

An independent investigation into the care and treatment of a mental health service user A in NAVIGO

March 2020

Author: Sue Denby, Practitioner, Governance and Investigations.

Lead partner: Nick Moor

First published: March 2020

Niche Health and Social Care Consulting 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.

Our Report has been written in line with the terms of reference as set out in the Terms of Reference on the independent investigation into the care and treatment of A. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

This is a confidential Report and has been written for the purposes of NHS England alone under agreed framework terms. No other party may place any reliability whatsoever on this report as this report has not been written for their purpose. Different versions of this Report may exist in both hard copy and electronic formats and therefore only the final, approved version of this Report, the 'Final Report' should be regarded as definitive.

Niche Health & Social Care Consulting Ltd
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Telephone: 0161 785 1000

Email: enquiries@nicheconsult.co.uk

Website: www.nicheconsult.co.uk

Contents

1	Executive summary	1
	Mental health history	2
	Relationship with the victim.....	6
	Offence	6
	Internal investigation	7
	Independent investigation.....	8
	Conclusions	8
	Good Practice.....	10
	Review of internal investigation	10
	Recommendations.....	11
2	Independent investigation.....	13
	The homicide	13
	Approach to the investigation.....	13
	Contact with the victim's family.....	15
	Contact with service user A.....	16
	Structure of the report	16
3	The care and treatment of service user A.....	17
	Childhood and family background.....	17
	Contact with criminal justice system.....	17
	Psychiatric history	18
	Gynaecology admission 5 - 8 December 2007	18
	Treatment in the community 9 - 12 December 2007.....	19
	First admission 1 - 17 December 2007	19
	Treatment in the community 18 December 2007 - 22 February 2008	19
	Second admission 22 February - 12 May 2008.....	19
	Treatment in the community 12 May 2008 - 1 June 2015.....	20
	Third admission 1 - 12 June 2015.....	25
	Treatment in the community 12 June 2015 - 22 September 2016.....	26
	Fourth admission 22 September - 6 October 2016	27
	Treatment in the community 30 September 2016 - 15 March 2017	28
	Fifth admission 14 March - 7 April 2017.....	32

	Treatment in the community 7 April - 22 September 2017	36
4	Arising issues, comments and analysis	44
	Care planning	44
	Care Coordination.....	50
	Care plans, safeguarding and risk to self and others.....	52
	Discharge planning	53
	Safeguarding, risk assessment and management	56
	Workplace culture	66
5	Internal investigation and action plan	69
	Implementation of recommendations	71
	NAViGO action one	75
	NAViGO action two.....	76
	NAViGO action three.....	76
	NAViGO action four.....	77
	NAViGO action five.....	78
	NAViGO action six.....	79
	NAViGO action seven	80
	NAViGO action eight	80
	NAViGO action nine	81
	NAViGO action ten	82
	Further recommendations from learning lessons report.....	83
6	Overall analysis and recommendations	83
	Predictability and preventability	83
	Key decision point 1	85
	Key decision point 2	87
	Key decision point 3	88
	Good Practice.....	90
	Care planning	91
	Risk assessment, management and safeguarding	93
	Workplace culture	95
	Review of the internal investigation	95
	Recommendations.....	96

Appendix A – terms of reference.....	98
Appendix B - documents reviewed	101
Appendix C – review of the internal investigation.....	102
Appendix C - chronology	104

1 Executive summary

- 1.1 NHS England North commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user service user A. Niche is a consultancy company specialising in patient safety investigations and reviews.
- 1.2 The independent investigation follows the NHS England Serious Incident Framework¹ (March 2015) and Department of Health guidance² on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A and include information that the family wished to be addressed.
- 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.
- 1.5 NAViGO Health and Social Care Community Interest Company (a non-profit making community interest company that provides all local mental health and associated services in North East Lincolnshire) is the main focus of the independent investigation. NAViGO came into inception in April 2011, prior to this the local mental health service provider was North East Lincolnshire Care Trust Plus (NEL).
- 1.6 Service user A is a 56-year-old woman with a partner, Keith, who presented to her GP between 1999-2004 feeling depressed and was treated with antidepressant medication. She was referred to the primary care mental health service in 2004 as she had been refusing to leave her home for some time, crying and not sleeping or eating. Records indicate that at that time she was living alone, felt isolated and unable to cope. Service user A was diagnosed with an anxiety state and prescribed a change of antidepressant medication.
- 1.7 Between 2005 and September 2007 records indicate that service user A was drinking heavily and was not always compliant with her medication but began to not feel so low in mood. In October 2006 service user A was referred to a North East Lincolnshire Community Mental Health Team (NEL CMHT).

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

² 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>

- 1.8 She was then admitted as an in-patient in 2007 and diagnosed with acute and transient psychotic disorder. Persistent Delusional Disorder (PDD)³ was diagnosed following a second admission between February and May 2008. She then received a range of community and outpatient services over the intervening years, being discharged from services on several occasions. After her last care episode with community mental health services, service user A was discharged from mental health care (now provided by Navigo, who in April 2011 replaced NEL as the mental health service provider) in August 2017.
- 1.9 Service user A set fire to her first floor flat in the early hours of 22 September 2017, leading to the death of her partner, Keith. At about midnight, she had taken a taxi to a cashpoint, withdrawn money with his card, went to a petrol station and asked the taxi driver to buy petrol and a lighter.
- 1.10 While Keith was asleep, she set fire to the bedroom using the petrol and lighter she had bought. Keith awoke while she was pouring petrol around the bedroom, before she threw lighted paper into a wardrobe and closed the door. Following an explosion, service user A leapt to safety through the window, leaving Keith to die. The police rescued several other disabled residents from six other flats in the block.
- 1.11 Service user A was arrested and placed on remand. She was transferred to a secure mental health hospital in November 2017 on Section 48/49⁴ of the Mental Health Act (MHA) 1983.
- 1.12 Service user A appeared at Kingston Upon Hull Crown Court on 8 March 2018. She pleaded guilty to manslaughter by reason of diminished responsibility and was sentenced under Section 37⁵ with restrictions under section 41, of the MHA 1983.
- 1.13 We would like to express our condolences to the family of Keith. 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 service user A.

Mental health history

- 1.14 In 1999 service user A presented to her GP feeling depressed and was treated with antidepressant medication. She was also prescribed an antidepressant by

³ <https://icd.who.int/browse10/2016/en#/F22> Includes a variety of disorders in which long-standing delusions constitute the only, or the most conspicuous, clinical characteristic and which cannot be classified as organic, schizophrenic or affective.

⁴ <https://www.mind.org.uk/information-support/legal-rights/courts-and-mental-health/section-4849/#.XlCgmi2ca1s> If you are on remand in prison or in an Immigration Removal Centre, you can be sent to hospital for treatment under section 48. Usually the Ministry of Justice will add special restrictions to your transfer under section 49. This is known as a section 48/49.

⁵ <https://www.mind.org.uk/information-support/legal-rights/courts-and-mental-health/section-37/#.XlCF-C2ca1s> A court decided that instead of going to prison you should be in hospital for treatment of a serious mental health problem. A Section 37 is called a "hospital order". The judge decided that because of concerns about public safety you also need to be on a Section 41 which is known as a "restriction order"

her GP in 2002 and was referred to the primary care mental health service in February 2004.

- 1.15 Service user A was referred by her GP to NEL CMHT in October 2006 having not taken her antidepressant medication and feeling low in mood, extremely anxious, hearing voices telling her to kill, intrusive thought processes, not sleeping and psychosomatic symptoms.
- 1.16 Service user A had a termination of pregnancy in October 2006 which she regretted, felt very guilty about and said that Keith had mentally abused her to undergo the procedure. She had suicidal thoughts and was self-harming.
- 1.17 She was referred to the crisis team, although she felt that something was physically wrong with her and sought medical help, rather than accepting the support offered.
- 1.18 In December 2006 she became suspicious, believed her family were trying to poison her, that medication was poison and she had suicidal thoughts. She was detained under Section 2⁶ of the MHA 1983 and admitted for three days before being discharged with a diagnosis of a psychotic disorder (with associated acute stress).
- 1.19 Service user A did not comply with her medication, was focussed on her physical symptoms, started to feel that her family were against her, was increasingly paranoid and suspicious and made repeated threats to kill herself. She felt cameras had been placed inside her and that people were trying to poison her. Service user A was admitted for a second time under Section 2 of the MHA 1983 on 22 February 2008 and made subject to Section 3⁷ of the MHA 1983 on 28 February 2008. She was discharged from hospital subject to Section 117 aftercare⁸ arrangements on 12 May 2008.
- 1.20 Service user A refused to accept a long acting antipsychotic injection (depot) on discharge and was prescribed an oral antipsychotic and an antidepressant. She began to improve, commenced counselling and was discharged back to the care of her GP in 2010.
- 1.21 However, in March 2011 service user A was referred by her GP to the NEL CMHT with Crisis & Home Treatment Team (CHTT) support due to concerns

⁶ <https://www.legislation.gov.uk/ukpga/1983/20/section/2> a patient suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) may be detained for a period not exceeding 28 days beginning with the day on which he is admitted.

⁷ <http://www.legislation.gov.uk/ukpga/1983/20/section/3> This section allows for a person to be admitted to hospital for treatment if their mental disorder is of a nature and/or degree that requires treatment in hospital. In addition, it must be necessary for their health, their safety or for the protection of other people that they receive treatment in hospital. Section 3 is used where the person is already well known to psychiatric services or following an initial assessment under Section 2. Under a Section 3 you can be detained for up to six months in the first instance.

⁸ <http://www.legislation.gov.uk/ukpga/1983/20/section/117> Section 117 of the Mental Health Act says that aftercare services are services which are intended to meet a need that arises from or relates to your mental health problem, and reduce the risk of your mental condition getting worse, and you having to go back to hospital

about her isolation, low mood, anxiety, alcohol intake, weight gain and disturbed sleep. She was suspicious of family members and health staff trying to poison her and focussed on her physical health. She had little insight and her compliance with medication was unclear.

- 1.22 This pattern continued through 2012 - 2013 with her oral antipsychotic medication being increased as a result. Service user A was discharged from the (now) NAViGO CMHT back to the care of her GP in January 2014.
- 1.23 During 2014 to early 2015 service user A was still fixated on physical issues, her compliance with medication was poor; her daughters and Keith reported their concern about her.
- 1.24 On 1 June 2015 service user A was admitted for the third time, this time informally. She was presenting with clear paranoid and persecutory delusions. She was fixated on her physical health, believing staff were covering up illness (despite normal investigations). One of her daughters said that she believed everyone, including all medical professionals, were trying to poison her and said that she had stopped all medication due to feeling sick.
- 1.25 Service user A was discharged from hospital nine days later with a diagnosis of PDD and somatoform disorder.⁹ The oral antipsychotic medication was increased, and the antidepressant was continued.
- 1.26 During 2015-2016 her family reported their concern and her lack of insight. service user A fixated on her physical problems, felt she had high levels of mercury in her blood and that metallic objects made her unwell. She stopped taking her medication and was admitted for the fourth time between 22 September and 6 October 2016 under Section 2 of the MHA 1983.
- 1.27 On discharge service user A was supported by the CHTT, however her family continued to express concern as she became more guarded and delusional. Her daughters advised that service user A had put rat poison in Keith's drink; they said that they had found medication all over the house and that service user A had a way of hiding medication in a hole in her tooth to pretend she has taken it.
- 1.28 Keith denied any concern for his safety; however, he had hit service user A on her arm in his frustration at the situation.
- 1.29 In January 2017, Keith reported that service user A had deteriorated, however they both wanted CHTT support rather than hospital admission and this took the form of daily visits to ensure compliance with her medication. The situation continued to deteriorate with Keith saying he was at breaking point and the daughters requesting hospital admission for the sake of the family. The family

⁹ <https://icd.who.int/browse10/2016/en#/F45>

The main feature is repeated presentation of physical symptoms together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient.

also expressed concern about Keith's safety and his ability to speak freely in front of service user A.

- 1.30 A MHA assessment was undertaken on 6 February 2017 with the outcome of CHTT support and an increase in her antipsychotic medication, however it was noted that if service user A was not compliant with her medication then admission under the MHA was to be considered. By the 24 February 2017 Keith reported that service user A was doing well, and she was discharged.
- 1.31 On 13 March 2017, her daughters sought help about their concerns that service user A was not taking her medication and requested an MHA assessment. Service user A was admitted for the fifth time under Section 2 of the MHA 1983 between 15 March and 7 April 2017.
- 1.32 Service user A was prescribed a depot, due on 24 April 2017, and provided with CHTT and CMHT support with care coordination on discharge. The daughters understood from a discussion with the inpatient consultant psychiatrist that the future crisis contingency plan would include consideration of an MHA assessment and the possibility of a Community Treatment Order¹⁰ (CTO) if service user A did not comply with a prescription of a depot in the community.
- 1.33 Service user A refused the depot on the due date, and was assessed as having capacity to do so, therefore a prescription for an oral antipsychotic was provided with Keith agreeing to supervise her compliance.
- 1.34 By June 2017 service user A was becoming preoccupied with physical health again, talking about mercury poisoning, requesting metal items be left in the hallway, paranoid about family members and preoccupied with thoughts that her daughters were siding with Keith's former alleged partner and choosing her over service user A. Her oral antipsychotic medication was increased. In July 2017 service user A asked to be discharged from services, supported by Keith, and this was agreed to be actioned and the process started on 4 July 2017 by her interim care coordinator (CC5) and new care coordinator (CC6).
- 1.35 On 9 and 14 July 2017 her daughters and sister reported concern about service user A. She said she had spoken to the Queen and claimed that the NHS and government were poisoning her. Service user A also reported that she wanted to poison Keith with bleach or weed killer, stated her depot was stopped by services because the metal was poisoning her body and that she was not taking her medication as it was rotting her insides.
- 1.36 A CHTT assessment found both service user A and Keith asserting medication compliance. The CHTT provided weekend telephone support for service user A and both she and Keith reported that all was well on each contact. Discharge from the CMHT was finally agreed on 28 July 2017, a letter was forward to the

¹⁰ http://www.mentalhealthlaw.co.uk/Community_Treatment_Order A Community Treatment Order under s17A must be considered when s17 leave of more than 7 days is being considered. The patient is subject to conditions and can be recalled for up to 72 hours; the supervised community treatment can then be revoked if this is justified.

GP confirming this on 8 August 2017 and a discharge checklist was completed 11 August 2017.

- 1.37 On 18 August 2017 service user A rang the CMHT single point of access (SpoA) to request confirmation that she had been discharged (which was confirmed). The CMHT SpoA is a seven days per week service for service users and their families experiencing a mental health crisis urgently needing help.
- 1.38 Service user A also called the GP practice that afternoon saying she had pain everywhere and requested sleeping tablets. When she was asked about her mental health, she said she was 'OK' and said she would ring back and book in to see a GP.
- 1.39 On 22 September 2017 service user A set fire to her first floor flat, leading to death of Keith. At about midnight, she had taken a taxi to a cashpoint, withdrawn money with his card, went to a petrol station and asked the taxi driver to buy petrol and a lighter.
- 1.40 While he was asleep, she set fire to the bedroom using the petrol and lighter she had bought. Keith awoke while she was pouring petrol round the bedroom, before she threw lighted paper into a wardrobe and closed the door. Following an explosion, service user A leapt to safety through the window. The police rescued several other disabled residents from six other flats in the block.

Relationship with the victim

- 1.41 Service user A 's partner was 59 years of age at the time of his death. They married in 1982 and had two daughters and three grandchildren together. They separated several times and Keith entered a new relationship before they eventually divorced. It appears they lived apart for three years or so, and in 2003, she was described as a single mother. However, they reconciled and were living together from 2007.

Offence

- 1.42 Service user A set fire to her first floor flat in the early hours of 22 September 2017, leading to death of Keith. At about midnight, a neighbour saw her walking on the road quickly, which appeared unusual.
- 1.43 She came back to her flat carrying something and then took a taxi to a cashpoint, withdrew money with Keith's bank card, went to a petrol station and bought a petrol can and petrol.
- 1.44 The taxi took her home. Service user A asked the taxi to pull up a street before her home, saying that her car was there, and then she walked back to her flat.
- 1.45 While Keith was asleep, she set fire to the bedroom using the petrol and lighter she had bought. Keith awoke while she was pouring petrol round the bedroom, before she threw lighted paper into a wardrobe and closed the door. Following an explosion, service user A leapt to safety through the window, leaving Keith to die. The Police rescued several other disabled residents from six other flats in the block.

1.46 Service user A said she had gathered up cushions around Keith's bed to set the fire. She told people that Keith was evil and wanted her dead.

Internal investigation

1.47 NAViGO undertook an internal investigation with a Lead Investigator, an Independent Investigator (a Mental Health Professor of Old Age Psychiatry), the Assistant Director Community and Psychological Therapy Services, the Assistant Director Acute and Rehabilitation Services, the Associate Director of Nursing and Quality and the Head of Psychology.

1.48 The conclusion was that whilst there were identifiable weaknesses within the care plan and management of service user A, these would not directly have caused the serious incident. On the basis of past behaviour and known risks, and on the balance of probabilities they found that the incident was not preventable.

1.49 Ten recommendations were made:

1. a quick summary including a snapshot of all known historic risk factors, risk factors and relapse signature and contingency plan should be available and updated at every point of review, transfer and made available to all members of the team;
2. CMHT staff to increase their notice period to three months allowing the additional two-month period for a robust handover;
3. review pathways to ensure inter service shared responsibility for joint planning and appropriate team agreements within specific timeframes;
4. ensure all interested parties, especially family members are involved in all Care Programme Approach (CPA)¹¹ care planning, review and discharge decision making within the confines of confidentiality;
5. when considering discharge, a CPA review must be arranged including, where practicable, all interested parties to enable effective decision making within the confines of confidentiality. This ideally would normally include family members, medical staff and all practitioners that have been involved in the delivery of the care plan. The CMHT discharge checklist could form the basis for this review;
6. where CPA needs are identified, the care coordinators (CC) is to be involved in patient care plans;
7. crisis and community teams to review how they record and respond to all communications from family members/carers and other parties. This has to be in line with patient confidentiality; however, confirmation of action taken needs to be communicated;
8. the use of the risk management tool to be reviewed to ensure it is effective;
9. community consultant psychiatrist to attend weekly access meeting; and
10. training in completion of Mental Capacity Act¹² (MCA) documentation to reflect least restrictive options and responding to family concerns.

¹¹ <https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/> The Care Programme Approach (CPA) is a package of care for people with mental health problems.

¹² <https://www.scie.org.uk/mca> The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. "Section 3(1) of the Mental Capacity Act 2005, provides the test of mental capacity as follows: (1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision; (b) to retain that information, (c) to use or weigh that information as part of the

1.50 Section 5 and Appendix B provides a review of NAViGO's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

Independent investigation

1.51 This independent investigation has drawn upon the internal process and has studied clinical information and other relevant information and documents. We have interviewed the clinical and managerial staff we felt could assist us to understand the timeline and provide further information in relation to queries against this. We have also spoken to service user A and members of the victim's family.

1.52 We also interviewed the Lead and Associate Investigator for the internal investigation report but did not find it necessary to interview other panel members. The Head of Psychology panel member perceived the fact that he was not interviewed to be a limitation of the investigation, and we discussed this with the Head of Psychology to hear their concerns on 16 January 2020. However, we did not find that not interviewing this panel member had limited the investigation.

1.53 Assurance has been sought from NAViGO against the internal investigation recommendations to review the progress made in implementing the action plans.

Conclusions

1.54 It is our view that the homicide was not predictable. However, our view was that after her last discharge from hospital, there was a foreseeable prospect that service user A would not take oral antipsychotic medication, in full or in part, given the prominent history of observed, suspected and self-reported non-compliance over the previous decade.

1.55 This in turn could have been reasonably expected to be associated with a recurrence or exacerbation of psychotic symptoms; with non-compliance being known to have been associated with each of her last four admissions (in early 2008, mid-2015, late 2016 and March 2017).

1.56 Again, based on service user A's known presentation when acutely unwell, it was likely that such a symptomatic relapse would have involved persecutory and somatic delusions, and delusions of jealousy, and further that these symptoms would be associated with significant distress and functional impairment on her part, with mistrust towards or disengagement from health professionals and services, and with substantial strain within her key relationships with Keith and her daughters.

1.57 Based on service user A's presentation during the year leading up to the homicide (during which she was admitted twice), when less stable

process of making the decision, or(d) to communicate his decision (whether by talking, using sign language or any other means).

or experiencing a clear relapse, it could have been anticipated that delusional beliefs were likely to involve service user A believing, with absolute conviction, that she was being poisoned (by mercury and, or, metals), that her body was affected in multiple ways (and that she was dying), that health staff were acting in concert to harm her, that family members were trying to poison (or kill) her, that Keith was having an affair, and that their daughters were complicit in this alleged infidelity.

1.58 It is our view that alternative interventions may have resulted in a different outcome, however we are not able to say this with certainty whether these interventions would have prevented the homicide.

1.59 The context of these interventions include:

- staff were not able to access a single, comprehensive summary or overview of service user A's past and recent concerns and presentation to services, including key symptoms, identified risks, relapse signatures, potential safeguarding concerns and third-party concerns. For example, frontline staff were not fully aware that Keith was thought to "collude" with service user A (that is, to support her account by default when seen by staff, for example when asked about her compliance with treatment or improvements in her mental health), or that he had told others that he felt unable to speak freely to staff in her presence;
- there were limitations in multi-disciplinary working which exacerbated this lack of collective knowledge of staff relating to risk-relevant clinical issues;
- a lack of process within the West CMHT to manage allocation of and handover to newly appointed CC; and
- a lack of response to service user A's daughters concerns (addressed at 4.54).

1.60 Our view is that within this context there were three key decision points where different interventions may have resulted in the outcome being different.

1.61 Firstly, our view is that the application of the NAViGO CPA and Non-CPA Care Co-ordination Policy (ratified June 2009, annual review) to service user A's discharge from hospital in April 2017, and following her request to be discharged from services in July 2017, would have ensured a proper review that complied with the good practice principles reflected in the policy. This would have included a more comprehensive discussion and recording of the relevant issues, including the concerns raised by service user A's wider family and agreement within the multi-disciplinary team about service user A's care plan and the way forward.

1.62 Secondly, when the issue of service user A's mental capacity was being considered, our view is that clinicians should have explicitly taken into account the context of both the nature of service user A's ascribed diagnosis of PDD, especially her morbid or delusional beliefs about her health and about the malign intent and behaviour of health professionals, her consistent denial of mental health (as opposed to physical health) difficulties, and the well-established historical pattern of non-compliance and disengagement.

- 1.63 We believe that when service user A declined depot medication in favour of oral antipsychotic medication (April 2017), and then requested discharge from mental health services (July-August 2017), this context should have led to further consideration being given to service user A's ability to understand the likely consequences of making a decision, and her ability to use, process or weigh up relevant information as part of the process of her decision making.
- 1.64 Thirdly, our view is that there were missed opportunities to safeguard Keith through the application of the NAViGO Safeguarding Adult Policy (ratified March 2011, review October 2018) and a lack of recognition that domestic violence, and or abuse was a risk, given her delusions (see 1.58) and the view that Keith may be 'colluding' with her. By 'colluding' we understand staff thought Keith may be acquiescing with her statements and wishes in order to avoid conflict rather than because he truly endorsed them (and he was not given a space by staff to state his true views if he had wished to do so).

Good Practice

- 1.65 On 14 February 2017, a joint CHTT and CMHT visit was planned which we regard as good practice and in line with relevant NICE guidance.
- 1.66 The risk of service user A harming herself or other people was assessed on 10 April 2017 during a two day follow up hospital discharge review on an unannounced home visit. We view this two-day review after hospital discharge as an example of good practice.
- 1.67 We found the response to the family's concerns in March 2017 to be good practice in that service user A was assessed and detained under Section 2 of the MHA 1983.
- 1.68 Service user A was offered medication in line with the NICE guidance "Psychosis and schizophrenia in adults: prevention and management".¹³

Review of internal investigation

- 1.69 We reviewed the NAViGO internal investigation against the National Patient Safety Framework and have included our detailed findings at Appendix B. In summary, we found that the internal investigation met most of these standards, however our view is that it was not comprehensive (see 5.5 to 5.8).
- 1.70 We undertook a quality assurance review using the Niche Assurance Review Framework (NARF), and graded the recommendations against the Niche criteria.
- 1.71 Of the ten recommendations made, none of the actions were complete, embedded and with impact. One was complete with evidence of practice being embedded, three were complete, three were partially complete and three had insufficient evidence to say whether they were complete.

¹³ ¹³ <https://www.nice.org.uk/guidance/cg178>

1.72 The quality assurance review gradings using the NARF was as follows:

Grade	Niche Criteria	Number
A	Evidence of completeness, embeddedness and impact.	0
B	Evidence of completeness and embeddedness.	1
C	Evidence of completeness.	3
D	Partially complete.	3
E	Not enough evidence to say complete.	3
	Total number of actions	10

Recommendations

1.73 We have focussed our recommendations on the key decision points where different interventions may have impacted on the outcome, and where the NAViGO action plan has not already addressed the issue, to further improve learning.

Recommendation 1:

NAVIGO must review their procedures for safeguarding adults and children, to include domestic violence, against the 2016 NICE Quality Standard (QS116) 2016¹⁴ and seek opportunities for specific multiagency training in how to identify and respond to domestic violence, using the learning from this independent investigation to prevent recurrence, and provide assurance through audit.

Recommendation 2:

NAVIGO must seek assurance through substantial audit that day to day practice for CPA meet the policy requirements.

Recommendation 3:

NAVIGO must commission Mental Capacity Act (MCA) training which includes attention to the issues of assessing capacity in people where symptoms relating to mental disorder (e.g. delusions or other morbid beliefs) might impair their ability to believe, appraise and weigh up information in the process of coming to a decision and seek assurance that staff understand and apply these principles using the learning from this independent investigation to prevent recurrence.

Recommendation 4:

NAVIGO must consider the appropriate guidance and provide assurance that when reviewing CMHT Consultant Psychiatrist job plans that time in the CMHT is reliable and consistent.

Recommendation 5:

NAVIGO must implement all the residual recommendations to provide assurance that all actions arising from the internal investigation are now addressed and embedded in practice.

¹⁴ <https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-3-Referral-to-specialist-support-services-for-people-experiencing-domestic-violence-or-abuse>

2 Independent investigation

The homicide

- 2.1 At the time of the homicide service user A was a 56-year-old woman with a longstanding history of mental health problems, who first presented to NEL in October 2004. service user A was diagnosed with an anxiety state and prescribed antidepressant medication.
- 2.2 Between 2005 and September 2007 records indicate that service user A was drinking heavily and was not always compliant with her medication, but her mood began to improve. In October 2006 service user A was referred to NEL services community mental health team (CMHT).
- 2.3 She was only seen once, and then defaulted from further appointments. When she was then admitted in December 2007, she was diagnosed with acute and transient psychotic disorder. Persistent delusional disorder (PDD)¹⁵ was diagnosed on her second admission between February and May 2008. service user A was discharged from NAViGO services in August 2017.
- 2.4 Service user A set fire to her first floor flat in the early hours of 22 September 2017, leading to death of Keith. At about midnight, she had taken a taxi to a cashpoint, withdrawn money with Keith's card, went to a petrol station and asked the driver to buy petrol and a lighter.
- 2.5 While he was asleep, she set fire to the bedroom using the petrol and lighter she had bought. Keith awoke while she was pouring petrol round the bedroom, before she threw lighted paper into a wardrobe and closed the door. Following an explosion, service user A leapt to safety through the window, leaving Keith to die. The police rescued several other residents from six other flats in the block.

Approach to the investigation

- 2.6 The independent investigation follows the independent investigation follows the NHS England Serious Incident Framework (March 2015)¹⁶, Department of Health guidance¹⁷ on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.
- 2.7 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

¹⁵ <https://icd.who.int/browse10/2016/en#/F22> Includes a variety of disorders in which long-standing delusions constitute the only, or the most conspicuous, clinical characteristic and which cannot be classified as organic, schizophrenic or affective.

¹⁶ NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

¹⁷ 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>

identify areas where improvements to services might be required which could help prevent similar incidents occurring.

- 2.8 The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.
- 2.9 The investigation was carried out by Sue Denby, Lead Investigator for Niche, with expert clinical advice provided by Dr John McKenna, retired consultant forensic psychiatrist, safeguarding expertise provided by Sharon Conlon and family engagement and support provided by Christopher Gill. The investigation team will be referred to in the first-person plural in the report.
- 2.10 The report was peer reviewed by Nick Moor, Partner, Investigations and Reviews, Niche.
- 2.11 NHS England North verbally confirmed the scope of the independent investigation as commencing in 2014 to the date of the homicide. Where helpful, we have provided information prior to 2014 to illustrate service user A's history.
- 2.12 In terms of service user A's brief admissions to hospital since 2014, we focussed specifically on issues of detention and discharge processes, including communication between the inpatient and community services.
- 2.13 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.¹⁸
- 2.14 As part of the investigation we interviewed the clinical and managerial staff we felt could assist us to understand the timeline and provide further information in relation to queries against this:
- CMHT Consultant Psychiatrist.
 - Inpatient Consultant Psychiatrist.
 - CMHT Team Manager.
 - Ward Manager, Pelham Lodge (the adult acute in-patient unit)
 - Care coordinator 3.
 - Care coordinator 4.
 - Care coordinator 5.
 - Care coordinator 6.
 - CMHT Duty Worker.
 - CPN West CMHT.
 - Clinical Lead Adult Crisis Team.
 - GP.
 - North East Lincolnshire CCG Quality Assurance Lead.
 - North East Lincolnshire CCG Service Lead.
 - North East Lincolnshire CCG Designated Nurse Safeguarding.

¹⁸ National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

- 2.15 We also interviewed the Lead and Associate Investigator for the internal investigation report but did not find it necessary to interview other panel members. The Head of Psychology panel member perceived the fact that he was not interviewed to be a limitation of the investigation, however we did not find this to be the case.
- 2.16 A full list of all documents we referenced is at Appendix B.
- 2.17 The draft report was shared with NHS England, NAViGO and other stakeholders. This provided 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

- 2.18 Initial contact for the victim's family was arranged through NHS England and facilitated by Christopher Gill from Niche on 28 January 2019.
- 2.19 Family support was further provided through Julian Hendy, Hundred Families (a charity offering information, advocacy and practical support to families who have lost loved ones as a result of killings by people with mental illness).
- 2.20 The family told us that they wanted to be very involved in the process of the independent investigation. They provided us with information which greatly assisted in our understanding of their specific concerns about service user A's care and the internal investigation.
- 2.21 We note that service user A's daughters received a copy of the internal investigation report in April 2017, however Keith's brother did not receive a copy of the internal investigation report. The daughters told us that they met the investigators at the beginning of the process but not at the end for feedback.
- 2.22 NAViGO informed us that a meeting was offered to the family however they declined this, preferring to just pick the report up from NAViGO.
- 2.23 The family are concerned that NAViGO's policies were not followed and do not believe the internal investigation addresses their issues or concerns. In summary the views of the family included the following concerns and assertions:
- Keith was colluding with service user A but was not seen separately from her at any time. He was always trying to help service user A but couldn't handle being her carer (addressed at 1.63, 6.12 – 6.55);
 - the reports service user A gave of Keith's gambling were fictitious and were made to make him look bad (addressed at 4.102);
 - the family's view is that the homicide was preventable. They feel that service user A's risk was escalating, and she was neglected, particularly in terms of the impact of her not having her depot the second time with no further medication (preventability is addressed section 6).
- 2.24 A further family meeting took place on 20 May 2019 and included service user A's two daughters and the brother of the victim Keith. They raised several issues:

- Keith ‘signed things over to them’, for example, dealing with the doctors, as he was at the end of his tether (addressed at 3.151); and
- the ward manager on Pelham Lodge told them that service user A would come out of hospital a different person, that there was nothing to worry about, and that the first time she refused the depot she would be detained under Section 3 of the MHA 1983. The daughters said that they thought the ward manager was the person supposed to give her the depot when she left hospital (addressed at 3.160).

2.25 We met with the family on 13 November 2019 to share the findings of our investigation.

Contact with service user A

2.26 We contacted the responsible clinician (RC) for service user A at the start of the investigation, explained the purpose of the investigation and requested to meet with her.

2.27 Service user A consented to this and we met her on 12 February 2019 to share the purpose and process of the investigation, answer any questions and to gain her perspective. At this time, service user A had been an inpatient at Stockton Hall, York for approximately six months.

2.28 Service user A told us that her mental state had improved which she attributed to taking antipsychotic medication on a regular basis. She told us that she now knew she had a diagnosis of delusional disorder and that this meant she believed something that was not real.

2.29 She told us that at the time, she did not know what was wrong with her or why she needed to take the medication and didn’t want to have the depot. She thought her family were poisoning her and was very frightened. She now believes that NAViGO should have kept her on a depot and followed her up.

2.30 She told us that she did not see her care, crisis or contingency plans, that Keith should have had more support and that NAViGO didn’t explain things to him or take him to one side to have a chat.

2.31 We met service user A again on 31 January 2020 to feed back the findings of the report and our recommendations.

Structure of the report

2.32 Section 3 sets out the details of the care and treatment provided to service user A. We have included a full chronology of her care at Appendix C in order to provide more detailed information about the services service user A received from NAViGO.

2.33 Section 4 examines the issues arising from the care and treatment provided to service user A and includes comment and analysis.

- 2.34 Section 5 provides a review of NAViGO's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.
- 2.35 Section 6 sets out our overall analysis and recommendations.

3 The care and treatment of service user A

Childhood and family background

- 3.1 Our account about service user A's childhood and family background is based on her reports within the available records.
- 3.2 Service user A was born in Cleethorpes and recalls her childhood as having a strict upbringing due to her father's attitude towards parenting. After suffering persistent physical abuse by her father service user A has stated that she was not able to socialise in the usual way children do. She believes that influenced her own difficulties around social interaction as an adult.
- 3.3 Service user A reports being hit by her father throughout her childhood and she states that her father did not allow her to go out or have any friends. She has a twin sister, three other sisters and two brothers. Her parents divorced at an early age.
- 3.4 Service user A had a close relationship with her mother who died of cancer a number of years ago. She went to school in Cleethorpes and has described her school years as not enjoyable, because she was bullied at school and subsequently achieved only one academic qualification. When she left school, she went on a youth employment training scheme.
- 3.5 Service user A married Keith, and they had two daughters, and have three grandchildren. They separated several times, and Keith entered a new relationship before they divorced. They later cohabited again, and she reported he had been very supportive. In 2016, he was described as her partner of 36 years, and that she had been with him since the age of 17.
- 3.6 When service user A left school, she went on a youth employment training scheme. In later work as a cleaner she said she was bullied. Service user A stopped working in 2007-2008 when she was 45 years of age.

Contact with criminal justice system

- 3.7 Service user A did not, to our knowledge, have any previous contact with the criminal justice system. The records indicate, and her daughters informed us, that they had reported service user A to the police, when she had allegedly tried to poison Keith in 2016.
- 3.8 We have not investigated this further with the police, as our view is that the records are clear about the risk, and that this should have been considered as part of her risk assessment and management plan, whether or not the police were involved.

Psychiatric history

- 3.9 Between 1999 and 2004 service user A presented to her GP feeling depressed and was treated with antidepressant medication. She was referred to the primary care mental health service in 2004 as she had been refusing to leave her home for some time, crying and not sleeping or eating. Records indicate that at this time she was living alone without her partner, felt isolated and unable to cope. Service user A was diagnosed with an anxiety state and prescribed an antidepressant medication (citalopram).
- 3.10 Between 2005 and September 2007 records indicate that service user A was drinking heavily and was not always compliant with her medication, but her mood began to improve. In October 2006 service user A was referred to the primary care mental health service and then to a NEL CMHT.
- 3.11 In October 2007, service user A had a termination of pregnancy, and had 'post termination regret', saying that she felt mentally abused by Keith to do this, and felt like ending it all. She had self-harmed with a blade causing superficial scars on her forearm and had stopped taking her antidepressant medication.
- 3.12 Although service user A had been referred to a NEL CMHT in October 2006, she was referred by the GP at this point to the CHTT team. The plan of care was to offer her short-term support in the form of a once per week home visit and to discuss antidepressant medication with her GP. Appointments were offered, however service user A cancelled many, was difficult to engage and was reluctant to take the antidepressant medication until she had a blood test to confirm her physical health.
- 3.13 In October 2007, service user A was in contact with her GP, the primary care out of hours assessment centre and A&E (location unknown) complaining of feeling generally unwell and that everyone was covering up a misdiagnosis. She did not want to be referred to the CHTT team and would not agree to take antidepressant medication.
- 3.14 Records indicate that service user A stopped taking her antidepressant medication in November 2007 as she felt that she did not need them.

Gynaecology admission 5 - 8 December 2007

- 3.15 On 5 December 2007 service user A was admitted to Diana, Princess of Wales Hospital, Grimsby on a medical ward due to abdominal pain with 'post termination regret' and depression.
- 3.16 On 6 December 2007 the medical ward, contacted NEL mental health services as staff believed her abdominal pain was stress related.
- 3.17 On 7 December 2007 service user A was seen by NEL on the medical ward, noted to be very anxious, and an outpatient appointment was booked.
- 3.18 Around this time, service user A was seen by a consultant obstetrician, who noted that service user A claimed that she was forced to have a termination by Keith

and was full of regret. The impression was that she was suffering from post-termination of pregnancy syndrome.

3.19 On 8 Dec 2007 service user A took her own discharge against medical advice.

Treatment in the community 9 - 12 December 2007

3.20 On 9 December 2007 service user A saw her GP complaining of a burning sensation in her vagina and stomach, with pain in her hips. The GP noted that these symptoms were likely to be psychosomatic pains. service user A wanted further investigations, but not at Diana, Princess of Wales Hospital Grimsby, due to being unhappy at the care she previously received there.

3.21 On 11 December 2007 service user A requested blood tests from her GP as she felt that everyone was covering up a missed diagnosis.

3.22 On 12 December 2007 service user A attended A&E (unknown location) feeling unwell. Records indicate that she refused to accept that there was nothing wrong with her physically, would not take antidepressants and did not want to be referred to counselling or the CHTT team.

3.23 Records indicate that around this time service user A was discharged from the CHTT team after missing all eight offered appointments.

First admission 1 - 17 December 2007

3.24 In December 2007, service user A was detained under Section 2 of the MHA 1983 following a home visit. She was reported as being suspicious, with suicidal thoughts, believed her family were trying to poison her and that medication was poison. This was the first mention of her partner colluding with her.

3.25 Records indicate that service user A was experiencing an acute transient psychotic disorder and an acute stress reaction. She spent three days as an inpatient before being discharged with a prescription for antidepressant and antipsychotic medication.

Treatment in the community 18 December 2007 - 22 February 2008

3.26 She was followed up at seven days after discharge by the CHTT team and was subject to the Care Programme Approach (CPA).

3.27 Between December 2007 and early February 2008, service user A was difficult to engage. She was fixated on her physical health and was not compliant with her medication. She was discharged from the CHTT with service user A and her family agreeing to contact the GP if her mental health deteriorated.

3.28 During this period a consultant psychiatrist documented 'some issues' regarding her relationship with her partner. This discharge from services (her first of four) was followed by admission to hospital within a fortnight.

Second admission 22 February - 12 May 2008

- 3.29 On 22 February 2008 service user A was admitted to Derby City Hospital, under Section 2 of the MHA 1983 following an assessment by Derby CHTT team. service user A had been staying with her sister. The records indicate that service user A thought her family were against her, was increasingly paranoid and suspicious and had made repeated threats to kill herself. She felt cameras had been placed inside her and that people were trying to poison her. She had somatic symptoms (burning pain all over her body, bones disintegrating, lungs, throat and ears bursting out and abdominal pains).
- 3.30 On 28 February, service user A was transferred to a (unnamed) ward in Grimsby, granted leave but refused to return to the ward and was detained under Section 3 of the MHA 1983. Later records indicate that she was subject to Section 117¹⁹ aftercare arrangements on discharge.
- 3.31 On 16 March 2008 records indicate that service user A refused to return to the ward after being granted.
- 3.32 Records are not clear at this point but indicate that she was then offered and did not attend three urgent outpatient appointments.
- 3.33 On 21 March 2008 service user A was assessed at home, and found to be insight-less, refusing all medication and continually 'phoning family members to seek reassurance.
- 3.34 On 27 March 2008 service user A was allocated a care coordinator (CC1) and a depot (risperidone) was administered.
- 3.35 On 12 May 2008 service user A was discharged from inpatient care with a prescription of an oral antidepressant and a depot although records indicate that she did not want to have the injection as it made her feel dizzy.
- 3.36 Discharge information indicates that her mental health was still poor, and that she was having delusional thoughts about her physical health.
- 3.37 Service user A continued to be subject to Section 117 aftercare.

Treatment in the community 12 May 2008 - 1 June 2015

¹⁹ <https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-aftercare/#.XleP0C2ca1s> After-care' means the help you get when you leave hospital. You are entitled to section 117 after-care if you have been in hospital under sections 3, 37, 45A, 47, or 48 of the Mental Health Act 1983.

- 3.38 On 20 May 2008 a discharge letter stated that service user A's diagnoses were a somatisation disorder,²⁰ somatoform disorder and delusional disorder²¹. We note the discharge letter subheadings for past psychiatric history, personal history and pre-morbid personality state that the information was previously documented, however we could not find evidence that this was the case.
- 3.39 Service user A refused the depot once she was back in the community. Records indicate that she was not compliant with the oral antidepressant medication, with outpatient appointments and home visits. Alcohol abuse was again noted.
- 3.40 On 17 June 2008 service user A was prescribed a different oral antidepressant medication (fluoxetine) and soon afterwards a different antipsychotic oral medication (aripiprazole) was prescribed, which, in the UK, is licensed for treatment of schizophrenia, manic episodes and prevention of manic episodes.
- 3.41 The evidence points to this being used in her case as an antipsychotic, and that this continued to be prescribed almost without a break until 2017.
- 3.42 On the 26 August 2008 during an outpatient appointment, service user A was noted to have improved since the introduction of the different medication.
- 3.43 On 18 November 2008 during an outpatient appointment service user A was said to be no longer complaining of a burning sensation in her head or pains in her body. She mentioned that she had gained weight and asked if this was due to the medication.
- 3.44 On 25 November 2008 a new CC (2) was introduced to service user A due to service restructuring and took over these responsibilities on 22 January 2009.
- 3.45 In 2009, service user A started but discontinued psychology counselling sessions and moved into a new one bedroom flat with Keith. She said that the move would benefit her as her current property held a lot of bad memories.
- 3.46 On 10 March 2009 CC (2) sent the GP a copy of her care plan which stated that service user A had a diagnosis of depressive episodes with a 'somatic syndrome somatoform disorder'. It said that service user A was socially isolated and had intrusive thoughts regarding her termination of pregnancy. The care plan detailed her history of past medication non-compliance due to her belief that it was having an adverse effect on her physical health.
- 3.47 On 27 April 2009 an outpatient review stated that service user A was experiencing a mixed anxiety and depressive disorder and that a differential

²⁰ <https://www.icd10data.com/ICD10CM/Codes/F01-F99/F40-F48/F45-/F45.0> Pattern of recurring polysymptomatic somatic complaints resulting in medical treatment or impaired daily function. Usually begins before age 30 and extends over a period of years.

²¹ <https://www.icd10data.com/ICD10CM/Codes/F01-F99/F20-F29/F22-/F22> A disorder characterized by the presence of one or more nonbizarre delusions that persist for at least 1 month; the delusion(s) are not due to schizophrenia or a mood disorder, and do not impair psychosocial functioning apart from the ramifications of the delusion(s). A kind of psychotic disorder

diagnosis of somatoform disorder should also be considered. The previous diagnoses of psychotic disorders are not mentioned.

- 3.48 During 2010 service user A started counselling and on 15 March 2010 Keith was described as her carer.
- 3.49 On 6 October 2010 an outpatient review stated that service user A had a diagnosis of mixed anxiety and depression, had been stable for some time, and remained on the same prescription of an oral antidepressant and antipsychotic medication. Service user A was experiencing occasional flashbacks about her detention under the MHA, and guilt associated with the termination of pregnancy. She was initially regularly seeing the psychologist but was discharged after not attending and lack of engagement.
- 3.50 On 14 December 2010 service user A was reviewed in an outpatient appointment and discharged from the CMHT. This is the first recorded discharge of service user A from NEL services.
- 3.51 Just over three months later on 29 March 2011, service user A was referred back to the CMHT by her GP due to concerns about her isolation, low mood, anxiety, weight gain and disturbed sleep. In April 2011 NAViGO took responsibility for the mental health services from NEL.
- 3.52 We were told by the inpatient consultant psychiatrist (who was employed as a locum CMHT consultant psychiatrist at the time) that during her contact with service user A in the community from 2011 to 2014, she presented with anxiety and depressive symptoms, with low self-esteem. She did not present with psychotic symptoms. There was a recognised context of relationship difficulties.
- 3.53 On 20 April 2011 during the CMHT assessment it was noted that service user A presented as a little suspicious although with no evidence of psychosis. The plan was for the previous CC (2) to monitor service user A but not under the requirements of enhanced CPA.
- 3.54 On 31 May 2011 in an outpatient review Keith reported that service user A spent a lot of time in bed and did not bother to do much around the house. The antidepressant prescription was increased, and the antipsychotic medication was decreased.
- 3.55 On 23 August 2011 following an outpatient review the plan was for CC (2) to continue to support her in the community for a short period. CC (2) told us that during this period of her involvement (2009-2012), she had not been aware that service user A had previously been twice admitted with a diagnosis of psychosis (in 2007 and 2008).
- 3.56 In November 2011 alcohol abuse was noted as well as service user A being suspicious of family members and health staff trying to poison her. She was focussed on her physical health and appeared to have a lack of insight.
- 3.57 On 8 November 2011 during an outpatient review service user A said that her daughter was being very demanding, expecting her to look after her grandchild.

She stated that she was taking only half of the prescribed antidepressant medication and sometimes forgot to take the antipsychotic medication.

- 3.58 On 7 February 2012, following an outpatient review the prescription of the antipsychotic medication was increased due to increased paranoia and the fact that she was not leaving her house. Service user A was described as being panicky and anxious and said that many of her problems were related to her relationship with Keith. She said that he called her 'fat'. She repeated that when she was pregnant, he told her he would leave her if she continued with the pregnancy, and that she thought about this every day, and that she could not forgive herself or him. A further outpatient appointment was arranged for four months, and service user A was to receive anxiety management with CC (3) as CC (2) was absent from work due to sickness.
- 3.59 On 22 May 2012 during an outpatient review service user A appeared anxious and seemed to still have issues with her weight and her perception of being 'fat'. The plan was to review service user A at the request of the CC.
- 3.60 On 25 May 2012 CC (2) returned from sick leave and wrote to the GP to state that service user A was no longer subject to Section 117 aftercare arrangements and that CC (3) was to continue to be her 'lead professional'.
- 3.61 On 30 May 2012 it was reported that service user A was drinking heavily and felt that Keith would leave her again for another woman because of her weight. Records indicate that service user A did not engage with the offer of help from NAViGO drug and alcohol services.
- 3.62 On 12 June 2012 CC (3) referred service user A to CHTT due to her increased anxiety, issues regarding her body image and suicidal thoughts citing recent stress of service user A's daughter living with her and looking after her grandchildren.
- 3.63 In June 2012 records indicate that safeguarding concerns were raised in respect of service user A looking after the grandchildren.
- 3.64 In October 2012 service user A reported a reduced alcohol intake. She said she had financial worries, seemingly related to Keith's gambling and debts of £50,000 and needing to pay a £1,000 water bill.
- 3.65 Records indicate that appointments with service user A were hard to arrange and compliance with her prescribed medication was unclear. Service user A informed CC (2) on 8 October 2012 that she had stopped taking her prescribed medication in August 2011. This was followed by records of 27 December 2012 stating that she had stopped all medication because she thought she had leukaemia.
- 3.66 On 2 February 2013 a carer's assessment and needs form was completed for Keith. It was stated that a detailed assessment was required, although we have not found evidence of this having taken place. A carers additional support service application was completed.

- 3.67 On 5 March 2013 following an outpatient assessment the antipsychotic medication was increased.
- 3.68 On 28 March 2013 following a CPA review the diagnosis for service user A was recorded as a mixed anxiety and depressive disorder. She was experiencing low mood and anxiety exacerbated by social situations, was concerned about her weight and disclosed that she had been drinking 50-70 units per week for the previous year and financial hardship due to Keith's gambling. Service user A declined the offer of NAViGO dual diagnosis services and admitted past but denied current medication non-compliance.
- 3.69 On 10 June 2013 the records state that a home visit found that service user A was not improving as she was refusing to listen and take advice, had not been taking medication as prescribed and had not been engaging with services. Service user A said that if it wasn't for the stresses caused by her family her mood would be fine. Relationship counselling was suggested.
- 3.70 On 5 July 2013 a home visit record stated that Keith was spending vast amounts of his earnings on online gambling so much so that service user A had been unable to buy food. He was constantly commenting on her weight and called her fat.
- 3.71 On 8 August a telephone call to service user A found her extremely anxious, saying that she did not have any money, that Keith took no responsibility for the bills and food and that she was doing everything for him, and he was spending more money on gambling.
- 3.72 During August 2013 records indicate that service user A was avoiding engagement with services and on 12 August 2013 the record reported that she had been non-compliant with medication for one month.
- 3.73 On 12 December 2013 a carers assessment indicated that the services for the carer were information and advice, professional and emotional support with a detailed assessment being required. Keith described his role as supporting service user A who had a diagnosis of severe and enduring mental ill-health resulting in her being very forgetful, anxious, suffering panic attacks, struggling to go out, needing him there most of the time. Due to this he supported her with daily living skills and prompting her to take her medication, financial management, accompanying her to appointments. He described his carers needs as "me time, a break". It was recorded that he had applied for carers funding to enable time out to enjoy a break and undertake social activities with friends and family.
- 3.74 On 6 January 2014 service user A was reviewed in an outpatient appointment and discharged from Section 117 aftercare arrangements and further follow up.
- 3.75 Her diagnosis was recorded as mixed anxiety and depression and the prescribed antidepressant and antipsychotic medication remained unchanged. This was the second time service user A had been discharged from NAViGO services and at this point there was evidence of non-compliance and deterioration within four months of (after) her being discharged.

- 3.76 On 7 May 2014 service user A contacted the out of hours GP service with nausea, urinary frequency, yellow eyes, abdominal pain, loss of appetite and weight loss. She later attended A&E with her sister and was given antibiotics for a urinary tract infection. Records indicate that service user A was very anxious and concerned something might be wrong with her liver. Service user A admitted she had stopped both prescribed antidepressant and antipsychotic medication three months ago. Service user A was advised to see her GP.
- 3.77 In October 2014 a telephone call to NAViGO from service user A's daughter stated that service user A was not well, had abdominal pain, and was denying any mental health problems.
- 3.78 In October 2014 service user A presented to Diana, Princess of Wales Hospital, Grimsby A&E with abdominal pain three times. service user A was admitted for assessment and later had an outpatient hysteroscopy with biopsy.
- 3.79 On 31 October 2014 NAViGO received a telephone call from service user A's daughter saying that she was not well and was not taking medication. When they spoke to service user A, she denied any mental health problems, said she planned to change her GP, and a further telephone call was planned for 4 November 2014, however there are no records to indicate that this took place.
- 3.80 On 14 January 2015 GP records indicate that service user A said she was teetotal and on 20 January 2015 that she wanted to reduce her medication. An appointment was offered for this to be discussed. Further GP records indicate that the antidepressant and antipsychotic prescription remained unchanged.
- 3.81 Between March and May 2015 service user A attended her GP several times complaining of abdominal pain, burning and feeling unwell. In May 2015, she said she was not taking her medication.
- 3.82 On 1 June 2015 service user A's daughter reported her deterioration and that she had stopped all medication about one year previously. Service user A felt she was being poisoned by doctors. Service user A was assessed by the crisis team.

Third admission 1 - 12 June 2015

- 3.83 On 1 June 2015 service user A was admitted for the third time, this time informally. She was fixated on physical health, believing staff were covering up her illness (despite normal investigations). The admission records indicate that there was mild evidence of flight of ideas and clear evidence of paranoid and persecutory delusions with no insight.
- 3.84 On 3 June 2015 service user A was reviewed by the CMHT consultant psychiatrist who said that service user A reported that she was admitted for the wrong reasons, that she had been non-compliant on medication, and said that she had been poisoned by 'something'. Her family reported that she presented as suspicious constantly. Service user A was suspicious about phlebotomy needle. The CMHT consultant psychiatrist prescribed an increased dose of antipsychotic medication and the same dose of the antidepressant medication.

- 3.85 On 5 June 2015 service user A was granted overnight leave. Records indicate that she then remained on leave continuously until discharge on 9 June 2015 with Home Treatment Team (CHTT) follow up. Her diagnosis at this time was recorded as persistent delusional disorder and somatoform disorder. Risk of relapse following medication non-compliance was not highlighted.
- 3.86 On 12 June 2015 a seven-day follow-up from discharge, a review was conducted, and service user A was discharged from NAViGO services. It is unclear why she was discharged from services so soon after having been admitted in a psychotic state, and while being prescribed antipsychotic medication.

Treatment in the community 12 June 2015 - 22 September 2016

- 3.87 During this period there was no contact with NAViGO services, and all the contacts described here were with GP services.
- 3.88 On 24 November 2015 GP records indicate that service user A presented with lower abdominal pains, increased frequency of urination, foul smelling urine, aches and pains all over and had some excessive metal in her body, saying she felt “unwell near stainless steel”.
- 3.89 On 27 November 2015 service user A was advised to attend A&E as she said she had vaginal bleeding with lower abdominal pain.
- 3.90 On 26 January 2016 the GP noted that service user A and Keith felt that her symptoms were more physical. Service user A felt that she could not walk, had no strength and complained of palpitations. She was advised to attend A&E.
- 3.91 On 23 March 2016 service user A’s daughter called the GP saying that her mother had mental health problems and thought people were trying to poison her. When service user A had put the ‘phone down on her daughter she said she was going to kill herself.
- 3.92 On 24 March 2016 the GP noted that Keith attended with her to say that she felt she had high levels of mercury in her body. They both felt that the problem was not associated with her mental health and said that they had undertaken a test to discover if mercury was present in her body, which indicated that her levels were high.
- 3.93 Service user A was seen at Scunthorpe A&E later that day and records indicate that they found service user A to be very anxious, with general malaise, complaining of yellow faeces for 18 months and having had her urine tested for mercury by her daughter. The diagnosis was that service user A was suffering from delusions.
- 3.94 On 4 May 2016 service user A telephoned the GP to request “something to treat her mercury levels”.
- 3.95 On 24 August 2016 service user A registered with a new GP practice and attended with Keith requesting an urgent appointment but refusing to say why she needed this. She looked very anxious, stated that she was very poorly but was

unable to be specific about why this was the case, apart from to say that she had used a home urine test and found some metallic element in her body. Service user A and Keith stated that her illness had not been investigated as it was always put down to mental illness. The GP requested that her previous GP records were forwarded.

- 3.96 On 25 August 2016 service user A telephoned the GP to request a home visit rather than a booked appointment at the surgery. As there was no assessed clinical need for a home visit, she later attended. She reported feeling very anxious, had a problem over the last 18 months with abdominal and leg pain, and had put on a lot of weight. Service user A said that when she was near metallic objects it made her unwell. Service user A declined an abdominal examination or blood pressure measurement. She was prescribed medication for anxiety.
- 3.97 On 31 August 2016 service user A telephoned the GP practice manager saying that she felt very unwell and required medication. She said that a blood and urine test showed metal in her body and that she needed treatment to remove the metal.
- 3.98 On 16 September 2016, records indicate that service user A's carer's needs were assessed finding that service user A did not have any carer needs as her children were grown up and did not live with her and Keith. It is not clear in what context this this assessment was undertaken given service user A was not in contact with NAViGO services at this point.

Fourth admission 22 September - 6 October 2016

- 3.99 On 22 September 2016 service user A was detained under Section 2 of the MHA 1983 in Doncaster, with a diagnosis of persistent delusional disorder. She had reportedly stopped taking her medication several months earlier.
- 3.100 On 27 September 2016 service user A was transferred to a NAViGO inpatient unit in Grimsby (Pelham Lodge). A CPA mental health assessment tool completed on this day notes that service user A had a diagnosis of persistent delusional disorder, had been poorly compliant with prescribed medication, was tearful, distressed and anxious with paranoid persecutory delusions of being poisoned with mercury. Service user A had no insight, was vulnerable, had not bathed for several months (as she avoided metal taps), had voiced suicidal ideation, was preoccupied with her physical health issues. She believed that she had been poisoned by mental health services in the past. Service user A was reluctant to engage and refused physical examination, other diagnostic tests and blood tests.
- 3.101 On 28 September 2016 service user A said she wanted to go home to assist Keith and daughters moving to a new house. Service user A suggested staff had poisoned her using milk and was unsure why she had been admitted.
- 3.102 By 30 September 2016 it appeared that service user A had been allowed leave from the ward. A discharge meeting took place with service user A and Keith who reported her ideas about metal had 'settled'. The review noted that there was some evidence of overvalued ideas of having metal in the body but not as bad as before. It was stated that service user A had experienced a relapse of persistent

delusional disorder due to non-compliance with her medication. The Section 2 MHA was rescinded, and she remained in hospital after this but was often on overnight leave.

- 3.103 The discharge summary indicates that service user A was discharged on 6 October 2016 with a diagnosis of persistent delusional disorder, and notes that she had completely stopped taking her medication a few months previously. Service user A was to be supported by CHTT follow up and with CMHT Consultant Psychiatrist reviews. She was still being prescribed antipsychotic medication at the point of discharge.

Treatment in the community 30 September 2016 - 15 March 2017

- 3.104 On 11 and 12 October 2016 service user A told CHTT through her door and via the telephone that she was physically not well. Service user A was referred to NAViGO Open Minds (a mental health and well-being service).
- 3.105 On 13 October 2016 service user A told CHTT that she was dying. She was threatening Keith and telephoning her family excessively. Her son-in-law described Keith as 'not a strong person'.
- 3.106 On 17 October 2016 the CHTT seven day follow up review noted that service user A and Keith reported she was sleeping well, with no low mood, untoward thoughts or feelings. The records indicated clear delusional beliefs around metal and poisoning at this time.
- 3.107 On 18 October 2016 the GP practice noted that service user A maintained she was unable to attend the practice for her prescription as she could barely walk. It is therefore not clear at this point whether service user A was receiving her medication at all.
- 3.108 On 20 October 2016 NAViGO confirmed the prescribed antidepressant and the increased antipsychotic medication dosage with the GP.
- 3.109 On 27 October 2016 the GP practice again noted that service user A had tried to obtain her prescription over the telephone and was told she must attend in order to obtain this. However, on 3 November 2016 the GP undertook a home visit and prescribed the required medication.
- 3.110 Between 1 and 21 November 2016 CHTT reviewed service user A five times and reported that service user A and Keith said that she was sleeping well, was mentally well, with no low mood untoward thoughts or feelings. Service user A mentioned on 15 November that she was feeling embarrassed at being involved with mental health services. On 21 November 2016 service user A was discharged from the CHTT.
- 3.111 On 3 December 2016 NAViGO received a telephone call from service user A's son-in-law. Service user A was said to be unwell, stating she was dying, threatening Keith and calling the family excessively on the 'phone. He was advised that the CHTT would visit the next day. The son-in-law agreed to contact

the crisis services if the risks increased throughout the evening and to attend the assessment.

- 3.112 On 4 December 2016 a CHTT assessment was undertaken and found service user A guarded and delusional. Her daughter said that service user A had put rat poison in Keith's drink, and that she was experiencing suicidal thoughts (which she denied). Her son-in-law was concerned that Keith had been aggressive towards service user A when he got frustrated with her. Keith was said to be drinking daily.
- 3.113 The CHTT triage assessment noticed service user A's 'phone was in a sock and that she declined to use the pen on offer stating she was allergic to them. She was very emotional and crying all the time; felt that her issue was one of physical health, believed there was a 'big cover up' by the doctors and this was why she was not given a test for metal in her system. Service user A was found to be very paranoid about doctors. Her daughter and son-in-law stated they found medication all over the house and that service user A had a way of hiding medication in a hole in her tooth to pretend she had taken it.
- 3.114 Service user A denied the reports from her son-in-law saying that she was ringing her daughters, other family members and grandchildren telling them she was dying. She stated she did not want any support and did not want to go back into hospital. Keith denied any concerns for service user A's or his safety but was observed raising his voice at times to express his frustration when service user A was declining support.
- 3.115 Risk was assessed and the record states that service user A was at risk of deterioration in her mental health as the family were noticing relapse symptoms. There were no concerns about self-neglect however she was not attending to her needs as she usually would. She did not express any suicidal ideation or thoughts or plans to harm herself or others and denied being a risk to herself or anyone else.
- 3.116 In terms of her vulnerability and safeguarding, the records state that this was difficult to assess as service user A denied any concerns for her own safety. It was stated that this needed to be explored further when she would hopefully gain some trust to talk to the CHTT in an honest manner.
- 3.117 On 4 December 2016, it was recorded that service user A's daughter reported that she had put rat poison in her father's coffee.
- 3.118 On 5 December 2016 service user A was reported as being fixated on physical conditions and believed her body was being poisoned by metals. She did not want home visits and did not attend for an agreed appointment on 7 December 2016. Service user A telephoned and stated that she felt too unwell physically. She was reluctant to agree to a home visit but agreed to contact the services again on 9 December 2016.
- 3.119 On 9 December 2016 Keith was spoken to by 'phone and he reported all was well and he did not see any need for continued input. He stated he would contact services if he needed to. We found this surprising feedback considering the

previous five days and could not find evidence that this was challenged, or that Keith was seen separately from service user A to verify his views.

- 3.120 On 14 December 2016 service user A's daughter telephoned the CMHT SPoA saying that service user A was in a bad way, was standing in the garden and could not go near anything metallic. Her daughter was told that information about service user A could not be shared with anyone other than service user A's next of kin, and her daughter said that "a dog would get treated better than this".
- 3.121 The CMHT SPoA advice officer phoned service user A. Both service user A and Keith said they didn't want further support and this information was fed back to the crisis team.
- 3.122 On 1 Feb 2017 Keith reported that service user A had deteriorated and that he had become so frustrated with her that he had hit her on the arm. An MHA assessment was considered either on this date or 2 February 2017, but service user A and Keith requested treatment at home. It was agreed that a further MHA assessment and detention would be considered if service user A was not taking her medication.
- 3.123 The CHTT agreed to visit her daily to ensure compliance and visited three times on 2 February 2017 to do this. Keith's mother reported that she was very concerned about her son, as service user A had told her that she secreted her medication in her mouth and then spat it out and was telling her grandchildren she was going to die. Service user A's niece reported that Keith could not speak freely about her in her presence and that he felt guilty if he did.
- 3.124 On 3 February 2017 CHTT visited to ensure compliance with her medication.
- 3.125 On 4 February 2017 CHTT visited but were asked to wait at the door, while Keith took medication to her in bed.
- 3.126 On 5 February 2017 CHTT visited but were not allowed in. Service user A took medication at the door, and then went to the kitchen. The records of this visit indicate doubt that service user A was taking her medication. Service user A's daughter called CHTT several times this day, stating her mother needed to be in hospital.
- 3.127 On 6 February 2017 a referral was made to the Approved Mental Health Professional (AMHP) by the CHTT for an MHA assessment. The AMHP report states that service user A did not want the staff to enter her flat saying that they were hurting her with the metal they were carrying. She insisted that the staff spoke to her outside the building, then she left the flat and shouted to the staff from the outside.
- 3.128 According to the AMHP records, Keith said "he is at breaking point and can't cope with service user A anymore, yet he feels guilty and unable to speak in her presence due to her acquisitions [sic] of ganging up against her".
- 3.129 Service user A did not engage in a discussion and was not able to say why she was prescribed medication. She confirmed she was only taking the medication

because she did not want to be admitted into hospital. She denied a mental health disorder and expressed a belief that she had physical problems.

- 3.130 Both doctors assessing service user A were of the opinion that she was suffering from a mental disorder of a nature and degree that would warrant her admission into hospital under a section of the MHA 1983. Service user A was accepting of support from the CHTT (albeit reluctantly) and both doctors agreed that increasing her medication and continuing to monitor at home would be in her best interests at the time, however if there was non-compliance, admission under the MHA was to be considered.
- 3.131 The antipsychotic medication was increased, and it was recorded that if there was no improvement after a week, a different antipsychotic would be considered.
- 3.132 We were not able to find evidence of this detailed contact being referenced in the NAViGO internal investigation's summary of care received section.
- 3.133 On 7 February 2017 CHTT staff were asked to keep their distance, as service user A was scared of their identity card.
- 3.134 On 8 February 2017 service user A telephoned the CHTT and reported that she had diarrhoea and vomiting. Staff spoke to Keith who agreed to monitor her compliance with medication.
- 3.135 On 10 February 2017 Keith claimed that service user A had already taken her medication.
- 3.136 On 11, 12 and 13 February 2017 CHTT telephoned service user A who confirmed that she was taking her medication.
- 3.137 On 14 February 2017 CHTT and the CMHT planned a joint visit, however service user A told CHTT that she did not want any CMHT input. This request was passed on to the CMHT team manager, who told us that she understood that the CHTT were still involved, and she then actioned the discharge as allocation to the CMHT was not required.
- 3.138 On 16 February 2017 the CHTT undertook a home visit. Service user A was in bed and asked Keith to shut the bedroom door and then service user A refused to engage further with staff. Keith reported that service user A was much better; more active at home and taking her medication.
- 3.139 On 17 February 2017 the West CMHT team manager wrote to service user A stating that as she had expressed a wish to be discharged, that her case had been discussed at the team meeting and the decision was made to discharge service user A back to the care of her GP.
- 3.140 We viewed an extract from the relevant CMHT meeting which states that service user A was paranoid about services and reluctant to engage because of this. Service user A was contacted and stated she did not want a service from the CMHT, that she forgot to take her medication due to family stress issues, that her mood was okay, and she had no negative thoughts to harm herself.

- 3.141 This was the third time service user A had been discharged from NAViGO.
- 3.142 On 24 February 2017 the CMHT telephoned service user A as a follow up after discharge. Keith confirmed she was doing well and that he was happy with the discharge decision.
- 3.143 On 3 March 2017 both service user A's daughters attend Harrison House (the NAViGO acute inpatient unit) seeking help and asking to speak to the CHTT seeking an MHA assessment at which they would be present. They believed that service user A was not taking her medication, they were not allowed in the house, and said that she was not honest when assessed on her own. The daughters were advised that staff didn't have service user A's consent to share information but that they would listen to their concerns.

Fifth admission 14 March - 7 April 2017

- 3.144 On 14 March 2017 service user A was admitted via the CHTT to Pelham Lodge, Harrison House, under Section 2 MHA 1983 following deterioration and medication non-compliance. Service user A was tearful, anxious, distressed, paranoid about being poisoned with mercury, believed her family were trying to poison her, that Keith was having an affair (with a woman he had had a relationship with 20 years previously). Service user A was reportedly isolating herself since the previous admission, avoiding metal objects including taps, neglecting personal care and her diet. Service user A was prescribed an increased dose of antipsychotic medication and an antidepressant.
- 3.145 On 15 March 2017 a CPA assessment tool document recorded that service user A had a diagnosis of persistent delusional disorder with five admissions over the last nine years, with three admissions under the MHA 1983. Service user A had deteriorated over the few weeks and she had been poorly compliant with prescribed medications. Her family were concerned about her. Service user A had paranoid persecutory delusions of being poisoned with mercury, no insight into her mental health, the need for hospital admission and lacked the capacity to consent to admission.
- 3.146 Her family reported that service user A had not been tending to her personal care as she avoided metal taps and lights due to her delusional beliefs. She was preoccupied by her physical health issues and firmly believed she was going to die of mercury poisoning.
- 3.147 Service user A refused any physical observations and was reluctant to take medication. She had distrust for health care, she did not recognise her mental health problems and was reluctant to engage with mental health services. She had been self-neglecting.
- 3.148 Service user A had significant somatisation believing that that her body was 'full of mercury', her 'legs were skin and bone', her 'bones were cracking' and her 'veins were collapsing'. She was not getting out of bed or doing household chores.

- 3.149 In a ward review service user A denied that her family were poisoning her but said someone had tried to get her into trouble, and it might have been a family member. She said that she wanted to stay on the previously prescribed antipsychotic medication, however this was changed to a different antipsychotic (risperidone) after admission.
- 3.150 A care plan was completed for service user A which noted that she would not yet use the ward telephone as she had 'bombarded' her daughters with calls. It was noted that the family were to have some respite but also have the opportunity to attend reviews.
- 3.151 We were informed by the family that Keith 'signed things over to them', for example, dealing with the doctors, as he said he was at the end of his tether. The ward manager on Pelham Lodge told us that a supportive conversation took place with Keith (in the context of service user A's delusions about him) and the daughters saying that service user A needed space, and that Keith could take a step back, look after himself and leave her to be cared for by the inpatient unit.
- 3.152 On 16 March 2017 service user A was seen to be very reluctant to take the prescribed medication as she believed the staff were poisoning her and that she was dying.
- 3.153 On 17 March 2017 in the ward review service user A's daughters reported her conviction that she was dying from being poisoned with mercury by a doctor, that she had not gone out for six months, and she was neglecting her hygiene. Since having had an internal examination (hysteroscopy), she believed her insides were rotting. Service user A refused bloods or other diagnostic interventions and demanded to go home. It was recorded that service user A was experiencing a psychotic disorder with preoccupation with various somatic hallucinations, paranoid delusions about being poisoned by her family and the doctor.
- 3.154 On 19 March 2017 staff heard Keith shouting at her. Service user A had accused him of having an affair and that he had arranged her admission to the ward so that he could continue with this.
- 3.155 On 21 March 2017 due to persistent psychotic symptoms and non-compliance with oral medication a depot was prescribed. A test dose was administered with the oral antipsychotic medication continued (as a cross-tapering measure).
- 3.156 On the same day, a meeting took place with service user A and both daughters. Service user A still thought that they were plotting against her and trying to poison her with mercury, and also thought that the doctors were putting thoughts in her head. She thought Keith was having an affair with another woman with whom he did have a relationship with over 20 years ago.
- 3.157 Her daughters found service user A's medication under her bed at home. Service user A said that she would avoid an injection if she could help it and only sat on chairs made of wood. Her insight was very poor. She was noted to have the capacity to accept her medication.

- 3.158 The inpatient consultant psychiatrist told us that a discussion took place with service user A's daughters about the duration and powers of Sections 2 and 3 of the MHA 1983, and a general discussion about a community treatment order (CTO) as a possibility, as well as emphasising the importance of medication. The inpatient consultant psychiatrist told us that if service user A had later been re-admitted, then a CTO would have been considered on discharge. By this time, there was evidence of significant global improvement.
- 3.159 The internal investigation states that there was an undocumented discussion that included family (daughters), stating that in future an MHA assessment could be considered, and a CTO was possible in event of medication non-compliance in the community. The daughters have stated they took this to mean that this option would definitely be enacted in event of non-compliance (whereas clinicians saw this as an option only, dependent upon circumstances). We do not know when this meeting occurred because it was not documented in contemporary records, in the care plan, or in the discharge summary paperwork.
- 3.160 The family informed us that the ward manager told them that there was nothing to worry about; that service user A would come out of hospital a different person and the first time she refused the depot she would be placed on Section 3 of the MHA 1983. They believed that the ward manager was the person who would administer service user A's depot once she had left hospital.
- 3.161 The ward manager told us that he recalled a conversation with the daughters about the options for service user A including changing her care and treatment, coming back into hospital and use of the MHA. His intention was to reassure her daughters that service user A had an illness which could be treated, that there were options and there was always an entrance back into hospital if required. Neither the inpatient unit, nor the ward manager would be responsible for the administration of the depot in the community as this would be the responsibility of the CMHT.
- 3.162 On 24 March 2017 service user A was described as much brighter and settled. She asked to see the depot needle. She was granted leave (for up to five hours) in the company of Keith.
- 3.163 On 26 March service user A was still saying that all her family were trying to kill her so that Keith could start his life without her. She strongly believed that Keith was having an affair and that her family were trying to trick her into staying in hospital so that the other woman could move into her home. She was quite adamant that she had had mercury poisoning that her family were responsible for.
- 3.164 On 27 March 2017 the ward review noted that service user A had taken leave from the ward over the weekend, that this had gone well, and that there was a risk of further deterioration without medication. Service user A continued to deny previous non-compliance. She withdrew her appeal against her detention under the MHA 1983.
- 3.165 On 28 March 2017 service user A was granted one overnight leave (Keith signed a form stating he would be with service user A at all times), and also further accompanied overnight leave until Friday 31 March.

- 3.166 On 3 April 2017 service user A denied any unusual thoughts. The depot was discussed. It was recorded that service user A understood she had to be concordant with the prescribed medication.
- 3.167 During the CPA review, it was noted that service user A sat on a metal chair and would not hold a telephone, she no longer spoke about being poisoned or infidelity, she had an improved relationship with her partner, and her diet and self-care had improved.
- 3.168 Service user A was referred to the CMHT for CC allocation, was granted unescorted leave and was asked to return to the ward on Friday 7 April 2017 for her Section under the MHA 1983 to be rescinded. Service user A was described as more settled and less anxious. She did not fully agree with a persistent delusional disorder diagnosis, or fully attribute improvement to the depot. However, a later discharge summary noted that at this review she did not agree with her diagnosis of a psychotic illness, however recognised that her previous thoughts were delusional and not true.
- 3.169 On 4 April 2017 CC (4) was allocated service user A, but then advised the ward she could not make the ward review on 7 April 2017. However, the inpatient consultant psychiatrist told us that the CC (4) chose not to attend. The internal investigation report noted that service user A's daughters were not included in the discharge planning process, that CC (4) was unable to attend meeting at short notice, and there was no communication with the CMHT consultant psychiatrist. The review notes that these issues depart from NAViGO's local CPA policy.
- 3.170 On 7 April 2017 at the ward review the Section 2 of the MHA 1983 was rescinded and service user A was discharged. At discharge, service user A was prescribed the depot and an oral antidepressant. Her primary diagnosis was persistent delusional disorder and a two day follow up was to be arranged by ward staff.
- 3.171 The ward manager explained that at the time the inpatient unit provided home treatment after discharge prior to transition back to the CMHT. An unannounced two day follow up was therefore undertaken on 10 April 2017 as service user A had not answered the 'phone. She was asked to attend the ward which she did. Service user A said she was not back to her normal self but was assessed as being calm with no acute distress and with no current risk.
- 3.172 Service user A was seen 18 April 2017 in a joint home visit between the inpatient unit and her CMHT care coordinator when she said she was taking her medication and expressed concerns about the upcoming depot injection due date.
- 3.173 The discharge summary completed on 24 April 2017 states that service user A's daughters had been concerned about her mental health and they contacted the CHTT team as she had not been going out of house since discharge in October 2016. She also believed that her family was trying to poison her and that metallic objects were interfering with her teeth. Service user A suffered weight loss, significant deterioration of her social function, used to spit out medication and was not willing to engage with the CHTT.

3.174 The discharge summary goes on to say that service user A had persecutory delusions and a complete lack of insight into her mental health problems. She did not engage well. Service user A was much improved in her mental state on discharge with no evidence of active or ongoing psychotic symptoms. She was calm, co-operative and had established a good rapport with staff. She also described what appeared to be a delusional belief regarding her partner having an affair. At times she spat her medication out, refused to eat and believing she was being poisoned.

Treatment in the community 7 April - 22 September 2017

3.175 On 10 April 2017 service user A was seen at home with Keith following an unannounced visit, and then came to the ward. There was no mention of psychotic symptoms.

3.176 On 11 April 2017 service user A telephoned CC (4) to cancel a home visit.

3.177 On 13 April 2017 an unannounced CHTT home visit took place and found service user A initially reluctant to admit staff and expressing her reluctance to take her depot injection. Her partner supported the staff in the need for her to have this and service user A became angry with him. The grandchildren were present.

3.178 On 16 April a 'cold call' (unannounced visit) was attempted but there was no response this. Telephone calls were not answered either. A telephone call the following day was also not answered.

3.179 On 24 April 2017 her depot was due to be administered. This was the first time that CC (4) had met service user A face to face.

3.180 Service user A refused this as she was very anxious about the needle and requested oral medication. She said the dose was too high and she would be drowsy, but would take oral medication to avoid re-admission, and that she had learned her lesson.

3.181 CC (4) noted that service user A was at risk of relapse if she did not take her prescribed medication, and viewed this as a moderate risk considering her history of not complying with oral medication, however Keith stated that service user A was the best he had seen her in many years and he believed she would manage on oral medication.

3.182 CC (4) told us that she had not been aware that Keith had been thought to have "colluded" with his wife, and that if she had been aware of this she would have contacted service user A's daughters (however, instead, service user A had told her she did not want her to meet the daughters, a wish seemingly based on service user A's stated belief that her daughters preferred Keith's ex-partner to her).

3.183 CC (4) told us that although she had had a handover discussion with a ward nurse before service user A's discharge, she was not aware of an intention or plan to consider the use of the MHA 1983 should service user A go on to refuse her depot in the community.

- 3.184 CC (4) discussed the situation with Specialty Doctor 1 (who knew service user A well) who advised a MHA assessment, however after a further discussion between CC (4) and the CMHT team manager they decided that to do the MHA assessment was not the least restrictive option and believed service user A had the capacity to refuse treatment.
- 3.185 On 25 April 2017 CC (4) e-mailed the on-call doctor saying that service user A was now showing she had capacity to take oral medication and asking for aripiprazole to be prescribed. However, the on-call doctor was unwilling to amend her treatment given the complexities of her case. We have not found information about what factors were, and were not, taken into account in coming to this conclusion.
- 3.186 On 26 April 2017 CC (4) e-mailed the CMHT consultant psychiatrist to confirm service user A had capacity to decide to stop the depot injection. After discussion with CC (4), the CMHT consultant psychiatrist advised the use of an oro-dispersible antipsychotic medication; wrote the prescription for this and forwarded it to the GP by fax that morning.
- 3.187 The CMHT consultant psychiatrist told us that that CC (4) informed him about her discussion with the CMHT Team Manager two days previously, and that they discussed the option of using the MHA 1983. He said that he had not felt that service user A would have been detainable, especially as Keith supported the use of oral medication and promised that he would supervise her taking it. The CMHT consultant psychiatrist confirmed to us that he had not been aware of concerns that Keith had 'colluded' with his wife, or that Keith had told staff that he felt inhibited from talking to staff about her in her presence.
- 3.188 Between 28 April and 5 May 2017 service user A cancelled three planned visits, stating she was visiting her father-in-law (who had breathing difficulties) on one occasion and that she was unwell on the subsequent two planned visits.
- 3.189 On 8 May 2017 a planned CHTT home visit took place. Service user A and Keith confirmed she was taking her medication, and there was no evidence of unusual ideas, although some anxiety was noted.
- 3.190 On 15 May 2017 a planned CHTT home visit saw that service user A had improved confidence, however she said she was experiencing some stress due to helping her daughter (looking after grandchildren, during her house move). Service user A and Keith had agreed not to tell her daughters about the fact that she had stopped taking the depot, and asked CC (4) not to disclose this. CC (4) offered to speak to her daughters about her concerns that service user A was taking on too much. Service user A was anxious to reduce contact with mental health services.
- 3.191 On 7 June 2017 CC (4) was invited in when delivering a benefits form, and Keith reported service user A had been weepy and talking a lot about her physical health. Service user A appeared very anxious and preoccupied. CC (4) noticed signs of a decline in her mental health and thought she might benefit from an increase in her prescribed medication. CC (4) e-mailed the CMHT consultant psychiatrist stating that service user A was slightly paranoid. The CMHT

consultant psychiatrist replied to say he would fax the GP to ask for the antidepressant medication to be increased.

- 3.192 On 14 June 2017 service user A telephoned CC (4) to request a home visit. Service user A made CC (4) remove all metal things as she entered the flat. Service user A was talking about mercury poisoning and was very pre-occupied with ideas that her two daughters were choosing Keith's past partner over her and befriending her on Facebook.
- 3.193 CC (4) e-mailed the CMHT consultant psychiatrist that morning who stated that the oro-dispersible antipsychotic medication needed to be increased immediately. He asked CC (4) to tell service user A to take 15 mg twice daily from today (which she did by telephone call that day), and to book her into an emergency clinic on 22 June 2017 as he wished to see her as soon as possible.
- 3.194 On 16 June 2017 a home visit to service user A by CC (4) noted that she opened a door using a cloth on the handle, although she seemed less paranoid. CC (4) informed service user A that this was the last contact she would have with her before she changed roles within NAViGO. CC (4) told us that she gave Keith the work telephone number and said that she thought that service user A had been "doing very badly".
- 3.195 CC (4) changed roles within NAViGO and was replaced by CC (5) while the new allocated CC (6), was finishing her month-long induction.
- 3.196 CC (5) told us that she volunteered to take on this role, and support service user A, because she had previous knowledge of her. She received no handover and did not review service user A's records. She told us she had not been aware that service user A had been admitted in 2015 and 2016 and diagnosed with delusional disorder on both occasions.
- 3.197 On 14 June service user A's sister phoned a CMHT administrative assistant and said service user A had claimed she had spoken to the Queen. Staff should have known this, as it was in the clinical records.
- 3.198 On 19 June 2017 service user A wrote to the Queen which we were told was not known by staff at time, but the family told us that they took this letter to the services and it had been photocopied by staff. We found a record of the response from Buckingham Palace in the clinical record dated 28 June 2017.
- 3.199 On 22 June 2017 service user A cancelled the emergency appointment, saying she had sickness and diarrhoea. On a subsequent unannounced home visit, CC (5) found service user A to be guarded, fixated on body image and her looks, and asked that the CMHT consultant psychiatrist visit her at home. Service user A was anxious about getting a new CC and stated she no longer wanted mental health support. She requested telephone contact however was informed that this type of contact could not be offered. We are not clear why this was the case.
- 3.200 CC (5) told service user A that she needed to call the CMHT team manager to inform her that she wanted to stop having support from mental health services

and was provided with the telephone number. This interaction was not mentioned in a subsequent e-mail to the CMHT consultant psychiatrist.

- 3.201 CC (5) told us that she had not regarded service user A as deluded or psychotic, at this point, although she had noted that service user A had gained weight and her self-care and grooming had declined since she had last seen her.
- 3.202 The CMHT consultant psychiatrist undertook a home visit and found service user A to be quite weepy and distressed. She felt her trust in doctors had been broken in the past when she reported she had believed herself to be allergic to some metals and this was taken wrongly by the doctors. She thought she had been detained under the MHA 1983 due to this. She said she was scared to see doctors and was afraid that she would be detained again.
- 3.203 Service user A was sobbing throughout, saying that she used to be a beautiful woman, but now she was ugly, has gained weight and was unattractive to Keith. She was agitated, pacing and demanding the CMHT consultant psychiatrist confirm that she used to be beautiful.
- 3.204 Keith informed them that he was tired of reassuring her every minute. There were high amounts of rumination and pre-occupation with her looks and the allergy to metals, bordering on delusional content. Her insight was poor. Service user A was aware of her diagnosis, however, was not accepting it, believing that she did not have a mental illness. She demonstrated a fairly good capacity to make decisions around her ongoing care and agreed to continue her oro-dispersible antipsychotic medication on a higher dose and to continue support from the newly allocated CC (6) on a regular basis.
- 3.205 The CMHT consultant psychiatrist told us that he felt that service user A was improving, and that this had been the view expressed by Keith also. He said that both service user A and Keith said they were happy with her progress. He expected that she would continue to take the prescribed higher dose of the antipsychotic medication (which was now at this point the maximum advisory dose) and that she would improve further.
- 3.206 On 3 July 2017 CC (5) and (6) undertook a home visit to service user A to manage the change over from one CC to the other. This was the first and only time that CC (6) met service user A. Although the internal investigation states that she was allocated service user A while still in her induction period, she confirmed to us that her induction period had just ended.
- 3.207 During the visit, service user A stated she wished to be discharged from mental health services. In this, she was supported by Keith, who stated she had been more settled since visits were reduced. According to CC (6), service user A immediately made it clear she wanted no further involvement with services, and Keith agreed. We were told that service user A declined an offer of telephone contact or reduced visits.
- 3.208 She also told us that service user A seemed to find the whole situation quite distressing. CC (5) then asked service user A to contact the CMHT Team Manager to discuss this, that is, if she wanted to be discharged, this is what she

needed to do, which she did, and discharge was agreed. There is no documentary evidence that telephone contact was then considered as an interim option.

- 3.209 CC (6) told us that she did not understand how discharge process worked in her new service and found it “really confusing”. She had not been told or shown how the system worked.
- 3.210 According to the internal investigation, the CMHT Team Manager, CC (5) and (6) all agreed that service user A was not currently suffering from “severe and enduring mental health”. The GP was to be informed that service user A was to continue to receive Section 117 aftercare arrangements. The internal investigation noted that when service user A requested discharge, a review in line with NAViGO’s CPA policy was not carried out, and that there was no involvement of senior medical staff.
- 3.211 We have not been able to find any records of any such discussion within the team. While severe and enduring mental disorder is listed in the CMHT operational policy as an admission criterion, we cannot establish who decided it was not met or relevant in service user A’s case, or on what basis this decision was apparently made.
- 3.212 The decision to discharge service user A was taken by the CMHT Team Manager, CC (5) and (6) who did not take into account the relevant information that should reasonably have been known, and who did not recognise or consider what they might not know about relevant information.
- 3.213 There is no evidence in the records that the CMHT Team Manager, CC (5) and (6) took into account the recent admission, the recently documented multiple paranoid delusions, the recorded lack of insight, and the extremely well documented history of repeated non-compliance with medication and disengagement (historically associated with subsequent deterioration in well-being).
- 3.214 The available records did make it clear that service user A:
- had a recent, confidently made diagnosis of PDD;
 - had her antipsychotic medication recently doubled in dose;
 - had a prominent history of non-compliance;
 - had recently had her medication changed from depot to oral; and
 - had recently deteriorated following a recent relapse that required admission.
- 3.215 CC (6) told us that there was not a three-way discussion and that she was taking advice from the wider team. She felt as if the decision had already been made and was told that a discharge CPA meeting did not need to be take place.
- 3.216 CC (6) also told us that she had not been aware that service user A had been diagnosed as suffering from a psychotic disorder (adding that during her ‘unstructured’ induction process, she did not have a laptop with which she could access the in-house clinical record). She stated that she received “very little”

information about service user A or Keith, and the internal investigation noted that she received no handover regarding the case.

- 3.217 The CMHT team manager said that she later spoke to CC (5) and (6) who told her that service user A had capacity, that she did not require an MHA assessment and that she was “not mentally unstable at the time”. The CMHT team manager was aware that a diagnosis of persistent delusional disorder had been made “for long periods of time”.
- 3.218 CC (5) told us that service user A and Keith both reported that she was less well when the team visited, and that she was taking her medication. She had felt service user A had capacity to make this decision, and that she was not detainable.
- 3.219 The CMHT Team Manager said that Keith had telephoned her immediately after the home visit and that this had been an unexpected call. She said that Keith told her that visits were anxiety-provoking and not helpful, that service user A was taking her medication, and that she wanted no further visits. Service user A also spoke to the CMHT Team Manager and essentially repeated this.
- 3.220 The CMHT consultant psychiatrist confirmed to us that he was not involved in this decision, and that he had not been aware that such a discussion had taken place.
- 3.221 On 6 July 2017 the CMHT team manager told us that CC (5) discussed the issue of discharging service user A at the access meeting on this date. We viewed the minutes of this meeting and found these stated that service user A said telephone contact was preferable as “when people go to see her it makes her worse”. She said she did not want any services and Keith reported she was better without seeing the services and both were stated as knowing how to refer back if she deteriorated. The minutes further stated that it was not therapeutic for NAViGO to see service user A. Discharge was discussed and agreed. Service user A was stated as having capacity and it was noted she was not subject to a CTO.
- 3.222 We note that the letter to the GP stating the intention to discharge service user A was dated two days earlier on the 4 July 2017, despite being informed that letters are automatically generated administratively following agreement at access meetings and stated “CMHT agree to end involvement as there are no current mental health concerns.”
- 3.223 On 9 July 2017 service user A’s daughter contacted the CMHT SPoA to report concerns that service user A was not taking medication, was stating someone was poisoning her, that she was dying, and had gone to Derby to visit her sister. The CMHT SpOA crisis worker advised that the electronic system indicated that service user A had been discharged, but agreed to contact the CC.
- 3.224 There is no evidence of formal risk review at this point. Just before 7 pm, the CMHT team manager and CC (5) were advised that the Crisis Home Treatment Team had been contacted by service user A’s daughter to report concerns and asked, “could somebody please contact her daughter in the morning”.

- 3.225 Just after 10 pm, the CMHT Team Manager emailed CC (6) (copying to CC (5) and the CMHT duty worker) noting that as CC (5) was on leave between 7 and 17 July 2017, could she please check the records regarding recent family contact and respond appropriately.
- 3.226 On 10 July 2017 although CC (6) attempted unsuccessfully to contact service user A's daughter, no further efforts were made. The clinical entry says: "Tried contacting service user A's daughter about the concerns at the weekend. No answer on the 'phone and no answering machine facility. Will try and call back again later today".
- 3.227 Service user A then contacted the services (she was staying in Derby, while Keith stayed in Grimsby) and asked CC (6) if her daughter had been in touch, stating that her daughters were causing trouble for her, that they did not like her family in Derby, and that they were not happy with her being there. Service user A stated she had not been paranoid for some time, that she was compliant with medication, that she knew she could contact the crisis team, and that she still wanted to be discharged.
- 3.228 On 14 July 2017 service user A's sister in Derby contacted the CMHT administrative assistant to raise concerns, saying she was shocked at her presentation having not seen her for two or three years. Staff should have known this as it was in the clinical records.
- 3.229 She said that service user A had poor personal hygiene, claimed she had spoken to the Queen, that the NHS and government were poisoning her, reported that she wanted to poison Keith (with bleach or weed killer), that the depot injection was stopped by services because the metal was poisoning her body, and that she was not taking her medication as it was rotting her insides.
- 3.230 Service user A had spent four days at her sister's home having been dropped off by Keith 'for respite'. Service user A had reportedly been calling her sister in Derby since 5.40 am claiming that she had poisoned her food.
- 3.231 After this information was passed by e-mail to the CMHT Duty Worker, CC (5) and (6), CC (6) made an unsuccessful, unannounced home visit.
- 3.232 CC (6) recalls that Keith told her that service user A was at the shops. She told us that before this visit, she had spoken to the duty AMHP for advice, having wondered whether an MHA assessment might be required, and that she had been advised "to go out".
- 3.233 CC (6) told us that when she returned to the office, she discovered that the CMHT duty worker had already been out to service user A's address had seen her, and that he had no concerns. The CMHT duty worker told us that he had not seen the e-mail before he decided to undertake the visit, so he was not fully aware of all the issues raised.
- 3.234 During the visit, which was the last occasion of face-to-face contact with service user A, Keith again stated that he was not concerned, and both asserted medication compliance.

- 3.235 Service user A said she was being falsely accused of trying to poison Keith, and he stated he did not feel at risk. The CMHT duty worker recorded that CC (5) was due to return from leave the following week, and service user A was happy to have telephone contact from her. The CMHT duty worker asked about poisoning and about medication compliance and was reassured by service user A and by Keith on both accounts. He arranged for Crisis Home Treatment Team input over the weekend.
- 3.236 CC (6) told us that she had mentioned to the CMHT duty worker that she was aware that service user A had tried to poison Keith (but that she was not aware of other recorded aspects of their relationship, including Keith having said that he could not speak openly to professionals in his wife's presence).
- 3.237 She also told us that she spoke to the CMHT duty worker about whether the assertive outreach team (AOT) would be an appropriate service and was told she would not be suitable because she had not been subject to the MHA 1983. The CMHT duty worker noted that they felt that the family were possibly over-reacting. It was agreed to request Crisis Home Treatment Team support over the weekend and CC (6) advised service user A's sister and daughter of this.
- 3.238 CC (6) e-mailed the CMHT team manager and CC (5) to state she had spoken to service user A and then to Keith. Keith said he was not concerned. "I'm aware from others that he has a history of colluding with service user A; he thinks her family are making trouble".
- 3.239 On 15 July 2017 the CHTT telephoned service user A and Keith and were told everything was alright and that the grandchildren were staying.
- 3.240 On 16 July 2017 the CHTT telephoned service user A and Keith and offered a visit but were again told everything was fine.
- 3.241 On 17 July 2017 the CHTT contacted CC (5) to advise that as service user A and Keith had not wanted MH support over the weekend, they were handing the case back. Despite the fact that CHTT involvement had just been requested, the CMHT made no attempts to contact service user A for the next 11 days.
- 3.242 On 28 July 2017 service user A telephoned the CMHT to report that everything was alright. CC (6) called back and agreed formal discharge. She recorded "we agreed on discharge today". No medical staff were involved in this decision.
- 3.243 On 8 August 2017 CC (6) wrote to service user A's GP to confirm that she was now closed to the West CMHT. She told us that the CMHT team manager asked her to do this.
- 3.244 On 11 August 2017 the CMHT team manager signed a completed discharge checklist.
- 3.245 On 18 August 2017 service user A called the CMHT SPoA to request confirmation she had been discharged (which was confirmed).
- 3.246 The family told us that in September 2017, three days before the incident, a neighbour that knew service user A well contacted the NAViGO CHTT concerned

that service user A was talking to trees. The family told us that the CHTT did not respond.

- 3.247 We were informed that all contacts made to the CHTT are recorded on the electronic system, or on a daily log. We reviewed the NAViGO records for September 2017 and could not find an entry relating to the contact from the neighbour.
- 3.248 We reviewed the police statements made by the neighbours and found that in relation to concerns about service user A's behaviour one neighbour had contacted the SPoA on the 22 September 2017 to try and identify her and see if anyone had been reported missing from a hostel or hospital, without success.
- 3.249 Another neighbour, with reference to several worried neighbours, stated that she had spoken to the police a few days prior to the 21 September 2017. The statements indicate that the police asked for service user A's name and said they would check to see what they could do, however did not report back.
- 3.250 On 22 September 2017 service user A set fire to her first floor flat leading to death of Keith. At about midnight, she had taken a taxi to a cashpoint, withdrawn money with his card, went to a petrol station and asked the taxi driver to buy petrol and a lighter.
- 3.251 While he was asleep, she set fire to the bedroom using the petrol and lighter she had bought. Keith awoke while she was pouring petrol round the bedroom, before she threw lighted paper into a wardrobe and closed the door. Following an explosion, service user A leapt to safety through the window. The police rescued several other residents from six other flats in the block.

4 Arising issues, comments and analysis

Care planning

- 4.1 We view the diagnosis of PDD as being an important point in service user A's care and treatment, as this is a psychotic disorder characterised by the development either of a single delusion or of a set of related delusions that are usually persistent and sometimes lifelong.
- 4.2 We therefore examined whether service user A was offered medication in line with the NICE guidance "Psychosis and schizophrenia in adults: prevention and management". As it was first published in 2009 and updated in 2014, we focussed on service user A's care from 2014 rather than the requirements for managing her first episode of psychosis in 2007.
- 4.3 The NICE guidance includes:
- consideration of depot medication;
 - maintenance of responsibility for monitoring physical health and the effects of the antipsychotic medication until conditions have stabilised before transferring the responsibility to the GP under shared care arrangements;

- reviewing antipsychotic medication annually, including observed benefits and any side effects;
 - considering intensive case management if the service user was likely to disengage from treatment or services; and
 - providing treatment and care in the least restrictive and stigmatising environment possible and in an atmosphere of hope and optimism.
- 4.4 We reviewed service user A's care to determine which of these aspects of recommended best practice had been undertaken.
- 4.5 We also examined whether:
- the issue of non-compliance was considered and if care plans and risk assessments adequately reflected issues of non-compliance;
 - appropriate consideration was given to monitoring, testing and self-reporting processes; and
 - if the family's concerns relating to medication non-compliance were acted upon appropriately.
- 4.6 Service user A was first prescribed oral antidepressant medication in 1999 when she started feeling low in mood, weary, depressed, forgetful and tearful. Records indicate that service user A was not always compliant with this medication.
- 4.7 In 2007 service user A was reported as being suspicious, believed her family were trying to poison her, that medication was poison, and had suicidal thoughts. There was mention for the first time of Keith possibly colluding with her. The diagnosis was a psychotic disorder and she was appropriately prescribed a therapeutic dose of an oral antipsychotic medication (aripiprazole) in line with the relevant NICE guidance.
- 4.8 In 2008 service user A was prescribed a depot in addition to an oral antidepressant and was diagnosed with PDD. We view the change from an oral to a depot as being appropriate given this and this is also in line with the relevant NICE guidance.
- 4.9 However, service user A was not compliant with the depot and was prescribed oral antipsychotic medication in July 2008. Our view is that this may have been due to her delusions about being poisoned by mercury and being afraid of metal consistent with her diagnosis of PDD.
- 4.10 This can be seen as a reasonable decision, at this point in her history, and given that this was the first time a depot had been considered. We note that the oral antipsychotic medication dose was increased as appropriate in line with her clinical presentation, and as she remained stable for some time, it suggests that she was compliant.
- 4.11 In August 2014, compliance issues emerged, and service user A was advised to restart her medication, to re-engage with the CHTT if she needed further help and to have a new patient screening appointment, which she agreed to do. However, there is no record of the new patient screening appointment taking place and by October 2014, her daughters reported that service user A was not well; she was

complaining of abdominal pain and denied that she had any mental health problems.

- 4.12 Records indicate both a gap in time at this point, and a lack of a response to her daughters concerns until 4 November 2014 when her GP referred her to the crisis team. A CHTT telephone call was recorded on 2 November 2014 with service user A reporting only physical symptoms. A subsequent planned telephone call on 4 November 2014 did not take place.
- 4.13 We believe that a more assertive approach, either through the CMHT or the AOT should have been taken at this point. This would be in line with relevant NICE guidance, given that the GP had referred her to the CHTT as service user A had stopped taking her medication, she was denying mental health problems, was complaining of physical symptoms in accordance with her delusional beliefs, and her daughters reported concerns.
- 4.14 Records indicate a gap in time from after this until June 2015 when service user A was being monitored by her GP and there were medication compliance issues. She did not collect her prescription and told the GP she was not taking her medication. Her daughter reported that she was deteriorating and had stopped taking all her medication in June 2014.
- 4.15 The GP referred her to the CHTT, and she was admitted informally to hospital between 1 and 9 June 2015. During this time, service user A's oral antipsychotic medication was increased, and her antidepressant medication was continued at the same dose, which we view as an appropriate response to the situation.
- 4.16 However, service user A was discharged back to the care of her GP and advice was given to contact the services if the situation changed. Our view is that at this point service user A should have been referred to the CMHT under CPA and care coordination until her condition had stabilised before transferring the responsibility to the GP under shared care arrangements, in line with relevant NICE guidance.
- 4.17 The GP records indicate that service user A was subsequently seen monthly through October 2015 to January 2016 seemingly in relation to her physical health symptoms. In March 2015 the daughters contacted the GP, who spoke also to Keith. They expressed concern that service user A believed people were trying to poison her; she felt she had high levels of mercury in her body and said she was going to kill herself.
- 4.18 They were advised that service user A could be brought to Harrison House, or they could ring the CMHT SPoA and request an assessment if she refused to attend. In fact, service user A attended A&E, and asked the GP for something to treat her mercury levels. She registered with a new GP and requested a home visit as her physical symptoms prevented her from attending the surgery.
- 4.19 Clearly service user A had not been compliant with medication after discharge from hospital on 9 June 2015, and this culminated in service user A being detained again under Section 2 of the MHA 1983 and admitted on 27 September 2016. She was discharged three days later with an increase in her oral antipsychotic medication and supported by the CHTT until 21 November 2016.

She was then discharged back to the care of her GP having reported feeling mentally well, no low mood, with no untoward thoughts or feelings.

- 4.20 Our view is that this point service user A should have been referred to the CMHT for care coordination until her condition had stabilised before transferring the responsibility to the GP under shared care arrangements, in line with relevant NICE guidance.
- 4.21 By December 2016, service user A's son-in-law reported that she said she was dying, was threatening Keith and calling the family excessively on the 'phone. The CHTT assessed her, she was expressing delusional thoughts, did not want CHTT support or to go back into hospital. However, she eventually reluctantly agreed to daily CHTT visits to monitor her medication compliance, which took place from 2 to 5 February 2017 when she would not let the staff in, and doubts emerged about her medication compliance.
- 4.22 An MHA assessment was undertaken with the records stating that the outcome was that the least restrictive intervention was agreed by all parties as being home treatment so that she could be monitored taking her medication. However, service user A would not consent to discuss the outcome of this assessment with her daughters who expressed their dissatisfaction with this approach.
- 4.23 CHTT visits to monitor her medication compliance continued, with varying reports of her compliance. At this point, a joint CHTT and CMHT visit was planned which we regard as good practice and in line with relevant NICE guidance, however service user A did not want CMHT input or a mental health service at all. She was discharged back to the care of her GP on 17 February 2017.
- 4.24 Our view is that at this point, a more assertive approach, either through the CMHT or the AOT, and a further period of time with the CHTT could have been suggested to service user A. Although reluctant, she appeared to be tolerating the visits and her compliance with medication was not clear.
- 4.25 By March 2017, her daughters were expressing concern as service user A was not taking her medication and was expressing delusional ideas about metals. They requested an MHA assessment and on 14 March service user A was detained under Section 2 of the MHA 1983 and admitted via the crisis team. We note that this was the third consecutive admission, and the second admission under detention of the MHA 1983 following non-compliance with medication.
- 4.26 Whilst in hospital, she was prescribed a depot and a 'test dose' was administered in line with relevant NICE guidance. Service user A was discharged under CPA, with CHTT and CMHT care coordination support on 7 April 2017. We view these particular arrangements as being good practice and in line with relevant NICE guidance.
- 4.27 A more assertive approach through an MHA assessment was discussed including the use of a CTO in the event of medication non-compliance in the community. However, this was not documented as part of the usual discharge process for CPA and resulted in the daughters understanding this to mean that this option

would definitely be enacted in event of medication non-compliance (whereas the inpatient consultant psychiatrist saw this as an option only).

- 4.28 Although the approach was in line with relevant NICE guidance, we view this as an example of poor communication and record keeping, not only with the daughters but with the CMHT consultant psychiatrist (who would be responsible for MHA assessment and medication issues after discharge) and bearing in mind that the care coordinator was not present at the meeting. Our view is the lack of a robust and documented CPA review inhibited these issues being openly discussed, and agreement reached.
- 4.29 Service user A refused the depot when it was next due and requested oral medication. Although the risk of relapse was noted, Keith supported the use of oral medication, said that she would be compliant with this and reported she was the best he had seen her in years.
- 4.30 As a result, a discussion took place between CC (4), the CMHT team manager and the CMHT specialty doctor (with previous knowledge of service user A) who advised a MHA assessment, however CC (4) and the CMHT team manager both felt that prescribing oral medication would be the preferable, least restrictive option and believed service user A had the capacity to refuse treatment.
- 4.31 We have not found records to indicate how capacity was assessed and there is nothing in the records to indicate that staff considered the potential impact of service user A's known recent beliefs and documented lack of insight on her decision-making capacity.
- 4.32 It is unclear why medical advice from the CMHT specialty doctor, that an MHA assessment be undertaken was overruled by the CMHT team manager who did not know the patient, and with a CC who had met her only once.
- 4.33 Using the least restrictive option is seen as good practice in terms of the relevant NICE guidance, however, our view is that service user A's refusal to accept the depot may have been due to her delusions about being poisoned by mercury and being afraid of metal which would be consistent with her diagnosis of PDD.
- 4.34 Given this, we would challenge the view that service user A had mental capacity to refuse the depot, and we could not find evidence of how this assumption was made (despite evident delusional thinking) or a formal mental capacity assessment. We note, however, that the assumption was made in the context of a lack of knowledge and documented record about the CPA discharge arrangements including the option of an MHA assessment if she refused the depot.
- 4.35 The on-call doctor was contacted to amend the prescription, accordingly, however refused to do this given the complexities of service user A's case, and the CMHT consultant psychiatrist was then contacted two days later to confirm that service user A had capacity to refuse the depot.

- 4.36 After discussion with the CMHT consultant psychiatrist an oro-dispersible form of an antipsychotic medication (aripiprazole) was prescribed with Keith agreeing to supervise service user A's compliance.
- 4.37 The CMHT consultant psychiatrist told us that he had not felt that service user A would have been detainable, especially as Keith supported the use of oral medication and promised that he would supervise her taking it.
- 4.38 We note that although it was accepted that Keith assisted with the supervision of service user A's compliance, there were reported concerns he was colluding with service user A and had told staff that he felt inhibited from talking to staff about her, in her presence. Although this information was recorded in the clinical records, we found varying levels of knowledge in respect of this by the staff providing care.
- 4.39 Between April and 7 June 2017 CHTT supported service user A with home visits and telephone monitoring. CC (4) noticed signs of relapse in that service user A was slightly paranoid, weepy, talked a lot about her physical health, was very anxious and preoccupied. The CMHT consultant psychiatrist asked the GP to increase her antidepressant.
- 4.40 On 14 June 2017 service user A was showing clear signs of a psychotic relapse. She was becoming preoccupied with her physical health, talking about mercury poisoning, requesting metal items be left in hallway, preoccupied with thoughts that her daughters were siding with Keith's former partner and choosing her over service user A. The CMHT consultant psychiatrist asked the GP to immediately increase her oro-dispersible antipsychotic medication.
- 4.41 Following this, during home visits with an interim CC (5) and CC (6) for service user A, (CC (4) had changed roles within NAViGO at this point), she expressed a wish to be discharged from mental health services. She was reported as being guarded and fixated on her body image, the CMHT consultant psychiatrist visited her at home and service user A agreed to continue her oro-dispersible antipsychotic medication on a higher dose, and with continued support from her CC on a regular basis.
- 4.42 The CMHT consultant psychiatrist told us that he felt that service user A was improving, and that this had been the view expressed by Keith also. He said that both service user A and Keith said they were happy with her progress and expected that she would continue to take the antipsychotic medication (which was now prescribed at the maximum advisory dose) and that she would improve further.
- 4.43 On 3 July 2017 service user A stated again that she wished to be discharged from services and this was actioned. This is discussed in more detail in the care plans, safeguarding and risk to self, section of the report.
- 4.44 In summary, our view is that in line with NICE guidance, service user A was provided treatment and care in the least restrictive and stigmatising environment possible, however we did not find evidence of how this approach was balanced with the diagnosis of PDD, the associated risks, her history of disengagement

with services, non-compliance with medication and the assessment of her capacity to understand the impact of this.

Care Coordination

- 4.45 Our view is that this was compounded by CC (5) informing us there was not the time to look through service user A's notes to pull this information together themselves, due to the reported workload at the time. CC (6), who was newly in post, told us she had not received a handover about service user A, and was not able to access information, because she was not provided with a laptop and had no one to guide her about NAViGO systems and processes. We were told that the CMHT were short staffed, people were leaving, and there was a waiting list for care coordinators.
- 4.46 Additionally, service user A had three allocated CC'S between June and August 2017. CC (4) was a newly qualified nurse who commenced employment in the CMHT and was allocated service user A in April. CC (4) left the CMHT to work on the inpatient unit in June 2017, and had therefore known service user A for about three months, and had read some information but was not aware of plans for the use of the MHA if she refused medication or that it was thought Keith was colluding with her.
- 4.47 CC (5) knew service user A from 2008 when she was allocated as her CC and offered to 'hold' her case until a new CC was appointed and did not receive a handover on service user A. CC (5) was aware from being her CC in 2008, that service user A had medication compliance issues, but was not aware of her admissions since then and that she had been diagnosed as being psychotic; she was only aware that service user A had depression and anxiety. CC (5) told us that she could have found out this information by looking at the notes, but she had 30 people on her caseload and didn't have the time. CC (5) told us that she had offered to support service user A for a couple of weeks until CC (6) took on the role of CC for her and had not received a handover about service user A.
- 4.48 CC (6) commenced employment with the CMHT in June and was subject to four weeks induction without taking any patients' onto her caseload. She told us that the induction period was too long, unstructured and that she was not provided with the appropriate equipment or guidance and support. This issue has already been addressed in the internal investigation.
- 4.49 CC (5) introduced CC (6) to service user A during a joint home visit on 3 July 2017, and CC (6) took over her case at that point. She told us that she assumed she would receive a handover about service user A's care and treatment but did not, and was not able to access information, because she was not provided with a laptop and had no one to guide her about NAViGO systems and processes.
- 4.50 She told us that during the joint home visit, service user A said she did not want a new CC, or one at all, and appeared to find the situation distressing. CC (5) explained to service user A that if she wanted to be discharged, she would have to speak to the CMHT team manager. CC (6) felt confused about the discharge process in NAViGO, however understood that CC (5) had worked in NAViGO for a long time and did not challenge this.

- 4.51 We believe that a more assertive and intensive case management approach should have been considered, either in the CMHT, or through the AOT, given that service user A was likely to not be compliant with her medication and disengage from services as she had following her discharge from hospital on 9 June 2015 and 30 September 2016 and on 17 February 2017 when she was discharged from CHTT support.
- 4.52 At these points in time, our view is that service user A should have been supported by the CMHT under CPA and care coordination until her condition had stabilised before transferring the responsibility for this to the GP under shared care arrangements.
- 4.53 Staff should have made sure they felt adequately up to date about service user A's history before taking such key decisions and have taken steps to ensure that the relevant people were involved in making this decision (particularly the CMHT consultant psychiatrist who had recently assessed her at home).
- 4.54 Linked to this view, and notwithstanding issues of consent from service user A to share information, we found a lack of appropriate responses to the family's concerns in October 2014, March 2015 and February 2017 which we attribute to service user A not being assertively managed under CPA with care coordination.
- 4.55 In February 2017 staff were told (once by a relative and once by Keith himself) that he felt guilty about the situation and felt unable to speak freely to staff about service user A.
- 4.56 Our view is that staff should have placed limited weight on his later assertions, made over the telephone and which were likely therefore to have been made in service user A's presence, that everything was fine and that he had no concerns about service user A's wellbeing.
- 4.57 There is little or no evidence that staff questioned, or were curious about, these reports, that is that they did anything other than accept them at face value (and made decisions accordingly).
- 4.58 Although the risk assessments completed in July 2015, September 2016, February and March 2017 contained information about the issue of non-compliance, we found that service user A was not subject to a formal care planning process under CPA and care coordination.
- 4.59 We found the response to the family's concerns in March 2017 to be good practice in that service user A was assessed and detained under Section 2 of the MHA 1983. However, we found the subsequent CPA discharge arrangements to be unsatisfactory in that the discussion with the daughters about the use of the MHA and a potential CTO was not recorded. This led to a lack of open discussion and agreement about the way forward, and the plan for service user A's care.
- 4.60 We found that an unsuccessful attempt was made to contact the daughter in July 2017 after she had contacted the CMHT SPoA to report concerns that service user A was not taking medication, that someone was poisoning her, and that she had gone to Derby to visit her sister.

- 4.61 The CMHT team manager told us that there was a general awareness between her, CC (5) and CC (6) about Keith's possible collusion with service user A, and they had varying levels of knowledge about the fact that he did not feel able to speak freely in front of her, although service user A's niece reported this during the CHTT assessment on 2 February 2017. Staff accepted that Keith would assist in monitoring her medication compliance, and his reporting of her improvement without questioning him further.
- 4.62 Staff told us that if there were concerns about medication compliance the usual practice would include, checking that the service user had collected their prescription, a joint visit with the crisis team, instigating CHTT support, requesting a medical review, and utilising a regular weekly CMHT 'access' meeting for discussion. We found that these practices had all been used in relation to service user A's medication compliance at some point in her care and treatment.
- 4.63 However, we were informed that at the time, this meeting was focussed on new referrals, rather than discussion of complex cases. CC (6) told us that because of this, she did not feel able to discuss service user A's care and treatment in that meeting. The CMHT team manager told us that service user A was discussed in this meeting in relation to her discharge from services in February and July 2017. We have not found evidence of a discussion in July 2017. Care plans, safeguarding and risk to self and others
- 4.64 We note that following service user A's discharge from hospital in 2008, the discharge letter has subheadings of past psychiatric history, personal history and pre-morbid personality. Under each of these 'as previously documented' is recorded, however, we have not found evidence that these subheadings were previously documented or populated or that there was a single document containing a mental health history.
- 4.65 Our view is that this is not good practice because if it is assumed a history has been taken, this will not be repeated; so, if in fact there was no history taken in the first place, that gap is never corrected.
- 4.66 We reviewed the adequacy of risk assessments, risk management and appropriate escalation, considered whether her needs were assessed with her involvement and examined the effectiveness of her care plan including the involvement of the service user A and her family.
- 4.67 In terms of application of the Care Programme Approach (CPA) for service user A, we found that NAViGO had an appropriate policy in place at the time (ratified July 2009, review July 2017) encompassing the standards covered by the CPA, Assessment, Care Planning, Risk, Review, Transitions and Care Co-ordination.
- 4.68 The CPA and Non-CPA Care Coordination Policy stated that standard support was for individuals receiving care from one agency or worker, or more than one agency or worker, but who provide low level support to those who are able to self-manage their mental health problems and engage well with services. A 'lead professional' was to be appointed to assess, plan, deliver and review the care package for these service users under Non-CPA.

- 4.69 Enhanced support was described as being for individuals with more complex mental health issues who are likely to require care from multiple agencies or individuals and who are more likely to disengage from services. Those requiring care of this nature will be cared for under the CPA with a CC coordinating care.
- 4.70 In considering whether the service user requires care under the CPA the guidance asks whether the service user requires:
- multi-agency support;
 - active engagement;
 - intense intervention;
 - support with dual diagnosis;
 - support due to posing a higher risk.
- 4.71 In line with the policy requirements for enhanced care, service user A had a severe mental disorder with a high degree of clinical complexity with current or potential risks including:
- suicide, self-harm, harm to others;
 - relapse history requiring urgent response;
 - self-neglect/non concordance with treatment plan;
 - vulnerable adult, adult or child protection issues.
- 4.72 Our view is therefore that service user A required multi-agency enhanced support under the CPA and care coordination care in terms of needing intensive intervention and support due to posing a higher risk, assessment of Keith's carers needs and potential safeguarding concerns associated with their relationship and with looking after the grandchildren.

Discharge planning

- 4.73 On 3 July 2017 CC (5) and CC (6) undertook a home visit to service user A and she stated she wished to be discharged from mental health services, supported by Keith. The induction period for CC (6), as a new member of staff, had just ended and that this was the first time she had met service user A.
- 4.74 This was not only CC (6)'s first contact with service user A but also CC (5)'s last contact with service user A, and it is not clear whether either of them was fully acquainted with service user A's recent history of service contact (CC (6) told us she was unaware that service user A had been diagnosed as suffering from a psychotic disorder and CC (5) told us she had not had a handover about service user A). Further, we were told that CC (5) and CC (6) and the CMHT team manager "all agreed she is not currently suffering from severe and enduring mental health" (sic), notwithstanding the current diagnosis of PDD.
- 4.75 Service user A was asked to contact the CMHT team manager to discuss her discharge, which she did, and discharge was actioned on 8 August 2017. The CMHT consultant psychiatrist was not aware of this decision, and a discharge CPA review meeting was not held.

4.76 We found the timing of the discharge steps from July 2017 were as follows:

- 3 July: service user A requested discharge.
- 4 July: GP advised of intention to discharge.
- 9 July: daughter contacted team.
- 14 July: sister contacted team.
- 28 July: formal discharge agreed with service user A.
- 8 August: GP advised that case was now closed.
- 11 August: discharge checklist signed off.

4.77 In terms of the decision to discharge service user A, CC (5) asked service user A to speak to the CMHT team manager if this was what she wanted. CC (5) told us that she had advised this because she hadn't had a handover about service user A, however, the CMHT team manager previously provided supervision to the CC (4). CC (5) told us that because of this, the CMHT team manager would know what was going on with service user A, and at that time, the procedure was to speak to the CMHT team manager about discharges.

4.78 The CMHT consultant psychiatrist told us that to discharge service user A shortly after a relapse, and shortly after a consultant psychiatrist home visit, was "unusual". The CMHT team manager told us that discharge did "not generally work" like this.

4.79 It therefore appears that neither the CMHT team manager or CC (5) and (6) knew very much about service user A's current and recent clinical presentation, or about her identified risk profile, and that none of them took steps either to correct this deficit or to consult with someone who might have been expected to be more 'up to date' such as the West CMHT consultant psychiatrist, who had assessed her on 22 June 2017.

4.80 We have not found evidence that those making the decision to discharge took into account all possibly relevant issues in the decision-making process. In particular, there is no recorded evidence that the potential impact of recent psychotic relapse, of repeated previous medication non-compliance, of links between psychotic symptoms and mental capacity, of Keith's circumstances or of the views of other relatives were drawn together and appraised.

4.81 Furthermore, the staff involved had relatively limited knowledge of service user A's recent and prior mental health and service contact, did not have access to a comprehensive summary setting this out, and did not consult with clinicians who might have been expected to be better informed. Therefore, we conclude that the process involved in making the decision to discharge service user A was not demonstrably robust or clinically well-founded.

4.82 We found that there were gaps in providing service user A with enhanced support under the CPA with a CC coordinating care following her discharge from hospital on 9 June 2015 and 30 September 2016 and on 17 February 2017 when she was discharged from CHTT support.

- 4.83 The responsibilities of the CC are stated as including a comprehensive needs assessment, risk assessment and management, crisis and contingency planning and management, assessing and responding to carers needs, care planning and review, transfer or discharge.
- 4.84 We found gaps in the CC carrying out these responsibilities adequately, and in line with the policy, when service user A requested discharge in July 2017. We noted that a review was not held including service user A, Keith and the multidisciplinary team to establish ways in which service user A's needs had changed and the extent to which the care plan and crisis plan required amending.
- 4.85 We note that the NAViGO Care Programme Approach (CPA) and Non-CPA Care Coordination Policy was updated in August 2018 and clarifies that if a CC has determined via a review that the service user no longer requires the services of NAViGO then the service user will be discharged back to the care of the GP.
- 4.86 The CC will have provided in the review documentation a clear clinical rationale for the decision to discharge, which includes a summary of the presenting needs, the treatment, interventions given, the outcomes achieved and the views of the service user and family or carers.
- 4.87 In terms of the decision to discharge service user A on 8 August 2017, CC (6) told us that the CMHT team manager had asked her "whether discharge was still happening". She said she felt uncomfortable about the discharge process and had been "surprised" about service user A having to 'go through a manager' in order to be discharged. During her account to us, CC (6) used the words 'baffled', 'confused' and 'uneasy' to describe how she had felt. However, she felt that the wider team had no concerns about discharge.
- 4.88 CC (5) asked her to speak to the CMHT team manager because she hadn't received a handover about service user A, however, the CMHT Team Manager used to give supervision to the previous CC (4) so she would know what was going on with service user A, and at that time, that's what the procedure was.
- 4.89 The CMHT consultant psychiatrist stated that to discharge service user A shortly after a relapse, and shortly after a Consultant Psychiatrist home visit, was "unusual". The CMHT Team Manager told us that discharge did "not generally work" like this.
- 4.90 It therefore appears that neither the CMHT team manager or CC (5) and (6) knew very much about service user A's current and recent clinical presentation, or about her identified risk profile. Furthermore, none of them took steps either to correct this deficit or to consult with someone who might have been expected to be more 'up to date' such as the CMHT consultant psychiatrist, who had assessed her on 22 June 2017.
- 4.91 We have not found evidence that when making the decision to discharge service user A, they took into account all the possible relevant issues. In particular, there is no recorded evidence that the potential impact of recent psychotic relapse, of repeated previous medication non-compliance, of links between psychotic

symptoms and mental capacity, of Keith's circumstances or of the views of other relatives were drawn together and appraised.

- 4.92 Furthermore, the staff involved had relatively limited knowledge of service user A's recent and historic mental health and service contact, did not have access to a comprehensive summary setting this out, and did not consult with clinicians who might have been expected to be better informed. Therefore, we conclude that the process involved in making the decision to discharge service user A was not demonstrably robust or clinically well-founded.

Safeguarding, risk assessment and management

- 4.93 In order to review the adequacy, and appropriate escalation of, risk assessment and management including safeguarding we referred to the NAViGO Safeguarding Adults Policy (ratified March 2011, review October 2018), the Safeguarding Children Policy (ratified March 2011, review April 2019), the NICE Quality Standard (QS116) on Domestic Violence and Abuse²², and the Clinical Risk Policy (ratified July 2016, review July 2018).
- 4.94 We note that NAViGO is a member of North East Lincolnshire Safeguarding Adults Board (NELSAB). The first point of reference and main procedure manual for practitioners throughout North East Lincolnshire is the North East Lincolnshire Safeguarding Adults Policy, Procedure and Guidelines which is available on the relevant website.
- 4.95 We also noted the Care Quality Commission (CQC) Quality Reports (2016 and 2017) rated the community services for adults as good and stated that there was a good oversight of safeguarding from board level, that staff followed the organisations policy and knew how to report safeguarding and good links existed with the local authority in relation to both adults and children's safeguarding, with the lead for safeguarding attended North East Lincolnshire Safeguarding Board and reported back through the organisation via the NAViGO Board.
- 4.96 We interviewed the North East Lincolnshire CCG Quality Assurance Lead, Service Lead and the Designated Nurse Safeguarding to examine intelligence and any previous concerns about the quality of care or safeguarding in NAViGO.
- 4.97 We were informed that NAViGO are required to submit an annual safeguarding self-declaration which covers 69 safeguarding standards and a quarterly safeguarding return which examines training compliance and contributions to multiagency safeguarding arrangements.
- 4.98 The CCG indicate that they have good relationships with NAViGO safeguarding leads and find them to be visible and present; they attend the relevant health safeguarding forums and boards. The CCG indicated no major NAViGO safeguarding or quality of care concerns.

²² <https://www.nice.org.uk/guidance/qs116>

- 4.99 In terms of information sharing the CCG are not aware of this being problematic and have no concerns. NAViGO are seen by the CCG to be working proactively with other agencies and services are currently focusing on dementia and emergency care.
- 4.100 The CQC Quality Report (2017) stated that the service used a recognised risk assessment tool to assess and manage potential risks to patients and stated that NAViGO worked closely with other agencies to ensure safeguarding concerns were investigated.
- 4.101 We found that the NAViGO Safeguarding Adults Policy did not refer specifically to Domestic Violence or Abuse, however the relevant website provided appropriate guidance in this area, included working with children.
- 4.102 We considered whether the Safeguarding Adults Policy was applicable to service user A and Keith. This was confirmed by the statement of a vulnerable adult being defined as a person aged 18 or over (including carers), who:
- may need community care services by reason of mental or other disability, age or illness;
 - may be unable to take care of himself or herself; or
 - are unable to protect himself or herself against significant harm or exploitation.
- 4.103 The policy goes on to say that the immediate action in case of suspected abuse includes:
- taking all reasonable steps to ensure the adult is in no immediate danger;
 - seeking the person's consent to share information about them both within NAViGO and with colleagues from other agencies; and
 - logging an alert when abuse is suspected to ensure other relevant individuals are alerted.
- 4.104 The next steps include making a referral for the suspected case of abuse to be investigated, and if a crime has been committed to report this to the Police. The policy states that gaining consent at this stage is best practice but is not required. Thereafter the referral process allows for the convening of a strategy meeting and case conference to safeguard the person.
- 4.105 The NICE Quality Statement on Domestic Violence and Abuse provides information relating to four quality statements:
- people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion;
 - people experiencing domestic violence and abuse receive a response from trained staff;
 - people experiencing domestic violence or abuse are offered referral to specialist support services; and
 - people who disclose that they are perpetrating domestic violence or abuse are offered referral to specialist services.

- 4.106 We found that neither service user A or Keith were asked about their experiences in a private discussion or offered a referral to specialist services. Staff told us that, in hindsight, it would have been sensible to do so, but at the time they did not have any concerns about coercive control, although there was a general awareness that Keith may have been a controlling element in the relationship.
- 4.107 On 8 November 2011, 7 February 2012 and 15 May 2012 concerns were noted about her relationship with Keith and the stress service user A felt looking after the grandchildren. There is no record of signposting to domestic violence services or safeguarding action being taken from either an adult or child perspective.
- 4.108 However, staff told us that they had no concerns about the safety of the grandchildren, that service user A seemed relaxed when she spoke about them, seemed to enjoy spending time with them, and had age appropriate toys available.
- 4.109 In June 2012, records indicate that safeguarding concerns were logged about service user A looking after her grandchildren. We did not find evidence of this or a safeguarding response to these concerns either in NAVIGO or Local Authority records.
- 4.110 In October 2012, March and July 2013 service user A reported concerns about Keith's gambling habits and the ensuing debt. Citizens Advice and debt counselling was recommended and Gamblers Anonymous was signposted.
- 4.111 We were advised by service user A's daughters that her accounts of Keith's gambling were fictitious and were to make their father 'look bad'. However, our view is that the advice given, and actions taken were appropriate.
- 4.112 On 13 October 2016 service user A said she was dying, she was threatening Keith, calling her family excessively on the 'phone and on 4 December 2016 her daughter advised the Approved Mental Health Professional (AMHP) that service user A had put rat poison in Keith's drink. In addition, her son-in-law was concerned that Keith had been aggressive and making threats towards service user A when he became frustrated with her. There is no record of signposting to domestic violence services or safeguarding action being taken on either of these occasions.
- 4.113 On 1 February 2017 Keith attended Harrison House and reported that she had deteriorated, and that he had become so frustrated with her that he had hit her on the arm. There is no record of signposting to domestic violence services or safeguarding action being taken.
- 4.114 We view these as missed opportunities to take action. Our view is that both service user A and Keith should have been considered as potential domestic violence victims, and appropriately signposted to services.

Risk assessment and management

- 4.115 We enquired with staff and were told that the CMHT's have a safeguarding lead within the team structure and that the NAViGO safeguarding adults lead is approachable and knowledgeable and is often used for support and advice.
- 4.116 We found that the Clinical Risk Policy referred to the Safeguarding Adult and Children Policies but did not refer to domestic violence. We reviewed whether risk assessment and management for service user A followed the Clinical Risk Policy in relation to overall approach, CC responsibility, sources of information, when a new and a review of a risk assessment and management plan should be completed and how the plan is communicated.
- 4.117 The Policy advises to take a:
- collaborative partnership approach with service users and carers, emphasising strengths as part of the overall management strategy;
 - focus on recovery;
 - flexible, individualised and responsive to the nature of the risk;
 - integrated into CPA care planning practice; and
 - shared with others involved in the care of the service user where consent is obtained or done under the MHA or Mental Capacity Act (MCA.)
- 4.118 The Policy states that in the community the care coordinator is responsible for the risk assessment and risk management plans of service users and that the assessment should be done in collaboration with the person being assessed, and the following additional sources of information should be considered:
- relatives and carers
 - advocates;
 - previous contacts with other mental health, physical health and learning disability services (whether internally or externally);
 - Primary care records;
 - other health professionals involved;
 - other health or social services involved; and
 - Criminal justice service agencies, including police and probation.
- 4.119 The Policy states that a new risk assessment and management plan be completed in the following situations:
- as part of the initial assessment by any clinical team;
 - at the beginning of each new episode of care;
 - following admission to hospital (within four hours);
 - annually (as a minimum), as part of the CPA care plan review; and
 - at the commencement of any inpatient admission.
- 4.120 The Policy states that a risk assessment be reviewed:
- at each CPA care plan review;
 - if there is evidence of a change in the presentation, as shown in the following areas;
 - behaviour, especially known risk behaviours, mental state, physical condition;

- if there is information from a third party, including, carers, family members or other informants which suggests that the service users risk has changed;
- significant change in life events;
- following a serious incident, or absent without leave (AWOL) incident;
- any safeguarding concerns relating to the service user either by or against them;
- as part of the clinical assessment of suitability for transfer to another team
- within 7 days of discharge from an inpatient service or within 48 hours if the service user had been assessed as a high risk of suicide at any point during the admission;
- within four weeks following any transition in care so as to assess the impact of the transition.

4.121 The policy states that once a risk management plan has been developed or reviewed, it must become a live document and be communicated and shared with the person, family and all those involved in providing their care. Communication of risk information is essential to assist in effective team working, and because all clinicians have a duty of care to the wider public, especially to carers and family members.

4.122 We note that the CQC Quality Report (2017) indicated that not all patients had a completed and up to date risk assessment.

4.123 We found that on 7 November 2007 service user A's risk was assessed following a GP referral to the CHTT. Records state that service user A had self-harmed with a knife blade causing superficial cuts to her forearms due to feelings of guilt about the termination of pregnancy. The plan of care was to offer service user A short-term support in the form of a once a week home visit, and to discuss antidepressant medication with her GP.

4.124 Risk was assessed on 1 September 2008 and recorded in a letter to the GP from the consultant psychiatrist. Service user A denied any thoughts of harming herself.

4.125 Risk was assessed on 10 March 2009 together with a care and crisis plan is recorded, which looked at service user A's problem and needs, care goals, care components and whom these were assigned to including duration and frequency.

4.126 This assessment also included a risk management plan which indicated that a risk assessment had been completed to enable professionals to manage risks. The information notes that previously when her mental health had deteriorated, she became non-compliant with medication and believed it was having an adverse effect on her physical health.

4.127 Her intrusive thoughts increased with regards to her previous termination which she had not addressed. Historically she experienced suicidal thoughts (although there was no evidence of that) and this was noted as a significant risk. The management plan was to offer her time every two weeks, increase care coordinator visits, and request additional support from the CHTT.

- 4.128 Her history of past medication non-compliance was noted, stating that service user A believed it was having adverse effects on her physical health. Risk of delusional thoughts was also noted.
- 4.129 Risk was assessed on 14 April 2009 when a psychotherapist spoke to service user A when she attended Open Minds. service user A said that she had anxiety and depression and wished to attend the stress control course. She said that she had thoughts of self-harm and that three years ago she tried to cut her wrists with a knife, and she was sectioned and admitted to hospital. She said she currently had no thoughts of self-harm or harm to others; however, she drank approximately six bottles of lager on a Saturday. The impact of this was discussed with her and she said that she would cut this down. She said she did not drink at other times.
- 4.130 Risk was assessed on 7 February 2012. A letter to the GP from the consultant psychiatrist contained a statement indicating that there were no thoughts of any self-harm or harm to others.
- 4.131 Risk was assessed on 14 July 2014 by the CMHT consultant psychiatrist and this stated that there were no indications of any risks or intentions to harm herself or others and no risky behaviours present.
- 4.132 The CMHT community clinic follow up letter to the GP from the consultant psychiatrist set out her diagnosis CPA status, care coordination, MHA status, services involved, medication before and after review with reasons for change, progress, on-going cardio metabolic assessment, physical health, Mental State Examination (MSE), risk assessment, clinical impression, informed consent. Information provided, mental capacity and care plan.
- 4.133 Risk was assessed on 1 July 2015 as part of a CHTT assessment due to deterioration of her mental health and non-compliance with medication, service user A had anxiety and psychosomatic delusional beliefs. Risks were described as non-compliance with prescribed medication, persistent psychosomatic delusional beliefs and risk of further deterioration if not treated.
- 4.134 The clinical opinion was that she would benefit from the short stay in hospital for a period of assessment and medication review. A copy of this assessment was not given to service user A. In addition, a CPA mental health assessment tool was completed on the same day including her current mental health, mental health history, physical health, medication regime, carers needs, daily social and personal living skills, risk and clinical opinion.
- 4.135 Risk was assessed on 27 or 28 September 2016 as part of a CPA mental health assessment tool. The record state that service user A was extremely focused on physical health and displayed significant somatisation. She was not compliant with prescribed medication, self-neglecting, not getting out of bed or doing household chores which the family said she took pride in doing. Service user A expressed paranoid persecutory delusions of being poisoned with mercury.
- 4.136 Risk was assessed on 3 December 2016 following a telephone call from her concerned son-in-law. Service user A was said to be unwell, stating she was

dying, threatening Keith and calling the family excessively on the 'phone. The son-in-law agreed to contact the CHTT if the risks increased throughout evening, and to attend the CHTT assessment the following day.

- 4.137 Her son-in-law was concerned that Keith had been aggressive to service user A when he became frustrated and also reported that Keith was drinking vodka daily. Service user A denied any aggressive behaviour from Keith towards herself. In terms of her vulnerability and safeguarding, the records state that this was difficult to assess as service user A denied any concerns for her own safety. It was stated that this needed to be explored further when she would hopefully gain some trust to talk to the CHTT in an honest manner.
- 4.138 There were no concerns about self-neglect however she was not attending to her needs as she usually would. She did not express any suicidal ideation or thoughts or plans to harm herself or others and denied being a risk to herself or anyone else.
- 4.139 Risk was assessed on 6 February 2017 when service user A was referred for an MHA assessment. She was anxious, distressed, mistrusted those around her and said she had not taken medication since Christmas. The records state that service user A was "displaying relapse triggers". The outcome was that the least restrictive intervention was agreed by all parties as daily support from the CHTT, so that she could be monitored taking her medication, which service user A accepted as the "only alternative to admission". If service user A was non-compliant, then detention under the MHA 1983 was to be considered.
- 4.140 However, service user A's daughter called to report that her mother was deteriorating further, she had a history of spitting her medication out, and that Keith was becoming suspicious of her as she had tried to poison him in the past when she was unwell. He said he was at breaking point and couldn't cope with her anymore yet felt guilty and unable to speak in her presence. The daughter was not happy with the outcome of the assessment as she felt it had been agreed that service user A would be admitted. Service user A did not give permission to discuss the outcome of this assessment with her daughters.
- 4.141 Risk was assessed on 15 March 2017 as part of a CPA mental health assessment tool. The CPA assessment tool document stated that service user A had a diagnosis of persistent delusional disorder with five admissions over the last 9 years with the three admissions under the MHA. Service user A had deteriorated over the past few weeks and she had been poorly compliant with prescribed medications, with paranoid persecutory delusions of being poisoned with mercury and no insight. She avoided metal taps and lights due to her delusional beliefs and was preoccupied by her physical health issues, believed she was going to die of mercury poisoning, refused any physical observations, reluctant to take medication, self-neglecting the last few months, not getting out of bed or doing household chores.
- 4.142 Risk was assessed on 10 April 2017 during a two day follow up hospital discharge review on an unannounced home visit. Service user A had not been answering the phone; no problems identified, she was just about to eat, agreed to visit the acute site later which she did with Keith. It was reported that all was well,

no acute distress was observed, and no risks identified. We view this two-day review after hospital discharge as an example of good practice. No risk management plan was required.

- 4.143 Risk was assessed on 24 April 2017 when her depot was due. Service user A refused to accept this as she was very anxious about the needle. Service user A requested oral medication, Keith reported she was the best he had seen her in years and supported this request. An MHA assessment was discussed, however a decision was taken to use the least restrictive option, given service user A had capacity to refuse the depot medication.
- 4.144 Risk was assessed on 7 June 2017 during a home visit, when service user A was weepy, anxious and preoccupied. Her medication was increased as a result.
- 4.145 Risk was assessed on 14 June 2017 when service user A was showing clear signs of psychotic relapse. Her medication was increased immediately as a result and the CMHT consultant psychiatrist arranged to see her urgently.
- 4.146 On 9 July 2017 concern was reported by service user A's daughter through the CMHT SPoA that service user A was not taking medication, was stating someone was poisoning her, and had gone to Derby to visit her sister. The CHTT worker advised that the system indicated service user A had been discharged but agreed to contact CC (6).
- 4.147 CC (6) attempted to contact service user A's daughter. Service user A contacted the services (from Derby) and asked if her daughter had been in touch, stating that her daughters were causing trouble for her, that they did not like her family in Derby, and that they were not happy with her being there. Service user A stated she had not been paranoid for some time, that she was compliant with medication, that she knew she could contact the crisis team, and that she still wanted to be discharged. Service user A's daughter was not contacted back, and we did not find evidence of formal risk review at this point.
- 4.148 On 14 July 2017 service user A's sister (in Derby) contacted the CMHT administrator to raise concerns, saying she was shocked at her presentation having not seen her for two or three years. Staff should have known this as it was in the clinical records.
- 4.149 She described service user A as having poor personal hygiene, claimed she had spoken to the Queen, claimed that the NHS and government were poisoning her, reported that she wanted to poison Keith (with bleach or weed killer), stated that her depot was stopped by services because the metal was poisoning her body and that she was not taking her medication as it was rotting her insides.
- 4.150 After this was passed to CC (6) and the CMHT duty worker, the former made an unsuccessful unannounced home visit. Keith (by telephone) reported that service user A was fine, and after being advised of her sister's concerns he said he had no concerns about these issues.

- 4.151 We found that CC (6) took the concerns seriously and thought an MHA assessment might be required. CC (6) contacted the AMHP for advice and was advised to assess her at home.
- 4.152 CC (6) went out to see service user A at home but Keith answered the door and said she was out at the shops. On return she found that the CMHT duty worker had managed to see service user A and had no concerns, however he hadn't contacted CC (6) to inform her he was going to do this.
- 4.153 The CMHT duty worker told us he was being proactive and using his initiative in seeing service user A. He arrived just after midday and they had returned. He was invited into the property and spoke to service user A and Keith together for about 35 minutes.
- 4.154 The CMHT duty worker told us he was at work from lunchtime onwards that day and his role was to cover "everything and anything that came through". He thought that the best option was to do a face to face visit; he didn't have any knowledge of service user A or Keith, just the information passed on to him verbally from the CMHT administrator.
- 4.155 The email said that service user A said she had spoken to the Queen; some information about poisoning someone and he told us he had asked service user A about this. However, he didn't see the email before he went to see service user A. He knew the calls of concern had come through from her sister but didn't know the details. He only knew limited information from a brief check of her notes.
- 4.156 The CMHT duty worker didn't think service user A was psychotic at the time. She was expressing paranoid ideation, her appearance and how she presented was very good, with no evidence of self-neglect.
- 4.157 In terms of poisoning Keith, service user A said she wouldn't, and he agreed, saying he was monitoring her and would be the first to say if he felt at risk. He said he knew where to access help.
- 4.158 Due to the comments being made that service user A was not telling the whole truth about the situation and in terms of support for Keith and to monitor the situation, the CMHT duty worker put in place CHTT telephone calls and visits if required to provide support over the weekend until the Monday. Service user A and Keith both agreed to this plan.
- 4.159 The Duty Worker told us that as an invited guest, he didn't think that speaking to separately was possible. He didn't have the opportunity, the rapport or the relationship to do this and it would have been difficult. He told us that in hindsight he should have done, but the opportunity didn't arise. Collusion did cross his mind, but Keith was saying the right things.
- 4.160 He asked about the days preceding the visit regarding concordance and compliance with medication and the suggestion that service user A wasn't complying. This was refuted by service user A; said she missed the occasional dose but did take it and needed more ordering.

- 4.161 In summary, we found that in terms of an overall approach, that a collaborative approach to risk was taken with service user A, however, her sister, son-in-law, mother-in-law and daughters all expressed concerns about this approach and felt that the services did not respond adequately to the risks that service user A posed and to their concerns.
- 4.162 They felt that the services could not see that the relationship between service user A and Keith was controlling and coercive. Most staff told us that this was not an issue of concern for them.
- 4.163 We found that risk was integrated through a CPA functional assessment, into care and crisis plans 10 March 2009, 14 July 2014, 1 July 2015, 27 or 28 September 2016, 4 December 2016 and 15 March 2017.
- 4.164 In terms of communication about risk assessment and management, there is evidence that on 7 and 14 June 2017 that CC (4) communicated with the CMHT consultant psychiatrist about risk issues noting clear signs of psychotic relapse with the outcome that her medication was increased immediately. The CMHT consultant psychiatrist felt she was on the right track to recovery and expected that she would be followed up by her CC booking her in to see him when required.
- 4.165 At the time of the incident, there was no single place in the clinical record that staff could access to gain a full picture of the historical risk. We were told by staff that the situation remains the same even though NAViGO has moved to a new clinical information system. CC (6) told us that at the time of the incident, there was not the time to go through the clinical records to obtain this history. CC (6) told us she had not received a handover about service user A and was not able to access information, because she was not provided with a laptop and had no one to guide her about NAViGO systems and processes.
- 4.166 All staff interviewed said that to discuss cases and risk with medical staff at the time was difficult, as the CMHT consultant psychiatrist was only part time. However, staff could either email, phone or book an urgent review and there was a full-time specialty doctor offering senior advice and seeing CPA patients.
- 4.167 The CMHT consultant psychiatrist told us that he worked part-time and was physically present in the CMHT one and half days per week. Additionally, the CMHT consultant psychiatrist worked for another service (the therapeutic community for personality disorders day service).
- 4.168 All staff interviewed indicated that, at the time, there was a weekly meeting in the CMHT called the access meeting, which in theory was a place where cases and risk could be discussed but in fact focused on new referrals. Since this incident daily meetings called 'huddles' have been put in place and communication about risk has improved
- 4.169 Information was not shared with her daughters as service user A requested this information was withheld. However, our view is that the daughters didn't feel listened to, and that an approach could have been taken to discuss risk and management without breaching service user A's confidentiality.

- 4.170 There was nothing to prevent staff contacting family members to listen to any concerns or information they wished to raise; to respond in general terms about matters of concern without breaching specific confidences); and, to provide direct staff contact details and encourage them to contact services in future if concerned.
- 4.171 We note that the CPA Policy is clear that carers should be communicated with as far as possible and staff should recognise that lack of consent to disclose information should not be a barrier to carer involvement; that general information can be provided (not service user specific) and staff can listen to a carer's views in these situations.
- 4.172 We did not find evidence of how the collaborative approach to risk taken was balanced with the diagnosis of PDD, the associated risks, her history of disengagement with services, non-compliance with medication and the assessment of her capacity to understand the impact of this. Poor multidisciplinary working impacted adversely on the collective knowledge staff had about service user A.

Workplace culture

- 4.173 We explored whether any aspects of workplace culture potentially impacted on the incident through our interviews with staff, through understanding the changes that were taking place within NAViGO at the time of the incident and the NAViGO service developments at the time and since then.
- 4.174 In terms of context, we note that NAViGO experienced its first full CQC inspection in January 2016 and the services were rated as "Good". We note one relevant provider action for the adult CMHTs regarding mandatory training compliance which was below target for safeguarding adults, safeguarding children and information governance. However, this was successfully addressed at the January 2017 CQC inspection with the CQC revising their inspection report rating accordingly.
- 4.175 The NAViGO Annual Report 2015-16 outlined changes to the infrastructure to provide a more integrated team approach to support the treatment and care teams. In relation to the staff survey NAViGO recognised that more needed to be done to improve ongoing vacancy difficulties, as well as a general lack of engagement with organisational activity, fluctuating sickness rates and staff transferring between teams as well as reduced engagement with questionnaires and surveys.
- 4.176 The NAViGO Annual Report 2015-16 described a project directly looking at the main concerns amongst staff by carrying out focus groups, drop in sessions, attending team meetings and gaining information from exit interviews. Meetings were planned with teams where morale was good, sickness was low, conduct was good and team working was effective to gain insight into best practice so as to share this throughout the organisation.
- 4.177 We were informed by the Assistant Director Community and Well-Being services that this project was undertaken between January and April 2017 and completed

by May 2017 followed by minor changes being made by June or July 2017. Regular monthly updates were provided to staff and a final presentation was undertaken in July 2017.

- 4.178 The National Staff Survey Results 2016 -17 indicated that NAViGO's lowest ranking relevant score was the percentage of staff appraised in the last 12 months. The action was to improve compliance with annual development reviews and the corporate supervision policy with line managers completing quarterly returns to the Workforce Department. The relevant top score was staff satisfaction with resourcing and support, and staff recommendation of the organisation as a place to work or receive treatment.
- 4.179 Staff told us that changes to the CMHTs during 2016-17 resulted in staff feeling stressed and that there were recruitment and retention problems. We were told by the Assistant Director of Community and Well-Being Services that there was an awareness that the CMHT was under stress as they had been carrying vacancies from the year before.
- 4.180 The CMHT Team Manager told us that she was spending considerable time in the recruitment and selection of staff, and the allocation and re-allocation of clinical cases. This situation led to the development of a waiting list for care coordinators.
- 4.181 Specifically, staff told us that morale was low, there was a waiting list for the allocation of CC'S, that patients were allocated CC'S on annual leave, however, the CMHT Team Manager told us that the allocation of CC'S whilst on annual leave was due to administrative error and was not routine practice in the CMHT.
- 4.182 Staff also told us that the discharge of patients from caseloads seemed to be difficult, so that care coordinators felt they could not reduce the size of their caseloads. This was compounded by poor multidisciplinary working and gaps in knowledge about service user A were not addressed.
- 4.183 We were told by the Assistant Director of Community and Well-Being Services that waiting lists for care coordinators did not arise as an issue during the review process. A few months previously, as a result of another serious incident, it was agreed across the organisation that if a member of staff was leaving, and there was no care coordinator capacity, then the CMHT team manager would look after the patient until the new CC was inducted. However, the CMHT team manager told us that she was made aware of this agreement in June 2017, and her view was that this was not a robust contingency plan given the overall role responsibilities.
- 4.184 As part of the project the CMHT caseloads were reviewed through utilising focus groups and available data. A new model encompassing 'recovery'²³ was introduced to address these concerns, discussions were ongoing with the

²³ <https://www.mentalhealth.org.uk/a-to-z/r/recovery> Recovery is a strength-based approach that does not focus solely on symptoms and which emphasises resilience and control over life's challenges. This model aims to help people with mental health problems move forward, set new goals, and take part in relationships and activities that are meaningful.

consultant psychiatrist to agree discharges, a clinical lead for complex cases was holding sessions where care coordinators could discuss complex cases to obtain advice, and in June 2017 a discharge checklist was put in place.

- 4.185 As an example of a gap in knowledge due to a lack of a handover from the CMHT team manager, CC (5) told us that she was aware from being her CC in 2008, that service user A had medication compliance issues, but was not aware of her admissions since then and that she had been diagnosed as being psychotic; she was only aware that service user A had depression and anxiety. CC (5) told us that she could have found out this information by looking at the notes, but she had 30 people on her caseload and didn't have the time. CC (5) told us that she had offered to support service user A for a couple of weeks until CC (6) took on the role of CC for her and had not received a handover about service user A.
- 4.186 As an example of a poor CMHT induction process, CC (6) told us that she commenced employment with the CMHT in June 2017 and was subject to four weeks induction without taking any patients onto her caseload. She told us that the induction period was too long, unstructured and that she was not provided with the appropriate equipment or guidance and support. However, the CMHT team manager told us that she had arranged a mentor and supervisor and the administrative aspects of the induction including lists and contacts of key people to arrange shadow visits. There was a delay in the provision of the ordered laptop however this had arrived by the time of the handover visit to service user A on 3 July 2017.
- 4.187 We were told by the Assistant Director of Community and Well-Being Services that the CMHT team manager was responsible for the development of a structured induction as part of the CMHT review process.
- 4.188 The final structured induction was completed by July or August 2017. However, the Assistant Director of Community and Well-Being Services requested that measures were put in place to ensure staff had an induction before this and was assured that this was in place. We were told by the CMHT team manager that the CMHT already had an induction process in place although it was not structured in format.
- 4.189 We were told by the Assistant Director of Community and Well-Being Services that between May and June 2017 a process was put in place to ensure cases were handed over appropriately, including joint visits and 'shadowing' staff members before a case was fully handed over.
- 4.190 As an example of a poor CMHT handover process, CC (5) introduced CC (6) to service user A during a joint home visit on 3 July 2017, and CC (6) took over her case at that point. She told us that she assumed she would receive a handover about service user A's care and treatment but did not, and was not able to access information, because she was not provided with a laptop and had no one to guide her about NAViGO systems and processes. However, the CMHT team manager told us that she had arranged a mentor and supervisor for CC (6) and the administrative aspects of the induction for CC (6) including lists and contacts of key people to arrange shadow visits.

- 4.191 Staff told us that although they were able to contact various medical practitioners via email or 'phone when needed, the CMHT did not have consistent senior medical time allocated to it. A non-medical staff member we interviewed said that discussing cases and risk with doctors could be difficult, in that the CMHT consultant psychiatrist had additional clinical commitments, and alternative doctors tended not to be clinically familiar with patients of current concern.
- 4.192 The CMHT consultant psychiatrist told us that he worked part-time in the CMHT as he also worked for another service (the therapeutic community for personality disorders day service) and was physically present in the CMHT one and half days per week.
- 4.193 Care coordinators told us that that clinical supervision was regular and good, and that caseload difficulties, and options to address these, were discussed with the CMHT team manager in management supervision but a suitable outcome was not able to be achieved.
- 4.194 We were told that prior to the new Supervision Policy in August 2017, clinical and managerial supervision were provided during the same supervision session.
- 4.195 Staff told us that the service is now more focussed about meaningful interventions and goal orientated. Staff are receiving regular supervision and receive constructive feedback from managers about how to work with complex cases. Caseloads are now smaller, and staff are happier and more settled, but can utilise self-referral or be referred to Occupational Health if necessary.
- 4.196 In summary, our view is that, at the time of the incident, multidisciplinary working was poor, senior medical input to the CMHT was not consistent and gaps in knowledge about service user A were not corrected.
- 4.197 Our view is that the workplace culture was a contributory factor and that within this context there were three key decision points where alternative interventions may have resulted in the outcome being different. These are discussed in more detail in the key decisions section and section 6 of the report.

5 Internal investigation and action plan

- 5.1 NAViGO undertook an internal investigation with a Lead Investigator, an independent investigator (a Mental Health Professor of Old Age Psychiatry), the Assistant Director Community and Psychological Therapy Services, the Assistant Director Acute and Rehabilitation Services, the Associate Director of Nursing and Quality and the Head of Psychology.
- 5.2 The conclusion was that whilst there were identifiable weaknesses within the care plan and management these would not directly have caused the serious incident. On the basis of past behaviour and known risks, on the balance of probabilities they found that the incident was not preventable.
- 5.3 Ten recommendations were:

- a quick summary including a snapshot of all known historic risk factors, risk factors and relapse signature and contingency plan should be available and updated at every point of review, transfer and made available to all members of the team;
- CMHT staff to increase their notice period to three months allowing the additional two-month period for a robust handover;
- review pathways to ensure inter service shared responsibility for joint planning and appropriate team agreements within specific timeframes;
- ensure all interested parties, especially family members are involved in all CPA care planning, review and discharge decision making within the confines of confidentiality;
- when considering discharge, a CPA review must be arranged including, where practicable, all interested parties to enable effective decision making within the confines of confidentiality. This ideally would normally include family members, medical staff and all practitioners that have been involved in the delivery of the care plan. The CMHT discharge checklist could form the basis for this review;
- where CPA needs are identified, the care coordinator is to be involved in patient care plans;
- crisis and community teams to review how they record and respond to all communications from family members/carers and other parties. This has to be in line with patient confidentiality; however, confirmation of action taken needs to be communicated;
- the use of the risk management tool needs to be reviewed to ensure it is effective;
- community consultant psychiatrist to attend weekly access meeting; and
- training in completion of Mental Capacity Act (MCA) documentation to reflect least restrictive options and responding to family concerns.

5.4 We reviewed the NAViGO internal investigation against the National Patient Safety Framework and have included our detailed findings at Appendix B.

5.5 In summary, we found that the internal investigation met most of these standards, however our view is that it was not comprehensive for the following reasons.

5.6 We note that the internal investigation states that there was “no record of delusional symptoms” between late 2007 and September 2016. We conclude that this was not a correct statement. This is because in February 2008, service user A clearly evidenced delusions, and was diagnosed as suffering from PDD. An injectable antipsychotic was prescribed at this point and was replaced by an oral antipsychotic (aripiprazole) in July 2008.

5.7 In late 2011, paranoid ideas were recorded, and in early 2012 the dose of aripiprazole was increased because of paranoid ideas. In 2013, the dose was again increased, and in 2014 paranoia was again reported.

5.8 When service user A was re-admitted in June 2015, delusional beliefs were recorded and a PDD diagnosis was again ascribed. It is therefore not clear to us why it was concluded that service user A had recovered between late 2007 and 2016. Although a diagnosis of PDD does not exclude symptomatic remission,

persistent fluctuating symptoms may be seen as compatible with the clinical picture often where such a diagnosis is made.

- 5.9 The CMHT consultant psychiatrist told us that in his view, service user A had been clearly psychotic, that she had improved very quickly, and that she had responded very well to antipsychotic medication.
- 5.10 The internal investigation states that no issues of vulnerability over the ten-year care period were raised by members of staff regarding Keith's relationship with service user A. However, we found that it is recorded that he alleged she had tried to poison him, that latterly he was reluctant to accept drinks from her as a result, that she had delusions of jealousy, and that she linked him to her mercury poisoning.
- 5.11 The internal investigation states that during the September 2016 admission service user A had a diagnosis of PDD, adding "although no record of delusional symptoms had been evident since late 2007". We found that this latter phrase is not accurate.
- 5.12 The diagnosis of PDD would make it hard to understand why a diagnosis that was made in 2008 and in 2016 would have been absent for the period 2009-2015.
- 5.13 We note that service user A's daughters received a copy of the internal investigation report in April 2017, however Keith's brother did not receive a copy of the internal investigation report. The daughters told us that they met the investigators at the beginning of the process but not at the end for feedback. They are concerned that NAViGO's policies were not followed and do not believe the internal investigation addresses their issues of concern. In summary the views of the family included the following views and assertions:
- Keith was colluding with service user A but was not seen separately from her at any time. He was always trying to help service user A but couldn't handle being her carer (addressed at 1.63, 6.11 – 6.53);
 - the reports service user A gave of Keith's gambling were fictitious and were made to make him look bad (addressed at 4.102);
 - the family's view is that the homicide was preventable. They feel that service user A's risk was escalating, and she was neglected, particularly in terms of the impact of her not having her depot the second time with no further medication (preventability is addressed at 6.5 – 6.11).

Implementation of recommendations

- 5.14 We undertook a quality assurance review using the Niche Assurance Review Framework (NARF), to provide a well evidenced and rigorous assurance process.
- 5.15 In order to complete this review, we requested assurance information against each of the recommendations.

5.16 Given the serious nature of this incident NAViGO set up a specific group chaired by a non-executive board member to oversee the implementation of the action plan and ensure all agreed recommendations are implemented within the agreed time frames and provide assurance to the Board.

5.17 Membership of the group includes the lead identified in the action plan:

- Chief Executive Officer (CEO).
- Medical Director and chair of Practice and Clinical Governance Committee.
- Director of Operations.
- Associate Director of Nursing and Quality.
- Associate Director Business and Service Delivery.
- Assistant Director Acute Mental Health and Rehabilitation Services.
- Assistant Director Community Mental Health and IAPT Services.
- Head of Psychology.

5.18 We viewed the NAViGO action plan and found it to be adequate with the recommendation, details and level of the person implementing the action, the timescale for completion, the resource required, evidence of completion, how lessons could be shared, monitoring arrangements and a rag rated system of the current position.

5.19 We graded our findings using the following Niche criteria:

Grade	Niche Criteria
A	Evidence of completeness, embeddedness and impact.
B	Evidence of completeness and embeddedness.
C	Evidence of completeness.
D	Partially complete.
E	Not enough evidence to say complete.

Number	Original Report Recommendation	NAVIGO Action	Niche Grading
1	A quick summary including a snapshot of all known historic risk factors, risk factors and relapse signature and contingency plan should be available and updated at every point of review, transfer and made available to all members of the team.	Agree key information to be included and format for same. To be included within the crisis/contingency element of the CPA care plan. Update relevant policy (risk and CPA) and procedures/pathway to reflect this change. Consideration of how this could become an alert once the new electronic care record system (SystemOne) becomes operational. Monitoring arrangements through case notes audit.	C
2	CMHT staff to increase their notice period to three months allowing the additional two-month period for a robust handover.	Agenda at Joint Consultative Committee (JCC) Meeting. Consultation with staff membership. Update Workforce Policy. Disseminate to all concerned.	E
3	Review pathways to ensure inter service shared responsibility for joint planning and appropriate team agreements within specific timeframes.	Research best practice examples and possible pathways to include active CCO contribution to in-patient care and discharge planning, and pathways for all Specialist Teams, including Forensic teams, Assertive Outreach Teams (AOT).	E
4	Ensure all interested parties, especially family members are involved in all CPA care planning, review and discharge decision making within the confines of confidentiality.	Brief all teams. Update CPA policy. Ensure evidence of who was invited is included in the CPA review template.	C
5	When considering discharge, a CPA review must be arranged including, where practicable, all interested parties to enable effective decision making within the confines of confidentiality. This ideally would normally include family members, medical staff and all practitioners that have been involved in the delivery of the care plan. The CMHT discharge checklist could form the basis for this review.	Brief all teams. Update CPA policy. Ensure recommendation is covered in CPA training package. Agree standard checklist when discharge is being considered.	D
6	Where CPA needs are identified, the CC to be involved in patient care plans.	Process to be embedded in acute and community pathways. Update CPA policy.	D

Number	Original Report Recommendation	NAViGO Action	Niche Grading
7	Crisis and community teams to review how they record and respond to all communications from family members/carers and other parties. This has to be in line with patient confidentiality; however, confirmation of action taken needs to be communicated.	Review current record keeping policy.	E
8	The use of the risk management tool needs to be reviewed to ensure it is effective.	Review evidence base for use of standardised risk assessments and how the risk management tool will integrate with the risk summary document.	D
9	Community consultant psychiatrist to attend weekly access meeting.	Job planning meeting.	C
10	Training in completion of Mental Capacity Act (MCA) documentation to reflect least restrictive options and responding to family concerns.	Commission training.	B

NAViGO action one

Number	Original Report Recommendation	NAViGO Action	Niche Grading
1	A quick summary including a snapshot of all known historic risk factors, risk factors and relapse signature and contingency plan should be available and updated at every point of review, transfer and made available to all members of the team.	Agree key information to be included and format for same. To be included within the crisis and contingency element of the CPA care plan. Update relevant policy (risk and CPA) and procedures and pathway to reflect this change. Consideration of how this could become an alert once the new electronic care record system (SystemOne) becomes operational. Monitoring arrangements through case notes audit.	C

- 5.20 We viewed the West CMHT audit of 65 crisis and contingency plans undertaken on the first five service users from the care coordinators caseload list. The audit examined whether there were care plans and a crisis and contingency plan in place and whether the information this contained was appropriate for the service user, detailing triggers and indicators of risk and relapse.
- 5.21 Out of 65 cases, three did not have a care plan and of those that did 12 required review, five did not have a crisis and contingency plan, and of those that did, one required review as it was out of date. Three crisis and contingency plan identified service user specific indicators but no triggers.
- 5.22 Where action was required this was detailed and, as an example, included supervision and speaking to the CC about diarising protected administration time each week to update the documentation.
- 5.23 We have been told that NAViGO intend to undertake case note audits at each supervision and document the outcome of these within the supervision paperwork. As part of this the crisis and contingency plan quality will be checked, and attention paid to any outstanding paperwork within the bi-monthly supervision sessions.
- 5.24 We have therefore graded this action as C being completed in West CMHT, but not yet embedded in practice. We have not received assurance about the implementation of this action across the NAViGO adult services and recommend NAViGO implement plans to do so.
- 5.25 In terms of a residual recommendation to evidence the impact of this action NAViGO must seek assurance that this action is effective in preventing reoccurrence of this service delivery problem through audit of serious incident investigations to ensure that information contained in crisis and contingency plans information is not a recurring contributory factor.

NAViGO action two

Number	Original Report Recommendation	NAViGO Action	Niche Grading
2	CMHT staff to increase their notice period to three months allowing the additional two-month period for a robust handover.	Agenda at Joint Consultative Committee (JCC) meeting. Consultation with staff membership. Update Workforce Policy. Disseminate to all concerned.	E

- 5.26 The timescale for this action was by June 2018. All qualified staff were to be emailed and receive an amendment to their contract letter.
- 5.27 We were informed that a notice period has been to the JCC and approved for all new NAViGO employees, however they were unable to implement this for current employees, although all are requested to work three months' notice.
- 5.28 We have not been provided with the assurance associated with the updated Workforce Policy, a template of the letter to new employees, or the communication with existing staff in relation to working three-month's notice. Our view is that the assurance is not yet available for the implementation or embeddedness of this action and we have therefore graded this as E.
- 5.29 In terms of a residual recommendation to evidence the impact of this action NAViGO must seek assurance across the services that this action is effective in preventing reoccurrence of the associated service delivery problem through audit of serious incident investigations.

NAViGO action three

Number	Original Report Recommendation	NAViGO Action	Niche Grading
3	Review pathways to ensure inter service shared responsibility for joint planning and appropriate team agreements within specific timeframes.	Research best practice examples and possible pathways to include active CC contribution to in-patient care and discharge planning, and pathways for all Specialist Teams, including Forensic teams, Assertive Outreach Teams (AOT).	E

- 5.30 We viewed a transition between inpatient and community mental health services flowchart (undated).
- 5.31 We have not been provided with assurance that the pathways have been reviewed in line with best practice examples to ensure inter-service shared responsibility for joint planning and team agreements within specific time frames.

- 5.32 We have therefore graded this as E as not having enough evidence for the completion of the action.
- 5.33 In terms of a residual recommendation to evidence embeddedness and impact, NAViGO must seek assurance that the reviewed pathways operate within an agree operational policy to address the recommendation.

NAViGO action four

Number	Original Report Recommendation	NAViGO Action	Niche Grading
4	Ensure all interested parties, especially family members are involved in all CPA care planning, review and discharge decision making within the confines of confidentiality.	Brief all teams. Update CPA policy. Ensure evidence of who was invited is included in the CPA review template.	C

5.34 Both the 2017 and the updated 2018 version of the CPA and Non-CPA Care Coordination Policy has a section clarifying that NAViGO will:

- communicate with carers as far as possible and recognise that lack of consent to disclose information should not be a barrier to carer involvement; we are still able to provide general information (not service user specific) and we can listen to a carer's views in these situations;
- identify within all assessments the main carers, their relationship to the service user and their contact details;
- establish what support each carer provides, this may include practical assistance with activities of daily living but may also include assistance with social and recreational activities;
- ensure carers are informed that they may be entitled to an assessment of their own needs and offer to refer for this;
- consider offering an individual support plan for carers or include carer's role in the service users care plan and offer them a copy of this (consent applicable);
- ensure carers know how to contact care coordinators and who to contact out of working hours if necessary; and
- encourage carers to have direct involvement in key decisions such as reviews, discharge from hospital.

5.35 The CPA review section of the Policy clarifies the consent issues further stating that with the service users consent, all those involved in their care will be invited to every review. Where consent is not given the limitations of not including all in a review should be discussed with the service user. In the event that consent is not gained the care coordinator should gain the views of all involved and present this at the review, they should then hold a separate meeting with all involved to ensure that any new plan going forward has the agreement of all services involved.

- 5.36 The service user should be given opportunity to invite whom they want to attend their review; the care coordinator should ensure that they arrange the review at a time agreed with the service user in good notice so that they can prepare for it. The care coordinator should meet with the service user at least a week before a review to establish what their views are, and to assist them in developing a list of what they want to discuss.
- 5.37 The CPA care plan review template has a section to be completed detailing who is involved in the care plan and whether they were invited and attended with a further section to include the views of the carer.
- 5.38 We were informed that a lessons learnt message was communicated to all staff stating that to ensure a robust care package is in place it is important where possible to include family members, and, or significant others and all members of the multidisciplinary team in CPA care planning, review and discharge decision making. Staff must ensure that all invited individuals to CPA review are documented on the template.
- 5.39 We note that the revised CPA Policy makes the recommendation from the internal investigation clear as a reason for review and amendment.
- 5.40 Our view is that the action has been completed and have graded this as C. We advise a residual recommendation for NAViGO to seek assurance through CPA audit and through family and carer feedback that the practice is embedded and having the required impact.

NAViGO action five

Number	Original Report Recommendation	NAViGO Action	Niche Grading
5	When considering discharge, a CPA review must be arranged including, where practicable, all interested parties to enable effective decision making within the confines of confidentiality. This ideally would normally include family members, medical staff and all practitioners that have been involved in the delivery of the care plan. The CMHT discharge checklist could form the basis for this review.	Brief all teams. Update CPA policy. Ensure recommendation is covered in CPA training package. Agree standard checklist when discharge is being considered.	D

- 5.41 We were informed that a lessons learnt email was sent to staff stating that to ensure a robust care package is in place. It is important where possible to include family members, and, or significant others and all members of the multidisciplinary team in CPA care planning, review and discharge decision making. Staff must ensure that all invited individuals to CPA review are documented on the template.
- 5.42 We were provided with the CMHT discharge checklist template which requests information to address the recommendation that a CPA review must be arranged when considering discharge. The template asks whether a discharge CPA meeting was held and if not, what attempts were made to do so.

- 5.43 However, the checklist does not address the recommendation to ensure that the meeting is held with all interested parties. It does not ask for who were invited and attended.
- 5.44 This information is contained in the 'Discharge from CPA' section of the policy and in the care plan review template which states that under no circumstances can agreement for discharge be reached via a telephone conversation, and when considering a discharge, a CPA review must be arranged including inviting all interested parties to enable effective decision making.
- 5.45 The Policy also states that discharge from CPA should never be processed without:
- a CPA discharge meeting which enables a full discussion with the service user and their carer;
 - a formal review or handover to either 'lead professional' or GP;
 - plans for review or follow-up;
 - a crisis and contingency plan in place;
 - an exchange of relevant information to all concerned, including service user and carers; and
 - completion of the CPA discharge checklist.
- 5.46 The policy also states if a service user is requesting their own discharge then every attempt must be made to hold a CPA review, all people currently involved in the care plan must be invited and if they can't attend every effort should be made to gather their views and opinions to feed into the review. The discharge checklist needs to be used to form the agenda for this meeting and all views and options.
- 5.47 We have not been provided with assurance that the recommendation is covered in the CPA training package. We have therefore graded this action as D being partially completed.
- 5.48 We advise a residual recommendation for NAViGO to seek assurance through CPA audit and through family and carer feedback that the practice is embedded and having the required impact.

NAViGO action six

Number	Original Report Recommendation	NAViGO Action	Niche Grading
6	Where CPA needs are identified, the care coordinator is to be involved in patient care plans.	Process to be embedded in acute and community pathways. Update CPA policy.	D

- 5.49 We found the CPA Policy included involving the care coordinator in patient care plans, however we have not been provided with assurance that this process is embedded in acute and community pathways (see recommendation 3).
- 5.50 We have therefore graded this as D being partially complete.

5.51 In terms of a residual recommendation to evidence embeddedness and impact, NAViGO must seek assurance that the reviewed pathways operate within an agree operational policy to address the recommendation.

NAViGO action seven

Number	Original Report Recommendation	NAViGO Action	Niche Grading
7	Crisis and community teams to review how they record and respond to all communications from family members/carers and other parties. This has to be in line with patient confidentiality; however, confirmation of action taken needs to be communicated.	Review current record keeping policy.	E

5.52 We were informed that a lessons learnt email was sent to all staff about concerns raised by family members, and, or interested parties and linked this communication to the findings of the internal investigation.

5.53 The communication stated that any conversation with a service user's family, or carer, either face to face or over the phone, must be documented on the electronic care records system and to ensure these are easily identified they must be documented using the drop down option of 'liaising with professions, and, or family'.

5.54 An audit of one month's calls took place between December 2017 and January 2018 which NAViGO have determined will now take place quarterly on a rolling basis.

5.55 The audit indicated that there had been five recorded family, and, or friend calls to crisis and all were recorded on the electronic care records system but did not clarify whether these were recorded in the relevant drop-down option. Additionally, staff told us that they would record this information in the progress notes.

5.56 We have not been provided with further audit or the assurance associated with the review of the record keeping policy and as a result, despite the email sent to staff, and the audit of five cases, we have graded this E being not enough evidence to say that the action is completed.

5.57 In terms of impact, we advise a residual action of seeking feedback from family and friends as part of the rolling audit process.

NAViGO action eight

Number	Original Report Recommendation	NAViGO Action	Niche Grading
8	The use of the risk management tool needs to be reviewed to ensure it is effective.	Review evidence base for use of standardised risk assessments and how the risk management tool will integrate with the risk summary document.	D

- 5.58 We viewed a specific review of suicide risk assessment tools used within NHS mental health services with the aim of developing a comprehensive understanding of how suicidality risk assessment tools are utilised throughout mental health provision in the NHS and to review their representation in academic literature.
- 5.59 NAViGO currently employ the use of a risk assessment and management system called DICES²⁴ and are implementing a further system called CAMS²⁵ which is recommended for use in adult suicide risk assessment.
- 5.60 The report reviewed DICES and recommended that NAViGO should continue to use this in risk assessment processes for a period of 24 months, whilst CAMS is embedded within mental health services. At the 24-month stage NAViGO will re-evaluate as to whether continuance of the use of DICES is worthwhile to the services, and most importantly service users.
- 5.61 We found that this review was specific to the utilisation of suicide risk assessment tools and did not address the action to assess standardised risk assessments and how the risk management tool would integrate with the risk summary document.
- 5.62 This is an important consideration, specific to the learning from the internal investigation where this is explicitly linked with recommendation one.
- 5.63 We therefore graded this as D being partially completed. The impact of this action is also linked to recommendation one. In terms of a residual recommendation to evidence the impact of this action NAViGO must seek assurance that this action is effective in preventing reoccurrence of this service delivery problem through audit of serious incident investigations.

NAViGO action nine

Number	Original Report Recommendation	NAViGO Action	Niche Grading
9	Community consultant psychiatrist to attend weekly access meeting.	Job planning meeting.	C

- 5.64 We were informed that an audit of the weekly CMHT access meeting minutes between October 2018 – January 2019 showed that of the 17 access meetings the CMHT consultant psychiatrist attended 14; missing one due to sickness and two due to annual leave.

²⁴ The DICES® acronym is a registered trademark used by APT, the Association for Psychological Therapies, in risk assessment and management in mental health. It stands for:

- Describe the risks;
- Identify all the possible options;
- Choose your preferred option;
- Explain your choice;
- Share the decision with others.

²⁵ The CAMS framework is a clinical philosophy of care and stands for Collaborative Assessment and Management of Suicidality

- 5.65 We have graded this as C, complete. In terms of assurance of the action being embedded we would expect to see the outcome of the job planning meeting reflected in the job planning template, and evidence that the medical input into complex case discussions is covered during leave and other absence.
- 5.66 In terms of impact we advise that NAViGO seek assurance that this contributory factor to a service delivery problem identified in the internal investigation does not recur through audit of serious incident investigations.

NAViGO action ten

Number	Original Report Recommendation	NAViGO Action	Niche Grading
10	Training in completion of Mental Capacity Act (MCA) documentation to reflect least restrictive options and responding to family concerns.	Commission training.	B

- 5.67 NAViGO are currently working with the CCG and local community social care organisation on developing an annual competency tool for ensuring the competency of all staff.
- 5.68 NAViGO now commission all MCA training from the local community social care organisation. In addition to this they have appointed, on a six-month temporary basis, a member of staff with extensive experience in capacity assessments to assist and advise all NAViGO staff on complex cases relating to the MCA.
- 5.69 We have not been provided with details of the commissioned training; however, we viewed an MCA audit (undated but referred to cases open in 2018) which reviewed a total of 72 cases; 36 from adult services and 36 from older people's services. The audit stated that it would be reviewed in the clinical audit committee and repeated quarterly.
- 5.70 Cases were selected through random sample and focussed on the following:
- the completion of the consent form to include if the clinician had completed the form in full identifying what the capacity to consent was in relation to; either assessment, review, admission or treatment;
 - if the care plan recorded that the service user had capacity to complete the care plan and understand its content;
 - whether capacity was reflected in relevant correspondence;
 - whether the record documented capacity to consent to discharge;
 - the evidence of capacity assessments in the record and the quality of the recording; and
 - recorded evidence of decisions made in the persons best interest.
- 5.71 The audit stated that the consent form has a yes or no tick box in regard to whether the service user has capacity to consent to assessment, review or admission. If it was 'no' then the form prompts the staff member to complete capacity assessment.
- 5.72 The audit highlighted three areas of concern:

- poor adherence to policy regarding updating consent and confidentiality annually, at review and where any change has occurred;
 - little evidence that when a service user is discharged that capacity is considered; and
 - where clinicians did not assess the service user to have capacity, they did not always indicate what was being done thereafter.
- 5.73 Staff told us that the MCA training they receive includes least restrictive options and responding to family concerns.
- 5.74 We graded this action as C, being implemented but not yet embedded in practice. As we have not been provided with evidence of the commissioned training and the assurance provided is only in the form of an initial audit without further audit or clinical audit committee review.
- 5.75 We advise a residual recommendation for NAViGO to seek assurance of the impact of this action through further audit and clinical audit committee review.

Further recommendations from learning lessons report

- 5.76 We were advised that NAViGO produced a separate learning lessons report and produced four additional recommendations and actions concerned with the aftermath of the incident.
- 5.77 We have not reviewed these recommendations or actions as these are not within the scope of this independent investigation.

6 Overall analysis and recommendations

Predictability and preventability

- 6.1 It is our view that the homicide was not predictable. However, our view is that after her last discharge from hospital, there was a foreseeable prospect that service user A would not take oral antipsychotic medication, in full or in part, given the prominent history of observed, suspected and self-reported non-compliance over the previous decade.
- 6.2 This in turn could have been reasonably expected to be associated with a recurrence or exacerbation of psychotic symptoms. Non-compliance was known to have been associated with each of her last four admissions (in early 2008, mid-2015, late 2016 and March 2017).
- 6.3 Again, based on service user A's known presentation when acutely unwell, it was likely that such a symptomatic relapse would have involved persecutory and somatic delusions, and delusions of jealousy, and further that these symptoms would be associated with significant distress and functional impairment on her part, with mistrust towards or disengagement from health professionals and services, and with substantial strain within her key relationships with Keith and her daughters.

- 6.4 Based on service user A's presentation during the year leading up to the homicide (during which she was admitted twice), when less stable or experiencing a clear relapse, it could have been anticipated that delusional beliefs were likely to involve service user A believing, with absolute conviction, that she was being poisoned (by mercury and, or, metals), that her body was affected in multiple ways (and that she was dying), that health staff were acting in concert to harm her, that family members were trying to poison (or kill) her, that Keith was having an affair, and that their daughters were complicit in this alleged infidelity.
- 6.5 It is our view that alternative interventions may have resulted in a different outcome, however we are not able to say this with certainty whether these interventions would have prevented the homicide.
- 6.6 The context of these interventions include:
- staff were not able to access a single, comprehensive summary or overview of service user A's past and recent concerns and presentation to services, including key symptoms, identified risks, relapse signatures, potential safeguarding concerns and third-party concerns. For example, frontline staff were not fully aware that Keith was thought to "collude" with service user A (that is, to support her account by default when seen by staff, e.g. relating to compliance, or recovery), or that he had told others that he felt unable to speak freely to staff in her presence;
 - there were limitations in multi-disciplinary working which exacerbated this lack of collective knowledge of staff relating to risk-relevant clinical issues;
 - a lack of process within the West CMHT to manage allocation of and handover to newly appointed care coordinators (CC); and
 - a lack of response to service user A's daughters concerns (addressed at 4.54).
- 6.7 Our view is that within this context there were aspects of care where different interventions may have resulted in the outcome being different:
- 1) Application of CPA policy
 - 2) Mental Capacity
 - 3) Safeguarding her partner
- 6.8 Firstly, our view is that the application of the NAViGO CPA and Non-CPA Care Co-ordination Policy (ratified June 2009, annual review) to service user A's discharge from hospital in April 2017 and following her request to be discharged from services in July 2017 would have ensured a proper review that complied with the good practice principles reflected in the policy. This would have included a more comprehensive discussion and recording of the relevant issues, including the concerns raised by service user A's wider family and agreement within the multi-disciplinary team about service user A's care plan and the way forward.
- 6.9 Secondly, when the issue of service user A's mental capacity was being considered, our view is that clinicians should have explicitly taken into account

the context of both the nature of service user A's ascribed diagnosis of PDD, especially her morbid or delusional beliefs about her health and about the malign intent and behaviour of health professionals, and her consistent denial of mental health (as opposed to physical health) difficulties, and the well-established historical pattern of non-compliance and disengagement.

- 6.10 We believe that when service user A declined depot medication in favour of oral antipsychotic medication (April 2017), and then requested discharge from mental health services (July-August 2017), this context should have led to further consideration being given to service user A's ability understand the likely consequences of making a decision, and her ability to use, process or weigh up relevant information as part of the process of her decision making.
- 6.11 Thirdly, our view is that there were missed opportunities to safeguard Keith through the application of the NAViGO Safeguarding Adult Policy (ratified March 2011, review October 2018) and a lack of recognition that domestic violence, and or abuse was a risk, given her delusions (see 1.55) and the view that Keith may be 'colluding' with her. By 'colluding' we understand staff thought Keith may be acquiescing with her statements and wishes in order to avoid conflict rather than because he truly endorsed them (and he was not given a space by staff to state his true views if he had wished to do so).

Key decision point 1

- 6.12 On 7 April 2017, prior to service user A being discharged from her fifth admission to hospital (and the third consecutive admission known to follow medication non-compliance) a ward review took place to plan for her discharge. service user A's daughters were not included in the review meeting, having been neither invited or invited to contribute their views and opinion (for example by phone) in advance of or after the meeting, and her allocated CC (4) was unable to attend the meeting as it was short notice.
- 6.13 An undocumented discussion took place between the inpatient consultant psychiatrist and service user A's daughters, stating that in future an MHA assessment could be considered, and a CTO was possible in the event of service user A not complying with her prescribed medication in the community. The daughters have stated they took this to mean that this option would definitely be enacted in event of non-compliance whereas clinicians saw this as an option only, dependent upon circumstances.
- 6.14 It is recorded that inpatient consultant psychiatrist met the daughters on 21 March 2017, but that it is not known if the undocumented discussion took place on this date or on another occasion. The lack of an adequate record makes it impossible to determine how these conflicting understandings came about, and further that the non-involvement of the daughters in the subsequent pre-discharge meeting (on 7 April 2017) meant that an opportunity to clarify this misunderstanding was lost.
- 6.15 We were informed by the inpatient consultant psychiatrist that it is her usual practice to inform patient and relatives about the relevant MHA section if the patient is detained and advise them of their rights especially if they are objecting

to the use of the MHA. This explanation would include the fact that an assessment would always be required prior to any detention under the MHA, which would not be an automatic process, as full details of the patients presentation at the time would need to be considered.

- 6.16 There were no records of a discussion taking place with the CMHT consultant psychiatrist (who would be responsible for MHA and medication issues after discharge) or of the discussion with her daughters, in contemporary records, in the care plan, or in discharge summary paperwork.
- 6.17 Our view is that this suggests poor communication, and secondly very poor record keeping. The lack of a robust CPA review on discharge inhibited such issues being openly discussed, and agreement reached.
- 6.18 On 9 and 14 July 2017 her daughters and sister reported concern about service user A who said she had spoken to the Queen, claimed that the NHS and government were poisoning her, that she was dying as a result of being deliberately poisoned, that she wanted to poison Keith with bleach or weed killer, stating her depot was stopped by services because the metal was poisoning her body and that she was not taking her medication as it was rotting her insides.
- 6.19 We have not found evidence that those making the decision to discharge took into account all possibly relevant issues in the decision-making process. In particular, there is no recorded evidence that the potential impact of recent psychotic relapse, of repeated previous medication non-compliance, of links between psychotic symptoms and mental capacity, of Keith's circumstances or of the views of other relatives were drawn together and appraised.
- 6.20 Furthermore, the staff involved had relatively limited knowledge of service user As recent and prior mental health and service contact, did not have access to a comprehensive summary setting this out, and did not consult with clinicians who might have been expected to be better informed. Therefore, we conclude that the process involved in making the decision to discharge service user A was not demonstrably robust or clinically well-founded.
- 6.21 The discharge process was not halted (by cancelling it) or explored in more detail (by speaking to the CMHT consultant psychiatrist and, or, convening a formal review) despite new and clearly unusual incoming information from several relatives.
- 6.22 The decision was taken by clinicians without adequate knowledge of service user A's recent symptomatic presentation or awareness of the potential difficulties in the relationship between her and Keith (that might have led staff to query the validity of his stated support of her discharge request).
- 6.23 There is no evidence that these staff were in a position to consider whether morbid beliefs (about ill health, deliberate poisoning, or conspiratorial behaviour) might be influencing her decision to make this request, might be affecting her capacity to make such decision, or might suggest that further consideration by services was required before agreeing to the request.

Key decision point 2

- 6.24 Following discharge on 7 April 2017, service user A expressed reluctance to take the prescribed depot. Keith supported staff in the need for this, however it was noted that service user A became angry with him as a result.
- 6.25 On 24 April 2017, when her depot was due, service user A refused consent for this to be administered and she was regarded as having capacity to make this decision. At this time, Keith reported that she was the best he had seen her in years and supported the use of oral medication. We did not find evidence as to how her capacity was assessed.
- 6.26 As CC (4) was not present at the ward review, she was not aware of an intention or plan to consider the use of the MHA should service user A go on to refuse her depot in the community, and following a discussion with the CMHT team manager they decided that to do a MHA assessment was not the least restrictive option, believing that service user A had the capacity to refuse treatment.
- 6.27 We have not found evidence of how this conclusion about her capacity to refuse treatment was reached, nor which potentially relevant considerations were taken into account or which were overlooked.
- 6.28 On 14 June 2017, CC (4) noted 'clear signs of psychotic relapse', notified the CMHT consultant psychiatrist who agreed with CC (4). The CMHT consultant psychiatrist increased the oral antipsychotic medication immediately and arranged an urgent outpatient appointment.
- 6.29 On 22 June 2017, an unannounced home visit, by CC (5), found service user A to be guarded, fixated on body image and her looks. She said she no longer wanted mental health support. CC (5) told us that she had not regarded service user A as deluded or psychotic at this point, although she had noted that service user A had gained weight and her self-care and grooming had declined since she had last seen her.
- 6.30 However, we found that in June 2017 the clinical records made it clear that a diagnosis of PDD had recently been made, that antipsychotic medication had been recently increased to the maximum advisory British National Formulary (BNF) dose, that service user A had a prominent history of non-compliance, that she had recently been changed from a depot to oral medication, and that she had recently deteriorated following a recent relapse that required admission to hospital.
- 6.31 On 22 June 2017, the CMHT consultant psychiatrist undertook an emergency home visit. He felt that service user A was improving, and this was the view expressed by Keith also. The CMHT consultant psychiatrist expected that she would continue to take the prescribed oral antipsychotic medication and that she would improve further.
- 6.32 On 3 July 2017 CC (5) and CC (6) undertook a home visit to service user A and she stated she wished to be discharged from mental health services, supported

by Keith. Service user A was asked to contact the CMHT team manager to discuss this, which she did, and discharge was agreed on 8 August 2017.

- 6.33 We found no record of any discussion between the relevant professionals (care coordinators and CMHT team manager), and although they told us that they had believed that service user A had capacity to make the decision to request discharge, we found no evidence regarding how capacity was assessed, such as which clinical factors were taken into account in reaching this conclusion.
- 6.34 Service user A was recognised to be psychotic when admitted in late 2007 and in early 2008; was prescribed aripiprazole (being used as an antipsychotic) from mid-2008 until early 2017, almost without a break; reported paranoid ideas in late 2011, early 2012, early 2013 and in late 2014; was clearly psychotic when admitted in mid-2015 and in late 2016; was regarded as psychotic when assessed in February 2017 and when admitted in March 2017; and, was regarded as clearly relapsing in June 2017.
- 6.35 At the very least, this history indicates that service user A was prone to relapsing psychotic symptoms, if not exacerbations of symptoms that might never have fully remitted. In any event, the possibility of a relapse or exacerbation (with delusional beliefs) does not appear to have been properly considered by staff at the points when service user A declined depot administration or requested discharge from mental health services.
- 6.36 As part of assessing service user A's capacity to make these decisions at the point she made them, staff involved in her care should have appreciated the longitudinal course, for example, relapsing nature, the nature or content of symptoms, for example involvement of services and Keith in her beliefs, and their functional impact, for example, marked distress, mistrustfulness, and thereby taken into account the ongoing risk of psychotic relapse.
- 6.37 In our view, it would have been good practice for staff to have been more aware and curious about service user A's previously expressed beliefs and concerns, and to have more fully explored (and documented) these areas with her as part of assessing her capacity, especially given the known history of repeated medication non-compliance and the previous admissions association of with this.

Key decision point 3

- 6.38 Records are clear that from 2007 service user A reported a difficult relationship with Keith following a termination of a pregnancy. She felt mentally abused and bullied into the termination by him. We found missed opportunities to take consider safeguarding action during this time period.
- 6.39 In 2012 service user A was still reporting a difficult relationship with Keith and said he was calling her 'fat'. In June 2012 safeguarding concerns were raised in respect of service user A feeling very stressed about looking after her grandchildren. We have not been able to find evidence of the outcome relating to this.

- 6.40 By October 2016 she was threatening Keith, who was described by other family members as 'not a strong person', and in December 2016 the daughter advised that service user A had put rat poison in Keith's drink. Keith was reported as being aggressive, drinking daily and making threats towards service user A, but reporting all was well with her and didn't see a need for input. We found this to be a missed opportunity to take safeguarding action.
- 6.41 In terms of service user A's vulnerability and safeguarding concerns for her, the records state that this was difficult to assess as service user A denied any concerns for her own safety. It was stated that this needed to be explored further when she would hopefully gain some trust to talk to the CHTT in an honest manner. We have not been able to find evidence of this being explored further.
- 6.42 By February 2017, Keith attended Harrison House and self-reported that he had become so frustrated he had hit her on the arm. We found this to be a missed opportunity to take safeguarding action.
- 6.43 However, although detention under the MHA was considered, both service user A and Keith said they wanted home treatment. At the same time, service user A's niece reported that Keith could not speak freely about her in her presence and that he felt guilty if he did. Keith's mother reported that she was very concerned about her son, who had told her that service user A secreted her medication in her mouth, under her false teeth, and then spat it out.
- 6.44 This was supported by service user A's daughter who also added that Keith was becoming suspicious of service user A as she had tried to poison him in the past when she was unwell. He said he was at breaking point and couldn't cope with her anymore yet felt guilty and unable to speak in her presence.
- 6.45 Despite this, on 6 February 2017, Keith agreed to monitor her compliance with medication and on 10,11,12,13 February 2017 claimed that she had taken it, that she was better and doing well up until 24 February 2017 when he was happy for her to be discharged from the CMHT.
- 6.46 Less than three weeks after service user A had, at her own request, been discharged from mental health services, on 14 March 2017 service user A was admitted on Section 2 of the MHA 1983 following deterioration and medication non-compliance, via the CHTT.
- 6.47 During this admission, service user A refused physical investigations, was seen to spit out medication (and was hence prescribed a depot), stated that Keith and her family were plotting against her to kill her by poisoning and believed Keith was having an affair (this affair was reportedly claimed to be with a woman he had a relationship with 20 years previously).
- 6.48 Following service user A's discharge on 7 April 2017 CC (4) and the CMHT team manager discussed the option of using the MHA with the CMHT consultant psychiatrist who did not feel that service user A was detainable, especially as Keith was supporting the use of oral medication and promised that he would supervise her taking it.

- 6.49 However, although we were told that the potential that Keith may be ‘colluding’ with her was known to the team manager, this was not known to the CMHT consultant psychiatrist and was not considered. Despite suspicions on this point, no steps were taken to work around this apparent difficulty, by trying to speak to Keith alone, although CC (4) told us that she provided Keith with CMHT telephone numbers he could ring if he needed to.
- 6.50 Staff told us they did not have any concerns at the time about coercive control, and although there was a general awareness that Keith may have been a controlling element in the relationship, staff were not aware of the extent to which Keith himself felt unable to speak with services.
- 6.51 The CMHT team manager told us that as Keith had the CMHT telephone number and had attended Harrison House in February 2017 without service user A to express concerns about her mental state, that he would have made contact with the services again had he been concerned.
- 6.52 On 13 April 2017 an unannounced CHTT home visit took place in which service user A expressed reluctance to take her depot medication which was due on 24 April 2017). It was reported that Keith supported staff in the need for depot, however service user A became angry with him as a result of this.
- 6.53 On 24 April 2017 service user A refused her depot and requested oral medication. Keith reported she was the best he had seen her in years, and supported use of oral medication.
- 6.54 We found that there were several missed opportunities to take safeguarding action and our view is that both service user A and Keith should have been considered as potential domestic violence victims, and appropriately signposted to services.
- 6.55 We found that neither service user A or Keith were seen separately for a private discussion, no attempt was made to set up such contact, nor were they offered a referral to domestic violence specialist services. Staff told us that, in hindsight, it would have been sensible to do so, but this felt difficult at the time.

Good Practice

- 6.56 On 14 February 2017, a joint CHTT and CMHT visit was planned which we regard as good practice and in line with relevant NICE guidance,
- 6.57 Risk was assessed on 10 April 2017 during a two day follow up hospital discharge review on an unannounced home visit. We view this two-day review after hospital discharge as an example of good practice.
- 6.58 We found the response to the family’s concerns in March 2017 to be good practice in that service user A was assessed and detained under Section 2 of the MHA 1983.

6.59 Service user A was offered medication in line with the NICE Guidance Psychosis and Schizophrenia in Adults: Prevention and Management.²⁶

Care planning

- 6.60 We view the consistent diagnosis of PDD as being an important reference point when considering service user A's care and treatment. In general, this disorder is characterised by one or more delusions that can be very persistent, and this pattern appears to have been the case here. As previously pointed out, delusional beliefs were noted on repeated occasions from late 2007 onwards, and in the three years or so up to 2017 there were repeated instances of service user A evincing delusional beliefs relating to her physical health, to being poisoned, to infidelity, and to family members acting in concert with the aim of harming her.
- 6.61 In summary, our view is that service user A was provided treatment and care in the least restrictive and stigmatising environment possible, however we did not find evidence of how this approach was balanced with the diagnosis of PDD, the associated risks, her history of disengagement with services, non-compliance with medication and the assessment of her capacity to understand the impact of this.
- 6.62 We believe that a more assertive and intensive case management approach could have been considered. Service user A was not seen at all by NAViGO between discharge in June 2015 and re-admission in September 2016, and it is unclear why or how this gap in contact occurred. Our view is that service user A was likely to not be compliant with her medication and disengage from services following her discharge from hospital on 9 June 2015 and 6 October 2016 and she was then seen in the community on several occasions until being discharged from services in February 2017.
- 6.63 At these points in time, our view is that service user A should have been supported by the CMHT under CPA and care coordination until her condition had stabilised before transferring the responsibility for this to the GP under shared care arrangements.
- 6.64 Linked to this view, and not withstanding issues of consent from service user A to share information, we found a lack of appropriate responses to the family's concerns in October 2014 and March 2015. There was a response in February 2017, in that an MHA assessment was undertaken, however our view is that there was a really critical failure to respond to family concerns in July 2017.
- 6.65 Although we viewed risk assessments completed in July 2015, September 2016, February and March 2017 contained information about the issue of non-compliance, we found that service user A was not subject to a formal care planning process under CPA and care coordination.
- 6.66 We found the response to the family's concerns in March 2017 to be adequate in that service user A was assessed and detained under Section 2 of the MHA

²⁶ <https://www.nice.org.uk/guidance/cg178>

1983. However, we found the subsequent CPA discharge arrangements to be unsatisfactory in that the discussion with the daughters about the use of the MHA and a potential CTO was not recorded, leading to a lack of open discussion and agreement about the way forward, and the plan for service user A's care.

- 6.67 We found that an unsuccessful attempt was made to contact the daughter in July 2017 after she had contacted the CMHT SPoA to report concerns that service user A was not taking medication, that she was claiming that someone was poisoning her, and that she had gone to Derby to visit her sister.
- 6.68 The CMHT team manager told us that there was a general awareness between her, CC (5) and CC (6) about Keith's possible collusion with service user A, and they had varying levels of knowledge that he did not feel able to speak freely in front of her, although service user A's niece reported this during the CHTT assessment on 2 February 2017. Staff accepted that Keith would assist in monitoring her medication compliance, accepted his views about this and his reporting of her improvement without questioning him further.
- 6.69 Staff told us that if there were concerns about medication compliance the usual practice would include, checking that the service user had collected their prescription, checking their medication with them, and their carer or family member if supervising, a joint visit with the crisis team, instigating CHTT support, requesting a medical review, and utilising a regular weekly CMHT 'access' meeting for discussion. We found that these practices had all been used in relation to service user A's medication compliance at some point in her care and treatment.
- 6.70 We found that NAViGO had an appropriate Care Programme Approach (CPA) and Non-CPA Care Coordination Policy in place at the time (ratified July 2009, review July 2017) encompassing the standards covered by the CPA, Assessment, Care Planning, Risk, Review, Transitions and Care Co-ordination.
- 6.71 Our view is that service user A required multi-agency enhanced support under the Care Programme Approach with care coordination in terms of needing intensive intervention and support due to posing a high risk, assessment of Keith's carers needs, and potential safeguarding concerns associated with their relationship and with looking after the grandchildren.
- 6.72 We found that there were gaps in providing service user A with enhanced support under the Care Programme Approach with care coordination following her discharge from hospital on 9 June 2015 and 30 September 2016 and on 17 February 2017 when she was discharged from CHTT support.
- 6.73 We found gaps in the care coordinators responsibilities when service user A requested discharge in August 2017 in that a review was not held including service user A, Keith and the multidisciplinary team to establish ways in which service user A's needs had changed and the extent to which the care plan and crisis plan required amending. This review process also did not include taking soundings from her daughters and, or, sister about her wellbeing and soliciting their views about her care.

Risk assessment, management and safeguarding

- 6.74 We found that risk was integrated into care and crisis plans 10 March 2009, 14 July 2014, 1 July 2015, 27 or 28 September 2016, 4 December 2016 and 15 March 2017.
- 6.75 In terms of communication about risk assessment and management, there is evidence that in terms of identified risk on 7 and 14 June 2017 that CC (4) communicated with the CMHT consultant psychiatrist about risk issues noting clear signs of psychotic relapse with the outcome that her medication was increased (the antidepressant was increased on 7 June 2017, and the antipsychotic on 14 June 2017).
- 6.76 The CMHT consultant psychiatrist felt service user A was on the right track to recovery of on 22 June 2017, when he reviewed her in person. He prescribed more medication, and added medication for anxiety, that is, three medication increases and changes in two weeks. The CMHT consultant psychiatrist expected that she would be followed up by her CC booking her in to see him when required.
- 6.77 At no stage in her recent care was there one place in the clinical record that staff could access to gain a full picture of the historical risk. Within the record, we found no evidence that her background history, including recent service contact, was formally reviewed, summarised and documented in her records. This was compounded by poor multidisciplinary working and gaps in knowledge about service user A were not addressed.
- 6.78 Although staff were able to contact various medical practitioners via email or phone when needed, the CMHT did not have consistent and fixed senior medical time allocated to it. A non-medical staff member we interviewed said that discussing cases and risk with doctors could be difficult, in that the CMHT Consultant Psychiatrist had additional clinical commitments, and alternative doctors tended not to be clinically familiar with patients of current concern.
- 6.79 On 6 July 2017 the CMHT team manager told us that CC (5) discussed the issue of discharging service user A at the access meeting on this date. We viewed the minutes of this meeting and found these stated that service user A said telephone contact was preferable as “when people go to see her it makes her worse”. She said she did not want any services and Keith reported she was better without seeing the services and both were stated as knowing how to refer back if she deteriorated. The minutes further stated that it was not therapeutic for NAViGO to see service user A. Discharge was discussed and agreed. Service user A was stated as having capacity and it was noted she was not subject to a CTO.
- 6.80 However, we note that the letter to the GP stating the intention to discharge service user A is dated two days earlier on the 4 July 2017, despite being informed that letters are automatically generated administratively following agreement at access meetings and stated “CMHT agree to end involvement as there are no current mental health concerns.”

- 6.81 Information was not shared with her daughters as service user A requested this information was withheld, however our view is that they didn't feel listened to, and that an approach could have been taken to the discussion of risk and management without breaching service user A's confidentiality. We note that the CPA Policy supports this approach.
- 6.82 Our view is that there were two aspects to not feeling listened to; information not being responded to reliably when they did offer it, and they were not also proactively given the opportunity to provide further information or opinion to staff if they wished (this would not have been a breach of service user A's wish for confidentiality).
- 6.83 There was nothing to stop staff contacting family members to listen to any concerns or information they wished to raise; to respond in general terms about matters of concern without breaching specific confidences); and, to provide direct staff contact details and encourage them to contact services in future if concerned.
- 6.84 It was not just about discussing risk with her daughters, it was also about making sure they had the chance to speak to services around the times of key decision points, such as the proposed discharge.
- 6.85 We found a partnership approach to risk was taken with service user A, however, her sister, son-in-law, mother-in-law and daughters all expressed concerns about this approach and felt that the services did not respond adequately to the risks that service user A posed and to their concerns. They felt that the services could not see that Keith was 'colluding' with her.
- 6.86 We did not find evidence that the partnership approach to risk was balanced with the known diagnosis of PDD, given the nature and degree of delusional beliefs associated with that diagnosis, the associated risks, her history of disengagement with services, non-compliance with medication and the assessment of her mental capacity to understand the impact of this. Poor multidisciplinary working impacted adversely on the collective knowledge staff had about service user A.
- 6.87 We found that NAViGO had an appropriate Safeguarding Adults Policy (ratified March 2011, review October 2018), and a Safeguarding Children Policy (ratified March 2011, review April 2019) in place.
- 6.88 However, we found that the NAViGO Safeguarding Adults Policy did not refer specifically to 'Domestic Violence or Abuse', however we viewed the local authority website which provides appropriate guidance in this area, including working with children.
- 6.89 We found that neither service user A or Keith were asked about their experiences in a private discussion or offered a referral to specialist services. Staff told us that, in hindsight, it would have been sensible to do so, but this felt difficult at the time, however they did not have any concerns about coercive control, although there was a general awareness that Keith may have been a controlling element in the relationship.

- 6.90 On 8 November 2011, 7 February 2012 and 15 May 2012 concerns were noted about her relationship with Keith and the stress service user A felt looking after the grandchildren. There is no record of signposting to domestic violence services or safeguarding action being taken from either an adult or child perspective.
- 6.91 In June 2012, records indicate that safeguarding concerns were logged about service user A looking after her grandchildren. We did not find evidence of this or a safeguarding response to these concerns either in NAViGO or local authority records.
- 6.92 On 13 October 2016 service user A said she was dying, she was threatening Keith and calling her family excessively on the 'phone. On 4 December 2016 her daughter advised the AMHP that service user A had put rat poison in Keith's drink, and her son-in-law was concerned that Keith had been aggressive and making threats towards service user A when he became frustrated with her. We did not find evidence of signposting to domestic violence services or safeguarding action being taken on either of these occasions.
- 6.93 On 1 February 2017 Keith attended Harrison House and reported that she had deteriorated, and that he had become so frustrated with her that he had hit her on the arm. We did not find evidence of signposting to domestic violence services or safeguarding action being taken. Even if, after a safeguarding discussion, such a referral was considered unnecessary, the fact of such concerns should have been clearly documented in her health records. We found no evidence that staff involved were adequately aware of the relationship difficulties that had previously been apparent to, or reported to, services.
- 6.94 We view these as missed opportunities to take safeguarding action and our view is that both service user A and Keith should have been considered as potential domestic violence victims, and appropriately referred to specialist services.

Workplace culture

- 6.95 In summary, our view is that, at the time of the incident, multidisciplinary working was poor, senior medical input to the CMHT was not consistent and gaps in knowledge about service user A were not corrected.
- 6.96 Our view is that the workplace culture was a contributory factor and that within this context there were three key decision points where alternative interventions may have resulted in the outcome being different. These are discussed in more detail in section 4 of the report.

Review of the internal investigation

- 6.97 We viewed the NAViGO action plan and found it to be adequate with the recommendation, details and level of the person implementing the action, the timescale for completion, the resource required, evidence of completion, how lessons could be shared, monitoring arrangements and a rag rated system of the current position.

- 6.98 We note that the internal investigation states that there was “no record of delusional symptoms” between late 2007 and September 2016. We conclude that this was not a correct statement. This is because in February 2008, service user A clearly evinced delusions, and was diagnosed as suffering from PDD. An injectable antipsychotic was prescribed at this point and was replaced by an oral antipsychotic (aripiprazole) in July 2008.
- 6.99 In late 2011, paranoid ideas were recorded, and in early 2012 the dose of aripiprazole was increased because of paranoid ideas. In 2013, the dose was again increased, and in 2014 paranoia was again reported. When service user A was re-admitted in June 2015, delusional beliefs were again recorded and a PDD diagnosis was again ascribed. It is therefore not clear to us why it was concluded that service user A had recovered between late 2007 and 2016.
- 6.100 Although diagnosis of PDD does not exclude symptomatic remission, persistent fluctuating symptoms may be seen as compatible with the clinical picture often where such a diagnosis is made.
- 6.101 The internal investigation report states that no issues of vulnerability over the ten-year care period were raised by members of staff regarding Keith’s relationship with service user A. We found that it is recorded that he alleged she had tried to poison him, that latterly he was reluctant to accept drinks from her as a result, that she had delusions of jealousy, and that she linked him to her mercury poisoning.
- 6.102 Additionally, in June 2015 although the internal investigation states correctly that the admitting doctor did not detect psychotic symptoms, it is clear that there was good evidence of psychotic symptoms (delusions); that the ascribed diagnosis on discharge was PDD, that is, a psychotic disorder and that she was being prescribed a higher dose of an antipsychotic medication.

Recommendations

- 6.103 We have focussed our recommendations on the key decision points where different interventions may have impacted on the outcome, and where the NAViGO action plan has not already addressed the issue, to further improve learning.

Recommendation 1:

NAViGO must review their procedures for safeguarding adults and children, to include domestic violence, against the 2016 NICE Quality Standard (QS116) 2016²⁷ and seek opportunities for specific multiagency training in how to identify and respond to domestic violence, using the learning from this independent investigation to prevent recurrence, and provide assurance through audit.

Recommendation 2:

NAViGO must seek assurance through substantial audit that day to day practice for CPA meet the policy requirements.

Recommendation 3:

NAViGO must commission MCA training which includes attention to the issues of assessing capacity in people where symptoms relating to mental disorder (e.g. delusions or other morbid beliefs) might impair their ability to believe, appraise and weigh up information in the process of coming to a decision and seek assurance that staff understand and apply these principles using the learning from this independent investigation to prevent recurrence.

Recommendation 4:

NAViGO must consider the appropriate guidance and provide assurance that when reviewing CMHT Consultant Psychiatrist job plans that time in the CMHT is reliable and consistent.

Recommendation 5:

NAViGO must implement all the residual recommendations to provide assurance that all actions arising from the internal investigation are now addressed and embedded in practice.

²⁷ <https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-3-Referral-to-specialist-support-services-for-people-experiencing-domestic-violence-or-abuse>

Appendix A – terms of reference

These individual Terms of Reference for the independent investigation have been drafted by NHS England North in consultation and with the agreement of North East Lincolnshire Safeguarding Adults Board.

These Terms of Reference have been developed further in collaboration with the offeror and affected family members.

- The investigation should seek to identify and promote effective learning and improvement action to prevent future deaths or the recurrence of serious harm
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, Police and other support organisations.
- Review NAViGO's internal investigation/ chronology of events and assess the adequacy of its findings, recommendations and resultant action plan.
- Review the progress that NAViGO has made in implementing the action plan associated with their investigation.
- Review the care, treatment and services provided by, the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence.
- Review how NAViGO monitored the perpetrators adherence and compliance to taking prescribed medication. Including;
 - if the perpetrators medication reviews considered the issue of non-compliance
 - if appropriate consideration was given to monitoring, testing and self-reporting processes
 - if the carer's/family concerns relating to medication non-compliance were acted upon appropriately
 - care plans and risk assessments adequately reflected issues of non-compliance
- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments, risk management and appropriate escalation.
- Consider the examination of the assessed needs of the perpetrators care plan with the involvement of the service user.

- Examine the effectiveness of the perpetrators care plan including the involvement of the service user and the family.
- Examine the effectiveness of the communication processes and support Navigo offered to carers and family members with reference to;
 - whether appropriate opportunity was provided to carers and family members to discuss or raise issues and concerns regarding the perpetrators care and treatment including non-compliance with medication
 - how carers wellbeing was supported including if staff identified escalating issues and if appropriate support was offered
 - whether appropriate consultation and adequate support was offered to the carer and family members following the perpetrators discharge from inpatient services in August 2017
 - the review of how information disclosed, in confidence, by family members was relayed back to the perpetrator and if this was appropriate
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Explore whether any aspects of workplace culture potentially impacted on the incident
- Review the effectiveness of governance and quality systems within the organisation, including whether arrangements for identifying and escalating risks, concerns and opportunities for improving quality of the service, were appropriate and embedded in practice.
- Consider the impact of commissioning and accountability arrangements in relation to effective quality monitoring, information sharing and safeguarding.
- Review how NAViGO considered the safeguarding needs of the perpetrators grandchildren, including the assessment of risk to any child in the care of the perpetrator and any risks to the perpetrator in undertaking caring responsibilities
- Examine intelligence and any previous concerns about the quality of care or safeguarding and review the appropriateness of responses with reference to local policies, national guidance and statutory obligations.
- Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement

- Provide a written report to NHS England which includes measurable and sustainable recommendations
- Provide a concise case summary and identify an appropriate mechanism to share the learning opportunities
- Deliver a learning event (Action Planning) for NAViGO and other key stakeholders to share the report's findings and to provide an opportunity to explore and fully understand the intention behind all recommendations
- Assist/support the Provider in developing a robust, measurable outcome-based implementation plan.
- Assist NHS England North in undertaking a brief post investigation evaluation.

Supplemental to Terms of Reference

- Support the Commissioners (CCG) where requested to develop a structured plan for review of implementation of recommendations. This should be a proposal for measurable change and be comprehensible to service users, carers, and others with a legitimate interest.

Appendix B - documents reviewed

1	NAVIGO	Clinical Risk Policy	Version 2: 27 January 2017
2	NAVIGO	CPA Policy	Version 1:10 February 2017
3	NAVIGO	CPA Policy	Version 2: 28 August 2018
4	NAVIGO	SPoA Policy	Version 2.2: 29 June 2017
5	NAVIGO	Duty of Candour Guidance	Undated
6	NAVIGO	MCA Deprivation of Liberty Policy	Version 1.2: 3 July 2017
7	NAVIGO	Mental Health Act Policy	Version 1.5: 13 April 2017
8	NAVIGO	Safeguarding Adults	Version 2.2: 4 July 2017
9	NAVIGO	Safeguarding Children	Version 2.3: 26 July 2017
10	NAVIGO	Extracts from CMHT Access meeting	2017
11	NAVIGO	Internal investigation	31 January 2018
12	NAVIGO	Clinical Notes	
13	NAVIGO	Final Lessons Learnt report	19 February 2017
14	NAVIGO	Integrated Health and Social Care Assessment	15 June 2017
15	NAVIGO)	Annual Reports and Quality Accounts	2015- 2017
16	Primary Care	Clinical notes	Not applicable
17	North East Lincolnshire Local Authority	Social Care Summary Notes	Not applicable
18	Family	Information received from the family	Not applicable

Appendix C – review of the internal investigation

Standard	Source	Met/Not met
Theme 1: Credibility		
The level of investigation is appropriate to the incident	NPSA	Met
The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	NPSA	Partial. Scope did not include a time frame for the chronology.
The person leading the investigation has skills and training in investigations	NPSA; NHSE-SIF	Met
Investigations are completed within 60 working days	NHSE SIF	Commissioned 3/10 completed 31/1= 68 working days.
The report is a description of the investigation, written in plain English (without any typographical errors)	NPSA	Met
Staff have been supported following the incident	NPSA	Met
Theme 2: Thoroughness		
A summary of the incident is included, that details the outcome and severity of the incident	NPSA	Met
The terms of reference for the investigation should be included		Met
The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people.	NPSA	Met
Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	NPSA, NQB	Met
Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	NPSA, NQB	Met
A summary of the patient's relevant history and the process of care should be included	NPSA	Met
A chronology or tabular timeline of the event is included	NPSA	Met
The report describes how RCA tools have been used to arrive at the findings	NPSA	Met
Care and Service Delivery problems are identified (including whether what were identified were actually CDPs or SDPs)	NPSA	Met
Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors)	NPSA	Met
Root cause or root causes are described	NPSA	Met
Lessons learned are described	NPSA	Met. In addition, a separate lessons learned report was developed addressing the aftermath if the incident
There should be no obvious areas of incongruence.	NPSA	Not met. See below.

The way the terms of reference have been met is described, including any areas that have not been explored	NPSA	Met
Theme 3: Lead to a change in practice - impact		
The terms of reference covered the right issues	NHSE SIF	Met
The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	NPSA, NHSE SIF, NQB	Met
Recommendations relate to the findings and that lead to a change in practice are set out	NPSA	Met
Recommendations are written in full, so they can be read alone	NPSA	Met
Recommendations are measurable and outcome focused	NPSA	Not met. Outcomes are in the body of the report. Recommendations are largely transactional.

Appendix C - chronology

Date	Source	Event	Information
28 October 1999	GP notes	Mental state and medication information	Service user A presented with dizziness, feeling weary, depressed, forgetful and tearful. Prescribed Fluoxetine 20 mgs once per day.
13 September 2002	GP notes	Mental state and medication information	The records indicate that service user A was depressed. Dothiepin 75 mgs was prescribed.
21 October 2002	GP notes	Mental state and medication information	Service user A described as still depressed and out of work for eight months, money has run out, single mother with sleep disturbance and poor appetite. Prescribed venlafaxine 75 mgs once per day. A prescription of dothiepin was ceased.
4 March 2003	GP notes	Medication information	Prescribed venlafaxine 75 mgs once per day.
7 June 2003	GP notes	Medication information	Venlafaxine prescription 75 mgs once per day was ceased.
11 June 2003	GP notes	Medication information	Prescribed venlafaxine 75 mgs once per day.
17 July 2003	GP notes	Medication information	Prescribed venlafaxine 75 mgs once per day.
19 August 2003	GP notes	Medication information	Prescribed venlafaxine 75 mgs once per day.
13 October 2003	GP notes	Medication information	Prescribed venlafaxine 75 mgs once per day.
1 November 2003	GP notes	Medication information	Prescribed venlafaxine 75 mgs once per day.
10 December 2003	GP notes	Medication information	Prescribed venlafaxine 75 mgs once per day.
29 January 2004	GP notes	Medication information	Prescribed venlafaxine 75 mgs once per day.
17 February 2004	GP notes	Mental state and medication information	Service user A was described as a 'new patient' and as having a depressed mood. Prescribed venlafaxine 75 mgs once per day.
12 March 2004	GP notes	Medication information	The prescribed venlafaxine was increased to 150 mgs per day.
April 2004	NAVIGO notes	Referral to primary care mental health nurse	Referred by GP to PHCT mental health nurse. "Refusing to leave home for some time. No real factor - crying, not sleeping, not eating, lives alone, no partner ... isolated, unable to cope".
26 April 2004	GP notes	Medication information	Prescribed venlafaxine 150 mgs per day.
3 September 2004	GP notes	Mental state	Service user A was described as being agoraphobic and panicky.
7 September 2004	GP notes	Referral to the mental health team	Service user A was referred to the mental health team. Records indicate that she was to be seen at home by a community psychiatric nurse.

Date	Source	Event	Information
13 October 2004	GP notes	Assessment + medication details + diagnosis	Seen and assessed following referral from the CMHT via the GP. Symptoms include severe anxiety, low mood, tearful, poor sleep with nightmares, appears to be thought blocking and hallucination or psychotic symptoms. Attended A&E with severe panic attack; now feels frightened. Lots of stressors in past from family dynamics and poor relationships. Commenced on citalopram 20 mgs and zopiclone 3.75 mgs. To be re-assessed in 2 weeks. The diagnosis was recorded as being as anxiety state.
17 November 2004	GP notes	Telephone contact + medication details	Did not attend her appointment with the primary care mental health nurse. She was contacted by phone and said she had forgotten however she was feeling no better and had refused to take the citalopram as her daughter's boyfriend had told her that she would feel worse. Advised firmly to commence as the symptoms would not cease on their own. A further appointment was arranged for three-weeks.
21 January 2005	GP notes	Medication review	Citalopram 20 mgs
19 July 2005	GP notes	Mental state + medication details	The records indicate that service user A was getting depressed again. She was advised to consider counselling and to restart the antidepressant medication
26 July 2005	GP notes	Mental state	The records indicate that her mother died 3 weeks previously and that service user A was experiencing a lot of anxiety. She was prescribed diazepam 2 mgs twice per day.
14 October 2005	GP notes	Medication details	Citalopram 20 mgs
8 February 2006	GP notes	Mental state and medication review	The records indicate that service user A was experiencing panic attacks. Citalopram 20 mgs and Diazepam 2 mgs twice per day.
25 October 2006	GP notes	Mental state + alcohol, abuse and medication information	Records indicate that service user A was tense and afraid to go out. Drinking 42 units of alcohol per week. Citalopram 20 mgs. She was referred to the community mental health team.

Date	Source	Event	Information
8 January 2007	GP notes	Assessment by?	Service user A was seen and assessed. She was low in mood, extremely anxious, had problems with accommodation, and stated that she hears voices telling her to kill but she was very vague about when this occurs or what exactly occurs. Query - intrusive thought processes? States that she is not sleeping, lots of psychosomatic symptoms plus anxiety symptoms present and she was quite agitated. She stated that her medication is not working. Her medication was changed to mirtazapine 15 mgs. To be seen again in two weeks to continue the assessment
5 February 2007	GP notes	Assessment by?	Service user A was seen and assessed. She was not compliant with medication, she remained much the same, was firmly counselled regarding her non-compliance and she agreed to take the medication. She was reported as not being so low in mood and no longer hearing voices. To be seen again in four weeks for counselling
23 February 2007	GP notes	Details of accommodation problems + medication details	Mirtazapine 30 mgs. Records indicate that she needed a change of residence as a young family lived nearby playing loud music and she was experiencing a lot of stress as a result. A letter was to be forwarded to the council in support.
7 September 2007	NAVIGO notes	Pregnancy	Seen with severe abdominal pain, bloody vaginal discharge, and positive pregnancy test (confirmed by scan). "Unsure" about whether to continue pregnancy. 6 weeks amenorrhoea.
3 October 2007	NAVIGO notes	Pregnancy	Reviewed in the pregnancy assessment clinic. She wanted to keep the pregnancy, but her partner wanted her to terminate it, Unable to make an informed decision due to her anguished mental state.
17 October 2007	NAVIGO notes	Pregnancy	Termination of pregnancy.
22 October 2007	GP records	Mental state	Following a termination of pregnancy, she said she regretted having this, and wanted medication to stop her thinking about it and getting depressed. Prescribed citalopram 20 mgs.
24 October 2007	GP records and NAVIGO notes	Referral to primary care mental health services	Referred to primary care mental health services for an assessment.

Date	Source	Event	Information
2 November 2007	GP records and NAViGO notes	A&E attendance + CHTT referral	Service user A had been self-harming the previous week (had superficial scars on her forearm), felt like ending it all. Records indicate that she tried to get off the bed in theatre, and the nurses allegedly forced her back telling her that she was 45 years old and "you don't want any more kids". GP referred her to the crisis team.
3 November 2007	NAViGO notes	Mental state	Very upset, reporting bleeding and abdominal pain. "Obviously very distressed regarding the termination"
5 November 2007	GP records and NAViGO notes	Seen by crisis team	Tearful, low mood: "informed us that she was mentally abused by her partner to terminate a pregnancy ... he is now saying they can try for another baby. J feels that a new baby would help to solve their difficult relationship ... stopped taking her [antidepressant] as she felt she did not need it ... has also self-harmed with a [blade] causing superficial cuts to forearms due to the feeling of guilt". Offered short-term support via HIV's.
7 November 2007	GP records	Risk assessment	Risk was assessed following a GP referral to the CHTT team. Records state that service user A had self-harmed with the Stanley knife blade causing superficial cuts to forearms you to feelings of guilt about the termination of pregnancy. The plan of care was to offer service user A short-term support in the form of a once a week home visit, and to discuss antidepressant medication with her GP.
7 November 2007	NAViGO notes	Care planning	A letter to the GP from the community practitioner in the CHTT team contained a plan of care following a GP referral assessment.
11 November 2007	GP records	Out of Hours assessment	The assessment was a physical one as she complained of bleeding post termination of pregnancy. The records indicate that "she felt very traumatized by the whole business, felt bullied by her partner and hospital staff – having counselling".
12 November 2007	NAViGO internal investigation	Follow up appointment offered	Cancelled by service user A
14 November 2007	NAViGO internal investigation	Follow up appointment offered	Cancelled by service user A
17 November 2007	NAViGO internal investigation	Follow up appointment offered	Cancelled by service user A
18 November 2007	NAViGO internal investigation	Follow up appointment offered	Attempt to see service user A in GP unit. service user A refused to engage

Date	Source	Event	Information
21 or 22 November 2007	GP records + NAViGO internal investigation	Assessment + medication details	Service user A still didn't feel right physically, felt as if she was burning up and felt like passing out. Records indicate that she was not keen on taking the medication advised by the crisis team. She didn't want an examination, but agreed to blood tests and if these were clear said she would take antidepressants. NAViGO's internal investigation indicated that Keith had arranged private counselling.
26 November 2007	NAViGO internal investigation	Follow up appointment offered	Visit offered but declined.
2 December 2007	NAViGO internal investigation	Follow up appointment offered	Visit declined. Home visit arranged for 4 December 2007.
4 December 2007	NAViGO internal investigation	Home visit	Declined.
5 December 2007	NAViGO notes	Gynaecology admission	Admitted because of "post termination of pregnancy regret syndrome and depression".
7 December 2007	NAViGO notes + internal investigation	Gynaecology admission	Seen on the medical ward, very anxious, outpatient appointment booked for 11 December 2007. Around this time she was also seen by a consultant (Obstetrics and Gynaecology) noted "she opened up and claimed that she was forced to have a termination by her partner and was full of regrets and our impression was of post termination of pregnancies syndrome".
8 December 2007	NAViGO notes	Gynaecology discharge	She took her own discharge against medical advice.
9 December 2007	GP records	Out of Hours assessment centre information + diagnosis	Service user A complained of a burning sensation in her vagina and stomach, pain in her hips and feeling generally unwell. She felt that everyone was covering up a misdiagnosis. The records indicate that she was previously on antidepressants, and that it was likely she was experiencing psychosomatic pains. The diagnosis was recorded as anxiety state. She was advised to see her GP.
10 December 2007	GP records	Assessment	Service user A told the GP that her stomach must have ruptured as she was in tremendous pain. She was referred to the primary care mental health nurse and was to start taking Citalopram.
11 December 2007	NAViGO internal investigation	Follow up appointment offered	Service user A cancelled the appointment. Concern raised about her non-engagement. Service user A was adamant that she was physically unwell.
12 December 2007	NAViGO notes	A&E attendance	She attended A&E feeling unwell.

Date	Source	Event	Information
12 December 2007	GP records	GP out of hours centre assessment	Service user A was seen with Keith and daughter. She refused to accept that there was nothing wrong with her, would not take antidepressants, did not want to be referred to counselling or the crisis team.
14 December 2007	GP records	A&E attendance	Service user A was seen in Grimsby A&E. She was requesting to see the CHTT but did not wait for treatment.
14 December 2007	NAVIGO internal investigation	Detention	Records indicate that an assertive home visit led to a mental health act assessment and sec 2 of the mental health act. She was reported as being suspicious, believed her family were trying to poison her, medication was poison, suicidal thoughts. "First mention of partner colluding with service user A".
17 December 2007	GP records	Discharge + diagnosis + medication details	Records indicate that service user A was discharged from hospital, that the diagnosis was a psychotic disorder and that she was prescribed mirtazapine 15mgs and olanzapine 10 mgs.
17 December 2007	NAVIGO notes	Discharge + diagnosis + medication details	Discharged. Diagnosis: "acute xxx [transient?] psychotic disorder (with associated acute stress). F23.XI". Prescribed olanzapine 10 mg and mirtazapine 15 mg.
17 December 2007	NAVIGO notes	CPA and care planning	A care plan as part of the CPA was recorded which contains a summary section describing the circumstances of her discharge from hospital with a 7 day follow-up from the CHTT team. This was not signed by service user A.
18 December 2007	NAVIGO internal investigation	Home visit	"delusional"
20 December 2007	NAVIGO internal investigation	Home visit	"Remains deluded in thoughts around medication harming her, concerns about risk of non-concordance with medication regime."
21 December 2007	NAVIGO internal investigation	Home visit	Failed.
23 December 2007	NAVIGO internal investigation	Home visit	Declined.
23 December 2007	GP records	GP out of hours centre assessment	Service user A was feeling dizzy and sick, very anxious and stressed, worried if she had jaundice. Advised to see her GP.
24 December 2007	NAVIGO notes + internal investigation	Home visit	Declined. Agreed to contact the team if needed.
27 December 2007	NAVIGO internal investigation	Home visit	Declined stating that she was taking medication regularly and was feeling better

Date	Source	Event	Information
29 December 2007	NAVIGO internal investigation	Telephone contact	"fixed on physical health needs". Seen in A&E. After discharge, non-concordant with antidepressant and antipsychotic medication, and disengaged from Crisis Team.
8 January 2008	NAVIGO internal investigation	Mental state information	Service user A stated her mood was stable.
10 January 2008	NAVIGO internal investigation	Telephone contact	Arranged to visit 14 January 2008.
14 January 2008	NAVIGO internal investigation	Home visit	Service user A declined the visit. Concerns about disengagement raised, arranged urgent out-patient appointment, family agreed to bring her.
15 January 2008	NAVIGO internal investigation	Outpatient appointment	Attended. Not deluded or anxious.
17 January 2008	NAVIGO notes	CHTT Consultant assessment	"appears that J had a brief stress induced psychotic episode and needed [admission] ... Since then J has been reasonably stable in the community ... There were some issues regarding her relationship with her partner ... she is staying with her in-laws at present". She complained of dizziness, and olanzapine was stopped.
17 January 2008	NAVIGO notes	CPA and care planning + diagnosis	A GP letter from the consultant psychiatrist contains a care plan with details about her medication, care coordination and follow up with CHTT contact. The diagnosis was recorded as acute (transient?) psychotic disorder with associated stress F23.XI.
21 January 2008	NAVIGO internal investigation	Home visit	Anxious.
23 January 2008	NAVIGO notes + internal investigation	A&E attendance and hospital admission	Admitted to hospital with abdominal pain.
24 January 2008	NAVIGO internal investigation	Information about A&E attendance	Delusional and anxious. The CHTT met service user A and Keith. Follow up appointment made for 29 January 2008.
26 January 2008	NAVIGO notes	Information about mental state from GP	Unwell for months, with abdominal burning, thigh discomfort, vaginal discharge. Has had two antibiotic courses for pelvic infection. "Anxious ... thinks going to die".
29 January 2008	NAVIGO internal investigation	Did not attend outpatient appointment. service user A went missing.	Keith concerned about deterioration. service user A went missing. The CHTT contacted service user A on her mobile phone and the police were informed.

Date	Source	Event	Information
2 February 2008	NAVIGO internal investigation	Service user A found	Service user A was found at her daughters "remains delusional, urgent outpatient appointment arranged.
11 February 2008	NAVIGO internal investigation	Did not attend outpatient appointment	Service user A failed to attend. She stated that she was physically unwell, daughter agreed. Plan was to discharge her from CHTT with service user A and her family agreeing to contact the GP if her mental health deteriorated.
12 February 2008	NAVIGO notes	CPA and care planning	A care plan as part of a CPA was completed regarding her discharge from CHTT that day including follow-up arrangements CC details, depot medication details and crisis and home team contact.
22 February 2008	Derby CHTT document in her Grimsby notes.	Detention	Admitted to Derby City Hospital, under section 2 of the mental health act. Service user A had been staying with her sister: "due to thinking her family are against her ... increasingly paranoid / suspicious ... has made repeated threats to kill herself. She feels cameras have been placed inside her and that people are trying to poison her, somatic symptoms like burning pain all over her body, bones disintegrating, lungs, throat and ears bursting out, abdominal pains".
28 February 2008	NAVIGO Internal Investigation	Transfer	Transferred to Grimsby. Went absent without leave.
4 March 2008	NAVIGO notes	Care planning on discharge	. "mental health is still poor, having delusional thoughts about her physical health ... However service user A has not attended the last three urgent OPAs and has refused to engage with staff ...". A GP letter from the clinic to a practitioner in the CHTT team with regards to her discharge contains details of the steps she should take if service user A required any support in the future. This included a telephone helpline, The GP surgery and the primary care mental health nurse and the A&E department or the out of hours GP unit.
20 March 2008	LA notes	S117	S117 aftercare commenced
8 May 2008	NAVIGO notes	Medication on discharge	Service user A was being prescribed risperidone, but did not want to take it because of dizziness. In hospital, she was prescribed olanzapine and then risperidone injection, and was non-compliant with oral medication. She was prescribed citalopram 20 mg daily and risperidone injection 25 mg fortnightly at the point of discharge. Refused depot once she was back in the community.

Date	Source	Event	Information
12 May 2008	NAVIGO notes	Discharge from inpatient care	Discharged from in-patient care. Was being prescribed risperidone, but did not want to take it because of dizziness.
12 May 2008	NAVIGO notes	Information about alcohol abuse	Alcohol abuse noted.
20 May 2008	NAVIGO notes	CPA and care planning on discharge +_ diagnosis	A letter from the SHO to the inpatient consultant psychiatrist contained a discharge plan including follow-up arrangements CC details Depot medication details and crisis and home team contact. Diagnoses: delusional disorder and somatoform disorder. "after transfer she continued to have all these symptoms ... paranoid ideas saying staff had tried to inject something into her to poison her ... a gynae doctor tried to put something into her vagina to harm her ... She had no psychotic symptoms [sic] ... low in mood ...very anxious ... some overvalued ideas with delusions about people trying to poison her ... flight of ideas ..."
17 June 2008	NAVIGO notes	Outpatient medication details	"She felt that something had been done to her body whilst she underwent termination of pregnancy last October 2007. However, this did not have a delusional quality at the time of review". Commenced fluoxetine 20 mg daily.
15 July 2008	NAVIGO notes	Outpatient medication details	Continuing 'somatic symptoms' (pains in body, burning sensation in head), worried, poor sleep, anxious. Commenced fluoxetine 20 mg three weeks earlier. Aripiprazole 15 mg daily added.
17 July 2008	NAVIGO notes	CPA and care planning	A GP letter from the consultant psychiatrist contains management plan with details about the medication, care coordination and follow-up.
26 August 2008	NAVIGO notes	Outpatient medication details	Service user A was reported as having improved since prescribed aripiprazole 15 and fluoxetine 20 mg daily. "not keen on having any input from psychology at the moment as she found her sessions difficult".
26 August 2008	NAVIGO notes	CPA and care planning	A CPA review contains comments from the relevant professionals about service user A's care and treatment
1 September 2008	NAVIGO notes	Risk assessment	Risk was recorded in a letter to the GP from the consultant psychiatrist. She denied any thoughts of harming herself.

Date	Source	Event	Information
18 November 2008	NAVIGO notes	Outpatient information	"No longer complains of a burning sensation in her head or pains in her body ... failed to attend an anxiety management course ... undertaking emotional freedom techniques at the psychology services ...". Mentioned she had gained weight, and asked if this was due to medication. To be allocated new CC due to service restructuring.
19 November 2008	NAVIGO notes	Care planning	A patient review plan report was recorded as part of a letter containing comments on ongoing care by the care team. This consisted of comments made by relevant professionals involved in her care.
17 December 2008	GP records	Referral to Open Minds	Records indicate that service user A was referred and waiting for an assessment.
29 December 2008	GP records	A&E assessment	No further information available.
20 January 2009	NAVIGO notes	CPA and care planning	A CPA patient review plan report was completed with a further review noted to take place in three-months. This review format contained comments written by the professionals involved in her care.
22 January 2009	NAVIGO notes	Care coordination and outpatient medication details	Care coordination transferred. Remains on psychology waiting list. Records indicate that service user A as prescribed aripiprazole 15 mg and fluoxetine 20 mg daily.
2 February 2009	NAVIGO notes	Care planning	A GP letter from the consultant psychiatrist contains a management plan.

Date	Source	Event	Information
10 March 2009	NAVIGO notes	Risk assessment + Care and Crisis plan + diagnosis	A care and crisis plan is recorded, including looking at her problem and needs, the care goal and the standard care components with whom these were assigned to, the duration and the frequency. This also included a risk management plan which indicated that a DICES risk assessment had been completed to enable professionals and manage risks. The information notes that previously when her mental help had relapsed, she became non-compliant with medication and believed it was having an adverse effect on her physical health. Her intrusive thoughts increased with regards to her previous termination which she had not addressed. Historically she experienced suicidal thoughts (although there was no evidence of that) and this was noted as a significant risk. The management plan was to offer her time every two weeks, increase CC visits, and request additional support from the CHTT team. CMHT keyworker/CC 2 sent the GP a copy of the care plan: "has a diagnosis of depressive episodes with somatic syndrome Somato Form Disorder" [sic]. Socially isolated. Intrusive thoughts regarding past termination of pregnancy. History of past medication non-compliance noted - "believing it was having adverse effects on her physical health" at time when mental health deteriorated. Risk of "delusional thoughts" also noted, specifically believing that "medication is having adverse effects on her physical health".
14 April 2009	GP records	Open Minds psychotherapy assessment + risk assessment + alcohol abuse information	This psychotherapist spoke to service user A when she attended Open Minds. Service user A said that she had anxiety and depression and wished to attend the stress control course. She said that she had thoughts of self-harm and attempted self-harm three years ago when she tried to cut her wrists with a knife she was sectioned at this time and admitted to hospital. She said that recently she had been discharged from psychiatry but was still seeing the CC. She said she currently had no thoughts of self-harm or harm to others that she drank approximately six bottles of lager on a Saturday. The impact of this was discussed with her and she said that she would cut this down. She said she did not drink at other times.
27 April 2009	NAVIGO notes	Outpatient information + medication details + care planning information	Outpatient review three weeks after moving into a new flat. Concerned that future psychological work "would make her feel worse" Fluoxetine 20 and aripiprazole 15 mg daily. "Mixed anxiety and depressive disorder. A differential diagnosis of somatoform disorder should also be considered". A GP letter from the consultant psychiatrist contains a management plan.

Date	Source	Event	Information
28 May 2009	GP records	Open Minds discharge	No further information available
14 September 2009	NAVIGO notes	Outpatient CPA review + medication details + diagnosis	Records indicate that she was prescribed fluoxetine 20 and aripiprazole 15 mg daily. Experiences flashbacks of previous termination. "good relationship" with Keith. Diagnosis was recorded as being mixed anxiety and depressive disorder.
17 September 2009	NAVIGO notes	Care planning	A GP letter from the consultant psychiatrist contains management plan
6 October 2009	NAVIGO notes	Outpatient medication details	Records indicate that she was prescribed fluoxetine 20 mg and aripiprazole 10 mg.
6 October 2010	NAVIGO internal investigation + notes	CPA review + medication details + diagnosis	Diagnosis of mixed anxiety and depression, stable for some time, and prescribed fluoxetine 20 mg and aripiprazole 10 mg. Occasional flashbacks re MHA detention, and guilt associated with termination of pregnancy. Regularly seeing psychology. Plan to discharge to GP if still stable at outpatient appointment in 2 months' time.
29 March 2011	NAVIGO internal investigation	Re-referred to CMHT by GP	Re-referred to CMHT by GP due to concerns about low mood, anxiety, weight gain, isolation and disturbed sleep.
20 April 2011	NAVIGO internal investigation	CMHT assessment	To be monitored by 'lead professional' under Non-CPA. Debts.
3 May 2011	GP records	Open Minds information	Service user A was reported as having attended week 4 of the stress control group.
20 May 2011	GP records	Open Minds information	Service user A was reported as no longer being under the care of the CMHT, only attending outpatient appointments with the psychiatrist and that she had stopped attending psychology appointments in October last year. The record indicates that as she hadn't completed the stress control course and had not been in touch regarding any further input from Open Mind they discharged her at this point. They suggested that she considered a referral back to psychology if she wanted counselling.
31 May 2011	NAVIGO notes	Outpatient appointment information	Keith reported she spent much time in bed, and did not bother to do much around the house. "her twin sister has psychiatric problems and is under psychiatric care ... Her father had ? mental illness ? schizophrenia".
23 August 2011	NAVIGO notes	Discharged from Section 117 Aftercare and outpatient medication details	"Discharge from Section 117 Aftercare form". Saw both that day in OPA. "spends her daily routine doing household chores". Aripiprazole 10 mg and fluoxetine 20 mg daily. Latter increased to 40 mg, and former reduced to 5 mg.

Date	Source	Event	Information
October 2011	NAVIGO notes	Assessment by Consultant (Obstetrics and Gynaecology)	Advised hysteroscopy and endometrial biopsy.
8 November 2011	NAVIGO notes	Carers issues reported by daughter	In an outpatient appointment service user A stated that her daughter was very demanding and she was expecting her to look after her grandchild.
8 November 2011	NAVIGO internal investigation + notes	Outpatient medication details + alcohol abuse information	Records indicate that she was being prescribed fluoxetine 40 mg and aripiprazole 5 mg daily. Stated she was taking only half of former, and sometimes forgot; "drinks about 6 pints of beer a day ..." Suspicious of family members and health staff trying to poison her. Focus on physical health, and lack of insight.
December 2011	NAVIGO internal investigation	Care coordination information	Change of CC
7 February 2012	NAVIGO notes	Risk assessment	GP letter from the consultant psychiatrist contains a statement indicating that there were no thoughts of any self-harm or harm to others.
7 February 2012	NAVIGO notes	Potential safeguarding concerns	An outpatient review indicated that "Many of her problems are related to her relationship with Keith. She said that Keith calls her 'fat'. Also said the stress with her daughter has gone (who kept on demanding for service user A to babysit for her children).
7 February 2012	NAVIGO notes	Outpatient medication details + alcohol abuse information	Aripiprazole increased, from 5 to 10 mg daily. Records indicate that she continued on fluoxetine 40 mg: "has not been going out ... panicky and anxious ... some paranoid ideas were present ... GP has prescribed Orlistat ... wanted to increase [aripiprazole] due to increased paranoia and that she is not leaving her house". Service user A denied drinking regularly. For OPA review in 4 months, and anxiety management work.
17 February 2012	NAVIGO notes	Care planning	A GP letter from the consultant psychiatrist contains a management plan.
15 May 2012	NAVIGO notes	Carer issues raised	In an outpatient appointment with consultant psychiatrist ? Service user A was reported as being anxious as her daughter was under mental health services.
22 May 2012	NAVIGO notes	Outpatient information	"No evidence of any major anxiety ... There seems to be issues with her weight and her perception of being "fat" ... requesting to increase her medication [diazepam] ..." To be reviewed "at request of CC".

Date	Source	Event	Information
25 May 2012	NAVIGO notes	CC communication with GP	CC 6, wrote to the GP to state that the CPA / 117 review conducted on 23 August 2011 stated that "service user A is no longer subject to 117 Aftercare Entitlement as agreed by all parties present at the review ... she has returned to our service ... at service user A's request, WE has agreed to continue to be her 'lead professional'".
12 June 2012	NAVIGO internal investigation + notes	Liaison Psychiatry referral to CHTT + medication details + alcohol abuse information + diagnosis	Liaison Psychiatry referred her to CHTT due to increased anxiety and suicidal thoughts, excess alcohol, the recent stress of her daughter living with her, and looking after her grandchildren. Aripiprazole 10 plus fluoxetine 40 mg. Diagnosis is mixed anxiety disorder.
12 June 2012	NAVIGO notes	Care planning	An CHTT Acute Care plan identifying problems, goals client action and assessor action
12 June 2012	NAVIGO notes	Carer issues raised	In the outpatient appointment OPA with consultant psychiatrist service user A said she been under recent stress with her daughter living with her, and looking after her grandchildren. However cited her children and grandchildren as protective factors.
June 2012	NAVIGO notes	Potential safeguarding concerns	Records indicate that safeguarding concerns were raised and logged regarding looking after grandchildren.
July 2012	NAVIGO notes	Alcohol abuse information	Records indicate that service user A did not engage with offer of help with detox.
October 2012	NAVIGO notes	Financial and gambling issues	Financial worries seemingly related to K's gambling and debts of £50,000 and owing £1,000 water bill.
October 2012	NAVIGO internal investigation	Financial and gambling issues.	Citizens advice recommended for Debt Counsellor and information provided on Gamblers Anonymous. Engagement with Havelock housing support worker to support care planning activity.
October 2012	NAVIGO notes	Outpatient medication details + alcohol abuse information	Appointments hard to arrange. Compliance unclear. Reported reduced alcohol.
8 October 2012	NAVIGO internal investigation		Admits to stopping medication in August. Stressed and admits to increased alcohol intake. Financial worries. Keith advises that service user A stopped taking her medication to follow what her twin sister did and said that it was usual behaviour for service user A to copy her twin.

Date	Source	Event	Information
12 November 2012	GP record + LA notes	Carer support information	The records indicate that carer support was identified, the assessment was started but ended because the 'need changed in accommodation' and 'service delivered as planned'.
12 November 2012	LA notes	New service user - request for assessment	Request for assessment on 17 December 2012
2 February 2013	NAVIGO notes	Carer assessment	Carer's assessment form and Carer's Needs Form completed. Records indicate a "Detailed assessment required" and an application for a Carers Additional Support Service.
5 March 2013	NAVIGO notes	Outpatient medication details	Records indicate that the prescription of aripiprazole dose was increased to 15 mg.
28 March 2013	NAVIGO notes	Potential safeguarding concern	Disclosed financial hardship due to Keith's gambling.
28 March 2013	NAVIGO notes	Outpatient medication details + alcohol abuse information	Records indicate that service user A admitted past but denied current medication non-compliance. Prescribed aripiprazole 10 mg and fluoxetine 20 mg. Disclosed drinking 50 - 70 units per week for previous year. Declined dual diagnosis service.
July 2013	NAVIGO notes	Potential safeguarding concern	Persistent worries over Keith's gambling.
August 2013	NAVIGO Internal Investigation	Information about engagement	Avoided engagement with services.
2 December 2013	LA notes	New service user - request for assessment	Request for assessment on 16 December 2012.
2 December 2013	GP records + LA notes	Carer support information	The records indicate that carer support was identified, an assessment started and that the service was delivered as planned.

Date	Source	Event	Information
12 December 2013	NAVIGO notes	Carer assessment	A NAViGO carers assessment review data form was completed for Keith cited as the main carer for service user A. Brief details of services for the carer were described as information and advice, professional and emotional support with a detailed assessment being required. Keith described his role as supporting his partner who had a diagnosis of severe and enduring mental ill-health resulting in her being very forgetful, anxious, suffering panic attacks, struggling to go out, needing him there most of the time. Due to this he supported her with daily living skills and prompting her to take her medication, financial management, accompanying her to appointments. He described his carers needs as "me time, a break". It was recorded that he had applied for CASS to enable time out to enjoy social activities with friends and family.
6 January 2014	NAVIGO notes	Outpatient medication + diagnosis details	Medication left at aripiprazole 15 mg and fluoxetine 40 mg. Diagnosis: mixed anxiety and depression. Discharged from further follow up.
6 January 2014	NAVIGO Internal Investigation	S117 information	Discharged from S117. S117 Review held. All in agreement to discharge from S117 and from CMHT.
6 January 2014	GP records	Discharge from community mental health services	No further information available.
21 April 2014	GP records	GP out of hours centre assessment	Service user A complained of feeling sick, had a tooth infection and had been taking antibiotics. Advised to see her GP.
7 May 2014	GP records	GP out of hours centre assessment	Service user A complained of feeling unwell, feeling nauseated, that the whites of her eyes had gone yellow, abdominal pain and weight loss. She was upset and wanted to admit herself to hospital. Her sister was concerned that she might have stopped taking her medication (reported as being Aripiprazole) and service user A admitted that she had stopped her medication for the last 3 months but had started again that week. Advised to see her GP.
14 July 2014	NAVIGO notes	Risk assessment	Risk was assessed by the consultant psychiatrist in West CMHT Community follow-up clinic; stated that there was no indication of any risks or intentions to harm herself or others and no risky behaviours present.

Date	Source	Event	Information
14 July 2014	NAVIGO notes	CPA and care planning	West CMHT community clinic follow up letter to GP from Consultant Psychiatrist setting out diagnosis CPA status, care coordination, MHA status, services involved, medication before and after review with reasons for change, progress, on-going cardio metabolic assessment, physical health, MSE, risk assessment, clinical impression, informed consent. Information provided, mental capacity and care plan.
14 July 2014	NAVIGO notes	MCA assessment	MCA assessed in the follow-up appointment in the West CMHT Community clinic - she demonstrated a fairly good capacity to make decisions around her ongoing care. She was able to understand information given, attain it, way on balance and even though she did not agree with the diagnosis she consented to her care plan and she was able to express her view clearly.
August 2014	NAVIGO notes + internal investigation	Referral from Havelock Support Worker and medication details	"Stopped medication and became paranoid". Advised to restart medication (over telephone). New Patient Screening appointment offered as an option to re-engage with Mental Health Services, J agreed to this. J agreed to contact the CHTT if she needed further help.
October 2014	NAVIGO notes	Concern from daughter	Telephone call from daughter to say service user A was not well. She was presenting with abdominal pain and denied any mental health problems.
25 October 2014	NAVIGO notes	A&E attendance	Presented to Grimsby ED with abdominal pain
27 October 2014	NAVIGO notes	Acute outpatient attendance + A&E + acute admission	Outpatient hysteroscopy with biopsy. Was admitted via ED that afternoon with abdominal pain.
29 October 2014	GP records	A&E attendance	Service user A complained of pain all over. The records indicate that this was non anatomical abdominal pain radiating to her whole body (burning).
2 November 2014	NAVIGO internal investigation	Telephone call	Denied any mental health problems. Planned further phone call on 4 November 2014.
4 November 2014	GP records	Referral to the crisis team	No further information available.
14 January 2015	GP records	Alcohol abuse information	An alcohol use disorder identification consumption questionnaire was completed. Service user A indicated that she was teetotal.
20 January 2015	GP records	Medication information	Service user A wanted to reduce her mental health medication; she was offered an appointment to discuss the following week.
27 January 2015	GP records	Medication information	Aripiprazole 15 mgs and Fluoxetine 20 mgs

Date	Source	Event	Information
12 March 2015	GP records	Alcohol abuse information	Alcohol screen. Teetotal.
16 March 2015	GP records	Review. Medication information.	Attended with Keith with intermittent abdominal pain. Anxious on examination. Fluoxetine 20 mgs recorded as twice per day.
8 April 2015	GP records	Medication information	Aripiprazole 15 mgs once per day and Fluoxetine 20 mgs twice per day
18 May 2015	GP records	Medication information	Aripiprazole 15 mgs once per day and Fluoxetine 20 mgs twice per day. Uncollected FP10.
31 May 2015	GP records	A&E attendance and medication information	Attended with Keith. Complaining of abdominal pain, burning and feeling unwell. Anxious and hyperventilating. Said she was not taking any medication. Referred from A&E to GP.
1 June 2015	NAVIGO notes	Concern from daughter	Daughter reported deterioration and that service user A had stopped all medication about 1 year previously. Felt she was being poisoned by medical staff.
1 June 2015	NAVIGO notes	Carer assessment	Carer's needs were assessed as part of a CPA mental-health assessment tool functional assessment. There were no carer needs identified.
1 June 2015	NAVIGO notes	CHTT assessment + admission to hospital and medication details	Seen by CHTT and admitted. Prescribed aripiprazole and fluoxetine. Preoccupied with physical well-being. Daughter reports "thinks everyone is trying to poison her ... when she had an endoscopy, strange gel was used ... was given different antibiotics within a short interval ... strange apparatus was used to take her blood ... the medicals were trying to cover up ... she stopped her medications ... because she believed they were making her physically sick ... pressure of speech and was quite repetitive ... anxious ..."
1 June 2015	NAVIGO internal Investigation	Admission information	Admitted via crisis team, possibly delusional. "Clear paranoid and persecutory delusions". Fixated on physical health, believing staff were covering up illness (despite normal investigations). Daughter stated service user A believed everyone, including all medical professionals, were trying to poison her. Had stopped all medication due to feeling sick. Admitting medical member of staff observed anxiety and depression, but not delusions. Prescribed aripiprazole and fluoxetine.
5 June 2015	NAVIGO notes	Carer assessment	Carer's needs were assessed as part of a CPA mental-health assessment tool functional assessment. There were no carer needs identified.

Date	Source	Event	Information
9 June 2015	NAVIGO notes	Discharge + medication details + diagnosis	Records indicate that after this she saw her GP twice and attended A&E with abdominal pains. Aripiprazole increased to 20 mg, and fluoxetine 40 mg continued. Diagnoses of PDD and somatoform disorder recorded (F29.0 and F45.9).
12 June 2015	NAVIGO internal Investigation	7 day follow up	7 day follow-up. Discharged.
25 June 2015	GP records	Housing issue	Requested to move to ground floor accommodation.
1 July 2015	NAVIGO notes	Risk assessment + CPA functional assessment	Risk was assessed as part of a CHTT assessment due to deterioration of her mental-health, non-compliance with medication, Anxiety and psychosomatic delusional beliefs. Risks were described as non-compliance with prescribed medication, persistent psychometric delusional beliefs and risk of further deterioration if not treated. The clinical opinion was that she would benefit from the short stay in hospital for a period of assessment and medication review. A copy of this assessment was not given to service user A. In addition, a CPA mental health assessment tool was completed on the same day including her current mental health, mental health history, physical health, medication regime, carers needs, daily social and personal living skills, risk and clinical opinion. Both the risk and clinical opinion where the same as recorded on the assessment documentation.
2 October 2015	NAVIGO notes	Physical health information	BMI = 34 (> 25 = overweight, > 30 = obese), weight = 89 kg, height = 163 cm. Ideal weight = 61 kg.
24 November 2015	NAVIGO notes	Physical health information from GP	"Lower abdominal pains, increased frequency of urination, foul smelling urine, aches and pains all over ... has searched on internet and? has some excessive metal in body. Said she felt unwell near stainless steel".
27 November 2015	NAVIGO notes	Physical health information from GP	"Vaginal bleeding with lower abdominal pain ... gushing heavy blood". Advised to attend A&E.
26 January 2016	NAVIGO notes	Physical health information from GP	"Pt and her partner feel that today her symptoms are more physical. Feels cannot walk, no strength. Complained of palpitations". Tachycardic. Advised to attend A&E.
23 March 2016	NAVIGO notes + internal investigation	Concern from daughter.	Daughter called GP: "mum has mental health problems and thinks people are trying to poison her and when she puts phone down, she says she is going to kill herself." Advised that service user A could be brought to the acute site or they could ring the single point of assessment and request an assessment tomorrow if she refuses to attend. No further contact received.

Date	Source	Event	Information
24 March 2016	NAVIGO notes	GP record of discussion with family about their concerns.	GP stated that her partner came and explained that service user A felt she has high levels of mercury in her body ... they feel that the problem is not of her mental health; they have done some tests for mercury which gave results that indicated levels are high.
24 March 2016	NAVIGO notes	GP record of action following the family's concerns.	Service user A was seen in A&E and records indicate that she was in contact with her GP after this between April and September complaining of physical problems, e.g. metal in her body.
12 April 2016	GP records	Discharge information.	GP records refer to 'mental health discharge letter' dated 5 April 2016.
4 May 2016	GP records	Telephone call from service user A	Telephoned GP to request "something to treat her mercury levels".
24 August 2016	GP records	Change of GP request from service user A	Riverside surgery: "is registering with the practice requesting an urgent GP but refusing to tell reception why needs appt ... in surgery with her partner ... looks very anxious ... states she is very poorly but unable to be specific why ... did a home urine test and found some metallic element in her body ... her partner and patient state her illness has not been investigated, it is always put down to mental illness ... will not maintain eye contact, constantly rubbing hands together or rubbing her arms and face, very fidgety ... Barnetby practice asked to fax over her current meds.."
25 August 2016	NAVIGO notes	GP appointment requested by service user A and medication details	Service user A telephoned her GP to request a home visit rather than a booked appointment. The GP did not think there was a clinical need for this, and she later attended. Records indicate that she was "very anxious citing problems in the last 18 months with abdominal pain and leg pain and she had put on a lot of weight. When she is near metallic objects it makes her unwell". Prescribed diazepam 2 mg as necessary up to three times daily.
31 August 2016	GP records	Telephone call from service user A	Telephoned practice manager stating she was very unwell and requiring medication. Stated that a blood test showed metal in her body and that she needed treatment to remove the metal. She then said it was a urine test result. Described as a new patient to the GP, and there is reference to her having moved.
16 September 2016	NAVIGO notes	Carer assessment	Carers needs were discussed as part of a CPA mental health assessment tool. Records state that service user A did not have any carer needs as her children are all grown up and did not live with her and her partner.

Date	Source	Event	Information
22 September 2016	NAVIGO notes	Admission + detention+ medication + diagnosis details	Admitted on 22 September under section 2 of the mental health act in Doncaster having stopped her medication several months earlier. It was reported that the diagnosis was of persistent delusional disorder.
23 September 2016	GP records	GP change	GP change.
27 September 2016	GP records	Detention + admission + diagnosis	Detained under section 2 of the mental health act. Diagnosis persistent delusional disorder.
27 or 28 September 2016	NAVIGO internal investigation + notes	Risk assessment + CPA functional assessment	Transferred to Grimsby (Pelham Lodge). Risk was assessed as part of a CPA mental health assessment tool. The record state that service user A was extremely focused on physical health and displayed significant somatisation. Non-concordant with prescribed medication. Self-neglecting. Not getting out of bed or doing household chores which family's day she takes pride in doing. History of going AWOL from psychiatric units. However, the section entitled to current needs observed state that service user A expressed paranoid persecutory delusions of being poisoned with mercury. The records also advise GPs to refer to DICES risk management plan on Silverlink. Believed she had mercury in her body (due to cracked filled tooth), decline in social functioning, self-neglect (spending most of time in bed, her partner cooking meals). Focussed on physical health, with multiple somatic symptoms. Felt her bones were cracking and veins were collapsing. Anxiety.
27 September 2016	NAVIGO notes	CPA and care planning	CPA mental-health assessment tool completed which included current mental health, mental health history physical health, carers needs, daily social and personal living skills, risk, and clinical opinion.
27 September 2016	NAVIGO internal investigation	Advocacy referral	Referral made to advocacy.
30 September or 6 October 2016	NAVIGO notes + internal investigation	Discharge + medication details + diagnosis	Discharged. The records are not clear about the date of her discharge. The discharge summary indicates that this was on 6 October 2016 with a diagnosis of persistent delusional disorder, and notes that she completely stopped taking aripiprazole "a few months ago ... which triggered this episode ... reported that she was mistreated in Doncaster". Prescribed aripiprazole 15 mg.
11 October 2016	NAVIGO internal investigation + notes	Home visit	Through the door HV: "I'm not well, it's physical". An IAPT referral was received on this date.

Date	Source	Event	Information
12 October 2016	NAVIGO internal investigation	Telephone call with service user A	Claiming physical and not mental problems. Referral made for care coordination.
13 October 2016	NAVIGO notes	Information about mental state and carers concerns	Service user A said she was dying, threatening Keith calling family excessively on the 'phone. Her son-in-law described K as 'not a strong person'. On 4 Dec 2016 her daughter advised the AMHP that service user A had put rat poison in Keith's drink. Her son-in-law was concerned that Keith had been aggressive and making threats towards service user A when he got frustrated with her. Keith was said to be drinking daily. Reports from her son-in-law that she is ringing her grandchildren and telling them she is dying and rings her daughter and other family members often repeating her anxieties to them. Keith was raising his voice at times to express his frustration when J was declining mental health services support.
17 October 2016	NAVIGO internal investigation	7 day follow up information from ward and CHTT	service user A and her partner reporting all was well, sleeping well, mentally well, no low mood, no untoward thoughts or feelings.
18 October 2016	GP records	service user A telephone call to the GP	service user A said she wasn't well enough to attend an appointment to have her new patient checks and collect her medication. She said she could barely walk, but in no pain and nothing specific. She said she would ask her partner to bring her in.
20 October 2016	NAVIGO notes	Medication information	A SAS doctor confirmed that they had recently prescribed fluoxetine 20 mg and increased the aripiprazole dose to 20 mg (to her GP).
27 October 2016	GP records	Telephone call to the GP	Service user A rang again to request her medication. She said she had a cold and could not get in to have her new patient checks and collect her medication.
30 October 2016	NAVIGO notes	Medication details	Records indicate that service user A had recently been prescribed fluoxetine 20 mg and had the aripiprazole dose increased to 20 mg (to her GP).
1,3,11,15,21 November 2016	NAVIGO internal investigation	Follow up information from ward and CHTT	Service user A and Keith reporting all was well, sleeping well, mentally well, no low mood, no untoward thoughts or feelings. Service user A voiced on 15 November that she was feeling embarrassed at being involved with mental health services.
21 November 2016	NAVIGO notes	Discharge from CHTT	Discharge from CHTT.

Date	Source	Event	Information
3 December 2016	NAVIGO internal investigation	Telephone call from concerned son-in-law	Service user A was said to be unwell, stating she was dying, threatening Keith calling family excessively on the 'phone. Advised that the CHTT would visit next day. Son-in-law agreed to contact crisis services if the risks increased throughout evening. Agreed for son-in-law to attend the assessment next day.
3 December 2016	GP records	Home visit + medication details	Medication review undertaken. Aripiprazole 10 mgs and Fluoxetine 40mgs.
4 December 2016	NAVIGO notes	Crisis assessment + alcohol abuse information	A crisis/triage assessment form was completed. Service user A was guarded and delusional. Daughter advised AMHP that service user A had put rat poison in her partner's drink, and that service user A was experiencing suicidal thoughts (which she denied). Son-in-law concerned that her partner had been aggressive towards service user A when he got frustrated with her. Her partner said to be drinking daily. Her daughter and son-in-law state they find medication all over the house and that J has a way of hiding medication in a hole in her tooth to pretend she has taken it. Service user A was asked about the reports from her son-in-law that she is ringing her grandchildren and telling them she is dying and rings her daughter and other family members often repeating her anxieties to them. Her partner denied any concerns for his safety or for service user A's safety. Son-in-law said that her partner had been violent towards J and he had heard Keith making threats about J when he becomes frustrated with him; does believe that still her body has been poisoned with metal, states there is a big cover up by all the doctors. Keith was raising his voice at times to express his frustration when service user A was declining support. Son-in-law also reports Keith to be drinking vodka daily. Service user A didn't want CHTT home visits and didn't turn up to the acute unit as agreed.

Date	Source	Event	Information
4 December 2016		Risk assessment	Risk was assessed as part of a crisis triage assessments following concerns from family members regarding her behaviour. The record states that service user A was at risk of deterioration in her mental health as the family were noticing relapse symptoms. The son-in-law had raised concerns that Keith had been aggressive towards her when he became frustrated with her however service user A denied this to be the case. There were no concerns about self-neglect however she was not attending to her needs as she usually would. She did not express any suicidal ideation or thoughts or plans to harm herself or others and denied being a risk to herself or anyone else. Her son-in-law was concerned that her partner had been aggressive to service user A when he became frustrated and also reported her partner to be drinking vodka daily. Service user A denied any aggressive behaviour towards herself. In terms of her vulnerability and safeguarding, the records state that this was difficult to assess as service user A denied any concerns for her own safety. It was stated that this needed to be explored further when she would hopefully gain some trust to talk to the CHTT in an honest manner.
5 December 2016	NAVIGO internal investigation	Mental state information	Fixated on physical conditions and believes body is being poisoned by metals. Not wanting home visits.
7 December 2016	NAVIGO internal investigation	Mental state information	Did not visit acute unit as agreed two days earlier. Service user A phoned and stated that she felt too unwell physically. Reluctant to agree to a home visit but agreed to contact on 9 December 2016.
8 December 2016	GP records	Medication details	Aripiprazole 10 mgs and Fluoxetine 20 mgs.
9 December 2016	NAVIGO internal investigation	Telephone call follow up	Keith reported all was well and did not see any need for continued input. Keith stated he would contact services if he needed to.
14 December 2016	NAVIGO notes	Concern reported by daughter	Daughter phoned the CMHT SPoA saying that her mother was in a bad way and could not go near anything metallic.
15 December 2016	NAVIGO internal investigation	CMHT SPoA telephone call follow up	The CMHT SPoA Advice Officer phoned service user A. Service user A and Keith said they didn't want further support. CMHT SPoA feedback to Crisis Worker.
1 February 2017	NAVIGO notes	Potential Safeguarding concern	Keith attended the acute hospital site and reported that she had deteriorated, and that he had become so frustrated with her that he had hit her on the arm.

Date	Source	Event	Information
2 February 2017	NAVIGO internal investigation	Mental health act assessment	MHA assessment completed, considered but Keith and service user A requested treatment at home, J agreed to home treatment. Agreed that further MHA assessment to be considered if service user A is not taking medication. Home treatment agreed to visit daily to watch service user A take her medication and ensure she has taken it.
2 Feb 2017	NAVIGO notes	Crisis worker contact with and concern reported by niece and K's mother and medication details	Service user A's niece reported to APA Integrated Advice Officer that Keith could not speak freely about her in her presence and that he felt guilty if he did. Information passed to crisis worker. K's mother reported that she was very concerned about her son, who had told her that service user A secreted her medication in her mouth, under her false teeth, and then spat it out.
2 February 2017	NAVIGO internal investigation	Home visit	Home visit to observe medication.
2 February 2017	NAVIGO internal investigation	Home visit	Visit to check compliance with medication. No further information available.
2 February 2017	NAVIGO internal investigation	Home visit	Visits to check compliance with medication. No further information available.
5 February 2017	NAVIGO internal investigation	Home visit	Staff not allowed in. service user A took medication at door, and then went to kitchen. Crisis worker expresses clinical opinion that she was doubtful whether service user A was ingesting medication.
6 February 2017		Risk assessment + AMHP professional circumstances of assessment report and medication details	An approved mental health professional circumstances of assessment report stated that service user A was referred for assessment under the mental-health act on 2 February 2017 with the outcome that the least restrictive intervention was agreed by all parties as home treatment so that she could be monitored taking her medication. Service user A's daughter called to report that her mother was deteriorating further, she had a history of spitting her medication out, and that Keith was becoming suspicious of her as she had tried to poison him in the past when she was unwell. He said he was a breaking point and couldn't cope with her anymore yet felt guilty and unable to speak in her presence. Daughter phoned to state she is not happy with outcome as she felt it had been agreed that she would be admitted. Service user A did not give permission to discuss the outcome of this assessment with her daughters.

Date	Source	Event	Information
7 February 2017	NAVIGO internal investigation	Home visit	To monitor medication. No further information available.
8 February 2017	NAVIGO internal investigation	Telephone call from service user A to CHTT	Service user A called the CHTT and reported that she had diarrhoea and vomiting. Staff spoke to her partner who agreed to monitor her compliance with medication.
10 February 2017	NAVIGO internal investigation	Information from partner about service user A's compliance	Keith claimed that she had already taken her medication.
11,12,13 February 2017	NAVIGO internal investigation	Telephone calls from CHTT	All calls confirmed that service user A was taking her medication
14 February 2017	NAVIGO internal investigation	Joint CHTT and CMHT visit planned	Service user A was not wanting CMHT input – does not feel that she needs a service.
16 February 2017	NAVIGO internal investigation	Home visit	CHTT attends service user A's home. Service user A is in bed – speaks to Keith who reports that service user A is much better, more active at home and taking her medication.
17 February 2017	NAVIGO notes	Discharge from CMHT written communication with service user A	“as per your telephone conversation ... expressing your wishes to be discharged, your case has been discussed at the team meeting and the decision was made to discharge you from the CMHT back to the care of your GP...”
24 February 2017	NAVIGO notes	CMHT follow up call following discharge	A telephone call to Keith, who confirmed service user A was doing well and that he was happy with discharge.
13 March 2017	NAVIGO notes	Concerns reported by daughters and medication details	Daughters attend Harrison House seeking help, and wanting a MHA assessment at which they are present. Believe service user A is not taking medication and remains delusional about metals. CHTT advised the daughters that they didn't have service user A consent to share information but that they would listen to their concerns.

Date	Source	Event	Information
14 or 15 March 2017	NAVIGO notes	Admission + detention + medication details+ diagnosis	Admitted on sec 2 of the mental health act following deterioration and medication non-compliance, via the Crisis Team. Records indicate that service user A was tearful, anxious, distressed, paranoid about being poisoned with mercury, and believed K was having affair (with a woman he had had relationship 20 years previously). Reportedly isolating herself since previous admission, avoiding metal objects including taps, neglecting personal care and diet. Prescribed flupenthixol decanoate 40 mg four weekly, diagnosis of PDD. Aripiprazole was changed to risperdone after admission, and in hospital was service user A was observed to spit her medication out.
15 March 2017	NAVIGO notes	Risk assessment + CPA functional assessment	Risk was assessed as part of a CPA mental health assessment tool. The record state that service user A was extremely focused on physical health and displayed significant somatisation. Non-concordance with prescribed medication. Self-neglecting. Not getting out of bed or doing household chores which family's day she takes pride in doing. History of going AWOL from psychiatric units. However, the section entitled 'current needs' observed state that service user A expressed paranoid persecutory delusions of being poisoned with mercury. The CPA assessment tool document completed includes the following information "has a diagnosis of persistent delusional disorder ... 5 admissions ... over the last 9 years ... third admission under the mental health act ... has deteriorated over the few weeks and she has been poorly compliant with prescribed medications ... paranoid persecutory delusions of being poisoned with mercury ... no insight ... she avoids metal taps and lights due to her delusional beliefs ... preoccupied by her physical health issues and lies in all day ... firmly believes she is going to die of mercury poisoning ... refuses any physical observations ... reluctant to take [medication] ... self-neglecting the last few months ... not getting out of bed or doing household chores". Aripiprazole was changed to risperdone after admission, and in hospital was observed to spit her medication out.
15 March 2017	NAVIGO notes	CPA and care planning	CPA with details of what to do in a crisis emergency situation with the freephone telephone number. The care plan looked at her current needs in terms of her physical house, her family, her leave arrangements and in terms of the crisis and contingency elements what could happen if she relapsed.

Date	Source	Event	Information
15 March 2017	NAVIGO notes	Carer assessment	Carers needs were discussed as part of a CPA mental health assessment tool. Records state that service user A did not have any carer needs as her children are all grown up and did not live with her and Keith
21 March 2017	NAVIGO notes	Medication details	Because of persistent psychotic symptoms and non-compliance, depot medication was prescribed.
24 March 2017	NAVIGO notes	Section 17 Leave	Granted leave (for up to 5 hours) in company of Keith. This was renewed on 27 March (for up to 8 hours), for a week.
27 March 2017	NAVIGO notes + GP records	Section 17 Leave	Took leave from the ward over the weekend and reported this went well.
27 March 2017	NAVIGO notes	CPA and care planning	First clinical review of her care plan took place with no Record of either service user A or Keith's views. Records indicate that service user A refused to sign this.
28 March 2017	NAVIGO notes	Section 17 Leave	Granted overnight leave and also leave until 31 March.
3 April 2017	NAVIGO internal investigation	Inpatient review	Service user A was much improved and remembers delusions and laughs at them. Referred to the CMHT.
3 April 2017	GP records	Section 17 leave	Section 17 Leave granted
3 April 2017	NAVIGO notes	CPA and care planning	Clinical review of her care plan took place. This review contained service user A and Keith's views and the outcome of the MDT discussion with leave arrangements. This is not signed by service user A. Locum Consultant Psychiatrist 1 discussed Section 2, Section 3 and Community Treatment order (CTO) ... chase up allocation of CC ... to be returned to ward on Friday 7 April to be regraded to informal status ... increase day leave with view to overnight leave ... more settled, less anxious ... flupenthixol decanoate". Granted unescorted home leave until 7 April.
3 April 2017	NAVIGO notes	Medication details	"Discussed prescribed depot medication and discussed boundaries of Section 3 ... service user A understands she has to be concordant prescribed [sic] depot medication. ... flupenthixol decanoate"
5 April 2017	NAVIGO internal Investigation	CC information	CC 4 requesting to arrange to come and meet service user A and advised ward she could not make the CPA review on 7 April 2017. CC 4 calls service user A whilst on leave and arranges to visit at home on 11 April 2017. Service user A was advised regarding recurring of her presentation due to stopping of the medications against medical advice leading to further deterioration.

Date	Source	Event	Information
7 April 2017	NAVIGO notes	Discharge + detention details	Sec 2 rescinded and discharged, and referred for CPA care co-ordination, with CHTT. Family (daughters) were not included in discharge planning process, CC 4 was unable to attend meeting (short notice), and there was no communication with the CMHT consultant. There was an undocumented discussion that included family (daughters), stating that in future a MHA assessment could be considered, and a Community Treatment Order (CTO) was possible in event of medication non-compliance in the community. The daughters have stated they took this to mean that this option would definitely be enacted in event of non-compliance (whereas clinicians saw this as an option only).
7 April 2017	GP records	Discharge summary + diagnosis	Persistent delusional disorder (ongoing episode). Discharge summary includes: "had not been going out of house since discharge ... in October 2016. She also believed that her family was trying to poison her ... metallic objects were interfering with her teeth ... weight loss ... significant deterioration of her social function ... persecutory delusions ... complete lack of insight ... She also described what appeared to be a delusional belief regarding Keith having an affair ... At times she refused to eat, believing she was being poisoned".
7 April 2017	NAVIGO notes	MHA and CTO discussion with family	There was an undocumented discussion that included family (daughters), stating that in future a MHAA could be considered, and a CTO was possible in event of medication non-compliance in the community. The daughters have stated they took this to mean that this option would definitely be enacted in event of non-compliance (whereas clinicians saw this as an option only).
10 April 2017	NAVIGO internal investigation	2 day follow up – unannounced home visit	Service user A had not been answering the phone – no problems identified, she was just about to eat, agreed to visit the acute site later which she did with Keith. Reported all was well, no acute distress observed, and no risks identified.
11 April 2017	NAVIGO internal investigation	Service user A telephone call to CHTT	Service user A called CC 4 to cancel the home visit. CC agreed to visit on 18 April 2017.

Date	Source	Event	Information
13 April 2017	NAVIGO internal investigation	Unannounced CHTT home visit + medication details	Initially service user A was reluctant to admit staff, very brief contact. Expressed reluctance to take depot (due 24 April 2017). Grandchildren present. "Keith supported staff in the need for depot - service user A got angry with him".
16, 17 April 2017	NAVIGO internal investigation	Contact problems for CHTT	No further information available.
18 April 2017	NAVIGO internal investigation	CHTT handover to CC1	Handover to Community CC 4 by CHTT. Service user A reported that things were going well, been going out most days. Service user A voicing concerns about the depot. CC 4 agreed to take her further information on the next visit.
24 April 2017	NAVIGO internal investigation	Home visit by CC4. Medication details + MCA information + mental health act assessment information + assessment of risk	Depot due this date. Refused depot from CC 4 (very anxious about needle) and requested oral medication. Keith reported she was the best he had seen her in years, and supported use of oral medication. Regarded as capacitous. CC 4 discussed with a specialty doctor (part also working in acute services), who advised a mental health act assessment, but then the CMHT team manager advised that this would be least restrictive option, given service user A had capacity to refuse the depot medication. CC 4 notes "service user A is at risk of relapse if she does not take prescribed medication. This is moderate risk considering J's history of non-concordance with oral medication, however Keith states that J is the best he has seen her in many years, and he believes she will manage on oral medication". ESA forms started
25 April 2017	NAVIGO internal investigation	Medication details	Dr 3 (a cover doctor) unwilling to amend treatment "given complexities of case" and advises discussion with a medic who is familiar with the case and Acute Specialist Doctor (Doctor 1) from the ward who knew her, advises that MHA Assessment should be called for (same Doctor that treated her during the last inpatient admission). CC 4 discusses with Team Manager they decided that to do the MHA Assessment was not the least restrictive option and believed service user A had the capacity to refuse treatment. Agreed to refer to CMHT Consultant the next day. Consultant (aware of Doctors opinions from the day before prescribes Aripiprazole Dispersible.

Date	Source	Event	Information
26 April 2017	NAVIGO internal investigation	MCA and medication information	CC 4 e-mails the CMHT Consultant to confirm service user A has capacity to make decision to stop depot. After discussion with CC 4, CMHT Consultant Psychiatrist advised aripiprazole orodispersible 15 mg. Keith agreed to supervise service user A's concordance. CMHT consultant psychiatrist 5 writes prescription for aripiprazole 15 mg daily. This is forwarded to the GP.
28 April 2017	NAVIGO internal investigation	Home visit cancelled by service user A	Service user A cancelled a planned visit, stating she was visiting her father-in-law (who had breathing difficulties).
3 May 2017	NAVIGO internal investigation	Home visit cancelled by service user A	Service user A cancelled re-booked visit, stating she was in bed with a cold.
8 or 9 May 2017	NAVIGO internal investigation	CHTT home visit and medication information	Planned visit at home. Service user A and Keith confirmed she was taking medication. Some anxiety. Slightly odd behaviour, standing just outside door of lounge where others sitting and refusing offer of pen from CC 4. Appeared to be compliant with oral meds. Service user A and Keith both report 'good' mental health. Service user A showed CC 4 medication that demonstrated that she had taken tablets; Keith confirmed this was the case.
15 May 2017	NAVIGO internal investigation	CHTT contact	Reported improved confidence, and said she was experiencing some stress due to helping her daughter (looking after grandchildren, during her house move). Service user A and K had agreed not to tell daughter about stopping depot, and asked CC 4 not to disclose this. CC 4 offered to speak to her daughters about her concerns that service user A was taking on too much. Anxious to reduce contact with mental health services.
18 May 2017	NAVIGO internal investigation	CHTT contact	CMHT consultant prescribes more Aripiprazole. Telephone call to service user A to discuss collection of prescription. Did not follow through planning for break in NAVIGO caravan. Was enjoying looking after her grandchildren over the weekend (presumably 20 - 21 May).
23 May 2017	NAVIGO internal investigation	CC1 contact	Requested a telephone call rather than a home visit whilst her daughter was moving.
25 May 2017	NAVIGO internal investigation	Telephone call monitoring	No further information available.
5 June 2017	NAVIGO internal investigation	Telephone call monitoring	No further information available.

Date	Source	Event	Information
6 June 2017	NAVIGO internal investigation	Home visit cancelled by service user A	Service user A cancelled the home visit, she just wanted PIP forms collecting for CC 4 to complete. Telephone call later in the day confirming CC1 had successfully agreed an extension to the PIP application. Focused on physical health (nausea). CC 4 advised that she was leaving and that a new CC 5 would be being allocated. Agreed to visit the following week.
June 2017			Becoming preoccupied with physical health, talking about mercury poisoning, requesting metal items be left in the hallway, "paranoia" about family members being responsible for past poor relationships with them, preoccupied with thoughts that daughters were siding with Keith's former alleged partner and choosing her over service user A. Described as having minimal insight about this representing potential early warning of relapse. Service user A and Keith confirmed concordance with medication. CC 4 spoke to the CMHT consultant who increased aripiprazole to 30 mg daily and arranged an emergency outpatient appointment. CC 4 left and was replaced by an interim.
8 June 2017	NAVIGO notes	Outpatient medication information	CMHT Consultant Psychiatrist confirms continuation of FPXD 40 mg four weekly and asks GP to increase fluoxetine to 40 mg.
8 June 2017	GP records	Medication details	Records indicate that the GP received the medication details.
13 June 2017	NAVIGO notes	Medication information	Hospital prescription for aripiprazole 15 mg daily. Signed by locum specialty doctor.
13 June 2017	GP records	Medication details	Records indicate that the GP received prescribing advice. Aripiprazole 15mgs. Fluoxetine 40 mgs.
14 June 2017	NAVIGO internal investigation	Telephone call from service user A to CC	Service user A requested a visit. "Paranoid beliefs about metal and Keith returned". Last contact with CC 4.

Date	Source	Event	Information
22 June 2017		Cancelled outpatient appointment + unannounced home visit	<p>service user A cancelled her outpatient appointment, saying she had sickness and diarrhea. On a subsequent unannounced home visit, service user A was found to be fixated on body image and her looks and asked that the CMHT consultant visit her at home. There was then a HV by CMHT consultant psychiatrist 5 accompanied by CC5, who recorded a diagnosis of "persistent delusional disorder". Was anxious about getting a new CC. She said "her trust in doctors had been broken" because she had been detained when she reported she believed she was allergic to some metals (this being the only reason for detention). She was distressed and sobbing throughout and became agitated and pacing when relating how she used to be a beautiful woman but was now ugly, had gained weight and was unattractive to her partner. "her partner informed us that he is tired of reassuring her every minute that what she is thinking is not the case and she keeps repeating the same over and over again ... she feels lonely ...". She said she felt calmer since the recent aripiprazole dose increase and was prescribed prn lorazepam.</p> <p>"... there was clear high amounts of rumination and pre-occupation with her looks and the allergy to metals bordering delusional content [sic] ... is aware of her diagnosis, however, was not accepting it, believing that she does not have a mental illness ... agreed to continue her aripiprazole on a higher dose than it is at the moment ... to continue support from a CC on a regular basis."</p>
22 June 2017	GP records	Medication details	Records indicate that the GP received prescribing advice to increase service user A's medication. Aripiprazole 15mgs. Fluoxetine 40 mgs.
30 June 2017	NAVIGO internal investigation	Home visit information	Failed unannounced home visit (CC 5 absent).
3 July 2017	GP records	Medication details	service user A requested Aripiprazole 10mgs
3 July 2017	NAVIGO internal investigation	Home visit and discharge information	During a home visit by interim CC 5 and new CC 6. service user A stated she wished to be discharged from mental health services (supported by her partner, who stated she had been more settled since the visits were reduced).
4 July 2017	GP records	Medication details	Records indicate that the GP was advised to increase her medication. Aripiprazole 15 mgs twice per day

Date	Source	Event	Information
9 July 2017	NAVIGO internal investigation	Concern reported by daughter	Service user A's daughter contacted the CMHT SPoA to report concerns that service user A was not taking medication, was stating someone was poisoning her, and had gone to Derby to visit her sister. Crisis worker advised that system indicated service user A had been discharged but agreed to contact CC6.
10 July 2017	NAVIGO internal investigation	CC response to daughters concerns	CC6 attempted to contact service user A's daughter. Service user A contacted services (from Derby) and asked CC2 if her daughter had been in touch, stating that her daughters were causing trouble for her, that they did not like her family in Derby, and that they were not happy with her being there. Service user A stated she had not been paranoid for some time, that she was compliant with medication, that she knew she could contact the crisis team, and that she still wanted to be discharged. Service user A's daughter was not contacted back.
14 July 2017	NAVIGO internal investigation	Concerns reported by daughter and CC response	Service user A's sister (in Derby) contacted the CMHT administrator to raise concerns, saying she was shocked at her presentation - having not seen her for two or three years: poor personal hygiene, claim she had spoken to the Queen, claim that the NHS and government were poisoning her, report that she wanted to poison her partner (with bleach or weed killer), stating her depot was stopped by services because the metal was poisoning her body and that she was not taking her medication as it was rotting her insides. After this was passed to CC 6 and the CMHT duty worker, the former made an unsuccessful unannounced home visit. Her partner (by telephone) reported that service user A was fine, and after being advised of sister's concerns he said he had no concerns about these issues (CC 5 noted his collusion as a current risk). After CC 6 then contacted AMHP team for advice, it was agreed to request CHTT support over the weekend (CC 5 advised service user A's sister of this). A duty worker and a student nurse conducted a home visit, with Keith again stating he was not concerned, and with both asserting medication compliance.
14 July 2017	NAVIGO internal investigation	MCA assessment	Assessed in a follow-up appointment in the west CMHT Community clinic - she demonstrated a fairly good capacity to make decisions around her ongoing care. She was able to understand information given, attain it, way on balance and even though she did not agree with the diagnosis she consented to her care plan and she was able to express her view clearly.

Date	Source	Event	Information
15 July 2017	NAVIGO internal investigation	CHTT telephone contact	CHTT telephoned service user A and Keith, and were told everything was OK and that grandchildren were staying.
16 July 2017	NAVIGO internal investigation	CHTT telephone contact	CT telephoned and offered a visit but were again told everything was fine.
17 July 2017	NAVIGO internal investigation	CHTT contact with CC2	The CHTT contacted CC 5 to advise that as service user A and Keith had not wanted MH support over the weekend, they were handing the case back.
17 July 2017	GP records	Medication details	Service user A requested Aripiprazole 15 mgs
18 July 2017	GP records	Medication details	Aripiprazole 15mgs orodispersible
28 July 2017	NAVIGO internal investigation	Contact with CHTT from service user A	Service user A called CMHT to report that everything was OK. Called back and agreed formal discharge.
July 2017		Discharge	When the family voiced serious concerns and signs of early relapse after service user A was discharged in July 2017, a formal risk assessment was not completed, despite the reported change to service user A's condition. This was despite reports that service user A was reported as saying she wanted to poison K with bleach or weed-killer, and that it was noted that service user A was increasingly paranoid about family members, and that she had minimal insight into her 'relapse signatures'.
8 August 2017	GP records	Discharge	Records indicate that service user A was discharged from the community mental health team
11 August	NAVIGO internal investigation	Discharge information	CMHT Team Leader signed a completed discharge checklist.
18 August 2017	NAVIGO internal investigation + LA notes	Service user A call to single point of assessment about her discharge	Service user A called single point of assessment to request confirmation she had been discharged (which was confirmed). LA notes only state "I advised her to call back after 9 am Tuesday."
21 August 2017	GP records	Medication details	Aripiprazole 15mgs orodispersible. Fluoxetine 40 mgs
19 September 2017	GP records	Telephone encounter	Records indicate that a difficult discussion took place. service user A said she had pain everywhere, that she couldn't describe, for months, not sleeping, requesting sleeping tablets. When asked about her mental health she said she was ok. In the end she said she would ring back and book in to see the GP.
22 September			Manslaughter and arson.

Date	Source	Event	Information
17 December 2017	NAVIGO notes	Discharge summary with medication details	Olanzapine 10 mgs and mirtazapine 15mgs. After discharge, non-concordant with antidepressant and antipsychotic medication, and disengaged from Crisis Team.