inventory,<sup>21</sup> scoring 36 which signifies 'severe depression'. Scores over 40 suggest 'extreme depression'. Tom told staff he would kill himself if he had the chance.
- 4.62 He was not taking any antidepressant or antipsychotic medication at the time. Risperidone<sup>22</sup> 2mg twice a day was started. Tom's mood and mental state gradually settled, and at ward round on 13 July it was suggested he be offered a depot injection (risperdal consta),<sup>23</sup> to which he agreed. At this stage he expressed regret for what he had put his family through and was no longer suicidal, and spoke of undertaking a PhD in the future.
- 4.63 On 24 June 2011 an initial summary was sent to Tom's Rushden GP. Some of the identifiable triggers were:
- They had been trying for a baby for the last five years, and during the last visit to the fertility clinic Tom had to complete a form asking him to declare any mental health or child protection issues.
  - Between 2007 and 2009 he was jobless, and was not in receipt of any benefits. His DLA and jobseekers allowances expired, and he didn't bother to renew then because he was planning to work.
  - His grandmother died in February 2011, she was described as a great source of strength and inspiration. Tom said his grandfather had mental health issues, so he thinks the odds are against him and he will only get worse.

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<sup>21</sup> Beck, A.T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961) An inventory for measuring depression. *Archives of General Psychiatry*, 4, 561-571

<sup>22</sup> Risperidone is an antipsychotic use to treat symptoms of schizophrenia. <https://patient.info/medicine/risperidone-risperdal>

<sup>23</sup> Risperdal Consta is a long acting injectable form of risperidone <https://patient.info/medicine/risperidone-long-acting-injection-risperdal-consta>

- His wife has a demanding job and works far from home. She is able to keep up the mortgage payments. No relationship problems were disclosed but there were enough problems to put a strain on things.
- 4.64 A diagnosis of schizophrenia was made, which Tom and his family found upsetting, and information on the diagnosis and treatment options was shared. After many leave periods Tom was discharged from the inpatient ward on 2 August 2011. His hand had healed well and he was accepting depot medication, and felt much better. He did however complain of various side effects since the start of the depot. He was still on oral medication at this time, and this was being gradually reduced. At this time Sally was being seen monthly by the carer's support organisation, which she reported she found very helpful.
- 4.65 On the morning of 4 October 2011 Tom phoned CRHTT to say he had heard someone whistling at work and felt really uneasy. He was advised to speak to CPN1 in the morning. Tom was seen at home by CPN1 and the consultant psychiatrist Dr C later that day, he said he had not slept properly for two nights, lying awake ruminating and worrying. Yesterday at work he heard whistling and became very panicky, afraid he is relapsing, and he had attended the funeral of a friend of his wife who had committed suicide.
- 4.66 He showed no signs of psychosis but had catastrophic thinking, which was thought may be early warning signs of relapse. Tom stated he could keep himself safe at present and had intent or no plans to harm himself. He agreed to an increase in his depot risperidone to 37.5 mgs later in the week, and he was prescribed oral risperidone 2mg daily for 28 days, and zopiclone 7.5mg for 14 days to aid sleep. Dr C explained to Tom that the depot of risperdal consta 25mg fortnightly is a relatively low maintenance dose and it may be that this needs to be increased. Tom was reluctant to increase the medication, but he was prepared to listen to advice and agreed to the increase. Dr C wrote to his GP, with a copy to Tom, and the management plan was:
- Ongoing NSTEP involvement
  - To remain in receipt of CPA
  - Risperdal consta increased to 37.5 mg fortnightly from 6 October 2011
  - Risperidone 2mg orally daily for 28 days, and zopiclone 7.5mg for up to a maximum of 14 days.
- 4.67 It was noted that NSTEP were confident his family would be in touch if there were any difficulties, and the crisis plan was to contact key worker, or another member of NSTEP team if unavailable, out of hours or in an emergency contact primary care services in the usual way or the Crisis and Telephone Support Service (CATSS) which is a 24 hour service.

- 4.68 In October and November 2011 Tom presented as mentally well and was seen monthly by NSTEP and to administer his depot. On 17 November he complained of low mood and motivation. He did not express any suicidal ideas. A review meeting with Tom, Sally and Dr H took place, and the concerns were discussed. It was agreed that he would have a lower dose of depot injection. He was seen fortnightly by CPN1, and by the end of January 2012 Tom reported that he felt less sedated, had no 'breakthrough' symptoms, felt well and was working near Cambridge.
- 4.69 In March 2012 Tom complained of a fine tremor after his depot injection, and was prescribed procyclidine<sup>24</sup> 5mg and he later reported feeling more alert after starting this medication. In May 2012 Sally and Tom asked if he could come off the depot injection, and at a review meeting with the junior psychiatrist Dr H on 14 June 2012 this was agreed, with a plan to start oral medication one week later.
- 4.70 In July 2012 Sally called to say she was concerned that Tom was oversedated, and he was tired and irritable, although not showing any signs of psychosis. After discussion with Dr C, it was agreed to change from risperidone 3mg daily to 2mg daily for 28 days. He remained well and talked of moving to the Cambridge area with Sally and renting out their Rushden house, and that they were trying for IVF treatment.
- 4.71 At this time a possible referral to Rushden CMHT was discussed, and both Tom and Sally were noted to be in support of this.
- 4.72 Sally had started regular meetings with a carer support worker in September 2011 and was seeing her bi-monthly. At the time the carer support workers were allocated to individual CMHTs.
- 4.73 On 21 September 2012 Sally and Tom were seen by CPN1 and Dr H. Tom was noted to be very well, was enjoying his new job, and coping well with medication. It was noted they were trying for IVF treatment. Both Tom and Sally agreed it was appropriate to transfer him to Rushden CMHT, and their plans to move to Cambridge were no further forward. The plan was to 'send the CPA1 to Rushden CMHT'. This is the last Epex entry for Tom, although he continued to be seen at outpatient appointments.
- 4.74 There are monthly entries in Tom's Epex by the carer support worker, documenting her meetings with Sally, between September 2012 and November 2013. It was clarified that at this time the carer support workers worked as a member of the CMHT and made entries in the notes of the patient concerned, although this has now changed.

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<sup>24</sup> Procyclidine is used to relieve unwanted side-effects caused by antipsychotic medicines.  
<https://patient.info/medicine/procyclidine-arpicolin-kemadrin>

- 4.75 A 'CPA1' form was completed by CPN1 on 25 September 2012, which was the notification of transfer to East Northants CMHT. There are no Epex entries referring to the process of referral to the CMHT.

#### **East Northants Community Mental Health Team (The Gables)**

- 4.76 An appointment was offered by Dr D at The Gables on 2 November 2012, which was changed to 29 October 2012, and he was eventually seen for the first time by Dr D on 31 January 2013. It is not clear what caused this delay, and the level of CPA was not noted. There are no notes of any handover meeting between the clinical teams, and it was clarified that there was no handover meeting.
- 4.77 It was noted that he had a diagnosis of paranoid schizophrenia (ICD 10: F20).<sup>25</sup> Tom was seen with Sally, and they were concerned about side effects of medication because they had been trying to conceive and were about to undergo IVF treatment. Tom request that his medication be reduced, and a lengthy discussion about the risks of this was described. Sally in particular raised concerns that Tom tended to deteriorate very quickly and has harmed himself when experiencing auditory hallucinations. A trial of sildenafil<sup>26</sup> was proposed, which both accepted. Tom did not describe any psychotic symptoms or any thoughts of self-harm or suicide. It was decided that Dr D would review him again in April 2013, he was to continue on risperidone 3mg at night and procyclidine as required. A letter summarising this was sent to his Rushden GP.
- 4.78 On 26 March 2013 it was noted by Dr D that Tom and Sally reported that they had gone through IVF treatment but it was not successful, and the sildenafil had not helped. Dr D noted that that both were keen that Tom came off risperidone and requested an alternative medication to avoid relapse. It was agree that risperidone be decreased slowly, and aripiprazole was introduced from 10 April 2013. No risk were elicited during the assessment. His CPA status was noted as 'NCPA', with Dr D as care coordinator, which meant he was not on CPA. Dr D was technically the lead professional, not the care coordinator, and this was regarded as a typographical error.
- 4.79 Dr D saw Tom and Sally again on 28 May 2013, and Tom reported that he had become more preoccupied with his thoughts and had been sleeping less, although he had no breakthrough psychotic symptoms. A small dose of risperidone 0.25mg was started, to be taken at night as required. Both reported Tom waking up at night and becoming paranoid, and requesting something to aid sleep. Promethazine 25mg was suggested, and his GP was asked to prescribe this and the risperidone.

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<sup>25</sup> International classification of diseases. <http://apps.who.int/classifications/apps/icd/icd10online2004/fr-icd.htm?gf20.htm>

<sup>26</sup> Sildenafil is prescribed for erectile dysfunction. <https://www.evidence.nhs.uk/formulary/bnf/current/7-obstetrics-gynaecology-and-urinary-tract-disorders/74-drugs-for-genito-urinary-disorders/745-drugs-for-erectile-dysfunction/phosphodiesterase-type-5-inhibitors/sildenafil>

No thoughts of suicide or self-harm or other risks were elicited. His CPA status was noted as 'CPA', with Dr D as care coordinator.

- 4.80 Dr D saw Tom and Sally on 28 June 2013. Tom reported he had been taking risperidone with good effect, and said he wants to continue taking it as it helps to keep him mentally stable and aids sleep. There were no symptoms of psychosis and he was less concerned with his thoughts. It was noted that Tom and Sally said they were in the process of moving to Cambridgeshire and they were requested to let Dr D know so that his care could be transferred to the local CMHT. It was noted he remained stable, no risks were elicited and a further appointment was arranged for September 2013, where transferring his care would be discussed. His CPA status was noted as 'No CPA', with Dr D as CPA care coordinator.
- 4.81 At the appointment on 6 September 2013 Tom described feeling less well, with a recurrence of some of his delusional beliefs in relation to believing that he may have done something to a child in the past. He was preoccupied with these beliefs. Tom was noted to say he had never experienced any hallucinations but had experienced delusions of reference where he believed the TV may be referring to him. Despite this, he was working full time. Dr D's opinion was that Tom was suffering from a delusional disorder rather than paranoid schizophrenia, because he had not shown any disintegration of personality. Aripiprazole was increased to 15mg daily in order to counter some of his delusional beliefs.
- 4.82 It was noted that they were about to register with a new GP surgery in Cambridgeshire, and to avoid his care becoming lost in transition, Dr D agreed to see him again in November 2013. The intention stated was that the new surgery would be requested to refer Tom to the local community mental health team.
- 4.83 Dr D saw Tom and Sally on 22 November 2013 and Tom described an improvement in the way he was feeling since the increased aripiprazole. It was agreed by Dr D that he could be discharged to the care of his new GP, with a view to a referral being made to the local CMHT if needed. No risks were elicited and he did not describe any thoughts of self-harm or suicide, and he was noted to be compliant with medication with no reported side effects. A letter was sent to his new GP at Cedar House surgery in Cambridgeshire with this information.
- 4.84 On request, Dr D wrote to the Huntingdon CRHTT psychiatrist on 2 April 2014, to summarise the medication, and noted that Tom's mental health appeared stable at the last appointment in November 2013, and he had not described any thoughts of self-harm, nor did he describe any psychotic symptoms or any mood disorders.

## **Cambridgeshire 2014 - 2015**

### **First CPFT contact**

- 4.85 A referral was made to CPFT Advice and Referral Centre (ARC) on 28 March 2014, after Tom was seen at the surgery with his sister. Tom said he stopped the aripiprazole two weeks earlier and was not taking procyclidine either but was taking risperidone. He had told the referring GP he had not taken medication for two or three months. He said he had been feeling more anxious, had auditory hallucinations, feeling that songs on the radio were directed at him, and was not sleeping well. He said he had no suicidal ideas. An urgent assessment was requested from ARC.
- 4.86 This request was acknowledged within two hours, and allocated to the Adult Huntingdon Crisis Resolution Home Treatment team (CRHTT). A CRHTT social worker called Tom on his sister's phone. Tom said he was feeling much better that afternoon, mornings are worst. He agreed to come to Newtown Centre on 29 March 2014, was going home to his wife that afternoon and would be able to keep himself safe.
- 4.87 A 'notification of assessment outcome' form was faxed to the GP surgery on 31 March 2014, with a summary of the assessment conducted by a CPN on 29 March 2014. Tom was noted to believe songs on the radio relate to him, his motivation and energy levels had decreased to the extent he was finding it difficult to get himself to work. He was not sleeping well and had gained weight. His mood was rated as 4 or 5 out of 10. He did not feel at risk to himself but was worried it might become an issue. It was noted that this may be more of a chronic condition rather than a crisis, and an extended review with the team doctor was planned for 31 March 2014, and the current plan was to see Tom on alternate days until then. Tom accepted CRHTT engagement. Two zopiclone tablets were given to aid sleep. A referral to Huntingdon Adult Locality Team (HALT) was made.
- 4.88 Tom was seen for an extended assessment by the CRHTT junior doctor (Dr E) with Sally and Tom's sister. Side effects which affected their relationship were noted, and Sally and Tom made a gradual change reducing aripiprazole to 15 mg. The side effects improved and they decided to stay on the low dose of risperidone. They had moved and continue to try for a baby but his motivation and energy levels were low. This led to some relationship difficulties and at one point Sally was considering leaving him. It was noted by the GP that Tom had made the decision to come off medication to try to tackle all these things, and had not told Sally this. The GP advised the lesson to be learned was to try and involve his medical team in decisions. The confidential entry ended here. CPFT commented on the draft report that CPN2 was not aware of relationship difficulties during his care under HALT.
- 4.89 Ongoing psychological issues were noted that needed addressing, with loss of self-confidence and self-worth. The whole family were described as chronic worriers. Tom said he had never had any psychological work, which was not actually true. No risks were expressed, and Sally challenged him about this but Tom was clear he had no intent to act on his fleeting suicidal thoughts. Tom was taken on for crisis support for

anxiety management and daily planning. He was referred to HALT for ongoing support. The plan was to continue aripiprazole 15mg and risperidone 500mcg, with as required zopiclone. His old notes were requested from Northants.

- 4.90 A CPA review was recorded on 3 April 2014, with Dr E and Dr F, the CRHTT consultant. It was noted his worries were his lack of motivation on medication, and the challenges this brings for his work and life. It was suggested an antidepressant may be considered in the future, but at present stick with plans to structure his day with support.
- 4.91 Tom was seen daily, and reported an increase in his ability to structure his day and motivate himself. Sally had been referred to 'Making Space' and was seeing a counsellor. By 8 April 2014 Tom agreed he was no longer in crisis but would benefit from 'a more permanent support structure'. A referral to HALT had been made and he was discharged from CRHTT care on 10 April 2014, with an assessment appointment at the HALT offices at the Newtown Centre on 27 April 2014 with CPN2. Various contacts were made by Sally to say things were not too bad, and requesting the appointment be moved, then when rearranged for 20 May, she cancelled again as they were going on holiday.
- 4.92 The appointment was again rescheduled by Sally to 29 May, and Sally said he 'wasn't too bad' and was working at present. Tom did not attend the rescheduled home visit on 29 May, and when called he said things were a lot better, and asked for an appointment out of hours because he was working now. It was explained that HALT was a 9-5 service. Tom said he did not think he needed support from the HALT team now and said he would contact next week, Tom is noted to have said he has a good GP and his wife was supportive. CPN2 noted a plan to discuss this with the HALT psychiatrist Dr G, and the plan after this discussion was to discuss with Cedar House surgery with a view to transfer back to primary care as his mental state had improved.
- 4.93 CPN2 called Cedar House surgery on 16 June 2014 and it was agreed that Tom would be transferred back to primary care, with the understanding that he could be referred back to HALT via the CPFT Advice and Referral centre (ARC) if needed. No discharge letter was written, and it transpired that Tom was not formally discharged from CPFT systems.

### **Second CPFT contact**

- 4.94 Tom's mother called CRHTT on 17 September 2014, with concerns about his presentation. She stated he had been doing really well, but had a call from him today. He was in Norwich with work, sounded vague and said he was unable to think. It was advised he would need to see his GP to be re-referred to the CRHTT, or Tom could go to A&E to be assessed. Sally also called CRHTT, and said she had been called by Tom, who sounded very anxious. The route for referral was explained,

and Sally was noted to be not very happy as she thought he could be seen again by CRHTT without seeing his GP.

- 4.95 A 5 day referral was received on 19 September from his GP through ARC and was passed to CPN2, as it was noted that he still appeared 'open' to the HALT service.
- 4.96 An appointment was sent by CPN2 for 26 September 2014. Sally called to ask if the appointment could be rescheduled as they were hoping to take some holiday, so it was rescheduled for 6 October. Sally said he was very unwell again and she thought he had stopped taking his medication.
- 4.97 CPN2 saw Sally and Tom on 6 October, Tom reported a recent deterioration in his mental health having discontinued his medication. He said he had now restarted. He describe recent low mood, anxiety and panic attacks. He believed songs on the radio referred to him, and feels low in mood and motivation. The plan agreed was for a medication review (planned for 21 October with Dr G), continue to work, and meet with the CPN care coordinator to look at ways of coping. Sally said they were currently on a trial separation however said she still wanted to be supportive of Tom.
- 4.98 The next appointment was arranged for the beginning of November, and Dr G wrote to his GP after the meeting on 12 November 2014. It was noted that Tom said he stopped taking aripiprazole because he felt drowsy, but continued risperidone 1mg. He denied experiencing disturbing or paranoid thoughts, and said his mood tends to fluctuate, on bad days he finds no enjoyment in life and has no interest. His sleep was variable, he and Sally had been separated for a while and Tom was living with his parents. Sally was noted to be receiving counselling. There was no thought disorder elicited but Tom was noted to appear depressed and anxious. The impression noted was of a delusional disorder with depressive symptoms. There were no risk to himself expressed.
- 4.99 The plan was for Tom to be prescribed antidepressant medication, but Tom did not agree due to his reluctance to take medication. It was suggested they see a relate counsellor together, and he would be regularly seen by CPN2, who was his care coordinator. He was reminded that if he had increased thoughts of self-harm or suicide he should contact HALT, or out of hours GP or A&E. It was left that he would be seen by a psychiatrist if the GP or CPN requested it.
- 4.100 CPN2 spoke to him by phone on 9 December 2014, and he said things had deteriorated although he was still managing to go to work. He described finding it difficult to go out and sounded hesitant. He agreed to the earlier suggestion of an antidepressant, and it was arranged that Dr

G would prescribe fluoxetine<sup>27</sup>, and the prescription would be brought to him. Dr G prescribed fluoxetine 20mg for two weeks and faxed the request to continue to his GP.

- 4.101 CPN2 saw him on 12 December 2014 at his parents' house, with his father. Tom reported he had been feeling paranoid, and things were not good. He said he had started taking aripiprazole as well as risperidone to try to manage his mental health. Sally was going overseas to visit family over Christmas and he was unsure of the future of their relationship. He denied any thoughts of self-harm, and was encouraged to take the fluoxetine. It was planned to work on some goals at the next meeting.
- 4.102 At a phone call with CPN2 on 17 December 2014, Tom sounded brighter, reported that things were 'not too bad' and he planned to start fluoxetine that evening and was taking the other medications. Tom suggested he would make contact in the new year to arrange the next appointment, and he was reminded of the out of hours contacts if needed.
- 4.103 CPN2 called Tom on 26 January 2015 to arrange an appointment. Tom said he was 'fine' but was unable to talk as he was at work but would call back the following day. He did not call back.
- 4.104 CPN2 wrote to Tom on 2 February 2015, noting that it was a while since their last meeting, and offering him an appointment to review how he was doing. An appointment was offered for 19 February 2015. This letter was not copied to the GP. CPFT commented that these letters are not routinely copied to GPs, but that the importance of keeping the GP informed has been reflected upon.
- 4.105 On Monday 9 February 2015 the ARC had a call from a GP at Cedar House surgery; it was reported that Tom had cut his wrist deeply, and this was dressed at the surgery today. Apparently Sally had persuaded him to attend the GP surgery and expressed concern that she could not keep him safe. The GP prescribed 1-2 mg lorazepam. The referral was made to ARC but it was noted he was 'open' to HALT. The ARC called Tom, who said he had not been sleeping properly, was anxious, feeling that history might be repeating itself and increasingly paranoid. He said he stopped aripiprazole because of weight gain & lowered motivation. Has a gym at home but was not using it. The situation was discussed with his care coordinator CPN2, who asked for CRHTT input, with a request that CRHTT make contact that day or the day after day for assessment.
- 4.106 CPN2 spoke to Sally who reported a deterioration in Tom's mental state, and she said he had cut superficially which needed A&E attention over the weekend (this was inaccurate, he actually saw the GP only on

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<sup>27</sup> Fluoxetine is a selective serotonin reuptake inhibitor (SSRI) antidepressant. <https://patient.info/medicine/fluoxetine-oxactin-prozac-prozac>

February 9). Tom spoke to CPN2 and said he was feeling very paranoid, ruminating on things from the past and his accident; he was unsure he could keep himself safe. He was moved to the 'red zone' and CRHTT were contacted to see him that day, with a follow up visit from CPN2 by the Wednesday. The relevant policy was requested, but CPFT have clarified that HALT no longer use a 'zoning' system.

- 4.107 He was seen by CRHTT that evening, and it was planned to work on thoughts and negative thinking, carry out a carer's assessment and review his medication as soon as possible.
- 4.108 Tom was seen by the CRHTT Dr E and CPN2 on 10 February 2015. Tom was difficult to engage and slow to communicate. He stated this was a suicide attempt, but something stopped him going through with it, and he was unable to get over the initial pain. He had a feeling that he had let someone down, had said too much about something that led him to the conclusion that he needed to end his life. He was not clear about how long he had felt this way, and unclear about whether he had resolved this issue, but was *'able to admit that he may have been beating himself up over something that was not based in reality.'* Tom expressed regret for what he had done, mainly because of what it put his parents and Sally through. He told Dr E that there was no ongoing risk to himself, but could not give a concrete reason for this, but was eventually able to say he felt different today.
- 4.109 Tom said he did not believe he was depressed or low in mood, despite describing some of the classical symptoms of anhedonia: low energy, poor motivation, guilt, lack of future, feeling helpless and hopeless, having attempted suicide, anxiety and paranoia. He agreed after much discussion that there might be something that could help with this, he had some fluoxetine that was previously prescribed and he agreed to try this. Tom remained very concerned about possible side effects he had experienced before; weight gain, and sedation. He would not consider any change to his antipsychotic medication.
- 4.110 The doctor's opinion was that there was an element of mourning the loss of his premorbid life and personality, and he was also experiencing the stress of his relationship not being stable, and guilt that he had let his family down. Tom said he had had some psychological input on the past but did not feel it would be beneficial now, and needs to work so it would be hard to access. He spoke of work not being very sympathetic to mental illness. Dr E noted that he made sure Sally had an opportunity to speak up about her view points and concerns.
- 4.111 The plan agreed was:
- CRHTT to monitor and support over the next week or so, arranging visits as and when possible. He would start fluoxetine on 11 April, and continue with some 'as required' lorazepam.
  - CRHTT would monitor the effects of this.

- Brief anxiety focussed work with thought challenging and worry tree.
  - Crisis contacts to be used if the need arises.
- 4.112 A CPA review was held on 12 February 2015 by Dr E and Dr F, also described as a 'clinical review'. It was noted that he had just started antidepressant medication and was taking benzodiazepines in the short term, which needed monitoring. The plan was to engage to build rapport and offer carer support. Risk needed to be monitored closely. It was also noted he is with HALT and CRHTT needed to liaise with CPN2 for joint working.
- 4.113 Tom declined to complete a safety plan and felt the crisis/contingency plan in his CPA care plan was sufficient. This plan was to distract himself from his thoughts by working on his computer or reading, as these are things he enjoys. He stated he will talk to his wife or go for a walk with her if he feels things deteriorating. Relapse indicators/warning signs were listed as: increase in anxiety, lack of sleep, lack of appetite, restlessness, and fidgeting, increased consumption of alcohol. The crisis numbers were all available. The contingency plan was to attend A&E at Hinchbrook's or elsewhere, and/or call the emergency contact numbers. Tom was noted to be aware of the plan to transfer him back to HALT at the end of the week.
- 4.114 Tom was seen at the Newtown Centre on 12 February 2015 by a CRHTT staff nurse, he appeared flat but said he had no current thoughts to harm himself. He had not started the fluoxetine because he said he couldn't find the tablets, so a new prescription was provided. He had however been taking lorazepam and risperidone and said that had helped him to sleep. Tom had been back to work and been more active at his parents' house. Short term planning was discussed, along with the worry tree and information on unhelpful thinking. Tom was keen to meet a peer support worker to work on self-esteem. He agreed to see CRHTT on 14 February (Saturday).
- 4.115 Sally's view as carer was ascertained, she said she had seen a small improvement, but agreed he seemed flat and low in mood.
- 4.116 Tom was seen at the Newtown Centre on 14 February 2015, he appeared flat and tired, and slightly dishevelled. He said he was eating and sleeping well, found his concentration was poor at times, and said the lorazepam was making him less mentally aroused. He denied any current thoughts of self-harm or any thoughts or plans to end his life. He had started the fluoxetine, and the benefits of continuing this were discussed. It was agreed that Tom would make contact again on 16 February, as he was working away that day.
- 4.117 Sally's view was again sought and she said she feels he is still low but has improved slightly. Sally said they have been supporting each other and the focus is on supporting Tom, but recognising that they will ultimately need to make a decision about the future of their relationship.

- 4.118 Tom was seen by a CRHTT nurse at the Newtown Centre in the evening of 18 February 2015, he appeared tired with some delays in his responses, but his speech was normal in tone and volume. He said he had been taking risperidone, lorazepam and fluoxetine, his sleep was much better and he had no side-effects. Information on anxiety management was discussed, and a worksheet was given to him to log his low moods. Tom said he sometimes feels that music on the radio is played in connection with his feelings but recognised this was not real and tries to stop it affecting him.
- 4.119 A further CPA review, carried out by CRHTT, is noted on 19 February 2015 by Dr E and Dr F. It was noted he was not expressing any risk to himself but has declined to look at this in greater detail in the framework of a safety plan. His risk was thought to be dependent on his mood, he has accepted antidepressant medication to tackle this for the first time, but the impact will need monitoring by his community team. Tom had agreed to alert the team if things felt different for him, and this would be followed up and the safety plan revisited.
- 4.120 It was noted he was engaging with the team in that he is accepting medication and attending the team base for CRHTT reviews. There had not been a significant change in anything except his sleep, although he was not expressing any risk to himself. It was noted he had been given information to help with anxiety and unhelpful thoughts and worries, and was aware of the time frame for antidepressants to take effect. The plan was to transfer back to HALT at the end of that week.
- 4.121 Sally called the CRHTT on 19 February to check the prescription, and this was clarified. Tom called CRHTT on 19 February and reported he was doing well, busy at work and resting at home at the time of the call. He had collected his medication, and agreed to attend the Newtown Centre on 20 April for review and discussion about transfer back to HALT.
- 4.122 Tom was seen at Newtown Centre on 21 February 2015 by a CRHTT nurse. He said he gets up and goes to work which is a good thing, and he enjoys the work, which work takes him across the country. He said he feels down in the mornings, but was trying to do the best he can. Tom said the medication helps a bit, he was still having some paranoid thoughts but does challenge these thoughts to bring himself back to reality. How to manage his risks was discussed, Tom said he will call people to talk his worries through, and his family was a protective factor. He was encouraged to try to make a safety plan that could help when he is feeling impulsive and he said he would. Tom said he was taking the medication as prescribed. Carer support was discussed with Tom, in terms of how he thought Sally was coping. He was spending weekdays at his parents and weekends with Sally, they have been discussing whether they would split permanently but no decisions had been made. He said he does not think it is fair for her to cope with his illness, but things are easier for now as he is staying at his parents.

- 4.123 Tom said he did not see his care coordinator CPN2 regularly, as he is at work so just calls her to tell her how he is doing. He was encouraged to plan time to see her, possibly discussing with this work manager and planning in advance. Tom said he was no longer in crisis but was well aware that if things deteriorate he should contact CPN2 or his GP. He was noted to be happy with the plan to transfer back to HALT and was discharged from CRHTT on 21 February 2015.
- 4.124 CPN2 called twice, and arranged to see Tom on 5 March 2015. CPN2 texted a few days before this to check how he was getting on, with no response.
- 4.125 At a home visit on 5 March 2015 Tom spoke of enjoying his job, reflecting that it was important to him to have a sense of purpose. He reflected on the effects of the motorbike accident in 2004, recognising it had had a huge effect on his mental health. He reported that his mood had much improved, taking interest in things around him and being more active. Health coaching techniques were used to focus on his aim of improving his fitness. Tom said he was taking medication, and thought both fluoxetine and risperidone were helping his mood and psychotic ideation. He did say he doesn't like taking them but accepting that they were needed at the moment to manage his mental health.
- 4.126 He chose not to arrange another appointment due to work commitments but agreed to phone within four weeks. CPN2 noted a diary reminder to contact Tom if he had not contacted by 2 April.
- 4.127 On 2 April 2015 CPN2 spoke to Tom, he said things were going okay but had a bad day yesterday and was off work. He was aware that there is a medical review planned with Dr G at the beginning of May, Tom had holiday planned so suggested meeting the following week, and this clashed with CPN2's leave. It was agreed to make contact in the week beginning 13 April. CPN 2 texted Tom on 21 April to ask how he was, it was noted that he was aware he had an appointment with Dr G at the beginning of May, but there is no description of Tom's wellbeing reported.
- 4.128 Dr E tried to call twice on 11 April but had no response. His CPN 2 tried to call later on 11 April as previously planned, with no response. Two more failed contact calls were made to his mobile and home number. After checking consent to share information, his sister was called, who gave the team Tom's parents' number, where he was staying. Tom was spoken to, said he was fine and a meeting was arranged for 12 April at his parents' house.
- 4.129 A CPA/outpatient review was held on 4 May 2015, with CPN2, Tom, Sally and Dr G. Tom reported his mental state had much improved, he said he feels almost back to his normal self, only occasionally struggling to motivate himself or leave the house, and has only missed a few days off work. He had no concerns about sleep or appetite and had a good level of energy, and said his mood had improved since starting on the

fluoxetine. He was exercising regularly, and walking the dog. He had moved back to live with Sally and said he enjoys a good supportive relationship with her.

4.130 Tom said he was taking risperidone and fluoxetine regularly, and had cut down on the lorazepam to about once a month. He said he was taking it four days in a row initially and had some withdrawal symptoms when he reduced it, but none for the past month. On mental state examination he was noted to be well groomed, had good eye contact and rapport. Tom described his mood as normal and Dr G was not able to elicit any thought disorder or perceptual abnormalities. Dr G noted his impression as 'delusional disorder in remission' and 'recurrent depressive disorder currently euthymic' and noted that Tom had insight into his condition. A summary letter was sent to his GP.

4.131 The plan was:

- Continue fluoxetine 20mg and risperidone 500mcg.
- Discussion about CBT which had been beneficial before. Tom would consider this in the future but wanted to focus on full time work, which would make it difficult to engage in therapy.
- Discussion about the first signs and symptoms of mood deterioration and relapse prevention. He recognised that sleep disturbance, reduced appetite, increased anxiety and increasing paranoid thoughts would be the first signs. He was to continue work on his relapse plan with CPN2.
- He would be seen by CPN2 in due course, and he agreed if he showed relapse signs he should contact HALT, out of hours services or GP.

4.132 CPN 2 tried to call Tom on 2 June and 4 June, eventually speaking to him by phone on 4 June 2015. Tom reported that things were going well, and as discussed at the last CPA meeting it was planned to discharge him back to his GP. CPN2 noted that she emphasised that he should not make medication changes without first seeking medical advice and he should prioritise seeing his GP or attend A&E if his mental health started to deteriorate. It was noted that he was made aware he could be referred back to HALT if needed via those routes.

4.133 An 'outpatient review' letter was sent to Tom's GP by CPN2 on 14 July 2015, which appears to be the discharge letter. The letter summarised the last meeting on 4 May 2015 and reiterated that Tom said he would talk to his wife if he feels that things are getting worse for him. It was stated they are both aware of the out of hours services available and that he can be '*re-referred to our services via yourself*'. This letter does not specify whether Tom and Sally were consulted and agreed with this plan.

### **Third CPFT contact**

4.134 There was no further contact with CPFT services until 31 August 2015, when Hinchingsbrooke's Hospital requested a Mental Health Act assessment after the homicide.

## GP contacts 2013 - 2015

- 4.135 Tom made initial contact with his new Cambridgeshire GP in November 2013, having registered on 14 November. His history of self-harm and psychosis was noted, and the telephone contact was requested by the GP to clarify what psychiatric medication he was receiving. Tom phoned to clarify that he was prescribed aripiprazole dispersible 15mg, procyclidine 5mg and risperidone 500mcg tablets. The GP noted these did not require any specific monitoring and issued the prescription.
- 4.136 As part of their surgery health checks Tom was seen on 3 January 2014 to discuss his BMI and blood pressure. Diet and exercise were discussed and it was noted he was discharged from his previous mental health team in Northants. Tom reported no side effects and was doing well, and it was noted he was aware of warning signs and symptoms, and to contact the GP if there was any recurrence.
- 4.137 Tom saw his GP with Sally on 28 February 2014 and said he had stopped taking aripiprazole for the past two or three months as he felt it wasn't helping. He said he was taking regular risperidone 500mcg but not procyclidine. He said he was not sleeping well. The GP noted he had last seen a psychiatrist in November 2013. Risperidone was increased to 1mg daily to aid sleep. It was noted that it was planned to go through the notes and refer him to a local psychiatrist, but there were no notes to record that this was done.
- 4.138 On 28 March 2014 Tom was seen with his sister, the history taken was that he had been under the care of a psychiatrist in Northamptonshire and had been discharged on risperidone/aripiprazole /procyclidine, as his mood was stable. Tom said he had stopped aripiprazole 2 weeks ago as it makes him tired, and was also not taking procyclidine regularly. Recently he had become more anxious, had auditory hallucinations, feels songs are directed to him, not sleeping well, but no active suicide thoughts.
- 4.139 It was planned to refer him through ARC, as the GP felt he needed urgent assessment. A referral to ARC was faxed that day, and in discussion with ARC it was agreed they would call Tom's sister and Tom that day.
- 4.140 Tom had said he had stopped taking aripiprazole & procyclidine, ARC staff asked if these could be restarted but the '*GP did not feel confident to do this*' and was concerned about potential risk, referring to previous suicide attempts. It was agreed he would be referred through ARC and assessed over the weekend by CRHTT. The referral was actioned within two hours as discussed above at paragraphs 4.87 to 4.89.

- 4.141 The GP surgery continued to supply prescriptions with advice from CPFT services. On 22 April it was confirmed with HALT that aripiprazole and procyclidine would be added back onto the prescription and to be repeated.
- 4.142 On 9 June 2014 CPN2 called the surgery to inform them that Tom was unable to keep follow up appointments, that he felt well and that he and his wife agreed with the discharge. It was noted that CPN2 had discussed this with Dr G and he would be discharged. This was not followed by a discharge letter.
- 4.143 On 18 September 2014 Tom was seen by a GP with Sally, he said he had stopped medication himself three months ago, and had failed to go for psychiatric follow up. He reported feeling low, for the past three months he had been hearing auditory hallucinations on the radio, he was not threatening, and not suicidal. The plan was for referral to ARC. This referral was actioned as discussed above at paragraphs 4.96 and 4.97, when it was noted Tom was still 'open' to HALT.
- 4.144 On 9 February 2015 Sally called the GP, very concerned about Tom's mental health. The GP explained that she did not have permission to talk to Sally, but made an appointment for him later that day. Tom attended with Sally, and gave written permission for the GP to talk to her. He said some of his medications had been discontinued, and he never started taking the fluoxetine that was suggested by the psychiatrist. He had become increasingly paranoid and depressed, and cut his wrist on Saturday night quite deeply. He bandaged it himself, didn't ask for help or let Sally know. Sally said he has never taken an overdose, he has always cut himself when suicidal. He didn't attend A&E, but had the wound dressed at the surgery. The GP examined the wound which was described as '*slightly deep over ulnar aspect, not bleeding but not cleaned, dried crusted blood, no signs of infection*'.
- 4.145 Tom appeared withdrawn and monosyllabic. The plan was to discuss with mental health services, for urgent evaluation that night or in the morning. The GP suggested lorazepam would be helpful, and gave them 12 tablets for Sally to supervise. Sally was advised to call 999 tonight if she felt Tom was unsafe.
- 4.146 A five day referral was initially sent by the GP to ARC, but it was picked up as an open case with HALT. CPN2 discussed this with Dr E at the CRHTT and CRHTT input was agreed. The CPFT response to this referral is discussed above at paragraphs 4.106 and 4.107. A letter was sent to the GP with a plan, and the CRHTT '*notification of assessment outcome*' form was faxed to the GP on 11 February 2015.
- 4.147 The GP surgery continued to issue prescriptions, and a medication review was conducted on 19 May 2015. At this time he was prescribed fluoxetine 20mg, risperidone 1mg and lorazepam 1mg to be taken as required. Tom was seen in surgery for cellulitis on 18 June 2015.

- 4.148 A routine 'mental health review' was carried out by a GP on 23 July 2015. The notes record that Tom was seen with Sally on 14 July 2015 and their continued plans to conceive were discussed, noting they had been trying for five years. A sperm count test was planned, forms were given and it was noted that Sally would make an appointment. A planned recall for mental health review was noted for 23 July 2016. Random glucose and cholesterol checks were done & noted as normal.
- 4.149 On the morning of 21 August 2015 Tom attended the GP surgery with Sally. He reported ongoing problems with his mental health, and was "*trying to avoid taking medication*". He asked for a repeat prescription of lorazepam.
- 4.150 He said he had stopped taking fluoxetine eight weeks ago, of which Sally was apparently unaware. Tom said he tries not take risperidone because it causes sedation and he uses software at work so needs to concentrate. At this point he said he was not taking any medication, and felt paranoid and was very anxious. His past self-harm was noted, and that suicidal thoughts had been slow to build up in the past. Compliance was discussed with Sally; she said he had cognitive behavioural therapy and mindfulness in the past. Tom did not think it was helpful but Sally was noted to think it would be a good investment.
- 4.151 Tom appeared quite flat in mood and slow in responses, but said he had taken 1mg risperidone and 1mg lorazepam that morning. He asked for a repeat of lorazepam prescription but then said he had plenty for the weekend. The GP emphasised the need to take medication safely and sensibly. He agreed to take a new antidepressant, and was prescribed sertraline<sup>28</sup> 50mg tablets to be taken once a day. He was given seven tablets to start with.
- 4.152 On 26 August 2015 Tom saw an on-call GP with his parents. He was noted to have a long supportive chat, said he was unable to think and concentrate, couldn't work, was very anxious but didn't know why. He was regarded as not fit for work and was signed off with a medical certificate until 2 September 2015. The diagnosis noted was '*stress related problems*'.
- 4.153 On 28 August Tom attended the GP surgery again with Sally, saying he was paranoid and wanted lorazepam. The impression noted was that this was work related stress; he discussed work, saying he has to travel and work away for weeks at a time, staying in guest houses so very isolating. He also said he hasn't been taking his medication whilst away. He said he had fleeting ideas of suicide but no plans. On examination he was slow to answer questions but also restless.
- 4.154 The agreed plan was that he would take risperidone 1mg at night, switch the fluoxetine to sertraline, take 1mg lorazepam in the morning and one

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<sup>28</sup> Sertraline is prescribed for depression, anxiety disorders, and obsessive-compulsive disorder (OCD).  
<https://patient.info/medicine/sertraline-lustral>

at night, and a prescription was issued. If things escalated at the weekend Sally agreed to contact the out of hours service. It was also planned to send a fax to the Newtown Centre to CPN2 to ask for review/support. The fax was sent addressed to CPN2 at HALT with the title 'for urgent attention please' and made reference to Tom having relapsed due to not taking his medication, and requesting that CPN2 review him urgently.

- 4.155 The homicide was committed on 29 August 2015. Tom initially started to cut his own throat, and then attacked his wife after she called emergency services for help. He was found guilty of manslaughter by diminished responsibility in March 2016 and was detained indefinitely under the Mental Health Act.

## 5 Arising issues, comment and analysis

- 5.1 The terms of reference for this investigation are:
- Oversee and quality assure the IMRs from all the NHS providers that contributed to the care and treatment of [Tom]
  - To examine the referral arrangements and discharge procedures of the different NHS Trusts' involved in his care
  - Review and assess compliance with local policies, national guidance and relevant statutory obligations
  - Examine the effectiveness of the service user care plan, including the involvement of the service user and family
  - Review the appropriateness of the treatment of the service user in light of any identified health needs
- 5.2 The care and treatment of Tom by the two mental health Trusts has been reviewed against the terms of reference provided by NHS England.
- 5.3 The care provided by the Cedar House GP Surgery in relation to Tom's mental health is included where relevant.

### Quality assurance of NHS IMRs

- 5.4 There were two health IMRs, from CPFT and NHFT. The GP surgery did not complete an IMR.

### Cambridgeshire and Peterborough NHS Foundation Trust internal investigation/IMR

- 5.5 The internal investigation was completed as a 'Level 2 comprehensive investigation' as defined by the NHSE Serious incident Framework 2015.<sup>29</sup>
- 5.6 The report was completed on 18 May 2016, and the delay is explained as due to the police restriction on the Trust from investigating until the legal process had concluded. The date of the incident is given as 29 September 2016, which is incorrect. The correct date of 29 August 2015 is however referred to in the body of the report. We note that the GP records were not available to the CPFT investigating team.
- 5.7 The internal investigation team comprised:
- Associate Director of Performance Delivery

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<sup>29</sup> NHS England Serious Incident Framework 2015. <https://www.england.nhs.uk/patientsafety/serious-incident/>

- Consultant psychiatrist
- Service Manager, adult directorate

5.8 The terms of reference are given as :

- *To review the care and treatment of TA whilst under the care at Cambridgeshire and Peterborough NHS Foundation Trust against Trust policies, procedures and national guidance.*
- *To examine the clinical decision making process.*
- *To examine the care programme approach followed by the Trust.*
- *To identify whether any risk assessments were timely, appropriate and followed by appropriate action.*
- *To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records.*
- *To examine the adequacy of collaboration and effectiveness of communication between teams involved in care.*
- *To identify any learning for patient safety from this investigation through applying Root Cause Analysis techniques.*
- *To make recommendations for the future. To contact and engage with the family and or patient where appropriate.*
- *To feedback to all stakeholders. To identify the Senior Manager to ensure handover of actions to take forward implementations.*
- *To assess any risks against compliance against with essential standards*
- *To engage collaboratively with GPs or other stakeholders in the investigation process*

5.9 The report is written in a root cause analysis format and lists clear terms of reference. It is noted that two of the team are trained in root cause analysis. The actions of the GP practice in August and the subsequent last referral to CPFT are reviewed. The management of Tom after his arrest is also reviewed, which is not included in the scope of this independent investigation.

5.10 Tom's previous care in NHFT is summarised, and it is noted that he was discharged from secondary mental health care in Northampton to his new GP in Huntingdon/Cambridgeshire.

- 5.11 A detailed chronology is provided, although a further inaccurate date of 29 August 2016 is reported as the date that CPFT became aware of the incident (actually 29 August 2015).
- 5.12 Care and service delivery issues are analysed against the terms of reference, exploring the care provided in detail.
- 5.13 The efforts to involve both families is described, and noted that this was not taken up, but it was left that the Trust would communicate with them if they wished in the future. Involvement of Tom is not mentioned.
- 5.14 The process of the investigation is clearly described, including those interviewed and materials accessed.
- 5.15 No contributory factors were identified, but some additional findings were listed that required attention;
- relapse prevention plans: there is nowhere on RiO<sup>30</sup> (the electronic clinical notes) to easily access a relapse prevention plan, and there is no Trust-wide relapse prevention document:
  - clarification with GP surgeries of referral route into CPFT secondary services, including how this is expressed in discharge letters; and
  - HALT to amend their system for viewing incoming faxes.
- 5.16 There is a detailed discussion of the actions of the GPs following face to face consultations with Tom on 21 August, 26 August and 28 August 2015. He saw three different GPs.
- 5.17 It is noted that the GP who saw him on 26 August 2015 signed him off as unfit to work and planned to refer him to the mental health team but did not make a referral. The report notes that the GP did not make a referral because it was not assessed as urgent. However this assessment of the degree of urgency is not noted in the GP records, and there is no explanation of why the referral was not actioned on 26 August. However we note that it had still not been made by the time of the third visit on 28 August.
- 5.18 There is a detailed discussion of the actions of the GP after the consultation on 28 August in faxing a referral to HALT after seeing Tom and Sally. The GP appears to have assumed that as Tom had been seen by HALT before, a re-referral could be done by fax, instead of the accepted practice; which is to make all secondary mental health care referrals through ARC. The GP had said in interview for the CPFT internal report that a discharge letter stated he could be re-referred if needed to HALT. The relevant discharge letter written by CPN2 dated

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<sup>30</sup> RiO is an electronic patient notes system. [https://www.servelec-group.com/servelec-hsc/products-services/rio/](https://www.servelec-group.com/servelec-hsc/products-services/ri/)

14 July 2015 includes the line '*can be re-referred to our services via yourself*'.

- 5.19 The degree of 'urgency' of the fax and hence the referral is noted as a possible missed opportunity. It is stated in the report that based on the information available, the likelihood of any secondary care intervention may have been to offer an appointment after the bank holiday, and a missed opportunity for a phone call to Tom is noted.
- 5.20 The CPFT report reviewed the management of the request for an MHA assessment after his arrest in August 2015, which is outside the terms of reference for this investigation, so has not been commented on.
- 5.21 The root cause (spelt incorrectly as route cause on page 15 and 17 of the CPFT report) is given as '*T's mental ill health and the tragic sudden change to his mental state.*'
- 5.22 The CPFT report made six recommendations, which we review below.

**Recommendation 1:**

*Review the clarity of re-referral information in discharge correspondence.*

While this may be a useful action, we consider the contributory factor which resulted in Tom not being assessed by mental health services is not addressed here. The report notes that the GPs involved *believed they were dealing with a familiar relapse pattern*. While this may well be accurate, each of Tom's previous relapses (on 28 March 2014, 17 September 2014 and 9 February 2015) has required the input of the CRHTT.

Each of the previous referrals has been made through the ARC, in the expected way. There has been at least one occasion when he has still been under the care of HALT, and has been referred by the GP for urgent action through ARC. According to ARC protocols, a referral that is defined as urgent if it requires action within 24 hours or 5 days, and the protocol requires the primary care referrer to telephone the ARC to discuss the case in more detail. The ARC guidance is reproduced below:

*Why do referrals for 24 hour and 5 working day assessments need to be made by phone? We ask for all non-routine referrals to be phoned in so that any queries can be answered immediately and the referral can be dealt with promptly rather than being delayed by ARC chasing up information. A conversation is also the speediest way to establish the urgency of the referral.*

Based upon the response by ARC previously, with a similar presentation by Tom on three previous occasions, I considered whether this impacted on the potential speed of response by CPFT.

CRHTT involvement was deemed necessary in March 2014 and February 2015 (even though he was open to HALT). He was treated without CHRTT intervention at the referral in September 2014, accepted support from the GP and CPN2. While there is certainly a pattern of relapse, the primary initial

intervention has been to encourage Tom to restart medication, with support and follow up.

I suggest that an action should be that the systems for access to mental health services by primary care providers is made explicit by the relevant CCG and that there are processes in place to ensure locums are aware of this, and this process is monitored for assurance.

**Recommendation 2:**

*Clarify on call arrangements from the regional secure unit (out of scope, see 5.17)*

**Recommendation 3:**

*Noted that HALT have revised their process for managing incoming faxes. See comments on recommendation 1 above, the management of faxes is a lesson learned, but even if CPN2 had received the fax on that day, this would not necessarily have achieved the expected outcome of a re-referral to mental health services.*

**Recommendation 4:**

*Noted that an approved Section 12 approved doctor rota has been revised (out of scope, see 5.17).*

**Recommendation 5:**

*Trust to continue to identify means by which self-referral can be established and supported.*

This may well support the development of this service, however the Trust had robust systems already in place for the management of referrals from primary care, which were not followed.

**Recommendation 6:**

*Trust to add relapse prevention/wellbeing plans to be uploaded into a section on the RiO system rather than in the documentation list.*

This was noted as having been achieved.

5.23 The report discusses care and service delivery issues and notes areas of good practice as

- The process of the MHA assessment in August 2015
- Risk assessments and care plans were in place
- The HALT team worked hard to make themselves available to [Tom], who was reluctant to take time off work for appointments
- [Sally] was supported by Making Space
- The decisions to discharge him from mental health services were reasonable and made in conjunction with [Sally] and [Tom]

- 5.24 I agree that Sally appeared well supported by the carer service, and the HALT team worked hard to make themselves available to Tom. While I cannot comment on the process of the MHA assessment in August 2015, I question the reasoning behind the discharge as discussed below in the 'referral arrangements and discharge procedures' section.

### **Northamptonshire Healthcare NHS Foundation Trust internal investigation/IMR**

- 5.25 The internal investigation was completed as an IMR at the request of the DHR chair. It was carried out by the Head of Speciality Services, who had no involvement with the care and treatment of Tom. Tom's care was reviewed from his first contact with NHFT in 2007 up to his discharge in November 2013. The structure of the report is taken from the IMR format sent by the DHR chair, rather than using a serious incident report or root cause analysis format. Because Tom had been discharged from NHFT services more than a year previously, no internal incident report was completed. The report was completed in September 2016 at the request of the DHR chair.
- 5.26 A detailed chronology was developed from a review of electronic records and interviews with Tom's NSTEP care coordinator CPN1, and the community psychiatrist Dr D. There are some inaccurate dates.
- 5.27 Separate terms of reference are mentioned, but are not included.
- 5.28 It is stated that there are no missing notes, however there are no Epex clinical note entries from September 2012 to November 2013. There are however outpatient letters that describe each clinical contact in detail, which are sent to GPs. In the Epex system, the consultant contact was recorded in an admin area of the record as a meeting. NHFT has changed their electronic record to SystemOne, which requires the professional to log the contact made, and indicate that a letter has been sent. The system allows letters to be generated and to be sent to GPs electronically.
- 5.29 The IMR findings were that Tom had been treated appropriately for his mental health issues, but there was a lack of robust handover when Tom moved from NSTEP to Rushden CMHT, and when he was discharged from Rushden CMHT to the GP in Cambridgeshire.
- 5.30 The IMR made two recommendations:
- A professionals meeting should be held when a patient moves from one clinical service to another.
  - A patient should always be referred to secondary mental health services when they move to another county.
- 5.31 The first of these recommendations '*a professionals meeting should be held when a patient moves from one clinical service to another*' is already a clear expectation of the CPA policy CLP010 and therefore the recommendation should be that the implementation of this policy is

monitored to ensure standards regarding professionals meetings at handover are maintained.

5.32 The CPA policy includes a section on monitoring and review of the CPA policy:

‘Auditing and monitoring are integral components of the CPA and will allow us to monitor the effectiveness of our CPA processes.

Local audit should focus on:

- Service user and carer satisfaction and engagement including complaints and compliments
- The use of outcome measures, including user defined outcomes, to measure success
- The integration of risk management into CPA systems
- Consideration of equality issues’

5.33 We suggest that the implementation of the policy on transfers and discharges also be quality assured.

#### **Recommendation 1**

Northamptonshire Healthcare NHS Foundation Trust must provide assurance that the policies on handovers, transfers of care and discharges are implemented and standards maintained.

#### **Recommendation 2**

Cambridgeshire and Peterborough Clinical Commissioning Group must provide explicit information about routes of access to mental health services provided by Cambridgeshire and Peterborough NHS Foundation Trust and there should be processes in place to ensure locums are aware of this, which must be monitored for assurance.

#### **Recommendation 3**

Northamptonshire Healthcare NHS Foundation Trust health records policy must be adjusted to include the use of consultant outpatients letters as equivalent to a clinical record entry.

5.34 The second recommendation is to always refer to secondary mental health services if a patient moves to another county. We do not agree that this is a reasonable expectation. Tom had been under the care of a single professional on ‘non CPA’ since September 2012. He was

discharged to primary care (albeit in another county) in November 2013. Dr D was clear in his correspondence that he considered discharge to be appropriate, but would maintain Tom on his caseload until a new GP was identified in his local area. It cannot be said to be appropriate to refer him to a secondary mental health service in Cambridgeshire, when he was at the stage of being discharged from one secondary service.

- 5.35 We suggest the recommendation should be for the receiving CCG to implement a set of standards for reviewing the notes when a new patient with a secondary mental health history is accepted at the surgery.

#### **Recommendation 4**

Cambridgeshire and Peterborough Clinical Commissioning Group should implement a set of standards for reviewing the notes when a new patient with a secondary mental health history is accepted at a GP surgery.

- 5.36 The NHFT IMR is notably short at four pages, but does include a detailed chronology as an appendix. There is however a reasonable analysis of Tom's care, resulting in findings and lessons learned.
- 5.37 There is no evidence of senior level 'signoff' of the IMR report, but it was verbally reported that it was signed off by the Deputy Director for Adult Mental Health.
- 5.38 Part of the effect of this brevity has been a lost opportunity to highlight notable practice. There are two examples of notable practice which we wish to highlight:
- The provision of extensive psychological input, including couples therapy, through NSTEP
  - Carer support and counselling provided to Sally by Carer Support
- 5.39 We agree with the findings of the NHFT IMR and with one of the recommendations as discussed above. However in our view the report would be strengthened by including reference to policy expectations, and an analysis of what care or service delivery factors may have led to the lack of robust handover from NSTEP to East Northants CMHT.

### **Referral arrangements and discharge procedures**

- 5.40 We review the process used by each Trust, reflecting against their policies where available.
- 5.41 The first referral for mental health care was instigated by the Oxford Radcliffe department of plastic and reconstructive surgery, when Tom was referred to a consultant clinical neuropsychologist Dr B at Oxford Radcliffe hospital. This period is outside the scope of this investigation.

However it is notable that Dr B contacted Tom's GP in Rushden directly, and followed up by phone to convey her concerns.

- 5.42 There was good continuity of care in contacting the GP in Rushden and handing over thoroughly.

### **Northamptonshire Healthcare NHS Foundation Trust**

- 5.43 The initial referral to East Northants CMHT by the Rushden GP was acted on quickly. Tom was seen for assessment, then referred to CRHTT. This assessment was escalated to include Dr A when it became apparent that there was a need to prescribe medication. Tom's care was held by the CMHT until the NSTEP assessment was completed, and he was seen regularly.
- 5.44 The expected period of care with NSTEP is three years,<sup>31</sup> and Tom was treated for five years from April 2007 to 2012. While this may well have been clinically appropriate, there is no evidence of a documented considered reason for this. At interview with the psychologist PSY1 who worked with him in 2011, it was acknowledged that there were some internal challenges about discharge, particularly related to Tom's serious self-harm incident in 2011. The usual length of care period at that time was said to be three to four years.
- 5.45 At the point of handover to East Northants CMHT, there are records of discussion within the NSTEP team, but no evidence of a robust handover by NSTEP, which does not meet policy expectations as detailed below:

#### *'Discharge at Three Years*

*From entry into the EIS service, clients will be made aware of the three year time-scale to their care plan. Planning for discharge will start well in advance of the expected date. Clients will be offered support in preparing for discharge. Clients leaving the EIS may move on to one of a range of options:- Primary care or Ongoing input from a community mental health team, assertive outreach, rehabilitation service or inpatient team.*

*Staff likely to be involved in providing a service to the client following discharge from the EIS will be invited to a CPA meeting three to six months before discharge from the EIS is envisaged. At this CPA meeting a discharge plan will be agreed between the client, their family, the EIS and any service providing ongoing input. Where appropriate, family members will also be referred on to appropriate services when clients are handed over at the end of their time with the service.*

*This referral will include a written summary of work that family members have done and clear recommendations for future treatment. This document will be agreed with family members wherever possible. Where appropriate, transfer to move-on services will be gradual, if necessary with the EIS and the new service providing some services in parallel for a transitional period. Where appropriate the EIS will offer flexibility over the timing of discharge.'*

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<sup>31</sup> NHFT early intervention in psychosis operational policy.2010. OP- EIS/02/2010

5.46 We suggest the Trust should assure itself that the EIS/NSTEP operational policy is adhered to with respect to treatment periods and handover/discharge processes.

5.47 The NHFT 'Operational Policy And Clinical Services Standards Early Intervention Psychosis Service' (NSTEP) dated February 2010 describes the pathways out of NSTEP and with respect to discharge states as below:

*'Staff likely to be involved in providing a service to the client following discharge from the EIS will be invited to a CPA meeting three to six months before discharge from the EIS is envisaged. At this CPA meeting a discharge plan will be agreed between the client, their family, the EIS and any service providing ongoing input.*

*Where appropriate, family members will also be referred on to appropriate services when clients are handed over at the end of their time with the service. This referral will include a written summary of work that family members have done and clear recommendations for future treatment. This document will be agreed with family members wherever possible'.*

5.48 There is no evidence within the report or clinical notes that NSTEP staff maintained these standards and no exploration of any reasons for this.

5.49 The NHFT Care Programme Approach policy (CLP010) dated August 2010 states that:

*A service user will be considered for discharge from CPA when their mental health needs no longer require the involvement of a multi-disciplinary team. This process may take place in either the community or inpatient setting. During the process of discharge from CPA the care coordinator will:*

- Discuss and agree with the service user and their carer the options for transfer of care or discharge
- Ensure a review of the service users' needs takes place before the service user is discharged from secondary mental health services.
- Ensure the service users and those involved in their care are involved in this process and are provided with a copy of the agreed plan on discharge from secondary mental health services
- Complete relevant documentation within the electronic patient record

5.50 NHFT's 'Community Mental Health Teams Operational Policy & Standards' document dated September 2010 does not provide any guidance for the management of patients who may be discharged to another service external to Northamptonshire.

5.51 NHFT's CPA policy and practice guidance dated January 2015 states that:

*‘Where appropriate service users should be discharged to primary care promptly as part of promoting their recovery. A review, which includes everyone involved in the service user’s care, will be held before the service user is discharged from Northamptonshire Healthcare Mental Health and Learning Disability Services. At the review a plan will be agreed which contains at a minimum:*

- How the service user can access services if needed
- Action needed by the GP (primary care practice) if any
- Service user’s relapse signature.

*A written copy of the plan (letter format) will be given to the service user and everyone involved in his or her care including the service user’s GP. The closure /transfer checklist should be completed by the CPA care coordinator or lead professional and signed off by their manager’.*

- 5.52 The discharge to primary care in Cambridgeshire in November 2013 has been scrutinised in both internal reports. However we find that Dr D had been treating him as an outpatient since September 2012, and had documented both his opinion, and Tom and Sally’s agreement that he was ready for discharge. Dr D made a conscious decision not to discharge him until a Cambridgeshire GP was identified, with the express intention that the correspondence would not be lost or overlooked. Dr D said at interview that it was his expectation that the GP would refer to secondary mental health care and that Tom would be picked up by CPFT services. This is not explicitly stated in his discharge letter however, and the GP referred Tom to CPFT after he presented with his sister in March 2014.

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- 5.53 All primary care referrals to secondary mental health care in CPFT are processed through the ARC. Both 24 hour and 5 day referrals are classed as urgent and require the referrer to phone the ARC<sup>32</sup> to discuss and provide more detail.<sup>33</sup>
- 5.54 Referrals through ARC were responded to: 25 March 2014 made at 11.00 responded to by 13.57; with a response that it was allocated to Huntingdon CRHTT for assessment over the weekend. Telephone contact was maintained until the assessment on 29 March 2014, after which the outcome was faxed to the GP.
- 5.55 The CRHTT maintained contact and carried out a medical review, then referred on to HALT. The discharge from CRHTT was not carried out until 10 April, after a care coordinator from HALT was identified and an initial appointment arranged.

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<sup>32</sup> ARC Referral Template. NHS Cambridgeshire & Peterborough CCG

<sup>33</sup> Referral guidance – depression and anxiety. CPFT

- 5.56 CPN2 notes discussions about discharge from HALT on 16 June 2014 as his mental state had now improved and he was concordant with medication. A discussion with Dr G is noted. The policy expectation is that:

*‘Discharge from Trust services will be a considered decision taken in the context of a care review. It should involve the multidisciplinary team and others who are involved in the service user’s care, as appropriate. The review outcome must be formally documented in the clinical records. The intention to discharge a service user, and the reasons for it, must be discussed with the service user and carer (if appropriate) and recorded in writing. Information of how to contact services and who is to be contacted if circumstances change must be given to the service user and, with his or her permission to any carer(s)’.*

- 5.57 It is noted in both CPFT notes and GP records that CPN2 phoned the GP surgery to inform them of Tom’s discharge, but there is no written evidence of a letter confirming this to either the GP or to Tom. There is a record of a telephone discussion with Tom on 29 May 2014, where possible discharge was discussed, but no evidence of a formal discontinuation, or an appropriate handover and discussion with Tom and Sally about relapse and contingency plans.
- 5.58 It appears from later notes that Tom was not administratively discharged from Trust systems at this point, because when a referral through ARC was received on 17 September 2014, it was noted he was ‘open’ to HALT.
- 5.59 A letter entitled ‘outpatient review’ was sent to Tom’s GP by Dr G on 6 May 2015, after a CPA review on 4 May 2015 with Tom, Sally and CPN2. This letter gives details of medication for the GP to prescribe, notes he has a diagnosis of delusional disorder which is currently in remission, and he has no symptoms of his recurrent depressive disorder. A discussion about the first signs of mood deterioration, and relapse prevention was noted. Tom was said to recognise that sleep disturbance, reduced appetite, increased anxiety, deterioration in mood, and increasing paranoid thoughts would be the first relapse signs. It was noted that he would continue to work on his relapse plan with CPN2, and see her in due course.
- 5.60 A further letter also entitled ‘outpatient review’ was sent to the GP by CPN2 on 14 July 2015, which appears to be the discharge letter. This letter states that Tom has now been discharged from the HALT service. He was noted to have good insight into his condition, and with the help of his wife recognises early indicators of becoming unwell which are: increase in his anxieties, lack of sleep, lack of appetite, restlessness, and increased alcohol consumption. His coping strategies were to distract himself from these thoughts, by working on his computer, or reading, or may find it helpful to go for a walk with his dog or with Sally. It is also noted that he has said he will talk to his wife if he feels that things are getting worse for him. The letter ends with *‘they are both*

*aware of the out of hours services available, and that he can be re-referred to our service via yourself.*

- 5.61 This phrase was referenced by the locum GP after seeing Tom on 28 August 2015. The locum GP was said to be familiar with the process for usual referral through the ARC service, but responded to what he saw as an implied invitation to correspond directly with HALT, partly in response to Tom and Sally's expressed wish for Tom to be seen by someone who knew him.
- 5.62 After this was discussed with CPFT as part of this investigation, an audit of GP discharge letters was conducted in 2017. There was clear evidence in about half of those audited of good clarity in discharge letters about follow up/re-referral including the use of calling '111 option 2'. Some were excellent, having wellness plans describing early warning signs and actions to take. The remainder were variable, in that the re-referral information was unclear. CPFT have commented that while there was evidence of good progress found in the audit in documentation templates and guidance, improvements were still needed. The work on standardising the content and structure of correspondence including discharge letters continues with a working group overseeing this, which is expected to be concluded shortly after September 2017.
- 5.63 We suggest that the process for discharge to primary care is explicitly described in the CPA policy, such as who can write the letters, a list of standard inclusions such as interventions provided, an overview of what medication has been stopped or started, risks identified or not, to self or others, with bulleted actions to be taken, especially actions for the GP.

### **Recommendation 5**

The process of discharge from Cambridgeshire and Peterborough NHS Foundation Trust services to primary care must be supported by specific delivery standards that are formally monitored.

- 5.64 CPFT is currently developing its 'PRISM'<sup>34</sup> service. This service will be based in primary care, with CPFT mental health staff working alongside primary care colleagues, supporting 'step up' and 'step down' to and from secondary care. This is expected to improve services in that it will increase the face to face working in surgeries, supporting informal advice as well as active engagement with service users under the GPs care.

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<sup>34</sup> CPFT GP Q&A leaflet 'PRISM' May 2017

- 5.65 CPFT have also introduced a self-referral service called 'First Response'<sup>35</sup> which is accessed through the NHS 111 phone line, asking for 'option 2'.

## Compliance with policy and national guidance

### Northamptonshire Healthcare NHS Foundation Trust

#### **Risk assessment and care planning**

- 5.66 NHFT discharge, handover and transfer issues are discussed in Section 4, 4.73 to 4.76, and a recommendation has been made (see Recommendation 1).
- 5.67 Following the initial referral to NHFT, Tom was assessed using the NHFT CRHT assessment tool. This includes assessment against 12 domains of risk, which are then summarised in a structured assessment of risk using the HoNOS<sup>36</sup> framework. The initial summary assessment has three sections, and on 14 February 2007 contained this information:
- Risk: was that he had no suicidal ideation or behaviour, and no history of violent impulsive behaviour.
  - Support system: interested family and friends or others willing and able to help
  - Ability to co-operate: wants to get help but is ambivalent or motivation is not strong
- 5.68 From a review of the notes, I concur with this assessment, apart from the question of impulsive behaviour. There is a clear history of Tom attempting to kill himself in 2004 while in recovery from the motorbike accident, and of being aggressive to hospital staff who intervened. This information is contained in the referral 'initial screening tool' of 9 February 2007, but does not appear to have been regarded as evidence of impulsive or suicidal behaviour. The discharge summary of 19 February 2007 repeats this assessment. The reference to the hospital incident is clearly described in the NSTEP screening assessment form of 15 February.
- 5.69 The reference to the hospital episode is also clearly described in Dr A's summary letter to his GP on 20 February 2007. It was noted that no immediate risks to self or others were evident at Dr A's outpatients' appointment. I do not consider that this anomaly had any effect on the actual assessment of risk, as the history was clearly known. It does

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<sup>35</sup> CPFT Leaflet 'First response' August 2016

<sup>36</sup> Wing JK, Curtis RH, Beevor AS (1996) HoNOS. *Health of the Nation Outcome Scales: Report on Research and Development July 1993 – December 1995*. Royal College of Psychiatrists.

however suggest that information about risk may not be shared accurately.

- 5.70 On 7 March 2007 this risk assessment is reiterated, with the addition of Dr A's view that Tom does not in her opinion pose a particular risk to children.
- 5.71 NHFT CLP021 policy on 'working with risk' outlines the detailed process expected of clinicians in assessing clinical risk, based on the 'working with risk practitioners manual'.<sup>37</sup> An initial document 'working with risk 1' is the baseline risk screening tool that should be completed with everyone who comes into contact with mental health services. A second document 'working with risk 2' provides a format for more detailed analysis and reflection on risk information. The review period for both documents is given as 12 months, but also explains that professional judgement is expected to be used if there are changes.
- 5.72 The 'working with risk 1' and 'working with risk 2' were completed in February 2009, August 2009, and September 2010, with last review date of September 2011. He had refused to take antipsychotic medication in 2010 and 2011, and his risk to himself was noted as low, but that he was at risk of serious self-harm if his mental state deteriorated.
- 5.73 A 'risk screening assessment' was carried out in June 2007 at NSTEP by CPN 1, which was developed with Tom and his parents in attendance.
- 5.74 Risk indicators for suicide were noted as;
- Previous use of violent methods (after a serious motorbike accident and while under the influence of strong painkilling medication [Tom]thought his family had been killed and pulled out his femoral artery wishing to die. Since this incident he has not harmed himself in any way.
  - Major psychiatric diagnosis
  - Significant life event (serious motorbike accident in which he was badly burned and sustained serious injuries)
  - Expressing high level of distress (over memories of an incident that may or may not have taken place)
  - Male under 35
- 5.75 The only indicators for aggression or violence were:

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<sup>37</sup> *The Working with Risk Trainer's Manual supports the implementation of the Working with Risk Practitioner's Manual and local policy development (2007).* <https://www.pavpub.com/working-with-risk-trainers-manual/>

- Paranoid delusions about others (believes people are talking about him and when people walk past his house he feels they know he lives there and are talking about him)
  - Possible sexually inappropriate behaviour (talks of playing with a young child at his home. Tormented by a memory of having patted the child's bottom whilst playing behind the sofa. There is no evidence to suggest this either did or did not happen).
- 5.76 He was placed on enhanced CPA, and this risk assessment was reviewed in November 2007, March 2008 and September 2008.
- 5.77 Tom was referred for CHRT input after risks increased, when he made threats to kill himself with a knife at the team base in November 2008. He was discharged back to NSTEP after CRHT input. His low mood was seen as due to a fixed delusional belief that he was a paedophile and had abused a young girl, resulting in feelings of guilt.
- 5.78 There are comprehensive care plans from September 2007 up to 2011 at NSTEP, and these focussed on helping him to cope with his ongoing belief about touching a girl, joint psychology sessions with Sally, and monitoring his mental health while working or unemployed.
- 5.79 The incident that precipitated his admission to an acute mental health unit was regarded as a serious suicide attempt in which he cut both arms, on his right arm through to the tendon, requiring surgery. The trigger factors were noted to be the death of his grandmother, and being referred to a fertility clinic after trying for a baby unsuccessfully for five years. He was prescribed depot risperidone, and discharged into the care of NSTEP on 3 August 2011.
- 5.80 His last risk review noted that he had previously increased access to services when he has found his beliefs difficult to manage. His belief about being a paedophile had diminished when on risperidone depot, but his two previous episodes of self-harm have been driven by psychotic experiences, with both being regarded as very difficult to predict. At this time he was concordant with medication and was regarded as having developed greater insight into his mental health problems.
- 5.81 There are no Epex entries between 12 April 2007 and 12 July 2007. There are however paper notes from March to Sept 2007. There is an unexplained gap in the visits between December 2010 and March 2011, although there is reference to Tom caring for his grandmother at this time.
- 5.82 Although there are regular outpatient letters to his GP from NSTEP medical staff describing his care and treatment, these did not routinely mention risk. Dr C was asked to assess him urgently on 4 October 2011 after Tom had returned to work. He described not sleeping, hearing co-workers whistling and was very anxious that he would begin to hear

hallucinations again. He assured staff that he could keep himself safe and had no plans to harm himself. The team were confident that he and his family believed he was now more likely to alert people to his distress and was prepared to talk about it. This was seen as a significant protective factor.

- 5.83 The planned discharge to East Northants CMHT was made in conjunction with Tom and Sally, and he was described as having no current risk of self-harm. He was transferred to the care of East Northants CMHT in September 2012.

### Recommendation 6

Northamptonshire Healthcare NHS Foundation Trust must provide assurance that the 'working with risk' policy is implemented consistently in NSTEP, and that there are standards in place for the communication of risk information to primary care, which are monitored.

- 5.84 His CPA status changed to 'non CPA' in April 2013 that is to being under the care of the consultant psychiatrist. There is no documented discussion regarding the rationale for this.
- 5.85 There is no reference to this fertility correspondence in the Epex clinical records.

### Cambridgeshire and Peterborough NHS Foundation Trust

- 5.86 See **discharge policy** discussion at 5.56.

### **Risk assessment and care planning**

- 5.87 The CPFT Clinical Risk Assessment and Management Policy v6.1 dated April 2015 and CPFT Care Planning Policy v2.0 dated July 2014 are inter related, as expected. The initial assessment of a service user should be followed by the completion of a 'core assessment screen' on RiO which includes the initial risk assessment. The expectation is that these will be reviewed and updated at least six monthly, or more immediately if there are significant changes, and a list of examples is provided.
- 5.88 The most recent risk assessment on March 2015 was sent in a letter to the GP dated 3 March 2015. This assessment is divided into sections and the assessor is expected to include whether the issue has arisen in the last six months, and ever. A section for a narrative summary is included after each section. Tom's 3 March 2015 risk assessment contained this risk information:
- 5.89 Harm to self:
- Act with suicidal intent, ever; yes, last six months; yes.

- Self-injury or harm, ever; yes, last six months, yes.
- Suicidal ideation, ever; yes, last six months; yes.
- Self-neglect, ever; no, last six months; no.
- The narrative states Tom made a deep cut to his right wrist in a suicide attempt at home, did not tell inform anyone prior, but attended GP with wife. Recent suicide ideation with strong themes of hopelessness and helplessness. Agreed safety and engagement with CRHTT to manage risk and aware of crisis contacts should he need them.
- The previous attempts in 2004 and 2010 were noted (although the last serious attempt was actually 2011). At this time Tom stated he did not actually feel at risk of harming himself, he was just worried about it.

#### 5.90 Harm from others:

- this includes seven items, such as risk of abuse, neglect physical harm are all noted to be: ever; no, last six months; no.

#### 5.91 Harm to others:

- this includes 13 items such as violence to family, to other clients, sexual assault, risk to children, are all noted to be: ever; no, last six months; no.

#### 5.92 Accidents:

- This has five items including falls, unsafe use of medication, other accidental at home are all noted to be: ever; no, last six months, no..

#### 5.93 Other risk behaviours:

- This has 13 items, including MAPPA, incidents involving the police, absconding/escape, are all noted to be: ever; no, last six months, no.

#### 5.94 Factors affecting risk:

- This has 11 items, including substance misuse, major life event, current mental state, refusal of service, poor engagement with services. The section on major life event is noted to be: in the last six months: no, ever, yes. Current mental state is noted to be last six months: yes, ever; yes. All other items are; no.
- The narrative description lists his recent distress (February 2015) and restates the earlier narrative regarding his recent self-harm and treatment by CHRTT, along with the history from the accident in 2004 and his suicide attempt in 2010 (again wrongly dated).

- 5.95 In 'harm to self' and 'factors affecting risk' the date of his previous suicide attempt is given inaccurately as 2010, it was in fact 2011. In the overall summary section, the correct date is given as 2011.
- 5.96 In the 'accident' section it is stated he had no accidents, when it was well known, and documented elsewhere in this assessment, that Tom had a serious motorbike accident in 2004.
- 5.97 In 'other risk behaviours', no police contact was noted, which is inaccurate. Tom had reported himself to the police in 2009 as he said he had abused a young girl. Whilst the police took no further action, this incident gives an indication of the strength of his delusional belief.
- 5.98 I question the statement that Tom was not difficult to engage, in the 'last six months', or 'ever'. I believe his contact with CPFT and the GP thus far has shown him to be very difficult to keep engaged with services, with a repeating pattern of being brought by family in crisis, and then not engaging with follow up, or being concordant with medication. The overall summary does in fact note that he is difficult to engage.
- 5.99 At 7.3 of the Clinical Risk Assessment and Management Policy v6.1, there is a reference to Appendix 6, which is the RiO risk assessment document. I did not find this appendix in the policy.
- 5.100 The inaccuracies in this document could be seen as highlighting the risk of 'tick box' risk assessments,<sup>38</sup> however the policy does contain the expectation that a risk formulation be developed, in line with best practice as recommended in the referenced NCISH (2013) report. I could not locate a risk formulation in the notes provided.
- 5.101 There are no previous HALT risk assessments in the papers provided, so it is not possible to gauge whether reviews were conducted at expected intervals. A risk assessment was however made at each CRHTT referral in March 2014 and February 2015.
- 5.102 The care plan on file is dated 8 October 2015, which must be an error, as this is after the homicide. There is no other information that would give a clue to the date, other than that it was clearly reviewed in May 2015, so must be presumed to be after that date. It is reasonable to assume that this is the care plan referred to by Dr G in the outpatient review letter of 6 May 2015, as the content of this care plan is referred to.
- 5.103 The care plan focusses on Tom's strengths and needs, and his hopes for the future. Strengths are noted as 'has insight into his diagnosis', 'strong work ethic', and 'supportive family'. It was noted that he appears to have capacity to make decisions about his life, care and treatment. He is recorded as stating he wished to be discharged back to his GP and

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<sup>38</sup> *Quality of Risk Assessment Prior to Suicide and Homicide: A pilot study, June 2013 NCISH*  
<http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/RiskAssessmentfullreport2013.pdf>

*“understands that if he starts to experience early warning signs of becoming unwell he can be referred back to the mental health service”.*

- 5.104 The crisis, relapse and contingency plan was: [Tom] has stated that he will try to distract himself from his thoughts by working on his computer or reading as these are things he enjoys. He will also be encouraged to go for a walk with his wife if he feels things deteriorating when he is with her at weekends. Tom has stated he will talk to his wife if he feels things are getting worse for him. The out of hours numbers were provided.
- 5.105 The relapse indicators or early warning signs are listed with the statement: '[Tom] has recognised with the help of his wife [Sally] that his early indicators to becoming unwell are: increase in his anxieties, lack of sleep, lack of appetite, restlessness, not keeping still, fidgeting, and his alcohol consumption will increase'.
- 5.106 The contingency plan lists the services that can be accessed for help urgently.
- 5.107 My overall impression of the care plan and risk summary is that there was a lack of depth that could have been provided by a formulation of Tom's difficulties. This I believe would have given more weight to his pattern of disengagement after crisis, and his pattern of waiting for others to take him to seek help. The professionals involved said the Tom was very private and reluctant to engage with mental health services, and very driven to return to his normal working pattern. He presented as recovering quickly from relapse and returning to his normal functioning.
- 5.108 Sally was regarded as a protective factor, and integral to the support that Tom received in managing his illness. I do however question a crisis plan that relied on Tom to recognise and act on his relapse signs, as the history, perhaps with the benefit of hindsight, shows that he had not independently acted to seek help on early warning signs since his move to Cambridgeshire.
- 5.109 His insight is mentioned, and it may be that he did have an acceptance of his psychotic illness, but insight suggests an understanding both of the illness and the action needed by him and others to address it. Birchwood *et al* (1994) suggest that insight should not be seen as a binary concept<sup>39</sup> but as a continuum representing the juxtaposition of three factors; awareness of illness, need for treatment and attribution of symptoms. They suggest that interview alone is insufficient to gauge insight and suggest a validated scale to assist clinicians.
- 5.110 The concept of insight has important implications for management of psychosis, and has been noted to have at least three dimensions: (1)

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<sup>39</sup> Birchwood, M., Smith, J., Drury, V., Healy, J., Macmillan, F. and Slade, M. (1994), A self-report Insight Scale for psychosis: reliability, validity and sensitivity to change. *Acta Psychiatrica Scandinavica*, 89: 62–67. doi:10.1111/j.1600-0447.1994.tb01487.x

awareness of illness, (2) the capacity to re-label psychotic experiences as abnormal, and (3) treatment compliance.<sup>40</sup>

- 5.111 Tom could be regarded as having the first one and/or possibly the second of these, but was certainly not in my opinion compliant with treatment. I believe a learning point for the HALT service is in reference to the understanding of insight and its relevance to engagement.
- 5.112 Having said that, there is no history of violence beyond that which occurred toward hospital staff in 2004 when Tom was under the influence of strong sedative medication and had experienced extreme trauma. The risk assessment and care plans, while I consider them to be overly optimistic, are appropriately focussed on his risk to himself.

### Recommendation 7

Cambridgeshire and Peterborough NHS Foundation Trust must ensure that an understanding and assessment of insight is included in its risk management training.

### GP mental health care 2013-2015

- 5.113 When a new patient with a history of mental health care is registered with the Cedar Road GP practice, the local practice is that a double appointment is offered to go through the notes and carry out initial health checks. A plan of care would normally be agreed after this appointment. It is noted that the previous GP surgery in Northants was not using the same electronic system (SystemOne) which meant that his previous notes were not available until requested.
- 5.114 This was completed with Tom on 3 January 2014. He was seen by a GP for initial blood tests and by a nurse practitioner to take history of smoking, alcohol consumption and check blood pressure and weight. Health and wellbeing were also. A GP then discussed his mental health care with him.
- 5.115 The GP discussed his weight and blood pressure with him, explored his lifestyle and exercise, noting he had been discharged from NHFT mental health services. His current mental health care was discussed, and he was noted to be working, had a supportive wife and no children, was taking regular medication and was stable on this (aripiprazole, risperidone and procyclidine), had no side effects and no depression, delusions or hallucinations.
- 5.116 A plan was agreed, this was to return for a further blood pressure check in a month, continue to take his medication, and contact GP or out of hours services if he had any signs and symptoms.

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<sup>40</sup> *On insight and psychosis: discussion paper. David A (1990 Journal of the Royal Society of Medicine Volume 83 May 1990,3.*

- 5.117 There is a named senior partner GP who acts as a resource to other GPs in complex mental healthcare situations. We were informed that patients who require mental health services are discussed at regular practice meetings, which included sharing the most recent CPFT referral routes. The GP practice has begun to advise patients to make use of the 'NHS111 Option 2'<sup>41</sup> service also. This is a pilot scheme (First Response) launched in September 2016 by CPFT. People living in Cambridgeshire and Peterborough are now be able to access a new mental health team when they dial 111. Specially-trained mental health staff will speak to callers and discuss with them their mental health care needs, instead of them having to go to accident and emergency departments of local acute hospitals.
- 5.118 Subsequent referrals to CPFT were made through ARC as expected by CPFT policy and procedure, up until the last referral in August 2015.
- 5.119 At the GP consultation with Tom and Sally on 21 August, Tom said he did not wish to be referred to mental health services, but requested lorazepam. A 25 minute discussion followed, in which he stated that tries to avoid the prescribed risperidone because it makes him feel sedated, and he had stopped taking fluoxetine eight weeks earlier, which he had not told Sally. He agreed to a change of antidepressant to sertraline, and the GP discussed the need to take medication sensibly and safely. For this reason it was suggested that the sertraline be prescribed in a 'dosette' box so that it was easier to track when doses had been missed. The sertraline was prescribed for seven days, and it was established that he had sufficient lorazepam at home. It was noted that he was not suicidal.
- 5.120 The final referral to CPFT by the GP on 28 August 2015 was not made using the accepted ARC process. Tom was noted to have fleeting ideas about suicide but no plans.
- 5.121 As noted at 4.155, a fax was sent addressed to CPN2 at HALT with the title 'for urgent attention please' and made reference to Tom having relapsed due to not taking his medication, and requesting that CPN 2 review him urgently.
- 5.122 The locum GP was interviewed by the internal investigation team, and this is discussed above at 5.64.
- 5.123 **Reference to national guidance (NICE) Psychosis and schizophrenia in adults is discussed below from paragraphs 5.133 to 5.139.**

## The effectiveness of the care plan

### Family and service user involvement

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<sup>41</sup> <http://www.cpft.nhs.uk/Latest-news/Extended-111-service-will-help-those-in-mental-health-crisis.htm>

- 5.124 Tom's family were very involved in his care, bringing him to appointments and arranging for crisis input where needed. The support of his parents was acknowledged as very important to him, and although family therapy was offered to them it was not taken up. There are suggestions that Tom's family may have been overinvolved in his life, but Tom did not wish to explore this when given the opportunity.
- 5.125 Sally was seen by both NHFT and CPFT as central to Tom's care and treatment, and she was part of care planning and follow up meetings. All discharges were planned in conjunction with her. At CPFT CPA meetings there is a separate record of Sally's opinion, feelings about treatment and opportunity given to discuss any effect on her.
- 5.126 Carers' assessment were carried out at NHFT and CPFT, and Sally received carer support counselling at both Trusts. This was available to her for several years, and the service at NHFT ensured there was a handover to the CPFT service. This was an example of good practice.
- 5.127 Tom was offered and received responsive services, with care plans developed with him that attempted to address his needs. One of the distinctive features of his care is his approach to medication. There were many years of psycho-education and feedback about the efficacy of medication when taken regularly.

### **Medication**

- 5.128 Tom was noted to have an apparent acceptance of his diagnosis, and showed a good understanding of his early warning signs. He had developed a relapse prevention plan with CPN2 which was in place in 2014 and 2015.
- 5.129 However, each recent crisis was precipitated by Tom's reducing or stopping his medication. A full medication prescription history is at Appendix D.
- 5.130 In March 2014 he attended the GP practice complaining of hallucinations, believing songs on the radio were about him, not sleeping. He admitted he had stopped taking all medication because they were trying for a baby. He was seen by the CHRTT and HALT.
- 5.131 In September 2014 he told the GP that he had stopped taking all medication three months earlier and had not gone for psychiatric follow up.
- 5.132 In October 2014 he told Dr G at HALT that he had stopped taking medication and deteriorated but had now restarted. However in November 2014 he told Dr G at that he had stopped aripiprazole because he felt drowsy. He was prescribed fluoxetine for low mood, but refused to take them.
- 5.133 In December 2014 he reported feeling low in mood. He then agreed to take the previous prescription of fluoxetine.

- 5.134 A week later in December 2014 he complained of feeling paranoid, and said he had stopped taking aripiprazole and risperidone with the stated intention of trying to manage his mental health by himself. He was encouraged to take the fluoxetine and antipsychotic medication. A week later on 17 December 2014 he said he was now taking aripiprazole and risperidone, and planned to start the fluoxetine, having still not taken any yet.
- 5.135 On 9 February 2015 he attended the GP with Sally after cutting his wrists. He said he had stopped taking the aripiprazole and risperidone because of weight gain and low motivation. At this consultation he refused to believe he may be depressed, and refused any adjustment to his antipsychotic medication. He was very concerned about weight gain, sedation and lack of motivation. He did however agree to start the fluoxetine that had been prescribed in November 2014, which he said he had never taken. He was also prescribed lorazepam as required for anxiety.
- 5.136 In April 2015 he appeared flat in mood, and said he had just started the fluoxetine. In May 2015 he told Dr G his mood had improved since taking the antidepressant, and he was now taking risperidone and fluoxetine regularly, and had cut down on lorazepam from four times a week to once a week. He was discharged from HALT in June 2014, and the need to maintain medication compliance was emphasised, and he was encouraged not to change his medication without medical supervision.
- 5.137 On 19 May 2015 the GP conducted a medication review with Tom, and he said he was taking fluoxetine 20mg and risperidone 0.5mg, with lorazepam as required.
- 5.138 The repeat prescriptions were recorded as having been requested on 15 June, 13 July and 5 August 2015.
- 5.139 On 21 August 2015 Tom attended the GP with Sally in crisis again, and said he had stopped taking the fluoxetine two months earlier (possibly June), and 'tries to avoid' taking risperidone because it makes him feel unmotivated, and he wanted to be 'healthier'. It was clear at this meeting that Sally was unaware that he was not taking his medication. He was asking for a prescription for lorazepam for anxiety. He appeared to accept a change to sertraline, as he was not taking fluoxetine. On 28 August the GP suggested this be dispensed in 'dosette' boxes, to try to support his concordance.
- 5.140 Following his arrest blood tests noted that he had some evidence of antidepressant medication in his system, but of insufficient therapeutic dose, suggesting he had taken some of the prescribed medication.
- 5.141 We believe it is clear from this history that services made every effort to try to encourage Tom's concordance with medication. There were no indications that his capacity was impaired, and therefore no suggestion

that there should be any interventions to formally compel him to take medication, for example by using the Mental Health Act to arrange a formal admission to hospital.

- 5.142 The relationship between his mental health and medication were well known to him and Sally, and his relapse prevention plan was developed using his own suggested methods for intervening when early warning signs were present.
- 5.143 It is tragic that the evidence is that Tom did not act on his early warning signs when they were present, and it appears he did not act until he was in crisis, then relied upon others to intervene for him to get help.

### **Care planning**

Discussed at 4.75 to 4.85 above for NHFT and 4.96 to 4.111 above for CPFT

## **The appropriateness of treatment plans**

- 5.144 Tom's initial diagnosis in 2007 was 'psychotic episode', and it was noted that the differential diagnosis was between a depression with psychotic features and a delusional disorder. A diagnosis of schizophrenia was made at the inpatient ward in 2011, which he and his family found upsetting, and they received supportive interventions to help them understand his condition.
- 5.145 In 2015 a diagnosis of delusional disorder which is currently in remission, and recurrent depressive disorder were referred to.
- 5.146 The NICE guidance (2009 & 2014)<sup>42</sup> for the management of psychosis and schizophrenia now focusses on each stage of the person's psychotic illness:
- Preventing psychosis
  - First episode psychosis
  - Subsequent acute episodes of psychosis or schizophrenia and referral in crisis
  - Promoting recovery and possible future care
- 5.147 The referral to NSTEP provided the opportunity for treatment within national guidance; the NICE guidance for the management of psychosis and schizophrenia recommended these standards for psychological interventions:
- 5.148 'Psychological interventions:

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<sup>42</sup> *Psychosis and schizophrenia in adults: prevention and management.* <https://www.nice.org.uk/guidance/cg178>

- CBT should be delivered on a one-to-one basis over at least 16 planned sessions and: follow a treatment manual so that:
- people can establish links between their thoughts, feelings or actions and their current or past symptoms, and/or functioning
- the re-evaluation of people's perceptions, beliefs or reasoning relates to the target symptoms
- also include at least one of the following components:
- people monitoring their own thoughts, feelings or behaviours with respect to their symptoms or recurrence of symptoms
- promoting alternative ways of coping with the target symptom
- reducing distress
- improving functioning.

5.149 Family intervention should:

- include the person with psychosis or schizophrenia if practical
- be carried out for between 3 months and 1 year
- include at least 10 planned sessions
- take account of the whole family's preference for either single-family intervention or multi-family group intervention
- take account of the relationship between the main carer and the person with psychosis or schizophrenia
- have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work'.

5.150 Tom received many hours of individual psychological therapy from the NSTEP consultant clinical psychologist between 2009 and 2011. His engagement was described as variable, tending to be more engaged when he was in distress, and pulled away when he was feeling better.

5.151 Tom and Sally were seen for five sessions of couples work by two psychologists, and Sally was described as very caring and committed to him, and keen for issues to be brought into the open. Tom's self-referral to the police was discussed and it was noted that even though the feedback from the police was that there was no victim, this did not make any difference to Tom's preoccupation. The couple were described as very private, and appearing to have low conflict, that is they didn't argue. There was reported to be no sense of domestic violence or coercive control, and Sally was described as assertive in the relationship,

appearing comfortable to challenge Tom, where he would appear more passive.

- 5.152 The focus of the couples work was to try to enable them to discuss the future, possible children, and including their different cultural backgrounds. Their individual family genograms were used to explore family and parent relationships. It was reported that they had very different ideas about their wedding and had not discussed these. The sessions finished at Tom and Sally's request, and they were reported as feeling much better, especially after the wedding plans were in place.
- 5.153 Tom's family attended NSTEP's 'family and friends' psycho-educational programme about diagnosis and living with psychosis. Tom's family were offered the opportunity for family therapy but this was not taken up.
- 5.154 The guidance on medication in the 2009 NICE guideline was:
- 5.155 The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees. Provide information and discuss the likely benefits and possible side effects of each drug, including:
- metabolic (including weight gain and diabetes)
  - extrapyramidal (including akathisia, dyskinesia and dystonia)
  - cardiovascular (including prolonging the QT interval)
  - hormonal (including increasing plasma prolactin)
  - other (including unpleasant subjective experiences)
- 5.156 There is clear evidence that medication and its effects and side effects was discussed many times with Tom, and with Sally. His requests for changes because of side effects was discussed with him many times, and he was provided with education about the effects of the medication, and the risk of not taking the prescribed medication.
- 5.157 Various changes were made in response to his requests, and both the GPs and psychiatrists tried to find combinations and dosages that were acceptable to him. He was particularly concerned with their effects on the couple's desire to have children, citing this as the reason for stopping the medication. The NHFT CMHT psychiatrist prescribed medication to help with this in 2012, although Tom reported it was not effective.

- 5.158 Physical healthcare monitoring was provided by the GP practice in Rushden and Cambridgeshire, and reported as quality measure to the commissioners, through the quality outcomes framework<sup>43</sup> structure.
- 5.159 The NICE guidelines (2009) also suggested clozapine should be offered if there is not a good response to at least two antipsychotic drugs. This did not apply to Tom, as his psychosis appeared to respond well to risperidone and aripiprazole, when he took it consistently.
- 5.160 The question of Tom and Sally's plans or desires to have children is mentioned several times throughout mental health and GP notes. The first mention is in the NSTEP notes in May 2011 after a letter was received from a private fertility clinic asking if Tom was a possible risk to children. There appears to be a missed opportunity to discuss this, as there is no record of any discussion with Tom, although the team responded to the clinic.
- 5.161 Tom was supported to maintain his employment, which was very important to him. Appointments were arranged flexibly around his working hours where possible, and CPN2 maintained contact through calls and texts.
- 5.162 Crises were responded to quickly by NHFT, CPFT and GP services. The initial request to his GP to refer him to secondary mental health services resulted in swift and thorough assessments by the NHFT CRHTT, East Northants CMHT, and ultimately treatment by NSTEP for five years.
- 5.163 In this period Tom had several crises, the most serious of which resulted in his attempted suicide by cutting his wrists in June 2011. He accepted informal inpatient admission, and a diagnosis of schizophrenia was made. A formulation of his difficulties was also suggested, and this was discussed with Tom and Sam.
- 5.164 The discharge to the East Northants CMHT in September 2012 followed a five year period with NSTEP. While the handover was not managed as expected by policy, as discussed at 4.47 above, the treatment provided by East Northants CMHT was a stable period, and there was good engagement with Sally and Tom together.
- 5.165 The first crisis in Cambridgeshire was in March 2014, and the GP referral to ARC (CPFT) was followed by quick intensive input by the CRHTT.
- 5.166 Discharge processes are discussed at 4.45 to 4.67 above.
- 5.167 .

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<sup>43</sup> The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. <http://content.digital.nhs.uk/qof>

## 6 Overall analysis and recommendations

- 6.1 Tom's mental health care in NHFT began in 2007 and was his first diagnosed episode of psychosis. He was diagnosed initially with delusional disorder in 2007, schizophrenia in 2011 and this was changed to delusional disorder in 2013. The change to delusional disorder was explained at interview with the East Northants CMHT psychiatrist Dr D; that is based on the absence of a disintegration of personality such as would normally be seen in patients with a diagnosis of schizophrenia. He had an inpatient admission in 2011, and was subsequently treated as an outpatient only, not on CPA, from September 2012.
- 6.2 Tom's consultant psychiatrist at East Northants CMHT said at interview that he tried to ensure that the GP registration was established in Cambridgeshire, and requested that Tom's notes were transferred, so that the new GP had the records before Tom's discharge from NHFT. The GP practice in Cambridgeshire has no record of when the information arrived from the Rushden GP.
- 6.3 The implication (although it is not explicitly stated) from Dr D's discharge letter in November 2013 was that he would have expected the GP to make a referral to secondary mental health services. Although there was a routine double appointment made by the GP after his registration in Cambridgeshire in January 2014, a referral to secondary mental health services did not happen until the crisis presentation in March 2014.
- 6.4 There is a marked contrast between the treatment Tom received in NHFT and in CPFT.
- 6.5 CPFT assessed Tom in crisis on three separate occasions, March 2014, September 2014 and February 2015. The GP saw him in crisis again in August 2015 just before the homicide, and intended to make a referral to secondary mental health services. Tom was discharged on three separate occasions by CPFT services (albeit for one discharge the administration was not completed).
- 6.6 I consider that Tom's pattern of being non-compliant with medication, and lack of engagement with ongoing care should have triggered a more detailed discussion by CPFT mental health services, where this could have been discussed and treatment options considered.
- 6.7 He had a clear history of a serious and enduring mental illness, which had previously been relatively well maintained by outpatient supervision by a community psychiatrist. He did not engage well with CPFT services, and did not comply with treatment offered, which suggests that CPFT should have taken a proactive longer term view, rather than focussing on short term management.
- 6.8 There was however no history of violence to others, and no suggestion of any violence towards his wife prior to the homicide.



## Recommendations

### **Recommendation 1**

Northamptonshire Healthcare NHS Foundation Trust must provide assurance that the policies on handovers, transfers of care and discharges are implemented and standards maintained.

### **Recommendation 2**

Cambridgeshire and Peterborough Clinical Commissioning Group must provide explicit information about routes of access to mental health services provided by Cambridgeshire and Peterborough NHS Foundation Trust and there should be processes in place to ensure locums are aware of this, which must be monitored for assurance.

### **Recommendation 3**

Northamptonshire Healthcare NHS Foundation Trust health records policy must be adjusted to include the use of consultant outpatients letters as equivalent to a clinical record entry.

### **Recommendation 4**

Cambridgeshire and Peterborough Clinical Commissioning Group must implement a set of standards for reviewing the notes when a new patient with a secondary mental health history is accepted at a GP surgery.

### **Recommendation 5**

The process of discharge from Cambridgeshire and Peterborough NHS Foundation Trust services to primary care must be supported by specific delivery standards that are formally monitored.

### **Recommendation 6**

Northamptonshire Healthcare NHS Foundation Trust must provide assurance that the 'working with risk' policy is implemented consistently in NSTEP, and that there are standards in place for the communication of risk information to primary care, which are monitored.

### **Recommendation 7**

Cambridgeshire and Peterborough NHS Foundation Trust must ensure that an understanding and assessment of insight is included in its risk management training.

## Appendix A – Terms of reference

This investigation is to be conducted in partnership with the Domestic Homicide Review Terms of Reference, and is intended to be an external verification and quality assurance review of the NHS contribution to T's care and treatment with limited further investigation. This may be undertaken via a desktop review and is unlikely to involve detailed interviews with staff.

Additional health related Terms of Reference:

- Oversee and quality assure the IMRs from all the NHS providers that contributed to the care and treatment of T
- To examine the referral arrangements and discharge procedures of the different NHS Trusts' involved in his care
- Review and assess compliance with local policies, national guidance and relevant statutory obligations
- Examine the effectiveness of the service user care plan, including the involvement of the service user and family
- Review the appropriateness of the treatment of the service user in light of any identified health needs
- To work alongside the DHR Panel and DHR Chair to liaise with affected families
- Consider if this incident was either predictable or preventable
- To provide a written report to NHS England that includes measurable and sustainable recommendations. This report may be published as a stand-alone document or in partnership with the DHR report

## Appendix B – Documents reviewed

### CPFT documents

- Internal Serious Incident investigation report May 2016
- ARC referral forms
- GP guidance for using the ARC template
- Adult community locality team operational policy draft December 2014
- Being Open & Duty of Candour policy v3
- Care planning policy v2
- CMHT service structure
- Clinical Risk assessment policy v6.1
- CRHTT operational policy v1
- Guidelines for referral in the psychosis pathway undated
- Psychosis recovery pathway v1
- Incident management policy v4
- Interim operational pathway for urgent referrals undated
- Referral guide October 2104
- PRISM GP Q&As 18 May 2017

### NHFT documents

- IMR report and chronology September 2016
- CLP10 CPA policy v FINAL2011(dated 2009)
- CLP21 Working with Risk (Jan 12-Jan14)
- CRM002 Incident policy Version 2 – 30.04.2012
- CRM006 Being open policy (Apr12- Apr14)
- EIS Operational Policy and Clinical Services Standards 2009
- IGP107 Health records management policy, Version 5, 20.04.2012 and Version 6, 06.07.2016
- CLP066 Implementation of NICE Guidance Policy undated

- OP.CMHT/09/2009 COMMUNITY MENTAL HEALTH TEAMS OPERATIONAL POLICY & STANDARDS v 09/2009. Version: Final 2010
- CLP056 DISCHARGE AND TRANSFER POLICY FOR MENTAL HEALTH AND LEARNING DISABILITIES. Version 8 – 01.05.2015

**Other documents**

- Cambridgeshire Constabulary Individual Management Review June 2016
- Cedar House GP Surgery clinical records
- Employer's report for DHR (Tom)

## Appendix C – Professionals involved

Pseudonym	Role and organisation
Dr B	Ox Rad consultant clinical neuropsychologist
Dr A	NHFT consultant psychiatrist East Northants CMHT
Dr C	NHFT consultant psychiatrist NSTEP
Dr H	NHFT junior psychiatrist NSTEP
CPN1	NHFT care coordinator from September 2007 NSTEP
PSY1	NHFT consultant clinical psychologist NSTEP
PSY2	NHFT consultant clinical psychologist
Dr D	NHFT consultant psychiatrist East Northants CMHT
Dr E	CPFT junior psychiatrist CRHTT
Dr F	CPFT consultant psychiatrist CRHTT
Dr G	CPFT consultant psychiatrist HALT
CPN2	CPFT care coordinator HALT

## Appendix D – Medication history

Date	Role	Medication issue	Concordance
9 Feb 2007	GP	citalopram, short course of zopiclone	
14 Feb 2007	CMHT Dr A	quetiapine increasing to 200mg twice daily within four days. Dr increased his citalopram to 20mg, continue with zopiclone	
Feb 2007	CMHT Dr A	quetiapine and citalopram were increased to 500mg and 40 mg	
early April 2007	CMHT Dr A	Advice given about splitting the dosage of quetiapine differently because of sedation in the mornings	sedation in the mornings
18 April 2007	CMHT Dr A	taking the medication: quetiapine 500mg and citalopram 40mg	much brighter in mood, had been much more active,
November 2007	Dr H NSTEP	Quetiapine was stopped because he was not tolerating the side effects of drowsiness, and had begun to reduce it himself. Prescribed aripiprazole 15mg to increase to 30 mg after one week, and the prescription of citalopram 20mg remained.	Started taking his quetiapine at the same time as aripiprazole, despite the junior psychiatrist's (Dr H) advice not to take two antipsychotics.
December 2007	Dr H NSTEP	aripiprazole 30 mg, citalopram 20mg  Dr H noted his view to Tom and Sally that the agitation was a result of the combination of medications	Complained of poor sleep, agitation/anxiety since starting aripiprazole, & the citalopram had no effect. denied also taking quetiapine
March 2008	CPN 1 NSTEP	aripiprazole 30 mg, citalopram 20mg	Stopped taking aripiprazole against medical advice as felt it was affecting his concentration coming up to exams
April 2008	PSY1 NSTEP	aripiprazole 30 mg, citalopram 20mg	Stopped the antidepressants, but started taking them again because he started to feel low

			in mood, and they had helped.
May 2008	CPN 1 NSTEP	?change to mirtazapine	Said 'had started taking medication again (aripiprazole and mirtazapine)'
1 Oct 2008	Dr H NSTEP	increase in mirtazapine to 30mg	accepted an increase in mirtazapine to 30mg and continued taking the prescription of aripiprazole.
24 October 2008	Dr H NSTEP	taking aripiprazole and agreed to increase mirtazapine to 45mg.	taking aripiprazole and agreed to increase mirtazapine to 45mg.
11 November 2008	PSY1 NSTEP	He told PSY1 that he had stopped taking aripiprazole	stopped taking aripiprazole because of side effects
3 December 2008	CRHTT Dr	diazepam 5mg added short term	
		2008/2009 intensive psychology work	No medication
9 July 2009	SW NSTEP	Described visit to police station to 'confess'	stopped taking antidepressant about a week ago as it was making him drowsy
7 June 2011	Dr H NSTEP	confirmed he had received treatment for psychosis but was not taking any medication currently	Fertility enquiry, not taking any medication
18 June 2011	LRI liaison		Deep cut to wrists
21 June 2011	Avocet	Risperidone 2mg twice a day started.	Tom told staff he would kill himself if he had the chance. not taking antidepressant or antipsychotic medication
13 July 2011	Avocet	suggested he be offered a depot injection (risperdal consta)	complaint of dysfunction since the start of the depot
4 October 2011	Dr C,CPN1 NSTEP	increase in depot risperidone to 37.5 mgs, prescribed oral risperidone 2mg daily for 28 days, and zopiclone 7.5mg for 14 days to aid sleep. Dr C explained to Tom that the depot of risperdal consta 25mg fortnightly is a relatively low maintenance	catastrophic thinking, early warning signs of relapse. no plans to harm himself. Agreed to increase in depot, added oral risperidone & zopiclone 7.5mg. Tom was reluctant to increase the medication, but he was prepared to listen to advice and agreed to the increase

		dose and it may be that this needs to be increased.	
November 2011	Dr H NSTEP	depot risperidone 37.5 mg. A review meeting with Tom, Sally and Dr H took place, and the concerns were discussed. agreed that he would have a lower dose of depot injection.	complained of dysfunction, with low mood and motivation
March 2012	Dr H NSTEP	depot risperidone 37.5 mg.	complained of a fine tremor after his depot injection; prescribed procyclidine 5mg
May 2012	Dr H NSTEP	depot risperidone 37.5 mg, procyclidine 5mg	Sally and Tom asked if he could come off the depot injection, because of dysfunction
14 June 2012	Dr H NSTEP	Depot stop was agreed, with a plan to start oral medication one week later. Risperidone 3mg daily	
July 2012	Dr C NSTEP	After discussion with Dr C, it was agreed to change from risperidone 3mg daily to 2mg daily for 28 days	Sally called with concern that Tom was oversedated, and he was tired and irritable, although not showing any signs of psychosis.
September 2012	CPN1, Dr H NSTEP	Risperidone 2mg daily, procyclidine as required noted to be very well	Enjoying his new job, and coping well with medication.
January 2013	Dr D CMHT	A trial of sildenafil was proposed, which both accepted. Tom did not describe any psychotic symptoms or any thoughts of self-harm or suicide. Decided that Dr D would review him again in April 2013, he was to continue on risperidone 3mg at night and procyclidine as required.	Tom and Sally, concerned about side effects of medication because they had been trying to conceive and were about to undergo IVF treatment. Both asking for reduction in medication.
26 March 2013	Dr D CMHT	It was agreed that risperidone be decreased slowly, and aripiprazole was introduced from 10 April 2013	gone through IVF treatment but not successful, and sildenafil had not helped. both were keen that Tom came off risperidone and requested an alternative medication to avoid relapse

28 May 2013	Dr D CMHT	Aripiprazole 10mg, Risperidone 0.25mg was added, to be taken at night as required. Both reported Tom waking up at night and becoming paranoid, and requesting something to aid sleep. Promethazine 25mg as required was suggested	reported that he had become more preoccupied with his thoughts and had been sleeping less, although he had no breakthrough psychotic symptoms.
28 June 2013	Dr D CMHT	Aripiprazole 10mg Risperidone 0.25mg Promethazine 25mg	Taking risperidone with good effect, and said he wants to continue taking it as it helps to keep him mentally stable, aids sleep. No symptoms of psychosis and less concerned with thoughts
6 September 2013	Dr D CMHT	Risperidone 0.25mg Promethazine 25mg Aripiprazole was increased to 15mg daily in order to counter some of his delusional beliefs.	Feeling less well, with a recurrence of some of his delusional beliefs in relation to believing that he may have done something to a child in the past. Preoccupied with these beliefs.
22 November 2013	Dr D CMHT	Risperidone 0.25mg Promethazine 25mg Aripiprazole 15mg	Described an improvement in the way he was feeling since the increased aripiprazole.
28 February 2014	GP	Risperidone was increased to 1mg daily	Said stopped taking aripiprazole for the <b>past two or three months</b> as he felt it wasn't helping. He said he was taking regular risperidone 500mcg but not procyclidine
28 March 2014	GP	Refer to ARC	said he had stopped aripiprazole 2 weeks ago as it makes him tired, and was also not taking procyclidine regularly.
31 March 2014	Dr G CRHTT	It was noted that Tom had made the decision to come off medication to try to tackle all these things, and had not told Sally this  Prescribed aripiprazole 15mg and risperidone 500mcg, with as required zopiclone	started to experience hyperprolactinemia and delayed ejaculation. They had been trying for a baby and this adversely affected their plans, so they made a <b>gradual change, reducing aripiprazole</b> . The side effects improved and they decided to stay on the <b>low dose of risperidone</b> . They had

			<p>moved and continued to try for a baby but his motivation and energy levels were low, which affected functioning. This led to some relationship difficulties and at one point Sally was considering leaving him.</p>
18 September 2014	GP	<p>aripiprazole 15mg and risperidone 500mcg, with as required zopiclone.</p> <p>reported feeling low, for the past three months he had been hearing auditory hallucinations on the radio, he was not threatening, and not suicidal. referred to ARC</p>	<p>seen with Sally, he said he had <b>stopped medication himself three months ago.</b></p>
6 October 2014	CPN2	<p>aripiprazole 15mg and risperidone 500mcg, with as required zopiclone</p>	<p>Tom reported a recent deterioration in his mental health having <b>discontinued his medication.</b> He said he had now restarted.</p>
12 November 2014	Dr G HALT	<p>Aripiprazole 15mg and risperidone 500mcg, with as required zopiclone.</p> <p>plan was for Tom to be prescribed antidepressant medication, but Tom did not agree due to his reluctance to take medication.</p>	<p><b>Stopped taking aripiprazole because he felt drowsy, but continued risperidone 1mg.</b> He denied experiencing disturbing or paranoid thoughts, and said his mood tends to fluctuate, on bad days he finds no enjoyment in life and has no interest. His sleep was variable.</p>
9 Dec 2014	CPN2 HALT	<p>arranged that Dr G would prescribe fluoxetine 20mg daily, and the prescription would be brought to him</p>	<p>Things had deteriorated although he was still managing to go to work. He described finding it difficult to go out and sounded hesitant. Agreed to the earlier suggestion of an antidepressant.</p>
12 December 2014	CPN2 HALT	<p>Aripiprazole 15mg and risperidone 500mcg, fluoxetine 20mg with as required zopiclone.</p> <p>Reported he had been feeling paranoid, and things were not good. He denied</p>	<p>Said he had started taking aripiprazole as well as risperidone to try to manage his mental health. <b>Had not started fluoxetine</b></p>

		any thoughts of self-harm, and was encouraged to take the fluoxetine.	
9 February 2015	GP	Sally called the GP, very concerned about Tom's mental health. Increasingly paranoid, cut wrist. Lorazepam 1mg as required prescribed, referred to ARC. tablets to Sally to supervise.	He said some of his medications had been discontinued, and he <b>never started taking the fluoxetine</b> that was suggested by the psychiatrist. He said he <b>stopped aripiprazole because of weight gain &amp; lowered motivation.</b>
12 Feb 2015	Dr E & Dr F CRHTT	noted that he had <b>just started antidepressant medication</b> and was taking benzodiazepines in the short term, which needed monitoring.	
14 February 2015	CRHTT staff nurse	Aripiprazole 15mg and risperidone 500mcg, fluoxetine 20mg with as required zopiclone, as required lorazepam 1mg	He had <b>not started the fluoxetine</b> because he said he couldn't find the tablets, so a new prescription was provided. had however been taking lorazepam and risperidone and said that had helped him to sleep
18 February 2015	CRHTT staff nurse	Aripiprazole 15mg and risperidone 500mcg, fluoxetine 20mg with as required zopiclone, as required lorazepam 1mg	He said he had been taking risperidone, lorazepam and fluoxetine, his sleep was much better and he had no side-effects.
19 Feb 2015	Dr E & Dr F CRHTT	Aripiprazole 15mg and risperidone 500mcg, fluoxetine 20mg with as required zopiclone, as required lorazepam 1mg. His risk was thought to be dependent on his mood, he has accepted antidepressant medication to tackle this for the first time, but the impact will need monitoring by his community team. It was noted he was engaging with the team in that he is accepting	

		medication and attending the team base for CRHTT reviews.	
21 February 2015	CRHTT staff nurse	Aripiprazole 15mg and risperidone 500mcg, fluoxetine 20mg with as required zopiclone, as required lorazepam 1mg.	Tom said the medication helps a bit, he was still having some paranoid thoughts but does challenge these thoughts to bring himself back to reality.
5 March 2015	CPN2 HALT	Aripiprazole 15mg and risperidone 500mcg, fluoxetine 20mg with as required zopiclone, as required lorazepam 1mg.	Tom said he was taking medication, and thought both fluoxetine and risperidone were helping his mood and psychotic ideation.
4 May 2015	CPN2, Dr G HALT	Aripiprazole 15mg and risperidone 500mcg, fluoxetine 20mg with as required zopiclone, as required lorazepam 1mg. Continue fluoxetine 20mg and risperidone 500mcg, aripiprazole discontinued.	his mood had improved since starting on the fluoxetine. He was exercising regularly, and walking the dog. He had moved back to live with Sally and said he enjoys a good supportive relationship with her. Said he was taking risperidone and fluoxetine regularly, and had cut down on the lorazepam to about once a month. He said he was taking it four days in a row initially and had some withdrawal symptoms when he reduced it, but none for the past month.
19 May 2015	GP	risperidone 500mcg, fluoxetine 20mg with as required zopiclone, as required lorazepam 1mg  GP surgery continued to issue prescriptions, and a medication review was conducted on 19 May 2015	
14 July 2015	CPN2 HALT	Discharge letter. At this time he was prescribed fluoxetine 20mg, risperidone 1mg and lorazepam 1mg to be taken as required.	

15 June, 13 July, 5 August.	GP	Repeat prescriptions requested	
21 August 2015	GP	Crisis, ongoing problems with his mental health, appeared quite flat in mood and slow in responses, but said he had taken 1mg risperidone and 1mg lorazepam that morning. He asked for a repeat of lorazepam prescription but then said he had plenty for the weekend. The GP emphasised the need to take medication safely and sensibly. He agreed to take a new antidepressant, and was prescribed sertraline 50mg tablets to be taken once a day. Plan refer to ARC, not done	said he <b>had stopped taking fluoxetine eight weeks ago, of which Sally was unaware.</b> Tom said he <b>tries not take risperidone because it causes sedation</b> and he uses software at work so needs to concentrate. At this point he said <b>he was not taking any medication</b> , and felt paranoid and was very anxious
28 August 2015	GP	Med 3 given	He also said he hasn't been taking his medication whilst away. He said he had fleeting ideas of suicide but no plans. On examination he was slow to answer questions but also restless
26 August 2015	GP	Agreed plan was that he would take risperidone 1mg at night, switch the fluoxetine to sertraline (although already switched on 21.8), take 1mg lorazepam in the morning and one at night, and a prescription was issued.	attended the GP surgery again with Sally, saying he was paranoid and wanted lorazepam, fleeting ideas of suicide but no plans. On examination he was slow to answer questions but also restless.

