Independent Investigation

into the

care and treatment provided to Mr. A.T.

by the

Devon Partnership NHS Trust

Commissioned by
NHS South West
Strategic Health Authority

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1. Investigation Preface

This Independent Investigation into the care and treatment of Mr. A.T. was commissioned by NHS South West pursuant to *HSG (94)27.*[1]

This Investigation was asked to examine the circumstances associated with the death of Miss. S. in February 2007.

Mr. A.T. received care and treatment for his mental health condition from the Devon Partnership NHS Trust between 20th October 2006 and 13th February 2007. It is the care and treatment that Mr. A.T. received from this organisation that is the subject of this Independent Investigation.

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

Those who attended for interview to provide evidence were asked to give an account of their roles and to provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the Trust senior management who have granted access to facilities and individuals throughout this process. The Trust Senior Management Team has acted in a highly professional and open manner at all times during the course of this Investigation and has engaged fully with the root cause analysis ethos of the Investigation.

We would like to thank the mother of Mr. A.T. who co-operated fully with this Independent Investigation. We acknowledge her distress and that of her family.

[1] DoH Guidance EL (94)27, LASSL (94) 27

The co-operation of all these individuals has allowed the Investigation to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

2. Condolences to the family of Miss S

The Independent Investigation Team would like to extend their sincere condolences to the family of Miss S. Unfortunately, despite their best efforts neither the Trust nor the police were able to furnish the Investigation with the contact details of Miss S's family and in consequence we were not able to consult them in the course of this Investigation. This is regretted deeply by the Independent Investigation.

3. Executive Summary

3.1 Incident description and Consequences

Summary of Events

At the time of the homicide Mr. A.T. was 23 years of age. He was living at home with his parents[2] and was employed as a civil servant.[3]

Mr. A.T.'s first contact with mental health services as an adult was on 20 October 2006. On this date he presented to the A & E department of the Royal Devon and Exeter Hospital, accompanied by his mother requesting help. He reported that he had driven to the New Forest the previous day with the intention of committing suicide by carbon monoxide poisoning. He had, however, not carried out his planned suicide attempt.[4]

The A & E staff had requested an assessment by the mental health services reporting that Mr. A.T. appeared to them to be psychotic and was talking of wanting to kill "*people and goats*".[5] Mr. A.T. was assessed by the Crisis Resolution Service (CRS) and accepted on to their case load.[6] During a home visit on the same day, it was recommended to Mr. A.T. that he should consult a private Cognitive Behaviour Therapy (CBT) therapist.[7]

The CRS made contact with Mr. A.T.'s GP who prescribed an anti-depressant medication.[8] On the 24 October 2006 Mr. A.T. was assessed at home by the CRS consultant psychiatrist.[9] Mr. A.T. was telephoned next day by the CRS to monitor his mood and mental state. During this call Mr. A.T. indicated that he would prefer to organise counselling via his GP and that he wished to disengage from the CRS.[10]

[2] File 5 p. 10/File 5 page 27
[3] File 5 p.10/File 5 page 27
[4] File 5 Page 10 and Mrs T's statement
[5] File 5 pages 9-12
[6] File 5 page 10
[7] File 5 page 27
[8] File 5 page 27/page 53
[9] File 5 page 28
[10] File 5 page 28

On the 26 October 2006, Mr. A.T. reported to the CRS that he had contacted two CBT therapists. One was unable to accept a referral at the current time, the other was unavailable. At this point the CRS discussed a possible referral to the local Community Mental Health Team (CMHT) with Mr. A.T.[11] However on 30 October 2006, again in a telephone conversation, Mr. A.T. reported that he had been in contact with his employers and they were able to offer him a "full service" including a "psychiatrist and counselling service".[12] Mr. A.T. indicated that he would prefer to take this route and with his agreement he was discharged from the care of the CRS.[13] There is no evidence that Mr. A.T. was ever engaged with any employer provided service.

Two weeks later, 14 November 2006, Mr. A.T. was seen by his GP who recorded that he was "*feeling reckless and is gambling*". Mr. A.T. was identified as being moderately depressed[14] and his antidepressant medication was increased.[15]

Two weeks after this Mr. A.T. was again seen by his GP. He complained about the side-effects of his medication and agreed to a change in medication from Citalopram Hydrobromide to Venlafaxine 75 mgs.[16]

On 8 December 2006 Mr. A.T.'s locum GP referred him to the "Primary Care Mental Health Team"[17]. This was five weeks after he had been discharged from the CRS.

On the 19 December 2006 Mr. A.T.'s anti-depressant medication was increased to 150 mgs by his GP.[18]

[11] File 5 page 28
[12] File 5 page 29
[13] File 2 page 49
[14] File 5 page 4
[15] File 5 page 53
[16] File 5 page 53/55
[17] File 2 page 46
[18] File 5 page 53

The GP's referral arrived at the CMHT on 21 December 2006[19] and on 27 December 2006 Mr. A.T. was sent a standard "opt-in" letter asking him to confirm that he wanted to be seen by the Community Mental Health Team.[20] On 25 January 2007 Mr. A.T. was sent an appointment letter offering him an assessment appointment on 13 February 2007.[21]

On 26 January 2007 Mr. A.T. drove his car into the doors of Barclays Bank, Exeter. He was detained by the police, referred to the CRS and assessed by them later that afternoon. Although there was some inconsistency in what Mr. A.T. told those assessing him the consensus view was that he did not want to kill himself but wanted to be taken into care, either into prison or hospital.l[22] It was reported that Mr. A.T. had been drinking heavily the evening prior to this event.

Both Mr. A.T.'s mother and his GP were concerned about the danger Mr. A.T. posed to himself at this time.[23] It was also noted during this assessment that Mr. A.T. had "lurid fantasies' about butchering people but no specific plans".[24]

On assessment the CRS team concluded: that there was a low risk of completed suicide in short term, that risk would be increased with alcohol consumption, that Mr. A.T. became impulsive and disinhibited when he consumed alcohol, that there were no symptoms of "severe mental illness" and that Mr. A.T. felt medication was not "particularly beneficial".

Mr. A.T. was again accepted by the CRS on to their caseload.[25] He was contacted by phone on 27, 28 and 29 January 2007.[26] The CRS contacted the CMHT who brought forward Mr. A.T.'s appointment from 13 February to 1 February 2007.[27]

[19] File 2 page 51/52
[20] File 2 page 45
[21] File 2 page 37
[22] File 2 page 2/3 & 41/42
[23] File 2 page 41
[24] File 2 page 3
[25] ibid
[26] File 4 page 111
[27] File 2 page 36

Mr. A.T. was assessed at home by the CRS consultant psychiatrist on 30 January 2007[28] and a report of this assessment was sent to the GP on 31 January. This assessment concluded that Mr. A.T. was suffering from "*A partially treated depressive illness on a background of some more dissocial personality difficulties*." It was also concluded that no psychotic features were present.[29]

The importance of alcohol as a factor in increasing risk was noted.[30]

Commenting on the risk to others it was noted: that Mr. A.T. was more likely to be involved in fights when intoxicated, that he had once tried to buy a hand gun while living in Portsmouth, but did not pursue this when he was told the gun was faulty, that Mr. A.T. had reported that he had fantasised about "*taking out" "groups of coloured youths he had seen hanging about"* and that "*in recounting this, there was little emotion, no sense of guilt or remorse.""*[31]

It was recommended that Mr. A.T.'s medication was reviewed by the community psychiatrist.[32]

Mr. A.T. was assessed by a member of the CMHT on 1 February 2007[33] and following a telephone conversation between this member of staff and the CRS on 2 February 2007 it was agreed that Mr. A.T. would be discharged from the CRS caseload and the CMHT would assume responsibility for his care.[34]

The CRS made a telephone call to Mr. A.T. on 5 February 2007 and having established with him that he had "*engaged with the CMHT*" he was discharged from the CRS caseload.[35]

On 2 February 2007 a telephone referral was made to the local addiction service.

[28] File 4 page 111
[29] File 2 page 35
[30] Ibid
[31] Ibid
[32] Ibid
[33] File 2 pages 4 & 23
[34] File 4 page 42
[35] File 4 page 42

Mr. .A.T. was discussed at the CMHT team meeting on 6 February 2007.[36] He was referred to the community psychiatrist for a review of his medication and placed on a waiting list for a care co-ordinator. A more comprehensive "level 2" risk assessment was not deemed necessary.[37]

Mr. A.T. was seen by the CMHT staff member on the 6 February to inform him that he had been placed on a waiting list for a care co-ordinator. He reported feeling more positive about the future and that he was trying to reduce his alcohol intake as he was aware that he was binge drinking.[38]

Mr. A.T. attended his appointment with the community psychiatrist on 12 February 2007 who noted: that Mr. A.T. was feeling depressed and "*had attempted suicide in the past*", that he lacked self confidence, that he had a problem with gambling and that he drank 8 to 10 pints of beer per night and subsequently loses his inhibitions and gets into fights. The community psychiatrist also noted that Mr. A.T. reported feeling *"bad" "for having bad thoughts towards certain people, especially black youths",* that he fantasised about killing them and that he lacked empathy.[39]

Mr. A.T. had reported that he felt his medication was helping and that he had "*found himself happier for past week or so*."

The psychiatrist recommended a referral to the team psychologist to explore the possibility of Attention Deficit Hyperactivity Disorder (ADHD). He also planned to see Mr. A.T.'s mother a month later to explore this diagnosis further.[40]

The advice given to Mr. A.T. at this consultation was:

- to continue with his current medication;
- to stop drinking;
- to keep his appointment with the addiction service;
- to undertake anger management and have a psychological assessment.[41]

[36] File 2 page 23
[37] File 2 pages 7 & 23
[38] File 2 page 23
[39] File 2 pages 26-28 & File 1 page 31
[40] Ibid

On 13 February 2007 Mr. A.T. was arrested on suspicion of the murder of Miss S, a woman he had met earlier the same evening.

Mr. A.T. was assessed under the Mental Health Act (1983) on 14 February 2007 and was deemed "*not sectionable*". He reported no psychotic or depressive features and "*appeared calm and collected and in control of the situation*".[42]

Mr. A.T. was tried and convicted for the murder of Miss S on 20 November 2007. In his sentencing remarks His Honour Judge Cottle commented:

"*I have no doubt that you were, at the time of this killing, suffering from depression and from a psychopathic personality disorder; the experts have agreed about that. However, as the jury have found, it was the excessive consumption of alcohol that night that was the principal trigger for you to act out your violent fantasies*."[43]

Mr. A.T. was ordered to serve a minimum of 15 years imprisonment.

[41] Ibid
[42] File 2 pages 10-12, 24-25
[43] R v A.T page 28

3.2 Background to the Independent Investigation

The HASCAS Health and Social Care Advisory Service was commissioned by NHS South West to conduct this Investigation under the auspices of Department of Health Guidance HSG (94)27.

The purpose of an Independent Investigation of this kind is to review the care and treatment received by the patient in order to establish the lessons that can be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of health services in the future, incorporating what can be learnt from a robust analysis of the individual case.

3.3 Terms of Reference

The Terms of Reference for the Independent Investigation were set by NHS South West. The Devon Partnership NHS Trust and Devon PCT were consulted with regard to the content of the Terms of Reference and did not wish to make any amendments. They are set out below.

1. Review the quality of the health and where relevant social care provided by the Trust and establish if whether this adhered to Trust policy and procedure.
2. To identify whether the Care Programme Approach (CPA) had been followed by the Trust.
3. To identify whether any risk assessments were timely, appropriate and followed by appropriate action.
4. To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records.
5. Review the Mental Health Act assessment process, where applicable.
6. To examine the adequacy of collaboration and effectiveness of communication with any other agencies who may have been involved in the care and treatment.
7. To review the Internal Investigation into the care of Mr. A.T. already undertaken by Devon Partnership NHS Trust and any action plans that may have been

formulated, including any immediate remedial action taken at the time of the incident, or action taken as a result of the Internal Investigation.

8. To consider any other matters that arise during the course of the investigation which are relevant to the occurrence of the incident or might prevent a reoccurrence the public interest may require.
9. To prepare an Independent Report for Devon Partnership NHS Trust, NHS South West and any other relevant bodies.

3.4 The Independent Investigation

Three types of independent investigation are commonly commissioned, these are:

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

Each of these has its own strengths which make it best suited to examining certain cases. The current investigation was commissioned by NHS South West as a type C Independent Investigation.

Main Investigator

Dr. L.A. Rowland	Director of Research, HASCAS Health and Social Care advisory Service.

Peer reviewer

Ms. Helen Waldock	Director of Nursing, HASCAS Health and Social Care Advisory Service.

Support to the Investigation Team

Mrs. Louise Chenery	Stenography and Administration, HASCAS Health and Social Care Advisory Service.

Independent Advice to Panel

Mr. Ashley Irons	Solicitor, Capsticks.

3.5 Findings

Key Causal Factors

The Independent Investigation identified no direct causal factors connecting the care and treatment of Mr. A.T. with the events 13 February 2007.

Contributory Factors

The Independent Investigation identified five factors, listed below, where the care and treatment of Mr. A.T. did not meet best practice standards and contributed to the less than optimal care of Mr. A.T. by the Devon Partnership NHS Trust. It must be noted here that these factors are not deemed to be contributory to the death of Miss. S.

1. Referral, discharge and transfer practices;
2. Assessment and care planning;
3. Risk Assessment;
4. The availability of psychological therapy;
5. The clinical management of Mr. A.T.'s care.

Service Issues

The Independent Investigation identified three Service Issues:

1. Record keeping and the management of clinical notes;
2. The existence, appropriateness and awareness of clinical staff of operational policies;
3. A dissociation between the senior management team and front line staff.

Internal Investigation Process Issues

1. The commissioning of the Internal Investigation including:

- composition of the Internal Investigation team which had an impact on the manner in which the investigation was conducted and the methodology employed;
- the scope of the terms of reference for the Internal Investigation and the preparation of the iinvestigation team.

2. The absence of a mechanism or strategy for the dissemination of learning and engaging clinical staff.

3.6 Conclusions

Mr. A.T.'s mother reported that she had found her son's behavior odd from a very early age. He had been seen by a CPN when he was six years old and his parents had placed him in a boarding school as a child in the hope that the structure there might help him. Mrs. T speculated that her son had coped well socially at school because his older brother looked after him and included him in a social network.

Although Mr. A.T. was reported to be intellectually bright and did well academically at secondary school he failed his first year examinations at university and abandoned his course in his second year.

Mr. A.T. reported that from his mid-teenaged years he had experienced psychological distress. He had cut himself on one occasion and frequently contemplated suicide. In October 2006 he drove to the New Forest intending to commit suicide by carbon monoxide poisoning. He aborted this attempted suicide and returned to his parents' home. His mother took him to the local A & E department and it was at this point that he first came into contact with adult mental health services.

Because of the manner of his presentation Mr. A.T. was seen by the Crisis Resolution Service (CRS). However after the crisis abated Mr. A.T. quickly indicated that he wanted to disengage from the service. The CRS advised Mr. A.T. to seek Cognitive Behaviour Therapy (CBT) via a private route. They had no direct access to psychological services and believed that a referral to psychological services within the Trust would result in a substantial delay in receiving treatment. It was inappropriate for an NHS service, having identified a need that it should reasonably be expected to meet, to direct an individual to a private provider as a first response to meeting that need. The Trust needs to review both the level of resourcing and accessibility of the psychological services and whether the national *Improving Access to Psychological Therapies (*IAPT) initiative meets the needs of people such as Mr. A.T.

Mr. A.T. informed the CRS that his employers could provide him with psychiatric and counselling input. There is no evidence that this help was forthcoming. The view was

formed that Mr. A.T. was at low risk of self harm and that the crisis was related to his consumption of alcohol.

Mr. A.T. was prescribed anti-depressant medication and his mental state was monitored by his GP. Mr. A.T., however, showed no improvement in his mental state and he was referred back to the mental health services in December 2006. This referral was made by a locum GP who addressed it to the Primary Care Mental Health Team. The referral took over two weeks to arrive at the Community Mental Health Team (CMHT) and even then Mr. A.T. was not offered an assessment appointment for over six weeks.

The Devon Partnership NHS Trust policies indicated that a re-referral such as Mr. A.T.'s should have been given some priority and even a routine referral should have been seen within four weeks. Mr. A.T.'s mother has complained about the time it took for her son to be seen and "properly" assessed, by which she meant a full assessment of his needs and mental state with a view to on-going treatment rather than the crisis service offered by the CRS. It would appear that her complaint has some substance.

In the event Mr. A.T. took matters into his own hands and drove his car into the doors of a local bank on 26 January 2007. He was seen promptly by the CRS. Mr. A.T. told those assessing him that he wanted to be taken out of society either into hospital or prison. Once again, as on his previous contact, he had been drinking alcohol and it was concluded that he was at low risk of harming himself but that alcohol exacerbated his problems. The CRS liaised with the community mental health team (CMHT) and his assessment appointment was brought forward by two weeks. As a result of this assessment Mr. A.T. was placed on the waiting list for a care co-ordinator. Mr. A.T. was informed of this and that he could contact the duty worker at the CMHT if he needed help. Although Mr. A.T. was placed on the waiting list for a care co-ordinator the CMHT worker who assessed him was not aware of any criteria against which to evaluate Mr. A.T.'s eligibility for care co-ordination or for secondary mental health services. Indeed staff of both the CRS and the CMHT were unaware of any operational policies governing the work of these two services. This is a weakness which the Devon Partnership NHS Trust needs to address.

Mr. A.T.'s mother believed that her son's mental state was deteriorating and that he needed more intensive assessment and care. His GP felt that he needed an in-patient admission after he had driven his car into the doors of the bank. There were indications that Mr. A.T.'s behaviour was becoming more dangerous. He had informed staff on a number of occasions that he had frequent thoughts of killing or harming people. However Mrs. T. was not included in any assessment of Mr. A.T.'s need or risk, and no comprehensive, multi-disciplinary level two risk assessment was undertaken. No risk management plan was put in place despite the fact that it had been identified that alcohol increased Mr. A.T.'s risk. The Devon Partnership NHS Trust needs to ensure that the families and carers of service users are appropriately and routinely involved in assessment and care planning, with the knowledge and consent of the service user, that clinical staff are clear about when it is appropriate to undertake a comprehensive risk assessment and that risk management plans are drawn up with the service user, particularly when ongoing risk factors are identified.

As has been noted Mr. A.T.'s mother had described her son's behavior as being odd from the time that he was a young child; a number of clinicians noted that there was something unusual about Mr. A.T.'s presentation using terms such as aloof, supercilious, and immature. The CRS psychiatrist suggested that Mr. A.T. had dissocial personality difficulties and the community psychiatrist was exploring the possibility of a diagnosis of Attention Deficit Hyperactivity Disorder (ADHA) However these observations were not drawn together to inform the understanding of Mr. A.T.'s behaviour. Had this been done the significance of various of Mr. A.T.'s behaviours might have been regarded differently. For example Mr. .A.T.'s mother believed that her son used alcohol as a coping strategy to deal with the difficulties he experienced. If she is correct then the advice given to Mr. A.T. to reduce his alcohol intake would not have been helpful in the absence of alternative coping strategies. Diagnosis and proper formulation is a key element in on-going assessment and intervention. The Devon Partnership NHS Trust needs to review the protocols, training and quality of formulation within the organization.

During the two weeks Mr. A.T. was under the care of the CMHT he was referred to the local addiction services and to the psychology service, who offered him a prompt appointment. He was seen by the community psychiatrist on 12 February 2007. He was also seen twice by the CMHT worker, on 1 and 6 February 2007, who appeared to be

co-ordinating his care. She was not allocated the role of care co-ordinator however and the boundaries of her role were unclear. The Devon Partnership NHS Trust has re-organised its services since 2007. The CMHT is now divided into a Well-being and Access and a Recovery and Independent Living team. The former has the assessment and brief intervention function and the latter the care co-ordination function. However the Independent Investigation was informed that due to a lack of resources people are at times retained by the Well-being team who perform unofficial and *ad hoc* care co-ordination. The Devon Partnership NHS Trust needs to review this and ensure that care co-ordination conforms to the most recent guidance.

Mr. A.T. killed Miss S on 13 February 2007. Again Mr. A.T. had been drinking prior to the event and the judge at his trial concluded that it was this, rather than his mental health problems, which triggered his violent behaviour.

A number of areas in which clinical practice might be improved have been identified. Had best practice standards been in place when Mr. A.T. was under the care of the Devon Partnership NHS Trust he would have received a better service. However it has to be acknowledged that Mr. A.T. was under the care of Devon Partnership NHS Trust for only a brief period, 10 days in October 2006 following an aborted suicide attempt, and from 26 January to 13 February 2007, 19 days. He was viewed as being at low risk of harming himself. The level of risk he presented and his disinhibited beahviour were believed to be associated with his excessive consumption of alcohol. Even his mother, who was most familiar with and concerned about her son's mental state, was fearful that he might harm himself, not that he was a risk to others. It is difficult to conclude reasonably that any aspect of Mr. A.T.'s care by the Devon Partnership NHS Trust had a direct causal relationship with his violent behaviour on 13 February 2007.

3.7 Recommendations

Following a review of the care and treatment received by Mr. A.T. from the Devon Partnership NHS Trust the following recommendations have been made.

3.7.1. Issues relating to referral, discharge and transfer.

Recommendation 3.7.1.1.

The Devon Partnership NHS Trust should undertake a review of its policies and practices to ensure that families and carers, where appropriate, are involved in assessment and care planning.

- The current CPA 2 Assessment should be revised to identify **the expectation** that families and carers are involved in assessment and care planning. This should provide information suitable for audit.
- The Devon Partnership NHS Trust should undertake an audit to establish whether families and carers are involved in an appropriate and timely manner. They might consider consulting carers directly as part of the audit and not rely exclusively on clinical notes.
- The Devon Partnership NHS Trust should look at best practice in involving carers exemplified elsewhere.
- The involvement of families and carers should routinely be monitored during supervision.

Recommendation 3.7.1.2.

The Devon Partnership NHS Trust should establish, via audit or survey, that the referral routes into and eligibility criteria for the Mental Health services are clear and easily accessible, and advice is readily available to referrers.

Recommendation 3.7.1.3.

Using both audit and regular supervision the Devon Partnership NHS Trust must ensure that its CPA policy and the guidance provided in *Refocusing the Care Programme Approach – policy and positive practice guidance, (2008)* are followed regarding the transfer of information when a client/patient is transferred between teams.

3.7.2. Assessment and Care planning.

Recommendation 3.7.2.1.

The Devon Partnership NHS Trust should draw up guidelines, in line with best practice, on case formulation.

- Amongst other things this should cover the importance of trait-like characteristic as well as more transient symptomatology, the involvement of the patient and his/her family/carers, and the regular reviewing of the formulation.
- In line with current policy formulations should be consonant with the recovery model and the promotion of well being.
- Where appropriate training should be provided.
- Compliance with the policy should be monitored/audited on a regular basis.

3.7.3. Risk Assessment.

Recommendation 3.7.3.1.

The Devon Partnership NHS Trust Clinical Risk policy should be reviewed.

- It should be brought more in line with the principles outlines in "*Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services"* (Department of Health, 2007).

- The risk policy should more closely align the risk screening tool (level 1) with the in depth risk assessment (level 2). The policy needs to specify that where a risk is identified at the screening stage then an in-depth assessment focusing on the identified risk needs to be conducted and a management plan developed.

- The Devon Partnership NHS Trust should ensure that staff understand when a comprehensive risk assessment is to be undertaken and apply this knowledge consistently. This might be achieved through either improvements in the policy document or in the associated training.

- The Devon Partnership NHS Trust's Risk Management policy should be structured to reflect the functions of the various teams e.g. Crisis Team, CMHT etc.

- The Devon Partnership NHS Trust needs to ensure that risk management plans are drawn up following risk assessments where either significant risk is identified or where current trigger factors, which might increase risk, are present.

- The Devon Partnership NHS Trust needs to ensure that the individual and, where appropriate, his/her family or carers are meaningfully involved in the risk assessment and management planning.

- The Devon Partnership NHS Trust should ensure that its Risk Management policy is being adhered to through a programme of regular monitoring and audit.

- Risk assessment is a component of the Care Programme Approach (CPA) process and is to be included in management and clinical supervision.

- Random audits need to be carried out to support the annual audit plan.

- A service audit needs to be completed six months after the implementation of the revised policy to ensure that it is being consistently acted on.

3.7.4. Availability of Psychological Therapy.

Recommendations 3.7.4.1.

The Devon Partnership NHS Trust should review the availability of psychological therapy service.

- The adequacy of the overall level of resourcing of this service with reference to current National Institute for Health and Clinical Excellence (NICE) guidelines for the treatment of mental health problems commonly encountered in secondary mental health services.
- How psychological therapy resources are allocated across services and functional teams.
- The timely access to psychological services.
- Access to psychological services for consultation, advice and support.

3.7.5. Clinical Management.

Recommendations 3.7.5.1.

The Devon Partnership NHS Trust should ensure that its policies and practices relating to care co-ordination conform to the standards identified in *Refocusing the Care Programme Approach – policy and positive practice guidance, (2008).*

- It should ensure that its operational policies and CPA policies are clear as to the allocation of a care co-ordinator.
- It must ensure that care co-ordinators have appropriate training.
- It must ensure that patients are not retained in the Well-Being and Access team and provided with “informal” or *ad hoc* care co-ordination because of a shortage of resources in the Recovery Team.

3.7.6. Documentation.

Recommendation 3.7.6.1.

Following the introduction the electronic record system RiO, the Devon Partnership NHS Trust must ensure, using regular audit and supervision, that:

- all relevant clinical information is stored in a manner that is readily accessible to all clinicians working with a client;
- information is appropriately cross referenced;
- the quality of clinical notes is of an acceptable standard and complies with best practice guidance and professional standards.

Recommendation 3.7.6.2.

The Devon Partnership NHS Trust must complete a review of clinical records and their storage against the standards cited in the Data Protection Act.

- All clinical areas must ensure that records have been returned to the central archive when patients are discharged or move through services.
- An audit needs to be conducted in relation to the most recent 10 near misses or serious incidents to ensure that the clinical records have been correctly archived following an Internal Investigation.
- Trust personnel must be reminded of their duties and obligations to maintain clinical records to a professional standard during clinical supervision
- Random audits of clinical case files should be conducted across all clinical teams to ensure correct ordering and storage of clinical records.

3.7.7. Existence, appropriateness and awareness of operational policies.

Recommendation 3.7.7.1.

Clear concise Operational Policies should be developed for each functional team to enable staff to understand their core function and responsibilities and the function of their team. These should include reference to core policies such as the Care Programme Approach (CPA) and key Clinical Practice Standards.

- Operational service managers need to develop a core operational policy for the area they manage identifying the age range of the population to be served, the geographical area covered and services available.
- Clinical team leaders need to plot out the systems and processes that operate within their team such as referral and eligibility criteria, assessment methods, liaison with primary care and specialist services, allocation, supervision, discharge criteria and team meetings.
- Operational policies must be consonant with best practice guidelines such as the national Policy Implementation Guides, CPA policy or NICE guidelines.
- A mechanism for the disseminating of policies and policy revisions needs to be devised and implemented by the Clinical Governance Committee.
- Adherence to operational policies needs to be regularly monitored as part of an on-going audit programme.

This will in effect create a service map and the beginnings of a service care pathway.

3.7.8. Dissociation between the senior management team and front line staff.

Recommendations 3.7.8.1.

The Devon Partnership NHS Trust should:

- review its strategies for engaging its staff;
- review the efficacy of its dissemination strategies;
- involve staff in identifying the likely impact of new initiatives;
- put in place clear management of change strategies.

3.7.9. Clinical Governance Processes.

Recommendation 3.7.9.1.

The implementation of the Clinical Practice Standards and the Practice Quality Audit needs to be strengthened across the Devon Partnership NHS Trust. Clinical audit participation needs to be developed through:

- being a standing item on all team meeting agendas;
- being included in individual annual appraisal and personal development plans;
- being monitored through supervision;
- forming part of all employees core job description.

Recommendation 3.7.9.2.

A robust annual audit plan, reflecting the Clinical Practice Standards and the standards specified in ‘Services Good Enough for My Family’, needs to be developed and widely disseminated. This will need to detail the roles and responsibilities of team leaders and managers not just in terms of data collection but also their involvement in action planning to rectify shortfalls.

- The support services that are available across the Devon Partnership NHS Trust, such as Coaching and Patient Safety Officers need to be targeted at those teams that struggle to complete the audit cycle.
- Clear timescales need to be incorporated into the annual audit plan to enable individual practitioners and teams to manage their time.

3.7.10. Internal Investigations.

Recommendation 3.7.10.1.

The Devon Partnership NHS Trust needs to review its Serious Untoward Incident (SUI) policy to include:

- the introduction of reflective feedback sessions following serious incidents and near misses;
- the involvement of clinical teams in the development of recommendations;
- how learning and recommendations are to be shared across the Devon Partnership NHS Trust;
- greater clarity about the involvement of victims' and perpetrators' families.

4. Background and Context to the Investigation

The HASCAS Health and Social Care Advisory Service was commissioned by NHS South West to conduct this Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 27, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

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

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

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

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

The purpose of an Independent Investigation is to review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

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

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

5. Terms of Reference

The Terms of Reference for the Independent Investigation were set by NHS South West. The Devon Partnership NHS Trust and Devon Primary Care Trust were consulted with regard to the content of the Terms of Reference and did not wish to make any amendments.

1. Review the quality of the health and where relevant social care provided by the Trust and establish if whether this adhered to Trust policy and procedure.
2. To identify whether the Care Programme Approach (CPA) had been followed by the Trust.
3. To identify whether any risk assessments were timely, appropriate and followed by appropriate action.
4. To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records.
5. Review the Mental Health Act assessment process, where applicable.
6. To examine the adequacy of collaboration and effectiveness of communication with any other agencies who may have been involved in the care and treatment.
7. To review the Internal Investigation into the care of Mr AT already undertaken by Devon Partnership NHS Trust and any action plans that may have been formulated, including any immediate remedial action taken at the time of the incident, or action taken as a result of the Internal Investigation.
8. To consider any other matters that arise during the course of the investigation which are relevant to the occurrence of the incident or might prevent a reoccurrence the public interest may require.
9. To prepare an Independent Report for Devon Partnership NHS Trust, NHS South West and any other relevant bodies.

6. The Investigation Team

Three types of independent investigation are commonly commissioned, these are:

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

Each of these has its own strengths which make it best suited to examining certain cases. The current investigation was commissioned by NHS South West as a type C Independent Investigation.

Main Investigator

Dr. L.A. Rowland	Director of Research, HASCAS Health and Social Care advisory Service.

Peer reviewer

Ms. Helen Waldock	Director of Nursing, HASCAS Health and Social Care Advisory Service.

Support to the Investigation Team

Mrs. Louise Chenery	Stenography and Administration, HASCAS Health and Social Care Advisory Service.

Independent Advice to Panel

Mr. Ashley Irons	Solicitor, Capsticks.

7. Investigation Methodology

7.1 NHS South West commissioned this Independent Investigation under the Terms of Reference set out in section six of this report. This investigation was led by a project manager, who was also the Investigation Chair, from the HASCAS Health and Social Care Advisory Service (HASCAS). In February 2010 a meeting was held with Devon Partnership NHS Trust, Devon Primary Care Trust, NHS South West and HASCAS to discuss and confirm the terms of reference.

7.2 Consent

NHS South West Strategic Health Authority approached Mr. A.T. on behalf of the Investigation requesting his permission to release his clinical notes and offering him the opportunity to contribute to the investigation. Mr. A.T. did not give his permission for the release of his clinical notes. The South West Strategic Health Authority consequently approached the Devon Partnership NHS Trust Caldicott Guardian requesting that Mr. A.T.'s clinical notes be released to the investigation in the public interest. The Caldicott Guardian gave his permission for Mr. A.T.'s notes to be released on 19 April 2010.

7.3 Communication with the Family of Miss S.

Unfortunately despite their best effort neither the Trust nor the police were able to furnish the Investigation with the contact details of Miss S's family and in consequence we were not able to consult them in the course of this Investigation. This is a source of regret to the Independent Investigation Team.

7.4 Communication with the Family of Mr. A.T.

The family of Mr. A.T. were invited to contribute to the Investigation. Mrs. T, Mr A.T.'s mother, accepted this invitation and she met with Dr. Rowland and Ms. Waldock at her home on 23rd July 2010.

7.5 Initial Communication with the Devon Partnership NHS Trust

The Chief Executive of the Devon Partnership NHS Trust was informed of the Independent Investigation. The Clinical Risk Manager was appointed as the liaison person for the investigation and the clinical records and policies were requested on 22 March 2010. Some clinical records were retrieved from the Trust on 7 April 2010.

An initial briefing meeting was held with the Chief Executive, one of the Medical Directors (this is a shared post), the Director of Compliance and Corporate Development (latterly the Director of Corporate Governance), the Clinical Risk Manager of the Devon Partnership NHS Trust and a representative of the HASCAS Health and Social Care Advisory Service to discuss access, process and involvement on 20 April 2010. At this stage a preliminary identification was made regarding further documentary evidence that the Investigation would require.

On 28 April 2010 further clinical records and policies were requested from the Trust.

It is the practice of the HASCAS Health and Social Care Advisory Service to offer all Trusts subject to Independent Investigation a clinical witness workshop to provide clarity around the process. This was scheduled for mid June as were the corporate interviews arranged for this time. However these had to be rescheduled as the clinical records were incomplete to the extent that not all clinical witnesses could be identified. On 17 June a further meeting was held with the Chief Executive, the Director of Compliance and Corporate Development and the Clinical Risk Manager of the Devon Partnership NHS Trust regarding significant gaps within the clinical records. Specific records in relations to crisis resolution service interventions and the Devon Partnership NHS Trust's Internal Investigation were requested. Further clinical records were submitted on 26 June 2010.

On 30th June 2010 a staff briefing session was conducted. HASCAS provided briefing packs to all identified witnesses and all witnesses were invited to speak with the Independent Investigation Chair if they had any questions or concerns. These packs contained the Investigation Terms of Reference, advice to witnesses, and a letter which detailed the Investigation process and what would be required of them. All witnesses were given a full list of the questions that would be asked of them in advance and were

invited to attend their interviews in the presence of either their Union Representative or a work colleague for support.

7.6 Witnesses Called by the Independent Investigation Team

Date	Witness	Interviewer
13 July	• Mr A.T.'s GP • CRS workers 1,2,3 • Current CRS manager • CMHT manager • Interval Investigating team	Independent Investigator and Peer Reviewer.
14 July 2010	• NHS Devon and Torbay Care Trust (PCTs): Commissioning and Patient Safety and Quality managers. • Medical Directors, Devon Partnership NHS Trust. • Director of Operations, Devon Partnership NHS Trust. • Director of Corporate Governance, Devon Partnership NHS Trust. • Chief Executive Officer, Devon Partnership NHS Trust.	Independent Investigator and Peer Reviewer. (Also present panel Chairs for other Independent Investigations that were running concurrently).
23 July	• Mrs. T	Independent Investigator and Peer Reviewer.
3 Sept	• CMHT worker	Independent Investigator and Peer Reviewer.

The Community Psychiatrist involved in Mr. A.T.'s care has since retired and was unwilling to contribute to the Independent investigation.

7.7 Root Cause Analysis (RCA)

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

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

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

1. **Data collection.** This is an essential stage, without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established. From this causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind the causal factors. This investigation utilised the Decision Tree and the Fish Bone approaches.
4. **Recommendations.** This is the stage at which recommendations are identified for the prevention of any similar critical incident occurring in the future.

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

7.8 Salmon Compliant Procedures

This Investigation adopted the Salmon compliant procedures during the course of its work. These are set out below:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.9 Anonymity

- All staff of the Devon Partnership NHS Trust have been referred to in this Investigation report by reference to their role titles e.g. CMHT worker, CRS worker, community psychiatrist or CRS psychiatrist, to preserve their anonymity.

The individual whose care and treatment is the subject of this report has been referred to throughout as Mr. A.T. and his mother as Mrs. T.

8. Information and evidence gathered (documentation)

The following documents were actively used by the Independent Investigation to collect evidence and to formulate conclusions:

1. Mr. A.T.'s Devon Partnership NHS Trust records;
2. Mr. A.T.'s GP records;
3. The transcription of the Summing-up, Verdict and Sentencing remarks of His Honour Judge Cottle, at the trial of Mr. A.T. at Exeter Crown Court ;
4. Secondary literature of review of the media reporting the death of Miss S and trial of Mr. A.T.;
5. The Trust Internal Investigation Report;
6. The Independent Investigation witness statements;
7. The Independent Investigation witness transcriptions;
8. Trust policies and procedures in operation both in 2006/7, and where different, the present day:
   - Discharge Policy 2008;
   - Corporate Identity Policy 2003;
   - Care programme approach policy 2006/2008;
   - Access to health records;
   - Records management and record keeping standards policy 2006;
   - Incident reporting, management and review policy;
   - Risk management, strategy, policy and risk assessment process 2005/2008;
   - Guidance on being Open 2008;
   - Peer walk around audit tool;
   - Policy Implementation Guide-Recovery Coordination;
9. Crisis Team Operational Policy;
10. The Annual Report of the Devon Directors of Public Health 2006;
11. Governance reporting structure;
12. Clinical Directorate Governance Arrangements 2010;
13. CQC Investigation report 2010;
14. Public Health Report 2006;
15. PCT Annual Report 2007, 2008;
16. The Devon Partnership NHS Trust Action Plan.

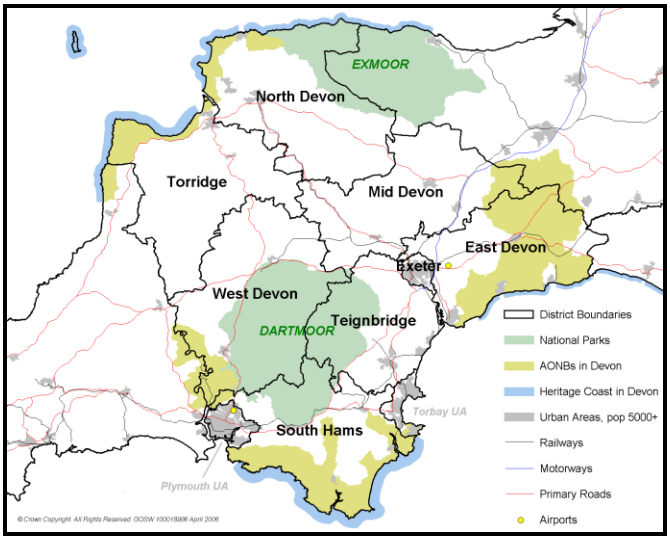
9. Profile of Devon Partnership NHS Trust (past and present)

Profile of the Mental Health Services

9.1 Demography

In order to provide a context for the mental health services provided in Devon it is necessary to have an overview of the demography of the county as a whole.

Devon has the largest land area of any county in the South West occupying 27.5% of the region's total land area. It also has the most districts (8) as shown on the map below and two large National Parks: Exmoor and Dartmoor.



Devon has the largest population of any county or unitary authority in the South West, and is home to 14.3% of the region's total population. However, Devon is largely rural and has the lowest population density of the region's counties and unitary authorities, and is the most sparsely populated district in the South West.[44] Rural Devon's population is increasing faster than the national average, with a particular increase in people over 60. In the short term this increase in the older population adds to the social capital and volunteering resource pool of the area, but puts pressure on housing for non-economically active residents. The longer-term impacts are likely to be an increased demand for health services, care facilities and services, and public/community transport.

[44] *ONS Mid Year Estimates 2008 (revised) /ONS Area data*

Linked to this is the dispersed settlement pattern which currently impacts upon service delivery. Market towns, with their relatively higher population density can provide a good range of key services and facilities but for the 15% of residents with no car and for those households with one car, used by the main wage earner on a daily basis, access to market towns remains a challenge.

Devon also contains two independent unitary authorities, Plymouth and Torbay.

9.2 The Devon Partnership NHS Trust

The Devon Partnership NHS Trust was established in 2001. It serves the whole of Devon with a population of around 900,000. The Devon Partnership NHS Trust employs around 2,000 members of staff and has about 100 staff members' assigned from Devon County Council and Torbay Unitary Authority. The Devon Partnership NHS Trust works in partnership with other health and social care providers. The Devon Partnership NHS Trust has two hundred and ninety-four mental health beds on eleven sites spread across the county. There are 70 community teams spread over 40 sites across the county.

The current Chief Executive was appointed in 2005 and the chair of the Devon Partnership NHS Trust has been in post since 2009. In 2005 the Devon Partnership NHS Trust was reporting a large financial deficit. An external review into alleged bullying and harassment was being under taken and this revealed that there had been deficiencies in human resource management, a lack of clinical engagement and a culture of fear. The Devon Partnership NHS Trust was also subject to a cross party parliamentary review due to concerns about partnership working.

The Devon Partnership NHS Trust embarked on a programme of financial recovery and break even was achieved in 2006/7. At the same time a decision was taken to have one lead commissioner for mental health services.

Service configuration prior to 2006

Prior to 2006 the Devon Partnership NHS Trust was divided into localities, each with its own Director:

- North and mid Devon locality;
- Exeter and East locality;
- Torbay South locality.

Each locality delivered a range of service to the local population: adult mental health services such as inpatient services and CMHT's, Older People's mental health services, drug and alcohol services and psychological therapies. In addition there was matrix responsibility such that a Locality Director also provided leadership across the Devon Partnership NHS Trust for a specialist area of service such as older peoples' services.

At this time the Learning Disability Services sat with the local authority.
Forensic Services were based at Langdon with the Medium Secure Services, Low Secure Services and the low Rehabilitation Services.

The Devon Partnership NHS Trust had responsibility for Child and Adolescent Mental Health Services including an inpatient provision.

Transition

- 2006 was a time of major change for the Devon Partnership NHS Trust
- in 2006 the Devon Partnership NHS Trust reorganised its specialist services (psychological therapies, drug and alcohol services, embryonic eating disorder service) and appointed a manager and leadership team for these.
- Child and Adolescent services ceased to be provided by the Devon Partnership NHS Trust and were transferred to NHS Devon.
- Changes were made to the inpatient services reflecting the strategy of moving from a predominately bed-based service to a more community-focused service. The following units ceased to provide an inpatient service:
    - Watcombe Hall (adult rehabilitation) in Torbay;
    - Harbourne Unit (older people) in Totnes ;
    - Ash and Bucknill wards (adults) in Exeter;
    - Redvers (older people) in Okehampton;
    - Boniface (older people) in Crediton;
    - Forest Hill House (learning disability) in North Devon;

- Ivycroft (learning disability) in Newton Abbot.

These units were replaced by two inpatient units in Exeter, two in North Devon and two in South Devon, some of which were new commissions, providing a more even spread of inpatient units across the county.

- Learning Disability Services developed community alternatives and worked more closely with mental health services.
- Adult Mental Health began moving to a network delivery of care model with a single point of access into the service wherever that might be and rapid access to specialist mental health services.
- In 2006, NHS Devon and Torbay Care Trust delegated the management of Individual Patient Placements (IPPs) to the Trust, which assumed responsibility for funding and case-managing those people whose needs could not be met within the county. The Trust's strategic plan was to provide as many services as possible locally.
- Consultant Psychiatrists implemented a functional spilt so that they covered either a community or an in-patient setting, moving towards *New Ways of Working.*[45]
- 2008 Crisis Resolution and Home Treatment teams came into being.

Structure of the drug and alcohol services in 2006/07

Prior to 2006 each drug and alcohol service was directly accountable to its locality mental health service. That is:

- Quay Centre – North Devon Mental Health;
- ENDAS – Exeter, East and Mid Devon Mental Health;
- Scrublands – Torbay, South and West Devon Mental Health.

During 2006 a project was undertaken to amalgamate these services into one dedicated service which was accountable to a general manager. This unified service and its

[45] DoH (2005) New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multiagency contexs

governance structure was formally incorporated into the Specialist Services Directorate and a Directorate Manager for Specialist Services was appointed in January 2007.

Services provided by the Devon Partnership NHS Trust 2010[46]

The Devon Partnership NHS Trust has introduced networks of care that deliver a core set of health and social care services through four network areas based on the following four geographical areas:

- North Devon;
- Exeter, East and Mid Devon;
- South and West Devon ;
- Torbay.

Each network area has three core network functions:
1) Mental Wellbeing and Access teams which work closely with GPs and provide a service that aims to be easily accessible for:

- People presenting with a mental health problem for the first time who need more help than their GP can provide;
- People who have previously used special mental health services and need further help;
- People experiencing common mental health problems;
- People experiencing a potential first episode psychosis.

These teams offer specialist assessment, consultation and advice between 8 a.m. and 6 p.m. Monday to Friday. They link with other network function teams to ensure a response is available outside these hours.

The Specialist Teams for Early Psychosis (STEP) focus on caring for people who are experiencing symptoms of psychosis for the first time. Typically, these are younger people. The team works with each person to help him/her manage his/her symptoms and provides support for them in their daily lives.

[46] The Devon Partnership NHS Trust web site August 2010

These teams work in partnership with a number of other providers to deliver a range of Psychological Therapies. These aim to meet the needs of each individual. These interventions adhere to nationally agreed best practice guidelines.

2) Urgent and Inpatient Care

This service provides care and treatment at home or in hospital for people at times of crisis and acute illness.

The Urgent and Inpatient Care Teams include hospital wards and the Crisis Resolution and Home Treatment Teams. Together they provide a flexible 24 hours a day, 7 days a week service to care for people who have an urgent need, are in a crisis, and for people who require a period of in-patient treatment.

When a hospital admission is needed the team works towards minimising the length of stay, involving carers and families to ensure arrangements are in place to support the individual when she/he is discharged.

3) Recovery and Independent Living Services

The purpose of the Recovery and Independent Living function is to support people's recovery through being holistic and promoting social inclusion, self-management and independence. This service is for people who have complex relationships with services and whose needs are unable to be met by the Mental Wellbeing and Access team.

By being flexible and tailoring services to meet the individual's needs, this service aims to support people in living a full and satisfying life, more effectively. This includes supporting people to live where they choose, gaining access to education, training and employment and engaging in social activities and relationships outside mental health services.

The Trust specifically provides the following services in this function:

- Assertive Outreach;
- Rehabilitation and Recovery;
- Vocational Rehabilitation.

In addition, the staff in the Recovery and Independent Living teams work closely with local providers in the public, private and voluntary sectors to address the identified needs of each individual and to support them in leading the life they choose.

The Devon Partnership NHS Trust began implementing clinical directorates in April 2010. There are four clinical Directorates:

- Adult Mental Health;
- Specialist Services Directorate incorporating Drug and Alcohol, Gender reassignment, Psychological Therapy Services, including Personality Disorder Services, and Secure Services;
- Older Peoples Mental Health;
- Learning Disability Services in Partnership with Social Care.

In each Directorate there is a medical clinical director who works in tandem with a "managing partner", a person whose background is in management and who may not be a clinician. This structure has been adopted to ensure that clinical services are led predominantly, by a clinician.

9.3 Commissioning

How services were commissioned

Prior to October 2006 work was initiated by the Chief Executive Officer (CEO) of Teignbridge PCT to bring together a Devon-wide commissioning arrangement to align service planning and investment decisions.

Devon PCT was formed in October 2006 with the amalgamation of six PCTs (Torbay was not included in this amalgamation). Prior to this each of the PCT's had their own commissioning arrangements. While each of these was in line with the national service framework there were significant geographical variations in the services provided due to the different levels of investment. Strategic planning was led by the Devon and Torbay Local Implementation Team (LIT) which brought together the Local Implementation Groups (LIGs) for each of the PCT areas, together with the statutory and voluntary sectors, users and carers.

Since 2006 Devon PCT has acted as the lead commissioner of mental health services from the Devon Partnership NHS Trust. Torbay Health Care Trust has the status of an associate commissioner. There is a functional separation between strategic commissioning and contract and performance monitoring.

Local authority services are not commissioned as part of the NHS contract but performance monitoring arrangements do include a number of local authority key performance indicators.

How services are monitored

It is recognised that prior to 2006 monitoring and performance were not well developed and varied across the PCT areas. Since then work has been done to improve the contract performance arrangements through the introduction of monthly meetings held with the provider Trust. These meetings have been separated into two components:

1. Clinical quality review
2. Contract and performance issues.

The same arrangements are in place for Torbay Health Care Trust.

There is a joint commissioning manager for Adult Mental Health and Alcohol Services with Devon County Council and NHS Devon.

10. Chronology of Events

This Forms Part of the RCA First Stage

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

Background Information

Mr. A.T. was born on 18 May, 1983. He was the younger of two siblings. At the time of the homicide Mr. A.T. was living at home with his parents.[47]

Mrs. T., Mr. A.T.'s mother, reported that Mr. A.T. was a normal delivery. However she described Mr. A.T. as "odd" from the time he was a very young child.[48] She felt that he did not display a normal development; he did not develop normal social behaviours as a child, he always had an aversion to being touched[49] and he did not respond to her as a child. She described him as being a disruptive and clumsy as a child.[50]

At the age of six, Mr. A.T. was referred to the local Child and Adolescent Mental Health Service (CAMHS) where he was seen by a community psychiatric nurse (CPN). Mrs. T. reported that she found the intervention of the CAMHS helpful.[51]

As Mr. A.T.'s behavioural difficulties continued he was enrolled in a boarding school at the age of seven. Mrs. T hoped that this would help with her son's difficulties. However Mr. A.T.'s behaviour did not improve.[52] Mrs. T felt that, at least in part, Mr. A.T. coped at

[47] File 2 page 5
[48] File 4 page 25
[49] Ibid
[50] File 4 page 78
[51] File 4 page 78
[52] Ibid

school because his brother looked after him, supported him and included him in a social network.[53]

Mr. A.T. did well, academically, at school and after completing his "A" levels went to Portsmouth University. According to his report on February 2007 Mr. A.T. failed all his first year modules. He retook his examinations but dropped out of university during his second year.[54]

Mr. A.T. remained in Portsmouth after leaving his university course. During this period he was in a relationship with a woman somewhat older that himself which Mr. A.T.'s mother described as supportive.[55]

Mr. A.T. reported that from around the age of 14 he lacked direction or purpose; at around 18 he inflicted minor cuts on himself and at around the age of 20 he drove to Beachy Head considering committing suicide.[56]

In 2006 Mr. A.T. returned to his parents' home in Exeter and in April of that year obtained employment in the Civil Service in an insolvency department.

On the **19 October 2006**, having spent some days visiting an ex-girlfriend in Portsmouth Mr. A.T. drove to the New Forest with intention of committing suicide via carbon monoxide poisoning.[57] He had taken duck tape and a hose with him.[58] Mr. A.T. reported that he had drunk eight cans of larger and half of a bottle of vodka.[59] He contacted his mother and (ex-) girlfriend and they alerted the police. [60]

Mr. A.T. reported that there was no specific, identifiable trigger for the suicide attempt.

[53] Mrs T's statement
[54] File 2 page 4
[55] Mrs T's statement
[56] File 2 p 2-3
[57] File 5 page 10
[58] File 5 page 27
[59] Ibid
[60] File 5 page 10

Mr. A.T. aborted his suicide attempt and drove to his parents' home. The police were informed and an on-call doctor attended Mr. A.T. Mr. A.T. was abusive to the doctor and the police advised that he should be taken to the A & E department to be assessed.

In the early morning of **20 October 2006** Mr. A.T. attended the A & E department accompanied by his mother, requesting help. [61]

In their report to his GP the A & E staff commented: "*Psychopath with killing thoughts, seen by crisis team, needs further psych follow up.*" [62] He had told the A & E staff that he had thoughts of wanting to kill people and animals, though he later confided to the Crisis Resolution Service (CRS) staff that the "*psychotic comments at triage were made with a view to eliciting a response from the triage nurse whom he perceived as being patronising*".[63]

Mr. A.T. was assessed by the CRS who on this occasion obtained a personal history of Mr. A.T. from his mother. This is the only recorded occasion on which his mother was involved in the assessment of Mr. A.T. The assessment concluded that he:

- showed a shallowness of affect;
- appeared not to empathise with his mother's anxiety;
- was at low risk of self harm but that this risk was exacerbated by alcohol.

The care plan recorded by the CRS was to accept Mr. A.T. on to its caseload, to monitor his mental state and to re-assess him when he was alcohol free.[64]

Mr A.T. was seen at home later the same day by two members of the CRS. They noted that he demonstrated no remorse or regrets for his actions and that he had trouble expressing his emotions. Their plan was to give Mr A.T. the telephone numbers of two private Cognitive Behaviour Therapy (CBT) therapists and to liaise with Mr. A.T.'s GP regarding the prescription of anti-depressant medication.[65]

[61] File 5 page 9
[62] Ibid
[63] File 5 page 10
[64] Ibid
[65] File 4 page 27

On **23 October 2006** Mr. A.T. was seen by his GP who recorded that she had discussed Mr. A.T. with the CRS and that they had agreed to obtain a consultant (psychiatrist) opinion and that the CRS had recommended private CBT.[66] She prescribed the anti-depressant medication, Citalopram 20mg.[67]

Also on **23 October 2006** Mr. A.T. was contacted by phone by the CRS and given the telephone numbers of two private CBT therapists.[68]

On the **24 October 2006** Mr A.T. was seen at home by the consultant psychiatrist of the CRS and a Community Psychiatric Nurse (CPN). It was noted that there were no specific precipitants for the suicide attempt but that he had had ideas of suicide since the "*year dot*". It was commented that Mr A.T. was "*generally aloof and [had a] cynical attitude to life*."[69] There was some discussion of the Trust paying for Mr A.T. to access private CBT therapy.[70]

The Consultant's notes for this visit are missing from Mr. A.T.'s clinical notes.

On **25 October 2006** Mr A.T. was telephoned by the CRS. During this call Mr A.T. said that he would prefer to obtain counselling via his GP. The CRS staff asked him: "*if he was discharging our services and he confirmed that he was.*"[71]

On **26 October 2006** Mr A.T. was again contacted by the CRS. Mr A.T. reported that he had tried to contact both CBT therapists: one was not taking referrals, the other was away. The possibility of referral to the CMHT was discussed with Mr A.T. during this telephone conversation.[72]

On **30 October 2006** Mr. A.T. telephoned the CRS informing them that he had seen his GP that day, that he was compliant with his medication, and was reporting no problems. He also informed the CRS staff that he had contacted his employer who had offered a

[66] File 5 page 55
[67] File 5 page 53
[68] File 4 page 27
[69] File 4 page 28
[70] ibid
[71] Ibid
[72] File 4 page 28

"full service" including "psychiatrist and counselling service". Mr. A.T. told the CRS staff that he would prefer to take this route. With Mr. A.T.'s agreement he was discharged from the CRS caseload that day. The CRS discharge summary notes: "*Further attempts were made to engage [Mr. A.T.] with the Crisis Resolution service, however, he declined*."[73]

The next recorded contact for Mr. A.T. was two weeks later**, 14 November 2006,** when he attended an appointment with his GP. Mr. A.T.'s GP recorded that he "*feels reckless and is gambling. Not ready for work but employer is arranging? cbt.*"[74] He scored 17/27 on the PHQ-9, a score indicating that he was moderately depressed. His GP increased his anti-depressant medication, Citalopram, to 40mg. [75]

Mr. A.T. was seen again by his GP 13 days later, **27 November 2006**. On this occasion his GP recorded that Mr. A.T. was complaining that the Citalopram was causing impotence and so he had stopped taking this. However he was prepared to try an alternative. He was prescribed the anti-depressant Venlafaxine 75mg.[76]

Mr. A.T. was seen again on **8 December 2006** by a locum GP who referred Mr. A.T. to the "Primary Care Mental Health Team". In his letter of referral the locum GP noted that Mr. A.T. was reporting suicidal thoughts but denying that he would act on them; that he felt isolated and worthless; that he was drinking heavily and that Mr. A.T. felt unable to return to work. He also noted that Mr. A.T. had been started on Venlafaxine 75mg "*nine days ago*".[77] Mr. A.T.'s GP felt that the referral was a reasonable one given that Mr. A.T. was not showing any improvement and had not received an appointment for psychological therapy.

Mr. A.T. was seen by his GP on **19 December 2006** when his Venlafaxine was increased to 150 mg.[78]

[73] File 4 page 29/File 2 page 49
[74] File 5 page 4
[75] File 5 page 53
[76] File 5 pages 53 & 55
[77] File 2 page 46
[78] File 5 page 53

On the **21 December 2006** the locum GP's referral of Mr. A.T. to the mental health services was received by the CMHT.[79]

On the **27 December 2006** Mr. A.T. was sent a standard opt-in letter asking him to contact the service with in 14 days.

On **15 January 2006** Mr. A.T. was again seen by his GP who noted that he had not yet received an appointment from the mental health services.[80]

On **25 January 2006** Mr. A.T. was sent a letter offering him an appointment with a CMHT worker on 13th February 2007. [81]

In the morning of **26 January 2006** Mr. A.T. drove his car into the doors of Barclays Bank in Exeter. Mr. A.T. reported that the previous evening he had gone to a snooker hall with friends where he had several beers and had driven home at around 2 a.m. He was feeling unsafe and so he woke his mother to talk to her about his feelings. He had then gone to bed. However he later got up again and had several vodkas. At around 7.a.m. he had taken his car and driven it into the doors of the bank. [82] The custody nurse requested an assessment by the CRS which was carried out later that day.

The initial assessment reported that Mr. A.T. wanted to kill himself.[83] However it was later reported that Mr. A.T. stated that "*he is desperate and wants to get himself out of society by hospital admission or prison*".[84]

The assessment concluded that Mr. A.T. was at "*low risk of completed suicide in the short term*" but that he became more impulsive and disinhibited and was at increased risk of self-harm when he drank alcohol. No symptoms of "*severe mental illness*" were evident. Mr. A.T. reported that he felt his medication was not "*particularly beneficial*".[85]

[79] File 2 page 51
[80] File 5 page 53
[81] File 2 page 37
[82] File 2 page 35
[83] File 2 page 41
[84] File 2 pages 2-3
[85] File 2 page 42

It was noted that Mr. A.T. displayed a "*shallow affect*" and "*no empathy*". He was reporting "*lurid fantasies"* about butchering people but he had no specific plans.[86]

It was noted that Mr. A.T.'s mother and GP were concerned about him harming himself.

The plan recorded by the CRS was to take Mr. A.T. onto the CRS caseload to monitor his mental state, to contact the CMHT for an urgent appointment and to "*consider review by Team Psychiatrist*".[87]

The CRS telephoned Mr. A.T. on **27 January 2007.** He reported that he had not been drinking alcohol and that he felt flat. It was recorded that there were "*no overt signs of mental illness."*[88]

Mr. A.T. was telephoned on **28 January 2006**. The CRS recorded that he was brighter, he had had no alcohol and had discussed recent events with his family.[89]

Mr. A.T. was contacted on **30 January 2006** again reporting that he felt brighter but declined a home visit. [90]

On **29 January 2006** Mr. A.T. was sent a letter bringing forward his CMHT appointment to the 1 February.

On 30 **January 2007** Mr. A.T. was seen at home by the CRS consultant psychiatrist and a CRS CPN. The psychiatrist sent a report of the visit to Mr. A.T.'s GP on 31 January 2007.[91]

It was concluded that Mr. A.T. was not displaying any symptoms of psychosis. Again it was reported that: "*Once he has drunk to excess he becomes disinhibited and is likely to act on his negative feelings. At these times he is more at risk*."

[86] File 2 pages 2-3
[87] Ibid
[88] File 4 page 41
[89] Ibid
[90] Ibid
[91] File 2 page 35

As for his medication Mr. A.T. had reported that it "*takes away his blackest of moments and he no longer feels weepy or tearful*."

Commenting on risk to others it was noted: that Mr. A.T. was more likely to be involved in fights when intoxicated, that he had once tried to buy a hand gun while living in Portsmouth but did not pursue this when he was told the gun was faulty, that Mr. A.T. had reported that he had fantasised about "*taking out" "groups of coloured youths he had seen hanging about"* and that "*in recounting this, there was little emotion, no sense of guilt or remorse."*[92]

The psychiatrist concluded that Mr. A.T. was suffering from: "*A partially treated depressive illness on a background of some more dissocial personality difficulties*." Having made some remarks about the possibility of increasing Mr. A.T.'s medication or introducing a further anti-depressant it was recommended that Mr. A.T.'s medication should be reviewed by the community psychiatrist.[93]

Mr. A.T. was seen by the CMHT worker on **1 February 2007.** Following this assessment it was decided to refer Mr. A.T. to the local addiction services, to organise an appointment with the community psychiatrist and to place Mr. A.T. on the waiting list for a care co-ordinator.[94]

On **2 February 2007** the CMHT worker contacted the CRS to inform them that she had seen Mr. A.T. It was agreed that he would be discharged from the CRS "*by phone*"; [95] Mr. A.T. was sent an appointment to see the community psychiatrist on 12th February and he was referred by telephone to the addiction services.[96]

On **5 February 2007** the CRS telephoned Mr. A.T. He reported that he was engaged with the CMHT and he was then discharged from the CRS case load.

The CMHT worker discussed Mr. A.T. at the team meeting on the **6 February 2007.** She reported that she was sufficiently concerned about Mr. A.T., following her first interview

[92] Ibid
[93] File 2 page 35
[94] File 2 page 5
[95] File 2 page 42
[96] File 2 pages 22 and 23

with him, to discuss him with colleagues and with her manager. [97] It was decided at the team meeting that Mr. A.T. should be referred to the community psychiatrist for a psychiatric assessment and placed on the waiting list for a care co-ordinator. He was also referred to a psychologist. [98]

Mr. A.T. was seen by the CMHT worker later the same day. The main purpose of the meeting was to inform him that he had been placed on the waiting list for a care co-ordinator but that he could contact the CMHT duty worker if he needed to contact the service.

Mr. A.T. reported, at this meeting, that he was feeling more positive about the future and that a great weight has been lifted from him as he had had "a good chat with his parents".

He reported that he was aware that he was binge drinking and that he was trying to reduce his drinking. It was concluded that he did not require a "level 2" risk assessment.[99] This is the more comprehensive, multi-disciplinary assessment of risk.

Mr. A.T. was seen by the community psychiatrist on **12th February 2007.** He wrote a report of this assessment to the GP on 7th March 2007.

He reported that Mr. A.T. identified his problems as:

- a lack of self confidence;
- addiction to alcohol and gambling;
- violent tendency.

It was also noted that when drinking Mr. A.T. became disinhibited and got into fights, *"[He] appears to be in a fight every week or two but denies using weapons*." It was recorded that he had a conviction for criminal damage some years previously and two convictions for being drunk and disorderly.

[97] RV statement
[98] File 2 page 23
[99] File 2 page 23

Mr. A.T. reported that he felt bad "*for having bad thoughts towards certain people, especially black youths.*" He had fantasises about killing them. It was noted that Mr. A.T. appeared to lack empathy.[100]

It was reported that Mr. A.T. had, in the past, taken a range of drugs including: cannabis, cocaine, speed, acid, mushrooms but not heroin or crack. He claimed that, at the time of the interview, he had not taken any drugs "*for months*". However he did acknowledge that he had taken ecstasy the previous week-end.

On this occasion Mr. A.T. reported that he had "*found himself happier for past week or so*" as a result of his medication.

Mr. A.T. was advised to:

- to continue taking his medication;
- to stop drinking;
- to attend the addiction service ;
- to attend anger management sessions and;
- to see a psychologist for assessment.

Mr. A.T. was referred to the team psychologist "because of the query about ADHD".

The psychiatrist planned to see Mr. A.T.'s mother to explore the possible diagnosis of ADHD. This appointment was planned for a month later.[101]

On **13 February 2007** Mr. A.T. was sent an appointment to see a psychologist on 22 February 2007.

On **13 February 2007** Mr. A.T. was arrested on suspicion of the murder Miss S. Mr. A.T. was assessed under the Mental Health Act (1983) but was not found to be detainable under the Act.[102]

[100] File 1 page 31
[101] Ibid & F2 page 24
[102] File 2 page 25

Mr. A.T. was tried and convicted for the murder of Miss S at Exeter Crown Court in November 2007. In his sentencing remarks His Honour Judge Cottle commented:

"*I have no doubt that you were, at the time of this killing, suffering from depression and from a psychopathic personality disorder; the experts have agreed about that. However, as the jury have found, it was the excessive consumption of alcohol that night that was the principal trigger for you to act out your violent fantasies*."[103]

Mr. A.T. was ordered to serve a minimum of 15 years imprisonment.

[103] R v A.T page 28

11. Time line and Identification of Critical Issues

Root Cause Analysis (RCA) Second Stage

11.1 Timeline

The Independent Investigation formulated a Timeline in table format and also a chronology in a narrative format in order to plot significant data and identify the critical issues and their relationships with each other. Please see Appendix 1. This process represents the second stage of the RCA process and maps out all of the emerging issues and concerns identified by the Independent Investigation.

11.1.1 Critical Issues Arising from the Timeline

On examining the timeline the Independent Investigation identified five critical issues that arose directly from the care and treatment that Mr. A.T. received from the Devon Partnership NHS Trust. These are set out below.

11.1.2 Critical Issues Arising from the Review of other Data

The Independent Investigation identified three further critical issues that were not immediately apparent from analysing the timeline and the chronology. These issues are set out below**.**

The above critical issues were identified by the Independent Investigation as requiring an in-depth review. It must be stressed that critical issues in themselves do not necessarily have a direct causal bearing upon an incident.

The Independent Investigation Team conducted a review into the Devon Partnership NHS Trust's Internal Investigation process, reporting, and action planning implementation outcomes. This is explored in section 15 below.

11.2 Critical issues arising from examination of the timeline

On examining the timeline the Independent Investigation identified a number of issues relating directly to the care and treatment that Mr. A.T. received from the Devon Partnership NHS Trust. These are listed below.

Mr. A.T. was in contact with the mental health services provide by the Devon Partnership NHS Trust for a relatively short period of time: from 20 October 2006 to 30 October 2006, 10 days, and from 26 January 2007 to 13 February 2007, 19 days.

1. Issues relating to referral, discharge and transfer.

- Mr A.T. initially presented to the A & E department on 20 October 2006. He was seen promptly by the CRS. The CRS carried out a level 1 risk assessment and took a history from Mr A.T.'s mother. However having identified that he would benefit from psychological therapy they discharged him on the basis of his assertion that his employer would provide the necessary psychological intervention. This was not corroborated and no contingency plan was put in place in the event of this support not being forthcoming.

- Mr A.T. was re-referred to the mental health service on 8 December. This referral did not arrive at the CMHT until 21 December and, after having to "opt-in", Mr A.T. was not offered an initial assessment appointment until 13 February, nine weeks after the initial referral.

- On 26 January, while waiting for his appointment with the CMHT Mr A.T. drove his car into the doors of a bank. Again the CRS responded promptly. They liaised with the CMHT who brought forward Mr A.T.'s appointment. Again a level 1 risk assessment was carried out but Mr A.T.'s family was not consulted as part of this assessment. The CRS liaised with a CMHT worker, orally, to transfer his care, however, there was no written referral or transfer of information, assessments or plans.

2. Assessment and Care planning:

- Although Mr. A.T. was seen and assessed on a number of occasions no clear formulation was made to inform either further assessments or intervention.
- Mr. A.T.'s mother was not involved in either the assessment of Mr. A.T.s mental state or in planning his care.
- Although a number of clinicians noted trait-like features in Mr. A.T.'s presentation there is no evidence that the presence of axis II factors in Mr. A.T.'s presentation influenced either the strategy for undertaking assessment or the formulation of Mr. A.T.'s problems.

3. Risk Assessment:

- There was a failure to note that Mr. A.T.'s behaviour was showing a pattern of escalating dangerousness.
- The CRS consultant psychiatrist concluded that Mr. A.T. "fantasised" about killing people.[104]The CRS worker 1, who assessed Mr. A.T. together with the CRS consultant on 30 January 2007, informed the Investigation that she felt Mr. A.T. became disinhibited when he had drunk alcohol and it was in these circumstances that he was more likely to make such statements. She and the consultant psychiatrist had questioned Mr. A.T. about his statements about killing people and he had told them he had no plans or intentions to act on these ideas.[105] Similarly CRS worker 2 commented: "*When he was sitting there sober he was able to give us assurances that there wasn't any chance that he was going to act on these thoughts."*[106] However there is no recorded evidence to show that Mr. A.T.'s statements that he wanted to kill certain groups of people were reflected on and a view formed as to why he was making such assertions.

[104] Statement 2 TG
[105] Interview MH
[106] Interview CP & DB

- A comprehensive risk assessment was not undertaken and there was a lack of clarity as to when to initiate a level 2 (multi-disciplinary) risk assessment.
- No risk or crisis management plans were formulated to address those factor identified as placing Mr. A.T. at increased risk.

4. Availability of Psychological Therapy

- Mr. A.T. was advised to seek private CBT at his first encounter with the mental health service.

5. Clinical Management

- There was a lack of clarity as to who was responsible for Mr. A.T.'s care while in contact with the CMHT's.
- There was a lack of clarity regarding allocation of care co-ordination.

11.3 Critical Issues Arising from the Review of other Data

The Independent Investigation identified three other issues that were not immediately apparent from analysing the timeline and the chronology. These are set out below:

6. Documentation

- The availability and accessibility of clinical notes during the Independent Investigation.
- There was no integrated set of clinical notes to which all clinicians had access.
- There was inconsistent/conflicting information recorded in clinical notes.
- The designation of members of staff writing in the notes was not recorded.

7. Existence, appropriateness and awareness of operational policies

- Staff were unaware of the operational policies for the Crisis Resolution Service and the CMHT.

8. Dissociation between the senior management team and front line staff

- The senior management team have instituted a number of positive, potentially service improving, initiatives however the front line staff appear to be unaware of these, unclear about the purpose of the initiatives and/or believe that the senior management does not understand the nature of their work.

It must be stressed that critical issues in themselves do not necessarily have a direct causal bearing upon an incident.

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

12.1 RCA Third Stage

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

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

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

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation has concluded had a direct causal bearing upon the events of 13 February 2007. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user receives and a subsequent homicide perpetrated by them.

Contributory Factor. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation to conclude that it made a direct contribution to the breakdown in Mr. A.T’s mental health and/or the failure to manage it effectively.

Service Issue. The term is used in this report to identify an area of practice within the Devon Partnership NHS Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 13th February 2007, need to be drawn to the attention of the Trust in order for lessons to be learned and the subsequent improvements to services made.

12.1 Issues relating to referral, discharge and transfer.

12.1.1 Context

There has at times been some confusion as to whether individuals referred to secondary mental health services are entitled to services based on their CPA status. The Department of Health has sought to clarify this position in its guidance: *Refocusing the Care Programme Approach* (2008).[107] It states:

"All individuals receiving treatment, care and support from secondary mental health services are entitled to receive high quality care based on an individual assessment of the range of their needs and choices. The needs and involvement of people receiving services (service users) and their carers should be central to service delivery. ***An underpinning set of values and principles of person-centred care which apply to all is essential****, and is described." (p. 2)*[108] (Emphasis added)

"It is clear that all service users should have access to high quality, evidence-based mental health services. For those requiring standard CPA it has never been the intention that complicated systems of support should surround this as they are unnecessary. The rights that service users have to an assessment of their needs, the development of a care plan and a review of that care by a professional involved, will continue to be good practice for all." (p.11)[109]

[107] Dept of Health (2008) *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*
[108] Dept of Health (2008) *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*
[109] The Devon Partnership NHS Trust CPA Policy 2006

The Devon Partnership NHS Trust CPA policy notes:
"*Some cases previously known to the service will have been closed on the understanding that they may be re-opened rapidly should circumstances require it. In these cases, the referral should be considered urgent unless indicated otherwise and allocation made a priority*."[110]

It continues: "*Routine assessments should be prompt – 4 weeks maximum, but working towards one week.*"[111]

12.1.2 Finding

Mr A.T. was re-referred to the mental health service on 8 December by his locum GP but this referral did not arrive at the CMHT until 21 December. Mr A.T. was then required to "opt-in" to the service. Only after this was he offered an initial assessment appointment. This was on 13 February, nine weeks after the initial referral.

12.1.3 Context

The DCP CPA policy stated:
"Contingency Planning
A vital tool in the management of risk is the early development and communication of a contingency plan. Such a plan should identify in particular, indicators of relapse or crisis, the service user's strengths and personal coping mechanisms and abilities, the service users preferences, who should be informed and who should do what in particular circumstances."[112]

12.1.4 Finding

Mr A.T. initially presented to the A & E department on 20 February. He was seen promptly by the CRS. The CRS carried out a level 1 risk assessment and took a history from Mr. A.T.'s mother. However having identified that he would benefit from

[110] Ibid page 20
[111] The Devon Partnership NHS Trust CPA Policy 2006 page 21
[112] Ibid Page 12

psychological therapy they discharged him on the basis of his assertion that his employer would provide the necessary psychological intervention. This was not corroborated and no contingency plan was put in place in the event of this support not being forthcoming.

In the event Mr. A.T. did not receive any psychological or medical support from his employer. In part because of this and in part because he was not showing any signs of improvement his locum GP re-referred him to the mental health services. [113]

12.1.5 Context

To ensure consistency and coherence of the treatment of a patient, as well as to ensure that misunderstandings do not arise, there should always be clear written records of the transfer of a patient. Amongst other things such transfers should either contain all relevant and current assessments and care plans or refer those assuming responsibility for the care of the individual to where this information can be accessed.

The DCP CPA policy in force in 2006 stated:

- "*Where possible, a transfer should be part of a planned process allowing time for a new care co-ordinator to be appointed and a handover completed.*
- *Transfer of patients to another CMHT should involve a joint CPA handover meeting.*
- *Disengagement should not occur before the new team has established a relationship….*
- *Transfers should follow a full review." (p.26)*[114]

In *Refocusing the CPA (2008)*[115] the Department of Health recommended:
"*To reduce documentation and cut down on duplication, services should aim to develop one assessment and care plan that will follow the service user through a variety of care settings to ensure that correct and necessary information goes with them. More use of*

[113] File 5 page 1
[114] The Devon Partnership NHS Trust Care Programme Approach Operational Policy 2006
[115] Department of Health, (2008) *Refocusing the CPA*

joint assessments and review, with common documentation between agencies and teams, would avoid duplication of paperwork."

12.1.6 Finding

On 26 January 2007, while waiting for his assessment appointment with the CMHT Mr A.T. drove his car into the doors of a bank. The CRS responded promptly. They liaised with the CMHT who brought forward Mr A.T.'s appointment. A level 1 risk assessment was carried but Mr A.T.'s family was not consulted as part of this assessment. Although the CRS liaised with a CMHT worker, orally, to transfer his care there was no written referral or transfer of information, assessments or plans.

12.1.7 Summary of finding

While the CRS had identified that Mr. A.T. would benefit from psychological therapy they discharged him from their care on his assertion that his employers would provide the necessary intervention. The CRS had noted that Mr. A.T. was keen to disengage from their service[116] yet they did not consult his family to gain corroboration of his plans. The CPA operational policy in force at the time recommended that significant others should be consulted during assessment and care planning.[117] There is no record that Mr. A.T.'s family was consulted at any point after his mother had provided details of his personal history at his initial assessment nor that consent was sought from Mr. A.T. to consult his family.

The risk assessment undertaken by the CRS on 20 October 2006 concluded that Mr. A.T. was at low risk of immediate self harm but that this risk was exacerbated by the consumption of alcohol. Despite the fact that he was known to be binge drinking and without any corroboration that Mr. A.T. was indeed going to receive psychological support from his employers Mr. A.T was discharged from the care of the CRS with no contingency plan in place.

[116] File 4 page 30
[117] The Devon Partnership NHS Trust CPA Operational Policy 2006 e.g. page 21

While it must be acknowledge that no plan had been put in place such that his case would be "re-*opened rapidly*", nevertheless given Mr. A.T.'s identified vulnerability, his on-going problems, an identified need that was not met and the fact that the GP accompanied his referral with "a recent letter … from the psychiatric services", it would be reasonable to assume that Mr. A.T. met the criteria for a priority assessment.

However, the locum GP's referral, made on 8 December, which was addressed to the "Primary Mental Health Team", was received at the CMHT only on 21 December. [118] Mr. A.T. was then asked to opt into the service[119]and was offered an assessment appointment on 13 February; nine weeks after his initial referral.

Mr. A.T. took matters into his own hands on 26 January when he drove his car into the doors of a local bank. Following this incident he stated that he was "desperate and wants to get himself out of society by hospital admission or prison."[120]

The CRS again assessed Mr. A.T. promptly and liaised with the CMHT worker who brought forward his assessment to 1 February. Mr. A.T. was then discharged from the CRS and his care taken over by the CMHT.

The liaison between the CRS and the CMHT and the bringing forward of the assessment appointment by the CMHT was good practice. However, other than there being a note in the CRS case notes[121] that Mr. A.T.'s care was being transferred there are no written records regarding the transfer of care, assessments or plans for Mr. A.T.

[118] File 2 pages 51 & 52
[119] File 2 page 45
[120] File 2 pages 2-3
[121] File 4 page 42

12.1.8 Conclusion

1. Mr. A.T.'s claims that psychiatric and psychological interventions were available via his employer were not corroborated, nor was the likelihood of him co-operating with these services. The Devon Partnership NHS Trust CPA policy and best practice are clear that families and carers should be involved in the assessment and care planning of an individual with his/her knowledge and permission. The Devon Partnership NHS Trust's policy and best practice were not followed.

2. Mr. A.T. was discharged from the care of the CRS without a contingency plan. The Devon Partnership NHS Trust CPA policy and best practice are clear that a risk/contingency plan should be put in place following a risk assessment.

3. There was a nine-week interval between Mr. A.T, being re-referred to the mental health service and his planned initial assessment.

    3.1 It appears that there was some confusion about how an individual should be referred to the mental health service.

    3.2 The Devon Partnership NHS Trust CPA policy indicated that:

        i) individuals being re-referred to the service should be treated as a priority;

        ii) people referred to the service should be seen within four weeks.

    Mr. A.T.'s case was not treated as a priority and he was not seen within the recommended time frame, instead, Mr. A.T., brought himself to the notice of the services by crashing his car into the doors of a bank.

4. Contrary to best practice there was no written record of Mr. A.T.'s transfer from the CRS to the CMHT. There is no written record of assessments and care plans being shared.

A number of factors have been identified each of which contributed to the care received by Mr. A.T. being less than would be expected by best practice. It cannot be concluded that they contributed to the events of 13 February 2007 but they may have contributed to his mental health problems being managed in less that optimal fashion.

12.1.9 Contributory Factors

1. No corroboration was sought from Mr. A.T.'s family that appropriate help was available from his employer or that he was likely to collaborate with this. As a result of this, although his need for psychological therapy and his continued binge drinking had been identified, no contingency plan was put in place. In the absence of such a plan Mr. A.T.'s mental state was not closely monitored by the mental health services and, according to his own account, he drove his car into the doors of a bank to escape from society. The absence of consultation with Mr. A.T.'s family and of a risk management plan being put in place contributed to the less than optimal management of Mr. A.T.'s mental health problems.

2. There was an interval of nine weeks between Mr. A.T. being re-referred to the mental health services and him being offered an assessment appointment.

   Two factors appear to have contributed to this delay: a lack of clarity of the part of the locum GP as to where to send his referral and the CMHT failing to follow the Trust guidance on re-referrals.

   Again it cannot be concluded that this delay contributed to the events of 13 February 2006 however it did delay the assessment of Mr. A.T.'s on-going needs and the establishment of a care plan to address these.

12.1.10 Service Issue

1. Contrary to best practice there was no written record of Mr. A.T.'s transfer from the CRS to the CMHT. There is no written record of assessments and care plans being shared. While this lack of transfer of written information does not appear to have had any significant impact on the care Mr. A.T. received, it is poor practice and if repeated with other service users is likely to lead to them receiving less than optimal care.

12.2 Assessment and Care planning:

12.2.1 Context

The Trust's CPA Operational policy in force at the time of the incident notes:

"*The assessment should include a diagnosis and formulation or summary*."[122]

The point of a diagnosis or formulation is to provide a conceptual framework in which to understand the problems, difficulties and needs of the individual. Without a clear formulation there is a real danger of assessment and intervention becoming routine, institutionalised and of little relevance to the needs and goals the individual.

The formulation should inform the on-going assessment and interventions by identifying the relationships between needs, strengths, difficulties and the individual's goals.

In carrying out an assessment of need and the consequent formulation good practice indicates that those who know the individual best, who may be affected by his or her mental health problems and who might contribute to the care plan should, where appropriate, be involved in the assessment and care planning process (e.g. *Refocusing The Care Programme Approach*[123]*, p.18, DCP CPA Policy*[124] *p.21).*

[122] The Devon Partnership NHS Trust CPA Operational Policy 2006, page 21
[123] Department of Health (2008) *Refocusing the Care Programme Approach – policy and positive practice guidance.*

12.2.2 Findings.

1. Mr. AT was seen by the CRS, during two episodes of care, and subsequently by a CMHT worker and community psychiatrist, however, there is no strategy recorded to guide further assessment, nor is there a clear formulation recorded which would inform future assessments or intervention.

2. Although a history was taken from Mr. A.T.'s mother when he first presented to the mental health services she was not included in the assessment of either his risk or needs thereafter.

3. It was noted by a number of clinicians Mr. A.T. was lacking in empathy and showed a shallowness of affect[125], that he had trouble in expressing his feeling[126], that he was aloof and cynical.[127] The CRS psychiatrist suggested a diagnosis of "*a partially treated depressive illness on a background of some more dissocial personality difficulties*"[128] and the community psychiatrist was exploring the possibility of a diagnosis of ADHD.[129] It was even noted that when Mr. A.T. was first assessed, his mother had observed that he had been "odd" since birth. Despite this Mr. A.T.'s mother was not consulted to give her understanding of and insight into her son's behaviour and the impact of trait or personality issues were not considered as explanations for Mr. A.T.'s behaviour.

[124] The Devon Partnership NHS Trust CPA Operational Policy 2006, page 21
[125] File 5 page 10
[126] File 4 page 27
[127] File 3 page 3 page 54
[128] File 2 page 35
[129] File 1 page 31

12.2.3 Conclusion

1. The guidance provided in the Devon Partnership NHS Trust CPA policy regarding the involvement of family and carers has been noted above. Mrs. T told the Independent Investigation that she wanted the services to appreciate that Mr. A.T. had been "odd" for most of his life and that his presentation should not be taken at face value.[130] Consulting Mr A.T.'s mother may have influenced the weight given to the various factors of Mr. A.T.'s presentation. Mrs. T. believed that her son used alcohol to cope with his difficulties.[131] If Mrs. T. was correct in her belief then advising Mr. A.T. to abstain from or reduce his alcohol intake would not have been an effective intervention strategy in the absence of alternative coping strategies.

2. It was noted that Mrs. T and Mr. A.T.'s GP were concerned for his safety when he drove his car into the doors of the bank on the 26 January 2006.[132] Mrs. T told the Independent Investigation that she was worried about her son and believed his mental health was deteriorating but that nobody from the mental health services spoke to her. She reported that for her part she phoned the mental health services on two occasions to enquire when her son would be seen and on at least two occasions to ask for advice.[133]

3. A number of trait-like features were noted by various clinical staff during his brief contact with the mental health service but these do not appear to have influenced the interpretations of Mr A.T.'s behaviour. It must, however, be acknowledged that the community psychiatrist who assessed Mr A.T on the 12 February did refer Mr A.T. to the psychologist for an assessment for ADHD,[134] and so, in this instance, these factors did influence the strategy for assessment.

[130] Interview of Mrs T
[131] Ibid
[132] File 2 page 41
[133] Interview of Mrs T
[134] File 1 page 31

4. In evaluating the care offered to Mr. A.T. by the Devon Partnership NHS Trust it must be recognised that:

    a. Mr. AT was in contact with the CMHT for only 13 days (1 to 13 February 2007);

    b. After his initial presentations on 20 October 2006 and 26 January 2007 Mr. A.T. appeared to the staff of CRS to be keen to disengage from the service. Both these presentations were associated with the consumption of alcohol.

5. A number of factors including the failure to include Mr. A.T.'s family in his assessment, the failure to arrive at a clear formulation to inform further assessment and intervention, and a failure to give sufficient weight to the trait-like features displayed by Mr. A.T. contributed to the less than optimal management of his mental health problems. However, it would not be reasonable to conclude that these factors influenced the events of 13 February 2007.

12.2.4 Contributory factors

1. Although Mr. A.T was seen and assessed on a number of occasions, no clear formulation was made to inform either further assessments or intervention. This may well have contributed to the less than optimal management of Mr. A.T.'s mental health problems. It cannot be reasonably concluded, however, that had a clear formulation been available this would have influenced the events of 13 February 2007.

2. Mr. A.T.'s family was not involved in either the assessment of his mental state or in the planning of his care. Their insights would have enabled a better understanding of Mr. A.T.'s problems to be arrived at and a more effective care package to be instituted. It cannot be reasonably concluded however that this improved care would have influenced the events of 13 February 2007.

3. Although a number of clinicians noted trait-like features in Mr. A.T.'s presentation there is no evidence that the presence of axis II factors in Mr. A.T.'s presentation influenced either the strategy for undertaking assessment or the formulation of Mr. A.T.'s problems. Giving greater significance to these factors may have improved the care Mr. A.T. received. It cannot be reasonably concluded however that this improved care would have influenced the events of 13 February 2007.

12.3 Risk Assessment:

12.3.1 Context

In his forward to *Best Practice in Managing Risk (2007)* Louis Appleby commented:
"*Safety is at the centre of all good health care. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk*."[135]

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

"Best practice

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

Fundamentals

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

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

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

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

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

Basic ideas in risk management

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

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

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

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

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

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

Working with service users and carers

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

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

Individual practice and team working

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

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

16. *A risk management plan is only as good as the time and effort put into communicating its findings to others". (P5-6)*[136]

The guidance goes on to distinguish between "positive risk management" and "defensive practice. It says:

"Positive risk management
Decisions about risk management involve improving the service user's quality of life and plans for recovery, while remaining aware of the safety needs of the service user, their carer and the public. Positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach.

Over-defensive practice is bad practice. Avoiding all possible risks is not good for the service user or society in the long term, and can be counterproductive, creating more problems than it solves. Any risk-related decision is likely to be acceptable if:
• it conforms with relevant guidelines;
• it is based on the best information available;
• it is documented; and
• the relevant people are informed.
As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at the time." (p.8)[137]

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

The Devon Partnership NHS Trust Clinical Risk Management policy was last revised in March 2008. It identifies four steps in risk assessment and management:

"STEP ONE – ***Risk screening*** *determines whether a significant level of risk is present.*

STEP TWO - ***In-depth risk assessment*** *of the extent and level of risk.*

STEP THREE - ***Risk management*** *is the process of maximising benefits while balancing risk within acceptable limits, by intervention before or after the event.*

STEP FOUR - ***Risk review*** *is a continuous process of revisiting the risk assessment and the management plan. Reviews should occur at agreed set time intervals or following changes in the individual's presentation and/or circumstances prior to making significant decisions about care."(p.4)*[138]

[137] DoH (2007), *Best Practice in Managing Risk*
[138] The Devon Partnership NHS Trust (2008) Clinical Risk Management Policy,

12.3.2 Findings

1. Mr. A.T.'s behaviour was becoming increasingly dangerous: he reported that at around the age of 18 he had cut his wrists, at the age of 20 he had driven to Beachy Head and contemplated jumping off the cliff.[139] He had presented to the A & E department on 20 October 2006 reporting that he had aborted an attempt to kill himself by carbon monoxide poisoning,[140] and on 26 February he drove his car into the doors of a bank[141] stating that he wanted to escape from society. The conclusions of the risk assessments were consistently that Mr A.T. was at low risk of committing suicide but that the consumption of alcohol increased that risk.[142] However Mrs. T. was convinced that her son's behaviour was deteriorating and that he was becoming an increasing danger to himself.[143] Following the incident in which Mr. A.T. drove into the doors of the bank his GP felt that he should be admitted to hospital.[144] Yet there is no record in Mr A.T.'s clinical notes of this escalating pattern being reflected on and it did not trigger a more comprehensive risk assessment.

2. Similarly, on a number of occasions it was noted that Mr A.T. had expressed ideas of killing people: when he was assessed following his first presentation to mental health services,[145] after he had driven his car into the bank,[146] when he was assessed by the CRS psychiatrist[147] and when he saw the community psychiatrist.[148] These repeated disclosures did not trigger a more comprehensive assessment either of risk *per se* or to understand why he was repeatedly making such disclosures.

   The Devon Partnership NHS Trust Risk management policy states: *"When significant or serious/complex risks are identified an in-depth risk assessment will be carried out using agreed protocols which have been ratified by Devon Partnership NHS Trust"*[149] *(p.4).* The document provides no guidance on what constitutes "serious or complex

[139] File 2 page 2-3
[140] File 5 page 10
[141] File 2 pages 41-42
[142] E.g. File page 42
[143] Interview of Mrs T
[144] File 2 page 41
[145] File 5 page 9
[146] File 2 page 2-3
[147] File2 page 35
[148] File 2 pages 26-28
[149] The Devon Partnership NHS Trust (2008) Clinical Risk Management Policy

risk". Staff appears to have been unclear as to the meaning of this phrase and when level 2 risk assessments were appropriate and should be initiated.

In the case of Mr. A.T.:

- he had twice attempted suicide in a period of three months, once spectacularly by driving his car into the doors of a bank;
- alcohol was identified an a factor increasing his risk of dangerousness/self harming behaviour and he was known to be binge drinking;
- he had recently been prescribed an anti-depressant, Venlafaxine, for which the guideline state that the individual should be closely monitored in the initial period of treatment because of an increased risk of agitated behaviour and suicide;[150]
- his mother and GP felt that he was at significant risk of self harm and should be admitted to hospital.

Despite this it was not felt appropriate to undertake a level 2 risk assessments.

3. As noted above the conclusion of the risk assessment was that Mr. A.T. became more disinhibited and his risk of self harm increased when he consumed alcohol. He was referred to the local drug and alcohol team[151] but despite the fact that it was known that Mr A.T. was binge drinking, no risk or contingency plan was put in place to address this identified risk.

4. The guidance emphasises the importance of collaboration with the patient in carrying out the risk assessment and drawing up a management plan, and the importance placed on clinical judgment, relevant knowledge and training. (See for example principle 1 above). However, a number of staff reported that they perceived the Devon Partnership NHS Trust's risk assessment to be a "box filling" exercise and not one that facilitated or enhance their assessment of risk or enabled them to draw up risk management strategies.[152] In *Best Practice in Managing Risk*[153] it is noted:

[150] NICE Depression in Adults Clinical Guideline 90 (2009)
[151] File 2 page 23
[152] Interview of CP & DB
[153] Department of Health 2007) *Best Practice in Managing Risk*: *Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services.*

"Based on practice-based evidence, this [Structured clinical judgment] is the most effective approach to violence risk management. Although, like the actuarial tools, these instruments are derived from research evidence, the clinician's discretion is seen as a vital element – especially in relation to formulating the assessment of risk and preparing risk management plans based on the risk factors identified."

12.3.3 Conclusion

1. Mr A.T. was displaying a pattern of increasingly dangerous behaviour, he reported on a number of occasions that he had ideas of killing people and his mother believed that his mental state was deteriorating and that he was increasingly becoming a danger to himself. In these circumstances a more comprehensive risk assessment should have been undertaken.

2. Despite the fact that a number of risk assessments were undertaken and the fact that consuming alcohol was identified as placing Mr. A.T. at increased risk, no contingency or risk management plans were drawn up. Mr. A.T.'s mother had attempted to help him control his drinking by removing his bank card,[154] but no comparable plan to manage trigger factors was drawn up by the clinical teams. Identifying risk factors is not sufficient; thought has to be given to how these might be managed.

3. The lack of a more comprehensive risk assessment which included the insights of Mr. A.T.'s mother hindered the development of a more comprehensive understanding of Mr. A.T.'s difficulties and the strategies he employed to deal with these. This probably contributed to the less than optimal care received by Mr. A.T. Similarly the absence of a risk management plan meant that while the fact that Mr. A.T.'s consumption was identified as a factor increasing his risk of self harm and disinhibition, no strategy was put in place to address this risk. While both these factors contributed to the less than optimal management of Mr. A.T.'s mental health problems and possibly to his deteriorating mental state. It would not be reasonable to conclude that they had a direct causal relationship to the events of 13 February 2007.

[154] Mrs T's statement

12.3.4 Contributory factors

1. Despite Mr. A.T. displaying a pattern of increasingly dangerous behaviour a comprehensive risk assessment was not undertaken. This probably contributed to the less than optimal management of Mr. A.T.'s mental health problems and possibly to his deteriorating mental state. It would not be reasonable to conclude that the lack of a comprehensive risk assessment had a direct causal relationship to the events of 13 February 2007.

2. Despite the fact that it was noted on a number of occasions that the consumption of alcohol was a trigger to increased risk of disinhibited behaviour and of self harm, no risk management plan was put in place. This probably contributed to the less than optimal management of Mr. A.T.'s mental health problems and possibly to his deteriorating mental state. It would not be reasonable to conclude that this had a direct causal relationship to the events of 13 February 2007.

12.3.5 Service issue

1. There was a lack of clarity amongst the staff as to when a level 2, comprehensive risk assessment should be undertaken. At least some staff is of the opinion that the current risk assessment format prescribed by the Devon Partnership NHS Trust does not facilitate good assessment or risk management planning. These factors may well have a deleterious effect on the care and treatment provided to those using the services of the Devon Partnership NHS Trust.

12.4 Availability of Psychological Therapy

12.4.1 Context

In the current Government's first substantial statement on the National Health Service, *Equality and Excellence; Liberating the NHS (2010)* the first principle identified is:

"*The Government upholds the values and principles of the NHS: of a comprehensive service free at the point of use and based on clinical need, not on the ability to pay*." (p.3)[155]

Refocusing the Care Programme Approach noted:

"The rights that service users have to an assessment of their needs, the development of a care plan and a review of that care by a professional involved, will continue to be good practice for all." (p.11) [156]

While it is always the right of the individual to seek to meet his/her needs in a manner she/he finds most acceptable and efficient, as indicated in the above statements it must remain the assumption that having identified a need for intervention which the NHS might properly be expected to meet, the service provider should either meet this need itself or facilitate the need being met or assure itself that the need is being met in a competent and evidence based manner *"based on need and not on the ability to pay"..*

[155] *Department of Healt (July 2010) Equality and Excellence; Liberating the NHS.* p.3
[156] Department of health (2008) *Refocusing the Care Programme Approach – policy and positive practice guidance.*

12.4.2 Finding

1. Mr. A.T. was advised when he first came into contact with the mental heath services to seek help from a private CBT therapist; he was also encouraged to seek psychological help via his employers. The CRS believed that the wait for psychological therapy within the Devon Partnership NHS Trust would be a long one. They had no direct access to psychological input.[157]

2. It is noted that within the CMHT there was a prompt response from the psychologist when a request for the assessment of Mr. A.T. was made.

12.4.3 Conclusion

1. While it is always the right of the individual to seek to meet his/her needs in a manner she/he finds most acceptable and efficient, it is inappropriate for a mental health service, having identified a need for intervention which the NHS might properly be expected to meet, to immediately direct the service user to private provision. That the CRS took this route so promptly, without exploring the possibility of accessing psychological therapy within the Devon Partnership NHS Trust, suggests that the belief that psychological therapy could not be accessed in a timely manner was strongly held.

2. The Devon Partnership NHS Trust needs to review how psychological therapies are accessed, how resources are allocated within this service, and the adequacy of the overall level of resourcing of this service.

3. It is unclear what effect the lack of availability of psychological therapy had on Mr. A.T.'s care and treatment. He appeared keen to disengage from the CRS and it is not clear that he would have engaged with this therapeutic service. Nevertheless it is reasonable to conclude that a service which could have been accessed in a timely manner and which had good communication with the CRS, the team caring for Mr. A.T., would have had a better chance of engaging him and addressing his needs than a more remote less integrated team. It would not be reasonable to conclude that

[157] Interview with CP & DB

the absence of a psychological therapy service contributed directly to the events of 13 February 2007.

12.4.4 The following Service Issue was identified:

1. Clients of the CRS did not have access to psychological therapies within the Devon Partnership NHS Trust and the CRS had no route or care pathway into psychological therapy for their clients. This being the case these service users did not have access to appropriate services, as indicated in best practice guidance, unless they went to an alternative provider. This does not, of course, imply that the Devon Partnership NHS Trust should wastefully duplicate any service the service user is receiving from a competent alternative provider.

12.5 Clinical Management

12.5.1 Context

If a mental health service is to function efficiently and effectively each of its component parts: team, units or ward, must have a clear remit as to its responsibilities, the functions it is to undertake and the services it is to provide, and the client group it is to serve. Amongst other things this means that each component unit needs a clear, explicit set of criteria identifying who is eligible for its services. These parameters need to be set by the organisation to ensure that there are no gaps in services or duplication of services and function.

Within teams case management ought to be characterised by:

- clear allocation of staff to specific task/roles;
- the establishment of a clear strategy for assessment;
- testing assessments against explicit eligibility criteria;
- establishing clear time frames;
- establishing a clear decision making process;
- ensuring that all relevant information is available within the clinical case notes.

At the level of the individual service user it is the care co-ordinator who has the key role. *Refocusing the Care Programme Approach*[158] observes:

"The care co-ordinator should have the authority to co-ordinate the delivery of the care plan and ensure that this is respected by all those involved in delivering it regardless of agency of origin. It is important that they are able to support people with multiple needs to access the services need." (p.36)[159]

12.5.2 Findings:

1. Mr. A.T. was seen for assessment by a CMHT worker. Following this assessment it was decided that Mr. A.T. would be placed on a waiting list for a care co-ordinator.[160] It is nowhere made explicit in what way Mr. A.T. met the criteria for care co-ordination. The CMHT worker informed the Investigation that she did not have and was not aware of a set of explicit criteria relating to eligibility for care co-ordination.[161]

2. While waiting to be allocated a care co-ordinator the CMHT worker appeared to undertake the care co-ordination role e.g. referring him to the addiction services[162], liaising with the psychiatrist[163], liaising with the CRS[164] and GP[165]. She was referred to in the notes of the CRS as the care co-ordinator[166], although we were told that the CRS staff tended to use this term loosely.[167]

3. The case was not meaningfully allocated to the CMHT worker therefore her responsibilities under CPA were unclear.

[158] Department of Health (2008) *Refocusing the Care Programme Approach – policy and positive practice guidance.*
[159] Ibid
[160] File 2 page 4
[161] Interview of RV
[162] File 2 page 23
[163] File 2 page 24
[164] File 4 page 42
[165] File 2 page 21
[166] File 2 page 4,
[167] Interview of RV

12.5.3 Conclusion

The CMHT worker undertook the initial assessment of Mr. A.T. but she did not have any clear, explicit eligibility criteria against which to evaluate either Mr. A.T.'s suitability for secondary mental health care (CMHT) or care co-ordination.[168] She discussed her assessment at the team meeting on 6 February. It was decided that Mr. A.T. should be placed on a waiting list for care co-ordination[169] again without any explicit reference to eligibility criteria or identifying what needs this would address. The CMHT worker's next appointment with Mr. A.T. was to inform him of the decision to place him on the waiting list for care co-ordination and that if he needed to contact the CMHT then he should do this via the duty system.[170] It was unclear how long Mr. A.T. would have to wait for a care co-ordinator, for an assessment of his needs or for a further risk assessment. However in the interim, out of a sense of responsibility, as she had carried out the initial assessment, the CMT worker took on the responsibility of co-ordinating Mr. A.T.'s care as noted above.

This lack of clarity about eligibility criteria and about care co-ordination is not safe practice for patients or staff and suggests a weak caseload management system.

The fact that the CMHT worker effectively co-ordinated Mr. A.T.'s care while he was the responsibility of the CMHT was misleading to other teams who projected the responsibilities of care coordinator onto this worker. However it must again be pointed out that Mr. A.T. was seen for the first time by the CMHT on 1 February and on only two subsequent occasions, 6 and 12 February, before the incident occurred.

A number of issues have been identified here:

- Lack of clarity as to the criteria for acceptance by the CMHT;
- Lack of clarity as to who was responsible for Mr. A.T.'s care while he was under the care of the CMHT;
- Lack of clarity regarding allocation of care co-ordination.

[168] Ibid
[169] File 2 page 23
[170] Interview of RV

However given the brief time that Mr. A.T. was in contact with the CMHT it is unlikely that these shortcomings significantly affected either the care he received or contributed to the events of the 13 February 2007. These weaknesses in the system can however be regarded as service issues which could affect the care and treatment of other service users.

12.5.4 Service Issues

1. There was a lack of clarity within the CMHT as to the eligibility criteria for acceptance into this service. This lack of such clarity runs the risk of service users not receiving a consistent service, of functions being duplicated and of limited resources not being used efficiently.

2. There was a lack of clarity within the CMHT regarding eligibility for care co-ordination. This confusion suggests that the service is not providing care and treatment in line with best practice guidelines. Service users may not be receiving co-ordinated care in line with CPA guidelines and that the responsibilities of staff are unclear.

Critical Issues Arising from the Review of other Data other than Timeline

12.6 Documentation

12.6.1 Context

'*The Data Protection Act gives individuals the right to know what information is held about them. It provides a framework to ensure that personal information is handled properly.*

The Act works in two ways. ... it states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- *Fairly and lawfully processed*
- *Processed for limited purposes*
- *Adequate, relevant and not excessive*
- *Accurate and up to date*
- *Not kept for longer than is necessary*
- *Processed in line with your rights*
- *Secure*
- *Not transferred to other countries without adequate protection."*[171]

All NHS Trusts are required to maintain and store clinical records in accordance with the requirement of the Data Protection Act. All records should be archived in such a way that they can be retrieved efficiently. All records pertaining to individual mental health service users should be retained by NHS Trusts for a period of 20 years from the date that treatment or contact with the service ended; or 8 years after the patient's death, if the patient died while still receiving treatment.[172]

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professional have adopted similar guidance.

[171] Data Protection Act 1998
[172] Data protection Act 1998

The GMC states that:

"*'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off."*

Standards for record keeping

The Devon Partnership NHS Trust CPA policy requires that:

- "*Trust CPA documentation and the Trust file format must be used as standard.*
- *Where electronic CPA forms are available, these should be used, keeping signed paper backups.*
- *Records should be kept of all contacts with the service user and with significant others in relation to the care that the patient receives.*
- *There should be a single, integrated, sequential, written record for each service user.*
- *All records should conform to the Mental Health Minimum Data Set.*
- *All documentation should be signed and dated. Black ink must be used and writing must be legible. Hard copies should be printed out from eCPA and signed as correct.*
- *Assessments completed under the Mental Health Act should be handed to the hospital on admission and should be placed on file whether or not an admission has been completed.*
- *Service users have the right to access files through existing Access to Records procedures*."[173]

[173] The Devon Partnership NHS Trust CPA policy 2006 pg 26

12.6.2 Findings

1. Many of the clinical records submitted to the Independent Investigation were not original. Five sets of clinical records, including the Internal Investigation archive and the Primary Care records, were submitted to the Investigation. However we did not receive the team meeting notes recording the team discussions relating to the care of Mr A.T.

2. The files submitted to the Independent investigation contained a mixture of unique and duplicate information. Several of the files were not organised in any obviously logical manner.

3. There were a number of documents missing e.g. the report by the CRS psychiatrist of her interview with Mr. A.T. on 24 October 2006, the Mental Health Act Assessment report 14 February 2007[174], the appointment letter from Addaction.[175]

4. Clinical notes were kept at separate locations and, as a consequence, could not be located in a timely manner. Event though Mr. A.T. was in the service only a short period of time there were two sets of clinical notes relating to him, the CMHT file and the CRS file, in addition there were notes contained in a team file relating to team discussions of Mr. A.T.'s care and an electronic record. All records were not available to all clinicians dealing with Mr. A.T. and did not follow Mr. A.T, as he changed services.

5. Important clinical decisions made during multidisciplinary team meetings were not recorded, with their rationale, in the client's clinical notes. For example although Mr. A.T. was placed on a waiting list for a care co-ordinator, referred to the addiction services and referred to psychology, there is no rationale for these decisions contained within his clinical notes. The absence of the ready availability of such information does not promote coherence in assessment or intervention.

[174] File 2 page 25
[175] File 2 page 23 7 File 4 page 70

6. There was no cross referencing within the notes e.g. hand written entries did not identify that there were fuller clinical assessments recorded on the electronic system. The purpose of having two sets of records, a handwritten and an electronic record, was unclear and unhelpful. The current Devon Partnership NHS Trust policy on record keeping states: "*8.7.1. Where information is documented elsewhere in the ongoing clinical record, this should be included in the file and cross-referenced to the document in the clinical record*."[176]

7. Inconsistent and conflicting information was recorded in Mr. A.T.'s notes e.g. in the CPA 1 record of 21 December 2006[177] it was recorded that Mr. A.T. was not accepted for assessment when this was clearly not the case, he was being put on a waiting list for a care co-ordinator; one account of Mr. A.T. driving into the doors of the bank on 26 January 2007 reports that he wanted to kill himself and that his blood alcohol level was normal [178], while a second account reports that he drove into the bank because he wanted to escape from society either by being admitted to hospital or by being committed to prison and that his blood alcohol level was twice the legal limit.[179] These discrepancies are not noted or commented on in the clinical notes.

8. Some members of staff kept their own copies of clinical notes and reports.[180] This is clearly contrary to both the Data Protection Act and good governance.

9. Notes were occasionally unsigned[181] and frequently the designation of the member of staff was not indicated.

[176] The Devon Partnership NHS Trust Record Keeping and Management Standard p.13
[177] File 2 page 51
[178] File 2 page 41
[179] File 2 page 2-3
[180] Interview of BL & TW
[181] File 2 pages 26-28

12.6.3 Conclusion

1. The standards of record keeping, the availability of clinical information to clinicians through clinical notes and the general management of clinical notes fell below best practice, good governance standards and, on occasion, may not have complied with provisions of the Data Protection Act.

2. While there is no evidence in the current case that the failings in relation to the management of clinical notes and the standards of record keeping either affected the care received by Mr. A.T. or contributed to the events of 13 February 2007, a number of service issues can be identified which might affect the standard of care received by other service users and the Devon Partnership NHS Trust's compliance with the Data Protection Act.

12.6.4 Service issues

1. There was no integrated set of clinical notes to which clinicians had access. As noted above, good clinical notes are essential for continuity of care and sound clinical practice. The absence of good clinical notes or the lack of access to a comprehensive set of clinical notes puts at risk the standards of care that can be offered to service users.

2. While there were some sound, good quality entries in Mr. A.T.'s notes the overall standard of the notes was not high: entries were at times brief and uninformative, inconsistent and conflicting information was recorded without any reflection, the names and designation of the person writing in the notes was not always recorded making it difficult to evaluate the entry. If good quality care is to be delivered to service users this must be based on sound, good quality information.

3. Clinical notes were not made available to the Investigation in an efficient and timely manner. The files made available were often organised poorly and confusingly. The standard for the archiving and retrieval of clinical records fell below the standards required under the Data Protection Act.

12.7 Existence, appropriateness and awareness of operational policies

12.7.1 Context

Without clear policies and effective disseminating and monitoring there is always the danger of a dissociation between the organisation's goals and structures and the goals, assumptions and practices of front line clinicians. In particular it is important that each unit, team or ward has a clear operational policy which sets out its functions and responsibilities, the services it should provide and the client group it is to serve, as well as its relationships to other parts of the organization and to external agencies.

12.7.2 Findings:

1. Many of the staff interviewed said there was not, or they were not aware of, an operational policy for their team.[182]

2. In the absence of a clear operational policy the CMHT staff created their own categorisation system which determined response times and priority for care co-ordination.[183] This raises issues of whole systems strategies, service interfaces and Key Performance Indicators.

3. There was a lack of clarity as to the care pathway into the CMHT with the result that the GP referral letter sent on 8 December was received by the CMHT only on the 21 December.[184] This raises issues of clarity, adequacy and accessibility of protocols.

4. The operational policy for the CRS was last reviewed in 2006. The team was developing and being re-organised at this time. This document appears to be as much a business/development plan as an operational policy. It is not clear from the document what the process of approval, acceptance and implementation was.

[182] Interviews of AHR & RV
[183] Interview CC
[184] File 2 pages 51-52

12.7.3 Conclusion

1. Operational policies governing the activities of at least the CRS and the CMHT did not appear to be in place. In the absence of such policies the teams and individual clinicians created their own categorisation system which determined response times and priority for care co-ordination.[185]

2. Given the absence of such policies there were no mechanisms in place to monitor adherence to the policies at either the team or individual level.

3. There is no evidence that the absence of operational policies affected the care received by Mr. A.T. It is unclear if an operational policy had been in place for the CMHT whether Mr. A.T. would have been allocated a care co-ordinator rather than being placed on a waiting list. It would not be reasonable to conclude that the absence of an operational policy contributed to the events of 13 February 2006. The absence of clear operational policies does, however, put at risk the consistency of services which service users receive.

12.7.4 Service Issue

1. Operational policies governing the activities of at least the CRS and the CMHT did not appear to be in place. Teams and individual clinicians created their own categorisation system which determined response times and priority for care co-ordination.[186] The absence of clear operational policies puts at risk the consistency of services which service users receive.

[185] Interview CC
[186] Interview CC

12.8 Dissociation between the senior management team and front line staff

1. The Devon Partnership NHS Trust Board has instituted a number of positive, potentially service improving initiatives. These include:

- introducing a Clinical Directorate model to manage services with the aims of enabling closer working between managers and clinicians, ensuring clear lines of accountability and establishing more robust clinical governance arrangements;

- the Introduction of a new electronic clinical record system, RiO;

- appointing a Co-Medical Director with the remit of improving quality, safety and clinical governance;

- introducing a range of initiatives to promote quality and safety, including:

    - a programme of work to improve medicines management;
    - a programme of regular peer reviews and executive 'walk around' audits of frontline services;
    - active participation in the local multi-agency safeguarding forum and the appointment of safeguarding officers within the organisation;
    - investment in Patient Safety Officer training and the appointment of a dedicated, Trust-wide lead with responsibility for patient safety;
    - the introduction of a programme of Practice Quality Audits at ward level.[187]

There seems little doubt about the enthusiasm of the Devon Partnership NHS Trust Board to improve the safety and quality of the service the Trust provides and it has to be acknowledged that it has worked hard to improve the level of engagement in the governance process. However there appears to remain a disconnection between the aspirations of the Board and what is occurring within the clinical teams.

[187] Statement of HS

- The front line staff appeared to be largely unaware of any but the most obvious organisational changes e.g. the re-organisation of the CMHT teams into Well Being and Recovery and Independent Living teams; although some staff were aware of the Executive walk-around initiative.

- The issue of a lack of awareness of operational policies has been noted above.

- Some staff felt that the senior management did not understand the nature of their work. Members of the CRS, for example, felt that the Devon Partnership NHS Trust's senior managers failed to appreciate that while risk assessment was a central element of their work, this was undertaken in a very particular context. In consequence of this lack of understanding, the Trust did not provide appropriate training thus failing to meet their need.[188]

- Participation in and adherence to the governance process remains weak and below what could be expected for a statutory organisation as is evidenced by the very low return rates with the latest Quality Practice Audits.

12.8.2 Conclusion

1. There does not appear to be a clear, evaluated strategy for disseminating initiatives and new strategies within the Trust.
2. There is no evidence that an analysis of the impact of new strategies is regularly undertaken.
3. There do not appear to be clear management of change strategies in place to complement any analyses of impact that are undertaken.
4. While the relationship between the senior management of The Devon Partnership NHS Trust and those providing direct clinical care is important for the success of the Trust and the improving quality of the services it delivers, there is no evidence that any dissociation between the vision of the Devon Partnership NHS Trust Board and the aims and practices of the clinicians treating Mr. A.T. directly impacted on either his care or the events of 13 February 2007.

[188] Interview of CP & DB

13. Summary of Conclusions

13.1.1 Root Cause Analysis

In order to ensure that the findings are understood within the root cause analysis methodology each finding is placed within one of the three categories: **causal factor, contributory factor**, **service Issue.**

13.1.1.1 Causal Factors

The Independent Investigation concluded that there were no direct acts of omission or commission that could be positively identified to have had a direct causal bearing on the events of 13 February 2007.

13.1.1.2 Contributory Factors

The Independent Investigation identified five factors that contributed to the less than optimally care and treatment provide by the Devon Partnership NHS Trust to Mr. A.T. received.

1. Referral, discharge and transfer practices;
2. Assessment and Care planning;
3. Risk Assessment;
4. Availability of psychological therapy;
5. Clinical Management.

13.1.1.3 Service Issues

The Independent Investigation identified three Service Issues:

1. Documentation;
2. Existence, appropriateness and awareness of operational policies;
3. Dissociation between the senior management team and front line staff.

Although there is no evidence that these service issues affected the care and treatment received by Mr. A.T. they need to be addressed if the care and treatment provided by the

Devon Partnership NHS Trust is to meet best practice clinical and governance standards.

13.1.2 Conclusions

As noted earlier in this report His Honour Judge Cottle, at the trial of Mr A.T., concluded that while Mr A.T. was suffering from a mental illness at the time he killed Miss S it was "the excessive consumption of alcohol"[189] which triggered his violent behaviour.

Mr A.T. first came into contact with the mental health services on 20 October 2006 and the homicide occurred on 13 February 2007, a little less than four months later. Mr A.T.'s mother stated that her son had been "odd" since birth, that he used alcohol as a coping mechanism related to this "oddness" and that his mental state was deteriorating. She complained that no-one spoke to her or sought her understanding of her son. Had they done so it is possible that those clinicians dealing with Mr A.T. might have conceptualised his behaviour differently and considered a different pattern of assessment and intervention.

It is possible that Mr A.T.'s needs and the risk he posed might have been better understood had a more comprehensive assessment been undertaken. However, even those who knew Mr. A.T. best, his mother and his GP, were primarily concerned about Mr A.T. harming himself rather than him being a risk to the safety of others. Such an assessment might have provided a better understanding of Mr. A.T.'s needs and difficulties but it is difficult to see how, given the time frame over which these events unfolded, this, in itself, would have averted the tragic events of 13 February.

Mr. A.T., himself, indicated that he was finding it difficult to cope and wanted to be removed from society. His manner of expressing this concern and discomfort led various clinicians to identify a sense of concern but one which they could not articulate or "not put their finger on." Mr. A.T.'s manner of presenting himself may well have been related to enduring characteristics rather than any transient symptomatology, Mrs. T. has informed the Independent Investigation that while Mr. A.T. has been in prison he has been given a diagnosis of Autistic Spectrum Disorder. However Mr. A.T was under the

[189] RvAT, Sentencing remarks of His Honour Judge Cottle

care of the CMHT for only two weeks, not enough time to properly assess and explore this issue.

A number of areas have been identified in which Mr. A.T.'s care fell short of best practice. However, given the short time Mr. A.T. was in contact with mental health services, it is difficult convincingly to conclude that had this better practice been in place this would have averted the tragic events of 13 February 2007.

14. Clinical Governance Processes

14.1 Context

Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.[190]

NHS Trusts implement clinical governance systems to ensure that healthcare is delivered in accordance with best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

National Service Framework Self Assessment

Following the publication of the National Service Framework (NSF) in Mental Health in 1999 a self-assessment process was introduced to monitor the progress Trusts were making in implementing the NSF targets. The Devon Partnership NHS Trust self assessment for the years 2005, 2006 and 2007 are reported below.

Table 1:

The Devon Partnership NHS Trust NSF Self Assessments for 2005, 2006 and 2007

2005	
Primary/secondary interface	At or above SHA average
Assertive outreach	At or above SHA average
Dual diagnosis	At or above SHA average

2006	
Primary/secondary interface	Amber
Crisis resolution	Green

[190] http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH

2007	
Primary/secondary interface	Amber
Assertive outreach	Green
Dual diagnosis	Amber
Crisis resolution	Amber

The Care Quality Commission's Annual Health Check gives all NHS organisations a two-part annual performance rating. The Annual Health check performance rating for the Devon Partnership NHS Trust in 2006/7 showed that the quality of the service was "excellent" and that its use of resources was "fair". In 2008/9 the performance rating for the Devon Partnership NHS Trust showed that the quality of the service was "fair" and that the use of resources was "good".

14.2 Findings

The Devon Partnership NHS Trust has acknowledged that there have been concerns around the clinical governance framework within the Trust. There have been three restructurings over the past four years.

In early 2006 it was recognised that there was a need to improve clinical engagement, leadership and involvement in the designing of services. The Devon Partnership NHS Trust worked with the Department of Health Clinical Governance Support Team to develop a Clinical Cabinet Model. The Clinical Cabinet was the overarching Clinical Governance Committee with a "plan, do and check" approach. Professional groups set minimum standards and Professional Expert Groups (PEG's) designed quality and implementation guides.

In 2009/2010 this structure was reviewed. The Clinical Cabinet was noted to be excellent as an engagement mechanism but not effective in terms of providing ongoing assurance. In consequence it was removed from the governance reporting arrangements in 2010.

In 2008 the Devon Partnership NHS Trust invested in patient safety and a small group of senior clinicians undertook advanced training. This led to a redesign of the clinical governance structure and strategy of the Trust with more emphasis being placed on the engagement and involvement of all Trust employees.

In April 2010 the Devon Partnership NHS Trust set up a Trust Management Board. This is made up of the executive team, and the clinical directors and their management partners. The role of this body is to ensure that clinical governance is incorporated in all areas of service delivery. Reporting to the Management Board are the four Clinical Directorates (adults of working age, older people, secure services and specialist services) and the Professions Directorate (medical, nursing, psychology, social work, occupational therapy, pharmacy).

The Devon Partnership NHS Trust has introduced a range of systems and processes to enhance and promote quality and safety across the organisation. These included:

- a major programme of work to improve all aspects of medicines management;
- a programme of regular peer reviews and executive 'walk around' audits of frontline services;
- active participation in the local multi-agency safeguarding forum and the appointment of safeguarding officers within the organisation;
- investment in leading-edge Patient Safety Officer training with the Institute of Health Improvement and Leadership for Patient Safety training and the appointment of a dedicated, Trust-wide lead with responsibility for patient safety;
- the introduction of a programme of Practice Quality Audits at ward level to be rolled out to all clinical teams;
- the introduction of team and corporate level Quality Dashboards which monitor, key performance indicators that have been prioritised by the Trust Board, across the safety, timeliness, personalisation, recovery focus and sustainability domains. This enables the Trust Board to have a more accurate picture of what is being achieved at an individual and team level;
- the Trust Board has introduced a "story telling" initiative where service users describe their experiences to enable Trust Board member to gain a better understanding of how clinical services function in practice;

- the introduction of “Good Enough for my Family” service standards;
- increased the Medical Director capacity by appointing a Co-Medical Director who has taken the lead responsibility for clinical governance (April 2010);
- strengthened the role of Director of Nursing with respect to professional practice.

The Independent Investigation identified three issues related to governance:

- Record keeping
- Operational policies
- Engagement of clinical staff

Clinical Records

The Devon Partnership NHS Trust has recognised and declared to its registering authority shortfalls in clinical recordkeeping in four areas:

1. the content of clinical records in relation to comprehensive care planning (including risk assessment);
2. the quality of the written records;
3. multiple records and inconsistent availability/use of electronic records;
4. the tracking and availability of archived records.

Action taken

Core practice standards have been developed across the Devon Partnership NHS Trust to address initial contact, assessment and formulation, personal recovery planning, coordination and delivery of services and managing transition. Support has been provided to teams in the form of coaching to support implementation. To date 14 teams have been engaged in the process. The implementation of the core practice standards is supported by teams monitoring their level of compliance using the Practice Quality Audit Tool.

A programme of audit of the record keeping standards, overseen by the Information Governance Group, commenced in 2008/9. This was rolled out across the Devon Partnership NHS Trust in 2009/10.

In early 2009 work began on designing and testing the use of a single clinical record system to address the historic variations across the Trust. This will become redundant with the introduction of RiO (electronic clinical record system). The RiO system, which has been implemented successfully in other Mental Health Trusts, is supported by intensive staff training and became operational in North Devon in May 2010. The system is currently being rolled-out across the rest of the organisation. It will be fully implemented by March 2011.

From March 2009 all staff were required to undertake Information Governance Training by way of e-learning. 85% of staff had completed this by March 2010.

The Devon Partnership NHS Trust has acknowledged the difficulty that the Independent Investigation experienced in relation to the tracking and archiving of records.[191] A process had been established for the collation of records required for Internal and Independent Investigations and other enquiries. The Trust took immediate action following concerns highlighted by the Independent Investigation and refined this process incorporating it into the Records Management Policy that was ratified by the Trust Board in July 2010**.**

The importance of the active engagement of staff in clinical audit as a tool for the improvement of clinical practice is clearly identified in 'Services Good Enough for My Family' in the strategic aims of the Devon Partnership NHS Trust. The Practice Quality Audit (PQA) was re-launched in April 2009 with the aim of promoting a more person-centred and recovery orientated approach to care and service provision within the Devon Partnership NHS Trust. The standards employed are those identified in the Recovery Co-ordination Policy Implementation Guide and the Devon Partnership NHS Trust's Care Programme Approach Policy, December 2008. To date three audit cycles have been completed across some areas of the Trust. (See Table 2 for details).

[191] CT 1 pg 8

Table 2:

Clinical teams undertaking Practice Quality Audits between November 2009 and June 2010

Date	November 2009 (Phase 1)	April 2010 (Phase 2)	June 2010 (Phase 3)
Teams	Torquay R&IL, Waverley, Torquay Assertive Outreach Team, Waverley Paignton and Brixham R&IL, Culverhay, Torbay MW&A, Waverley	Exeter,East & Mid AOT, Exeter, East & Mid Well Being and Access, Exeter East and Mid Devon R&IL, Exeter, East & Mid STEP, North Devon AOT, North Devon Well Being and Access, North Devon R&IL, North Devon STEP, S Hams& W Devon AOS, S Hams & W Devon R&IL,	AOS/STEP, CMHT, Psychology and Psychological Therapies, Psychotherapy, Recovery and Independent Living, Wellbeing and Access, Addictions, 10 inpatient wards including some from each of: Eating Disorders, OPMH, Adult Inpatients, Forensics,

		S Hams &W Devon Well Being and Access, S Hams/W Devon STEP, Torbay AOS, Torbay W&A, Torquay R&IL	

Table 3:

Response rate fro completion of Practice Quality Audits between November 2009 and June 2010

	November 2009	April 2010	June 2010
Number of eligible staff	**29**	**292**	**508**
Number of audits returned	**18**	**138**	**78**
Percentage	**62%**	**47%**	**15%**

The response rate for the audit in June 2010 was low, with only 15.4% of possible responses returned. The figures cannot, therefore, be confidently regarded as giving an accurate picture of the quality of the clinical services provided across the Devon Partnership NHS Trust

Assessment and formulation

Although the first phase of the PQA in November 2009 reported that 100% of the assessments were strengths based, this dropped to 75% in phases 2 and 3. Only 26% of assessments in phase 3 included the service user's desired outcomes**.**

Risk screening

Where people had had a risk screening and immediate risks had been identified immediate action plans were put in place in 100% of cases.

Personal recovery plan (care plan)

Only 32% of people in phase 3 had a personal recovery plan in place compared with 94% of people in phase 1 and 76% of people in phase 2. All of the recovery plans had been developed with the person. Where medication was part of the plan every person had had this reviewed but only 52% had a date set for the next review.

Review

75% of people who had been on a caseload for 6 months had had their personal recovery planned reviewed.

Record keeping and communication

The quality of the record keeping in phase 3 of the audit was generally high with over 90% of notes conforming to standards.[192]

The Clinical Record Self Monitoring (CRSM) Survey Result for June - July 2010 showed return rates between 22% and 100%. Data was available for 28 out of the 73 clinical teams.

There was an achievement rate of between 0% and 73% for recovery plans meeting identified standards.[193]

The quality dashboard, was at the time of writing this report, unable to note performance against the following Key Performance indicators (KPIs) as data collection was still in progress:

(KPI-156) Experience of patients;

(KPI-193) Clinical record keeping standards are met;

(KPI-194) Each person has a recovery plan;

[192] 08_061_PQA_Phase_3_Trustwide_report

[193] CRSMS_Analysis_June-July_10

(KPI-195) Recovery plans meet clinical standards;
(KPI-196) Care follows agreed pathways;
(KPI-197) Service compliant with registration standards;
(KPI-198) Practice quality audits delivered on time;
(KPI-201) Teams self improvement log up to date.

However where data are available they do provide a clear picture of achievement against targets, for example the percentage of individuals assessed within four weeks of referral is reported below in table 4.[194]

Table 4:
Percentage of referrals assessed within four weeks.

Jan-09		Feb-10		Mar-10		Apr-10		May-10		Jun-10	
Min Std	Actual	Min Std	Actual	Min Std	Actual	Min Std	Actual	Min Std	Actual	Min Std	Actual
72%	71%	72%	79%	72%	81%	72%	73%	72%	77%	72%	73%

The Devon Partnership NHS Trust is monitoring the compliance of staff with its policy on supervision and personal development (PDR). In October 2010 it was recorded that 83.1% of staff had a current PDR and 90.4% had had supervision in the pervious 60 days. This represented a 0.8% improvement with respect to the previous report.

14.3 Conclusion

In the case of Mr. A.T. there are a number of identifiable areas in which the Devon Partnership NHS Trust policies and national best practice guidance were not followed.

[194] Item_7_Performance_Report_Appendix_2

There are also a number of areas in which Trust policies and their dissemination can be improved.

Having said this it would be inappropriate to make any generalised statements about the functioning and clinical practices of the Devon Partnership NHS Trust based on the case of one individual who was under the care of the Trust for such a short period of time.

The Devon Partnership NHS Trust Board has worked hard and invested in its clinical governance arrangements; it has the reorganised its governance structures and is attempting to engage staff in service design and governance. Many of the everyday actions and decisions that take place in clinical practice fall ‘sub audit’ and governance systems often measure compliance and quantity rather than content and quality. The Devon Partnership NHS Trust is trying to build a quality monitoring system through the development of practice standards. It was clear to the Independent Investigation that the Corporate Team has a clear vision and high aspirations about where they are going and what they wish to achieve for the people of Devon. It is collecting information to help achieve this. While there remains a disconnection between front line clinicians, some of whom have yet to engage fully with the governance process, and the corporate team, the corporate team is making efforts to bridge the gap. It needs to be appreciated across the Devon Partnership NHS Trust that governance is not an optional activity but the responsibility of all Trust employees. Clinical governance is often seen as a complex process. It needs to be kept simple for busy clinical teams by incorporating it into systems and processes that are already in place. For example as case notes are already being scrutinised in supervision, this time can also be used to complete the Practice Quality Audit thereby bringing it to life and promoting local ownership of the audit process.

15. The Devon Partnership NHS Trust's Response to the Incident and the Internal Investigation

The following section sets out the Devon Partnership NHS Trust's response to the events of 13 February 2007.

15.1 The Devon Partnership NHS Trust Serious Untoward Incident Process

The Devon Partnership NHS Trust has an Incident Reporting Management and Review Policy which was scheduled for review in May 2010. This makes reference to the guidance given by the NPSA in *Being Open* and incorporates the principles of this guidance. The policy is designed as an electronic document with numerous hyper links to other documents for further explanation and detail.

15.2 The Devon Partnership NHS Trust Internal Investigation

In accordance with the Devon Partnership NHS Trust procedures an Incident Report Form was completed by the CMHT manager on 15 February 2007. The incident was graded as "Rare" and "Catastrophic".

A three day report was completed on 6 March by the CMHT Manager. This provided a brief chronology of Mr. A.T.'s contact with the Devon Partnership NHS Trust. It reported that he had been assessed by an ASW and a section 12 doctor in the police station following his arrest on 13 February 2007. They had concluded that an assessment under the Mental Health Act (1983) was not required, and that Mr. A.T. had been found fit to plead.

It was reported that Mr. A.T.'s mother had been contacted and support was offered by the CMHT manager on 15 February. A team debriefing had taken place on 5 March.

No issues of concern were identified and no recommendations were made.

15.3 Review of the Devon Partnership NHS Trust Internal Investigation

The Independent Investigation was provided with two internal inquiry reports. The first entitled "Report Re: The Review of the Clinical Care of Mr. A.T"[195] was dated 8 August 2007. The second report was entitled: "Second Internal Review Report Re: The Review of the Clinical Care for AT (6)." It was dated 27 November 2007.

The terms of reference for the first of these reports are recorded as:

- *"Client's contact with mental health services*
- *Assessment of risk*
- *Involvement with alcohol services*
- *Team debrief*
- *Family involvement*."[196]

The terms of reference reported for the second report were recorded as follows:
1. To review the original serious untoward incident of the care for Mr. A.T. (May 2007)
2. To complete a root cause analysis of the serious untoward incident and events leading up to the incident."[197]

The second report notes that it was commissioned "*following discussion with a representative of the Strategic Health Authority*."[198] No documentary evidence was presented to the Investigation as to the concerns of the SHA, but witnesses believed that the report was not robust enough and, amongst other things, the SHA wanted a root cause analysis to be part of the investigations process and report, hence the reference to this in the terms of reference for the second report.

The investigation team for the first investigation was made up of a Clinical Nurse Manager and an Assistant General Manager. A nurse consultant was added to this team for the second report.

[195] Mr A.T.'s name has been substituted by the initials A.T.
[196] First Internal Investigation page 1
[197] Second Internal Investigation page 3
[198] Ibid

15.3.1 Findings of the Internal Review

The findings of the two reports are essentially the same:

1. "*Mr. A.T. received timely and appropriate assessment, interventions and treatment plans from the Crisis Resolution Service, commensurate with his mental health presentation*."[199]
2. "In *relation to Mr. A.T.'s mental illness diagnosis of depression, he received ongoing treatment and medication reviews and was monitored by his GP.*"[200]
3. "*With regard to his alcohol misuse problem this was discussed with him and a referral was made to Addaction, although Mr. A.T. did not attend his appointment*."[201]
4. "*There was on-going assessment to assist in the formulation of Mr. A.T.'s mental health problems*."[202]
5. "*Assessment of risk was undertaken throughout Mr. A.T.'s contact with services. Emphasis was placed on risk to self, as this was a key element of Mr. A.T.'s presentation to services on each occasion. Although Mr. A.T. talked about thoughts of wanting to kill, none of the available assessment or intervention records indicate that he asked for help with these thoughts specifically. His risk to others manifested as fighting when intoxicated…. And none of the available assessment or intervention records indicated that Mr. A.T. was considered to be at risk of killing*."[203]
6. "*There is evidence of assistance to arrange access to private Cognitive Behavioural Therapy, at the request of Mr. A.T. and his mother. …… A psychology assessment was also planned for 22 February 2007*…"[204]
7. "*When considering the contents of notes recording the care Mr. A.T. received, his care co-ordination could be interpreted as superficial rather than not engaging i.e. he responded in relation to the contacts, but did not necessarily attend any appointments that would enable change e.g. Addaction."*[205]

[199] Ibid page 8
[200] ibid
[201] Ibid
[202] Ibid
[203] Ibid
[204] Ibid
[205] Ibid page 9

8. *"Mr. A.T. was seen by [the community psychiatrist] two days prior to committing the offence and reiterated his problems with alcohol and drug abuse and that drugs could cause him to loose his inhibitions and get into fights. During this meeting Mr. A.T. reported that the medication had started to help his mood and made him feel happier in himself. [The community psychiatrist] planned to meet with Mr. A.T. and his mother to continue the assessment and formulation."*[206]

Six service delivery problems were identified:

"*1. The Community Mental Health Team clinical file could not be located to assist this or the initial review and the lack of a single, accessible integrated patient record has hindered the completion of comprehensive reviews.*
2. *There were no copies of level one risk assessments in relation to Crisis Resolution Service contacts on 20 October 2006 and 26 January 2007, although this is a requirement for all new and re-referred service users. A level two risk assessment was not completed. Centralised risk information was therefore not available or accessible electronically until a level one risk assessment was completed on 1 February 2007.*
3. *A copy of the psychiatrist's letter following the home visit and review on 24 October 2006 could not be located.*
4. *Cognitive Behaviour Therapy could not be provided quickly or within the service.*
5. *There was a delay of approximately one month whilst Mr. A.T. responded to the standard "opt in" lette.r*
6. *Abbreviations were used in the Crisis Resolution Service notes e.g. H.V. for home visit, T.C. for telephone contact*."[207]

15.3.2 Comment on the Internal Review

The investigation team for the first Internal Investigation was comprised of an experienced nurse and an experienced general manager with a background in social work. One of these individuals had some experience in undertaking investigations but she reported that she had received no training for this and specifically no training in Root

[206] Ibid
[207] Ibid page 10

Cause Analysis (RCA).[208] The other member of the team reported that she had little experience in undertaking reviews.[209]

Further it was reported that:

- they were not allocated any time to undertake this serious investigation, it had to be carried out in addition to their normal work load;
- no-one discussed with them the terms of reference for the investigation nor clarified the purpose of the investigation with them.[210]

These Investigators volunteered during interview that they felt that their report was not as robust as it might have been and were happy that they were provided with the support of the third member of the team to review the original report. The third member of the team had received training in RCA and had used this methodology in a number of investigations.

With respect to her role in this investigation she reported:

"*I was commissioned……..to revise the internal report on 25 October 2007…with the requirement to complete the revised report in readiness for the planned meeting with the Strategic Health Authority on 17 December 2007*."[211] The role of this third member was then not to assist in a further Internal Investigation but to assist the other members of the team to evaluate the information they had collected in a more systematic manner, employing the RCA approach, arrive at more robust evidence based conclusions and restructure the report.

Conclusion:

The team initially recruited to undertake this serious investigation was not appropriately constituted. The members of the team did not have appropriate training, as they are happy to acknowledge, they were not given appropriate support and guidance, and they were not given the time to undertake the investigation in a rigorous manner. Although a third member of the team, with greater relevant experience, was later brought in, this was after the information had been collected and reviewed. Her role was essentially to

[208] Interview BL
[209] Statement EA
[210] Interview BL
[211] Statement of TW

improve the report of the investigation and ensure that its conclusions were explicitly based on the available information.

Terms of reference:
The terms of reference for the investigation make no reference to either best practice, national guidance or Devon Partnership NHS Trust policies which should enshrine these. They do, however, identify the need to review risk assessment, the involvement of the alcohol services and the involvement of the family.

Conclusion:
The terms of reference for the Internal Investigation could have been more robust. They should have been discussed with the Investigating team prior to them undertaking the investigation. The purpose of the investigation should have been made explicit and discussed with the investigation team.

Conduct of the Investigation:
The Internal Investigation reported that it had difficulty accessing clinical notes in a timely manner. A finding repeated in the current investigation two and a half years later.

As part of their investigation the Internal Investigation team interviewed Mr A.T.'s mother, his GP and the managers of the CMHT and the CRS. The CRS manager had had some contact with Mr A.T. but he was interviewed as the manager of the team rather than a clinician who was familiar with Mr A.T. and his care. Therefore, with the exception of Mr. A.T.'s GP, no clinicians involved with Mr. A.T.'s care were consulted as part of the Internal Investigation, nor are any statements from clinicians referred to in the reports.

Conclusion:
That Mr. A.T.'s mother's views were sought was an example of good practice. However, one would have expected, at least those clinicians who were most involved with Mr. A.T.'s care, to be interviewed or asked to provide statements, their insights into Mr A.T.'s behaviour sought and an explanation of their behaviour elicited.

Compliance with the *Being Open* Guidance

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006. The *Being Open* safer practice notice is consistent with previous recommendations by the NHS Litigation Authority (NHSLA, litigation circular, 2002) and Welsh Risk Pool (technical note 23/2001). These circulars encouraged healthcare staff to apologise to patients and/or their carers who have been harmed or placed at risk as a result of their healthcare treatment. The *Being Open* guidance requires that those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done[132].

The *Being Open* guidance focuses on the experience of patients and their carers, nevertheless the principles it identifies apply to harm that may have occurred to members of the public resulting from a potential healthcare failure.

Mr. A.T.'s mother was contacted on several occasions by member of the Trust staff. She was contacted on 15 February 2007 by the CMHT manager who offered support; [212] she was interviewed as part of the Internal Investigation and she was given oral feedback following the Internal Investigation.

"*Mrs. T recalls that she raised the same issues regarding the time frame for appointments and about not being consulted in any of the assessments. Mrs. T stated that the Trust came back to see her at the end on the internal investigation and went through a "raft of measures" with issues about records not being passed on and that in*

[212] File 4 page 67

the future people would be seen more quickly. Mrs. T's view is that the Trust did address her concerns and she is aware through her own social network that people are being seen more quickly for CBT or one to one therapy."[213]

It is not clear that in their oral feedback to Mrs. T that the Trust apologised or made a "sincere and compassionate statement of regret for the distress" she and her family were experiencing. These are not stated in the Internal Investigation report. However Mrs. T. told the Independent Investigation that she did feel that her concerns had been addressed by the Internal Inquiry.

There is no evidence that Miss S's family were contacted or in anyway involved in the Internal Investigation. There is no explanation offered in the notes as to why this was the case.

Conclusion:
The Trust did make contact with Mrs. T following the arrest of her son, she was interviewed as part of the Internal Investigation and she felt that her concerns had been addressed thus complying with a number of the *Being Open* principles. However there is no evidence that the Trust acknowledged the distress of Mr. A.T.'s family or offered any apology or statement of regret for the distress they were experiencing.

There is no evidence that the Trust attempted to make contact with the family of Miss. S. There is no explanation as to why this was the case.

15.3.3 Recommendations of the Internal Review

The Internal Investigation made seven recommendations:

1. *The Trust finalises the implementation of a single integrated service user clinical record.*
2. *A review of the current system for tracking and retrieving clinical files.*
3. *Crisis Resolution Service to incorporate level one and level two risk assessments into practice, pending a review of the Trust clinical assessment policy.*

[213] The statement of Mrs T.

4. *A review of the Trust clinical risk policy, particularly in relation to viable and efficient risk assessment and management tools.*
5. *All professionals should ensure they comply with Trust standards for recording e.g. printed names and no use of abbreviations.*
6. *Prompt access to psychological therapies be incorporated into the Trust's "Improving Access to Psychological Therapies" work.*
7. *The Trust review the usefulness of an 'opt in' process as part of its improvements to services and networks."*[214]

15.3 4 Devon Partnership NHS Trust's response to the recommendations.

The members of the Internal Investigation team informed the Independent Investigation that they were not involved in drawing up an action plan in relation to their recommendations and were unclear what had happened to them.[215]

In 2007 there were four incidents involving a homicide and the Devon Partnership NHS Trust consolidated the findings from each of the Internal Investigation into one action plan with 16 recommendations. The actions in relation to this case are detailed below:

1. The Devon Partnership NHS Trust will integrate service user clinical records to ensure there is a single clinical record for each person that receives care/treatment from our services.

   Action: The Devon Partnership NHS Trust will project manage the integration of service user records within inpatient services and community services.

   Position statement: 16 June 2010 RiO project in place to deliver an electronic integrated record system across the Trust. Implementation underway and due for completion in November 2011.

   Status: Amber.

2. The Devon Partnership NHS Trust will create a robust system for tracking and retrieving clinical files.

[214] Second Internal Investigation page 10
[215] Interviews of TW, EA, BL

Action: The Devon Partnership NHS Trust will identify the best system for tracking and retrieving clinical files. The Trust will implement the system across the organization.

Position statement: 7 July 2010 systems are in place for tracking and retrieving clinical records across the Devon Partnership NHS Trust. These systems vary, the information Governance team will advise/assist in accessing records. The implementation of the RiO system will remove the need for tracking of files as they will be available on line; implementation commenced June 2010 and completes in March 2011.

Status: Amber.

3. The Crisis Resolution Services will incorporate level one and level two risk assessments into practice pending a review of the Trust Clinical Risk Assessment Policy.

   Action: The Crisis Resolution Service Managers will be tasked with incorporating level one and level two risk assessments into their practice.

   Position Statement: 23/5/08 – Crisis Team Leaders were tasked with this on 31 March 2008 by the Deputy Director of Care and required to report back on any barriers to incorporating level one and two risk assessments into practice by the end of April 2008. 29/6/09 - ongoing assurance to be obtained via clinical audit programme; including peer and executive walk around audits and Practice Quality Audit.

   Status: Green.

4. The Devon Partnership NHS Trust will ensure all clinical staff are aware of the Trust standards for recording clinical information e.g. printed name and no use of abbreviations.

   Action: The Trust will communicate our expectation regarding the standards to all clinical staff.

   Position Statement: 3/3/09 - Expectations regarding the standards for recording clinical information have been communicated to all clinical staff. 29/6/09 - ongoing assurance to be obtained via clinical audit programme; including peer and executive walk around audits and Practice Quality Audit.

   Status: Green.

5. Access to Psychological Therapies will be reviewed and appropriate action implemented to ensure prompt access to Psychological Therapies is available.
   Action: Psychological Therapies Performance Group to review current accessibility to Psychological Therapies and to set out a clear action plan for improving access
   9/1/09 - Actions to achieve improved access are underway. Actions are in three areas – care pathway development, workforce mapping and development, and service growth through the national IAPT initiative.
   Position Statement: 24/06/09 Workforce mapping complete.

6. The Devon Partnership NHS Trust will review the usefulness of an 'opt in' process as part of its improvement to services and networks.
   Action: The CMHT co-ordination Group to review this as part of the implementation of networks.
   Position Statement: 18/12/08 - Opt in process still in use. On evidence from GPs in Torbay about telephone follow up opt in has been continued within Mental Wellbeing and Access. This may change as capacity, single point of access and duty systems develop. 21/09/09 - PEG [Professional Expert Groups] reviewed Care Pathway on 16/07/2009 to clarify the place/usefulness of the 'opt in' process. 07/07/2010 - Small tests of change, around DNA, being introduced to test improvements in service with a view to avoiding future use of opt in.
   Status: Amber.

15.4. Changes since the Internal Investigation took place

The Devon Partnership NHS Trust established a Serious Incident Review Group in July 2007.

- Membership of the group includes representatives from clinical risk team, patient safety team, operations and professions. This meet fortnightly.
- The group provides a strategic forum that oversees and monitors the reporting, review and management of serious untoward incidents (SUIs), ensuring remedial actions are undertaken and service delivery issues are addressed.

- The group ensures there are effective systems, policies and processes in place both for the reporting, monitoring and management of incidents/SUIs and for the assessment and management of clinical risk.
- The group considers all SUIs which have occurred from the information provided in the Incident Report and Initial Management Review Report.
- The group reviews all incidents relating to the death of those who are in contact with the Devon Partnership NHS Trust services, have recently been in contact with Trust services (within twelve months of the date of death), or who are referred to Trust services and were not seen prior to their death, from the information provided in the Incident Report and/or Initial Management Review Report.
- The group reviews all incidents which result in serious harm from the information provided in the Incident Report and/or Initial Management Review Report.
- The group oversees the management of and response to the incidents considered by operational management, professions and the risk management team.
- The group considers any further information received in relation to incidents (e.g. responses to requests for further information following review of the Initial Management Review Reports) and any reports from more detailed investigation and analysis, whether internal, external or multiagency.
- The group commissions more detailed investigation and analysis when indicated and oversee review processes, whether internal, external or multiagency.
- The group ensures corporate issues or learning points identified are progressed through Local Governance Groups, Operational Managers, Professional Leads, Clinical Cabinet, Lead Directors or other identified person/forum. Any corporate responses required which cannot be readily addressed are taken to the Quality and Safety Committee and consideration is given to inclusion on the Assurance Framework.
- The group overviews external reporting and communication with other agencies in relation to incidents/SUIs.

- The group regularly communicates learning from incidents and other information pertinent to patient safety to staff through the Devon Partnership NHS Trust communications channels and to Clinical Team Leaders and Consultant Psychiatrists specifically through Safety Bulletins.

15.5 Findings

While it is not the function of an Independent Investigation to replicate the work of the Internal Investigation it is noteworthy that a number of the recommendations of the Internal Investigation address the same issues as those identified in the current Investigation: accessible and comprehensive clinical notes, risk assessment, access to psychological services and prompt access to secondary mental health services.

The Devon Partnership NHS Trust responded to the recommendations of this Internal Inquiry together with those of three other investigations by drafting and integrated action plan. However, none of those who undertook the Internal Investigation was involved in the drafting of the action plan and the clinical staff who were interviewed reported that they had received no feed back following the Investigation. Members of the CRS did report that they had been informed that they had to implement the Trust policy on employing both level 1 and level 2 risk assessments but they were not informed why this was, nor engaged in any discussion as how this action would improve clinical practice.[216]

None of the witnesses to this Investigation were aware of any strategy for disseminating the learning following an investigation.

15.6 Conclusion

It was recognised that there were weaknesses in the initial Internal Investigation and the Trust sought to address these by adding a new member to the team whose role it was help re-draft the investigation report, employing a root cause analysis approach and making both findings and recommendations more explicitly linked to identifiable evidence.

The team originally assembled to undertake the investigation did not have sufficient experience of undertaking investigations or the relevant expertise to undertake an

[216] Interview of CP & DB

investigation of this seriousness. They were not given appropriate support nor the time to undertake the investigation in a robust fashion. Neither the purpose of the investigation nor the terms of reference were discussed with the investigating team.

While several of the terms of reference were pertinent to an investigation of the care received by Mr. A.T. there was no reference to best practice, national guidance or Trust policies, which should enshrine these.

The internal investigating team examined Mr. A.T.'s clinical notes but they did not interview or ask for statements from the clinical staff involved with Mr. A.T. In failing to do this they missed an important opportunity to understand both exactly what happened in Mr. A.T.'s care and why clinicians arrived at the decisions they did.

The internal investigating team consulted Mr. A.T.'s mother and provided her with feedback on the outcome of the investigation and she reported to the independent investigation that she felt that the Devon Partnership NHS Trust had addressed her concerns. This is good practice. However there is no record of the Trust, as an organisation, either apologising or expressing their regret at the distress Mr. A.T.'s family were experiencing.

Miss S's family were not contacted and no reason for this was given.

Despite the weaknesses in the Internal Investigation outlined above it identified a number of issues in its recommendations consonant with those identified in the current Investigation. The Devon Partnership NHS Trust responded to the recommendations by drawing up an action plan covering not only the recommendations contained in the investigation into Mr. A.T.'s care but also the recommendations of three other investigations. This was an entirely appropriate response. However those who conducted the investigation were not involved in drawing up the action plan, nor were the clinicians who had been involved in Mr. A.T.'s care. Clinical staff appear to have received no feedback from the investigation and none of the clinicians interviewed was aware of any strategy for disseminating learning and improving clinical practice.

Staff support

A debriefing session was held for the CMHT team. Mr A.T.'s GP was included in this and it is reported that the team found the exercise useful.

This debriefing was organised by the CMHT manager. Staff reported at interview that they were not aware of any formal support being offered by the Trust.

16. Notable Practice

The Independent Investigation did not identify any areas of notable practice. However it was noted that the CRS responded promptly on each occasion that Mr. A.T. was referred to it, and in liaising with the CMHT Mr. A.T.'s assessment appointment was brought forward.

It is acknowledged that the Devon Partnership NHS Trust is continuing to develop and refine its systems to ensure the development of clinical practice and more robust systems of governance.

17. Lessons Learned

The key lessons to be learned from this review of the care of Mr A.T. are mainly related to the importance of sound assessment.

In *Refocusing the Care Programme Approach* (2008)[217] the following guidance is offered:

"*Everyone referred to secondary mental health services should receive an assessment of their mental health needs. This initial assessment, which aims to identify the needs and where they may be met, may have alternative names such as screening (assessment) or triage (assessment).*

The outcome of the initial assessment should be communicated to the individual (in a way that they will understand) and the referrer promptly. If it is agreed that the person's needs are best met by a secondary mental health service, a care plan should be devised and agreed with the service user and, where appropriate, their carer."

This is the guidance which all Trusts should be following.

It might be useful, in the current context, to identify some of the elements touched on in this guidance.

Assessment is not just a data/information collecting activity, it must be purposive. The purpose here is to identify the individual's health and social care needs and, having done this, to identify how they might be best met. The assessment of need must include the needs to be safe and to protect the individual from causing harm to others.

[217] Dept of Health, (2008) *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance,* p.18

Competent assessment must be clear about what it is assessing and use appropriate methods to obtain the relevant information. Here it is the health and social care needs of the individual which the assessment seeks to identify. The primary source of information for this is the individual him/herself, but as the guidance makes explicit, the views and insights of those who know the individual are an enormously important source of both information and corroboration. Wherever possible these individuals, usually family and carers, must be included in the assessment, both of need and risk.

The other important source of information is the existing documentation: clinical notes, assessments and care plans. For these to be effectively used to inform the assessment they must be readily accessible to those conducting the assessment. The guidance notes:

"*To reduce documentation and cut down on duplication, services should aim to develop one assessment and care plan that will follow the service user through a variety of care settings to ensure that correct and necessary information goes with them. More use of joint assessments and review, with common documentation between agencies and teams, would avoid duplication of paperwork*."[218]

Having identified the individual's health and social care needs the object of the assessment is to make a decision as to how these needs are best met. To do this those making the decisions must have a clear conceptualisation of the individual's problems and needs, a formulation, and there must be clarity as to what different services offer, what needs they can meet and how they can meet the needs. Most commonly operation policies containing clear eligibility criteria fulfil his function.

Where a service decides that it is best placed to meet the individual's needs it must draw up a care plan promptly, with the service user and those who will play a key role in the care plan, and communicate this appropriately.

[218] Dept of Health, (2008) *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance,* p.18

18. Recommendations

The purpose of developing recommendations is to ensure that lessons are learned which inform the delivery, development and management of services, to enhance the quality and safety of the care and treatment service users receive and to promote the safety of service users and the general public.

The Independent Investigation worked with the Devon Partnership NHS Trust to formulate the recommendations arising from this investigation process. This ensures that the progress that has been made since 2007 is taken into consideration and that the recommendations made are relevant to the current needs and state of development of the Trust.

Each recommendation is set out together with the relevant contributory factor and the progress that the Devon Partnership NHS Trust has made in the area. Recommendations are grouped under the critical issues headings used above.

18.1. Issues relating to referral, discharge and transfer.

18.1.1 Contributory Factors

1. No corroboration was sought from Mr. A.T.'s family that appropriate help was available from his employer or that he was likely to collaborate with this. As a result of this, although his need for psychological therapy and his continued binge drinking had been identified, no contingency plan was put in place. In the absence of such a plan Mr. A.T.'s mental state was not closely monitored by the mental health services and, according to his own account, he drove his car into the doors of a bank to escape from society. The absence of consultation with Mr. A.T.'s family and of a risk management plan being put in place contributed to the less than optimal management of Mr. A.T.'s mental health problems.

2. There was an interval of nine weeks between Mr. A.T. being re-referred to the mental health services and him being offered an assessment appointment.

   Two factors appear to have contributed to this delay: a lack of clarity of the part of the locum GP as to where to send his referral and the CMHT failing to follow the Trust guidance on re-referrals.

3. It cannot be concluded that this delay contributed to the events of 13 February 2007 however it did delay the assessment of Mr. A.T.'s on-going needs and the establishment of a care plan to address these.

18.1.2 Service Issue

Contrary to best practice there was no written record of Mr. A.T.'s transfer from the CRS to the CMHT. There is no written record of assessments and care plans being shared. While this lack of transfer of written information does not appear to have had any significant impact on the care Mr. A.T. received it is poor practice and if repeated with other service users is likely to lead to them receiving less than optimal care.

18.1.3 Changes since 2007

The Devon Partnership NHS Trust has undergone significant re-organisation since the events of 2007 as described above. Of particular relevance here is the fact that the CMHT's have now been divided into two functional teams: the Mental Well Being and Access team and the Recovery and Independent Living team.

The former provides the single point of access to mental health services. It aims to work closely with GPs and their teams to provide an easily accessible service to:

- people presenting with a mental health problem for the first time who need more help than their GP can provide ;
- people who have previously used special mental health services and need further help;
- people experiencing common mental health problems;
- people experiencing a potential first episode psychosis.

The Mental Well Being and Access teams also encompasses the Early Psychosis teams (STEP) which focus on caring for people who are experiencing the symptoms of psychosis for the first time. In partnership with other providers it also makes available a range of Psychological Therapies.

The Recovery and Independent Living team's function is to "*support people's recovery through being holistic and promoting social inclusion, self-management and independence. It is for people who have complex relationships with services and whose needs are unable to be met through the Mental Wellbeing and Access function."*

Under the rubric of Recovery and Independent Living the Devon Partnership NHS Trust provides:

- Assertive Outreach;
- Rehabilitation and Recovery ;
- Vocational Rehabilitation.[219]

18.1.4. Recommendations

Recommendation 1.1.

The Devon Partnership NHS Trust should undertake a review of its policies and practices to ensure that families and carers, where appropriate, are involved in assessment and care planning.

- The current CPA 2 Assessment should be revised to identify **the expectation** that families and carers are involved in assessment and care planning. This should provide information suitable for audit.
- The Devon Partnership NHS Trust should undertake an audit to establish whether families and carers are involved in an appropriate and timely manner. They might consider consulting carers directly as part of the audit and not rely exclusively on clinical notes.
- The Devon Partnership NHS Trust should look at best practice in involving carers exemplified elsewhere.

[219] www.devonpartnershiptrust.nhs.uk,

- The involvement of families and carers should routinely be monitored during supervision.

Recommendation 1.2.

The Trust should establish, via audit or survey, that the referral routes into and eligibility criteria for the Mental Health services are clear and easily accessible, and advice is readily available to referrers.

Recommendation 1.3.

Using both audit and regular supervision the Trust must ensure that its CPA policy and the guidance provide in *Refocusing the Care Programme Approach – policy and positive practice guidance, (2008)* are followed regarding the transfer of information when a client/patient is transferred between teams.

18.2. Assessment and Care planning:

18.2.1 Contributory factors:

1. Although Mr. A.T was seen and assessed on a number of occasions no clear formulation was made to inform either further assessments or intervention. This may well have contributed to the less than optimal management of Mr. A.T.'s mental health problems. It cannot be reasonably concluded, however, that had a clear formulation been available this would have influenced the events of 13 February 2007.

2. Mr. A.T.'s family was not involved in either the assessment of his mental state or in the planning of his care. Their insights would have enabled a better understanding of Mr. A.T.'s problems to be arrived at and a more effective care package to be instituted. It cannot be reasonably concluded, however, that this improved care would have influenced the events of 13 February 2007.

3. Although a number of clinicians noted trait-like features in Mr. A.T.'s presentation there is no evidence that the presence of axis II factors in Mr. A.T.'s presentation influenced either the strategy for undertaking assessment or the formulation of Mr. A.T.'s problems. Giving greater significance to these factors may have improved the

care Mr. A.T. received. It cannot be reasonably concluded, however, that this improved care would have influenced the events of 13 February 2007.

18.2.2. Recommendations

Recommendation 2.1.

The Devon Partnership NHS Trust should draw up guidelines, in line with best practice, on case formulation.

- Amongst other things this should cover the importance of trait-like characteristic as well as more transient symptomatology, the involvement of the patient and his/her family/carers, and the regular reviewing of the formulation.
- In line with current policy formulations should be consonant with the recovery model and the promotion of well being.
- Where appropriate training should be provided.
- Compliance with the policy should be monitored/audited on a regular basis.

18.3 Risk Assessment:

18.3.1 Contributory factors

1. Despite Mr. A.T. displaying a pattern of increasingly dangerous behaviour a comprehensive risk assessment was not undertaken. This probably contributed to the less than optimal management of Mr. A.T.'s mental health problems and possibly to his deteriorating mental state. It would not be reasonable to conclude that the lack of a comprehensive risk assessment had a direct causal relationship to the events of 13 February 2007.

2. Despite the fact that it was noted on a number of occasions that the consumption of alcohol was a trigger to increased risk of disinhibited behaviour and of self harm no risk management plan was put in place. This probably contributed to the less than optimal management of Mr. A.T.'s mental health problems and possibly to his

deteriorating mental state. It would not be reasonable to conclude that this had a direct causal relationship to the events of 13 February 2007.

18.3.2 Service issue

There was a lack of clarity amongst the staff as to when a level 2, comprehensive risk assessment should be undertaken. At least some staff are of the opinion that the current risk assessment format prescribed by the Trust does not facilitate good assessment or risk management planning. These factors may well have a deleterious effect on the care and treatment provided to those using the services of Devon Partnership NHS Trust.

18.3.3 Changes since 2007

In 2008 the Devon Partnership NHS Trust invested in patient safety and a small group of senior clinicians undertook advanced training. This led to a redesign of the clinical governance structure and strategy with more emphasis on the engagement and involvement of all Trust employees.

In a recent audit the Trust reported that where service users had had a risk screening and immediate risks had been identified immediate action plans were put in place in 100% of cases.

18.3.4 Recommendations

Recommendation 3.1:

The Devon Partnership NHS Trust Clinical Risk policy should be reviewed.

- It should be brought more in line with the principles outlines in "*Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services"* (Department of Health, 2007).

- The risk policy should more closely align the risk screening tool (level 1) with the in depth risk assessment (level 2). The policy needs to specify that where a risk is

identified at the screening stage then an in-depth assessment focusing on the identified risk needs to be conducted and a management plan developed.

- The Devon Partnership NHS Trust should ensure that staff understand when a comprehensive risk assessment is to be undertaken and apply this knowledge consistently. This might be achieved through either improvements in the policy document or in the associated training.

- The The Devon Partnership NHS Trust's Risk Management policy should be structured to reflect the functions of the various teams e.g. Crisis Team, CMHT etc.

- The Devon Partnership NHS Trust needs to ensure that risk management plans are drawn up following risk assessments where either significant risk is identified or where current trigger factors, which might increase risk, are present.

- The Devon Partnership NHS Trust needs to ensure that the individual and, where appropriate, his/her family or carers are meaningfully involved in the risk assessment and management planning.

- The Devon Partnership NHS Trust should ensure that its Risk Management policy is being adhered to through a programme of regular monitoring and audit.

- Risk assessment is a component of the CPA process and is to be included in management and clinical supervision.

- Random audits need to be carried out to support the annual audit plan.

- A service audit needs to be completed six months after the implementation of the revised policy to ensure that it is being consistently acted on.

18.4. Availability of Psychological Therapy:

18.4.1 Service Issue:

4.1 Clients of the CRS did not have access to psychological therapies and the CRS had no route or care pathway into psychological therapy for their clients. This being the case these service users did not have access to appropriate services as indicated in best practice guidance.

18.4.2 Changes since 2007

Since 2007 there have been a number of changes in service provision most notably the Improved Access to Psychological Therapies (IAPT) initiative. The CMHTs have also been reorganised into two functional teams: the Mental Well Being and Access team and the Recovery and Independent Living team.

The former provides the single point of access to mental health services. It aims to work closely with GPs and their teams to provide an easily accessible service to:

- people presenting with a mental health problem for the first time who need more help than their GP can provide ;
- people who have previously used special mental health services and need further help;
- people experiencing common mental health problems;
- people experiencing a potential first episode psychosis.

In partnership with other providers it makes available a range of psychological therapies.

We were informed that the CRS still does not have access to psychology input for advice, consultation or interventions for its clients.

18.4.3 Recommendations

Recommendations 4.1:

The Devon Partnership NHS Trust should review the availability of psychological therapy services.

- The adequacy of the overall level of resourcing of this service with reference to current NICE guidelines for the treatment of mental health problems commonly encountered in secondary mental health services.
- How psychological therapy resources are allocated across services and functional teams.
- The timely access to psychological services.
- Access to psychological services for consultation, advice and support.

18.5. Clinical Management

18.5.1 Service Issues

1. There was a lack of clarity within the CMHT as to the eligibility criteria for acceptance into their service. The lack of such clarity runs the risk of service users not receiving a consistent service, of functions being duplicated and of limited resources not being used efficiently.

2. There was a lack of clarity within the CMHT regarding eligibility for care co-ordination. This confusion suggests that the service is not providing care and treatment in line with best practice guidelines. Service users may not be receiving co-ordinated care in line with CPA guidelines and the responsibilities of staff are unclear.

18.5.2 Changes since 2007

The structure of the CMHT has changed with the Well Being and Access team and a Recovery and Independent Living team performing different functions. Intervention within the Well-being team should be brief and the care co-ordination function should reside with the Recovery and Independent living team. Each of these teams should have clear eligibility criteria.

However the Investigation was informed [220] that it is not uncommon for there to be a lack of capacity within the Recovery team with the result that service users remain with the Well Being team, receiving informal and *ad hoc* care co-ordination.

18.5.3 Recommendations

Recommendations 5.1:

The Devon Partnership NHS Trust should ensure that its policies and practices relating to care co-ordination conform to the standards identified in *Refocusing the Care Programme Approach – policy and positive practice guidance, (2008).*

- It should ensure that its operation policies and CPA policies are clear as to the allocation of a care co-ordinator.

[220] Interview RV

- It must ensure that care co-ordinators have appropriate training.
- It must ensure that patients are not retained in the Well-Being and Access team and provided with "informal" or *ad hoc* care co-ordination because of a shortage of resources in the Recovery Team.

18.6. Documentation

18.6.1 Service issues

1. There was no integrated set of clinical notes to which clinicians had access. Good clinical notes are essential for continuity of care and sound clinical practice. The absence of good clinical notes or the lack of access to a comprehensive set of clinical notes puts at risk the standards of care that can be offered to service users.

2. While there were some sound, good quality entries in Mr. A.T.'s notes the overall standard of the notes was not high: entries were at times brief and uninformative, inconsistent and conflicting information was recorded without any reflection, the names and designation of the person writing in the notes was not always recorded making it difficult to evaluate the entry. If good quality care is to be delivered to service users this must be based on sound, good quality information.

3. Clinical notes were not made available to the Investigation in an efficient and timely manner. The files made available were often organised in a poor and confusing manner. The standard for the archiving and retrieval of clinical records fell below the standards required under the Data Protection Act.

18.6.2 Changes since 2007

The Trust has recognised and declared to its registering authority shortfalls in clinical record keeping in four areas:

1. the content of clinical records in relation to comprehensive care planning (including risk assessment);
2. the quality of the written records;

3. multiple records and inconsistent availability/use of electronic records;
4. the tracking and availability of archived records.

Action taken

Core practice standards have been developed across the Devon Partnership NHS Trust covering: initial contact with the Trust, assessment and formulation, personal recovery planning, coordination and delivery of services and managing transition. Support has been provided to teams in the form of coaching to support the implementation of these new standards. This is supported by teams self monitoring their level of compliance and the implementation of a self monitoring Practice Quality Audit Tool to provide independent verification of the self monitoring.

A programme of auditing record keeping standards, overseen by the Information Governance Group, started in 2008/9 and was rolled out across the Trust in 2009/10.

In early 2009 work began on designing and testing the use of a single clinical record to address the variations in record keeping and management across the Trust. This became redundant with the introduction of RiO. This electronic record system has been implemented in other mental health Trusts; it is supported by intensive staff training and became operational in North Devon in May 2010. The system is currently being rolled-out across the rest of the organisation and it is anticipated that this process will be completed by March 2011.

From March 2009 all staff were required to undertake Information Governance training by way of an e-learning module. 85% of staff had completed this by March 2010.

The Devon Partnership NHS Trust has acknowledged the difficulty that the Independent Investigation experienced around tracking and archiving of records.[221] A process had been established for the collation of records required for Internal and Independent Investigations and other enquiries. The Trust took immediate action following concerns highlighted by the independent investigation and refined this process incorporating it into the Records Management Policy that was ratified by the Trust Board in July 2010**.**

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18.6.3 Recommendations

Recommendation 6.1:

Following the introduction the electronic record system RiO, the Devon Partnership NHS Trust must ensure, using regular audit and supervision, that:

- all relevant clinical information is stored in a manner that is readily accessible to all clinicians working with a client;
- that information is appropriately cross referenced;
- that the quality of clinical notes is of an acceptable standard and complies with best practice guidance and professional standards.

Recommendation 6.2:

The Devon Partnership NHS Trust must complete a review of clinical records and their storage against the standards cited in the Data Protection Act.

- All clinical areas must ensure that records have been returned to the central archive when patients are discharged or move through services.
- An audit needs to be conducted in relation to the most recent 10 near misses or serious incidents to ensure that the clinical records have been correctly archived following an Internal investigation.
- Trust personnel must be reminded of their duties and obligations to maintain clinical records to a professional standard during clinical supervision.
- Random audits of clinical case files should be conducted across all clinical teams to ensure correct ordering and storage of clinical records.

18.7. Existence, appropriateness and awareness of operational policies

187.1 Service Issue

Operational policies governing the activities of at least the CRS and the CMHT did not appear to be in place. Teams and individual clinicians created their own categorisation system which determined response times and priority for care co-ordination.[222] The absence of clear operational policies puts at risk the consistency of services which service users receive.

18.7.2 Changes since 2007

It appears that operational policies had been in place across the Devon Partnership NHS Trust in the early to mid 2000's soon after the Trust was formed. More recently a series of Policy Implementation Guides (PIG's) have been developed through the Professional Expert Groups (PEG's). It is questionable whether these adequately fill the role of an operational policy for the staff delivering the service. In talking to the clinical staff they remain unaware of operational policies for their services and continue to be guided by what they believe to be sound clinical judgments.

18.7.3 Recommendations

Recommendation 7.1:

Clear concise Operational Policies should be developed for each functional team to enable staff to understand their core function and responsibilities and the function of their team. These should include reference to core policies such as CPA and key Clinical Practice Standards.

- Operational service managers need to develop a core operational policy for the area they manage identifying the age range of the population to be served, the geographical area covered and services available.
- Clinical team leaders need to plot out the systems and processes that operate within their team such as referral and eligibility criteria, assessment methods,

[222] Interview CC

liaison with primary care and specialist services, allocation, supervision, discharge criteria and team meetings.

- Operational policies must be consonant with best practice guidelines such as the national Policy Implementation Guides, CPA policy or NICE guidelines.
- A mechanism for the disseminating of policies and policy revisions needs to be devised and implemented by the Clinical Governance Committee.
- Adherence to operational policies needs to be regularly monitored as part of an on-going audit programme.

This will in effect create a service map and the beginnings of a service care pathway.

18.8. Dissociation between the senior management team and front line staff

18.8.1 Changes since 2007

The Devon Partnership NHS Trust Board has instituted a number of positive, potentially service improving initiatives. These include:

- introducing a Clinical Directorate model;

- the Introduction of a new electronic clinical record system, RiO;

- appointing a Co-Medical Director with the remit of improving quality, safety and clinical governance;

- introducing a range of initiatives to promote quality and safety, including:

    - a programme of work to improve medicines management;
    - a programme of regular peer reviews and executive 'walk around' audits of frontline services;
    - active participation in the local multi-agency safeguarding forum and the appointment of safeguarding officers within the organisation;
    - investment in Patient Safety Officer training and the appointment of a dedicated, Trust-wide lead with responsibility for patient safety;

- the introduction of a programme of Practice Quality Audits at ward level.[223]

There seems little doubt about the enthusiasm of the Devon Partnership NHS Trust Board to improve the quality of the service the Trust provides and it has to be acknowledged that it has worked hard to improve the level of engagement in the governance process. However there appears to remains a disconnection between the aspirations of the Board and what is occurring within the clinical teams.

18.8.2 Recommendations

Recommendation 8.1:

The Devon Partnership NHS Trust should:

- review its strategies for engaging its staff;
- review the efficacy of its dissemination strategies;
- involve staff in identifying the likely impact of new initiatives;
- put in place clear management of change strategies.

18.9. Clinical Governance Processes

18.9.1 Changes since 2007

The initiatives undertaken and progress made by the Devon Partnership NHS Trust have been noted in Section 14.0 *Clinical Governance,* above. The Devon Partnership NHS Trust has acknowledged that there have been, and continued to be concerns around the Clinical Governance Framework within the Trust. There have been three restructurings over the past four years. The Devon Partnership NHS Trust is aspiring to establish a high quality monitoring system through the implementation of the Practice Standards and the Practice Quality Audits. It appeared to the Investigation that the Trust Board has a clear vision as to what it wants to achieve for the people of Devon, however at this point in time this is an aspiration and there is a disconnection between front line clinicians, who have yet to engage with the governance process, and the vision of the Trust Board..

[223] Statement of HS

The following recommendations have been developed with the Devon Partnership NHS Trust in order to facilitate a higher degree of engagement in the Clinical Governance process.

18.9.2 Recommendations

Recommendation 9.1

The implementation of the Clinical Practice Standards and the Practice Quality Audit needs to be strengthened across the Devon Partnership NHS Trust. Clinical audit participation needs to be developed through:

- being a standing item on all team meeting agendas;
- being included in individual annual appraisal and personal development plans;
- being monitored through supervision;
- forming part of all employees core job description.

Recommendation 9.2

A robust annual audit plan, reflecting the Clinical Practice Standards and the standards specified in 'Services Good Enough for My Family', needs to be developed and widely disseminated. This will need to detail the roles and responsibilities of team leaders and managers not just in terms of data collection but also their involvement in action planning to rectify short falls.

- The support services that are available across the Devon Partnership NHS Trust, such as coaching and Patient Safety Officers need to be targeted at those teams that struggle to complete the audit cycle.
- Clear time scales need to be incorporated into the annual audit plan to enable individual practitioners and teams to manage their time.

18.10. Internal Investigations

18.10.1 Recommendations

Recommendation 10.1:

The Devon Partnership NHS Trust needs to review its Serious Untoward Incident (SUI) policy to include:

- the introduction of reflective feedback sessions following serious incidents and near misses;
- the involvement of clinical teams in the development of recommendations;
- how learning and recommendations are to be shared across the Devon Partnership NHS Trust;
- greater clarity about the involvement of victims' and perpetrators' families.

19. Glossary

ADHD	Attention Deficit Hyperactivity Disorder (ADHA) and Attention Deficit Disorder (ADD) refer to a range of problems associated with poor attention span, including impulsiveness and restlessness, hyperactivity and inattentiveness. It can interfere with learning, social performance and social relationships.
Axis II Factors	Axis II factors are those enduring pattern of thoughts, feelings and behaviours displayed by individuals and often referred to as personality, personality traits or, in some situations, as personality disorders. Personality is considered to be determined by an interaction of genetic inheritance and environmental influences. These factors are considered under Axis II of the DSM IV multi-axial diagnostic system.
Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach. Their role and training is set out in *Refocusing the Care Programme Approach* DoH (2008).
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.
Case management	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
Citalopram	An anti-depressant medication of the Selective Serotonin Re-uptake Inhibitor (SSRI) type. The normal dosage for treating depression is 20-30 mg daily with a maximum dosage of 60mg daily.

Dissocial personality difficulties	Some time known as Anti-Social Personality Disorder/difficulties • Can appear to be unconcerned about how their behaviour makes other people feel, they do not feel guilt or profit from experience. • Can blame other people for their problems or rationalise what they have done • Can disregard for social norms, rules • Cannot cope with a long term relationship, although forming one is not problematic • Cannot tolerate frustration and are prone to outbursts of aggression and violence.
Mental Health Act (83)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
NICE	The National Institute for Health and Clinical Excellence (NICE) is an NHS organisation set up in 1999 to ensure everyone has equal access to medical treatments and high quality care from the NHS. NICE provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a persons risk to both themselves and to others.

Service User	The term of choice of individuals who receive mental health services when describing themselves.
Venlafaxine	An anti-depressant medication of the SNRI type. Up to c. 150mg it acts as a Selective Serotonin Re-uptake Inhibitor (SSRI), blocking the re-uptake of serotonin above this dosage it also so acts to block the re-uptake of noradrenaline. In primary Care the normal dosage is between 75 mg and 150 mg daily, in secondary, specialist care the maximum dosage is 375 mg daily.

Appendix 1 – Time Line

Date		Event	
7.06.89		Letter from CPN to GP. AT referred by Ed. Psychol. to Iddesleigh House Clinic (CAMHS).	
28.6.89		Letter from CPN to GP.	
1997		From around age 14 “AT feels he lacked direction or purpose”.	
c.’99-‘01		GCSE: 7A’s & 3 B’s A levels: 2-B’s 1-C Feels a failure.	
2001		Age 18 – minor cuts to wrist	
?2001		Portsmouth University – Business Studies - failed all modules. Re-took First Year Exams. Left University	
24.01.02		Presentation at A&E with injury to right hand. “Treatment: Police removed patient.”	
?2002		“remained in Portsmouth for a few years”	
2003		Age 20 drove to Beachy Head and considered jumping off	
c. April 2006		Started job in Civil Service (Insolvency)	
2006		“Off sick for the last four months” From June 2006	
19.10.06		Drove to New Forest with the intension of CO poisoning Drank: 8 cans larger and ½ bottle of vodka Called mother and his G/F	
20.10.06		Presented to A&E with mother asking for help. Reporting thoughts of wanting to kill people and goats. Appeared psychotic	
20.10.06		• Assessed by CRS in A&E • History taken form mother. • Taken on to CRS case load	
20.10.06		Home visit by CRS • No remorse or regrets re. his action • Has trouble expressing his emotions • CRS to liaise with GP re anti-depressants • Recommend Private CBT therapist	
23.10.06		CRS contact GP and agree: • GP to prescribe anti-depressant • Review with consultant	

		• CRS recommend private CBT therapy CRS contact AT and provide contact numbers for two CBT therapists	
23.10.06		GP prescribed Citalopram 20mg	
24.10.06		Seen at home by CRS psychiatrist and CPN. • No specific precipitant for suicide attempt • Thinking of suicide since year dot. • "Generally aloof and cynical attitude to life" • "to discuss….possible DPT funding. Talk to parents i.e. paying for CBT	
25.10.06		• Telephone call from CRS, AT said he would go via GP for counselling. • "Asked him if he was discharging our services and he confirmed that he was."	
26.10.06		• Telephone call from CRS. • AT reported that he had tried both therapists: one not taking refs, other away • Discussed referral to CMHT	
30.10.06		• Telephone call from AT to CRS • Compliant with medication, reports no problems. • Contacted employer who offers a "full service" including "psychiatrist and counselling service." • AT prefers this route • AT discharged CRT Discharge summary 20.10.2006 – 30.10.2006 (10 contacts)	
14.11.06		GP Record: • "Feels reckless and is gambling. Not ready for work but employer is arranging? cbt." • PHQ-9 17/27 • Citalopram increased to 40mg	
27.11.06		GP patient record: • Citalopram causing impotence "so has stopped. Will try alternative and is ready to work again." • Prescribed Venlafaxine 75mg	
08.12.06		Referral letter by locum GP to "Primary Care Mental Health Team" • Suicidal thoughts but says will not act on them. • Isolated and worthless • Drinks heavily • Feels unable to work • Started on Venlafaxine 75mg "nine days ago"	
19.12.06		Venlafaxine increased to 150 mg	
21.12.06		Referral letter arrives at CMHT CPA1 record	

		• "Accepted for referral – No"	
27.12.06		"Opt-in" letter sent by CMHT manager	
15.01.07		GP Notes: • Depressive disorder • waiting for CMHT appointment	
25.01.07		Appt letter offering an assessment appointment at CMHT on 13.2.2007	
26.01.07		9:00 Arrested for driving car into Barclays bank	
26.01.07		14.05: Record of referral to CRS by "Custody Nurse" • Said wanted to kill himself • GP & Mother concerned about self harm • Blood alcohol "normal" • Request risk assessment • "Initially angry and when seen by the custody nurse." • Assessment planned for 17.30	
26.01.07		Assessed by CRS: • Low risk of completed suicide in short term • Risk is increased with alcohol • Impulsive and disinhibited with alcohol • No symptoms of "severe mental illness" • AT felt medication was not "particularly beneficial" • Taken on to CRT case load to "monitor mental state" • "Taken on – No" • "Requires Care co-ordinator – No"	.
26.01.07		CPA2a - Emergency/Crisis Mental Health Assessment. • Drove car into Barclays Bank "stating he wanted to kill himself". • AT stated that "he is desperate and wants to get himself out of society by hospital admission or prison" Risk: • Behaves more impulsively under the influence of alcohol • Shallow affect, no empathy • Felt dissociated and detached for many years • 'Lurid fantasies' about butchering people but no specific plans **Plan:** • Taken on to CRS case load • Monitor mental state • Contact CMHT for urgent Appt • "Consider review by Team Psychiatrist".	
27.01.07		Phone call CRS to AT: • No alcohol,	

		• mood flat • "no overt signs of mental illness"	
28.01.07		Phone call CRS to AT: • Brighter, • no alcohol. • Discussed recent events with family	
29.01.07		Phone call CRS to AT: • Brighter. • Did not want a home visit	
29.01.07		Appt letter from CMHT worker bring forward assessment appointment to 1.02.2007 following contact with CRS.	
30.01.07		Seen at home by CRS psychiatrist and CPN	
30.01.07		Message left "with CCO" to make contact with CRS after visit to AT	
31.01.07		Letter from CRS consultant to GP History/background to event: • He did not intend to kill himself • He wished "he would be locked up either in prison or in a psychiatric hospital" • Not psychotic • "Once he has drunk to excess he becomes disinhibited and is likely to act on his negative feels. At there times he is more at risk" Risk to others: • Fights when intoxicated • Tried to buy a hand gun while living in Portsmouth – but was told it was faulty and so did not buy it. • Fantasised about "taking out" "groups of coloured youths he had seen hanging about" • "In recounting this, there was little emotion, no sense of guilt or remorse." Diagnosis: • "A partially treated depressive illness on a background of some more dissocial personality difficulties" • Recommends a medication review with community psychiatrist	
01.02.07		Seen by CMHT worker for initial assessment CPA2 Assessment: HoNoS: Overactive, aggressive, disruptive or agitated behaviour: Moderate problem **Plan** • Refer to addiction service • Out patient appointment with community	

		psychiatrist • Placed on waiting list for Care Co-ordinator	
2.02.07		• CMHT worker telephoned CRS to inform them that she had seen AT. • It was agreed the AT would be discharged from CRS "via T/C"	
02.02.07		Letter for appointment with community psychiatrist for 12.02.2007	
02.02.07		Telephone referral to addiction service by CMHT worker	
5.02.07		CRS phone AT • He reports that he is "engaged with CMHT" • Discharged from CRS "as per plan."	
06.02.07		• AT discussed at CMH team meeting • Decided to refer to community psychiatrist • Placed on CMHT waiting list "awaiting allocation" for a care co-ordinator.	
06.02.07		AT seen by CMHT worker • Feeling more positive about the future • Talked of a "great weight has been lifted of having a good chat with his parents" • Had a date with a "young woman and hoping to see her again." • Trying to reduce drinking as he is aware that he is binge drinking • Received appointment with community psychiatrist • Informed that he was on waiting list for care co-ordinator.	
06.02.07		CPA2c – Risk assessment and Management (level 1): **Plan** • Visit GP • "Not to drink alcohol" • Not assessed for "Risk Assessment & Management (Level 2) • Further discussion at team meeting not deemed necessary.	
12.02.07		Seen by community psychiatrist. "Problems: • Lack of self confidence • Addiction to alcohol & gambling • Violent tendency" Drugs: • historically – cannabis, cocaine, speed, acid, mushrooms. No heroin or crack • "none for months" • "Ecstasy this weekend" Violence: • Anger comes in rage • Fights – could be every week	

		• No weapons • 1 conviction for criminal damage- few years ago • 2 convictions for drunk and disorderly – several years ago • "…. Lashed out at brother" School • Truanted from age of 13-14 • Junior school noticed he behaved oddly. Drinking and drugs – from age of 17 Medication: Venlafaxine 150 mg: "found himself happier for past week or so" "Advice: • to stay on medication • to stop drinking • to see addiction services • anger management, psychological assessment To see mother ADHD?"	
13.02.07		Discussion between CMHT worker and community psychiatrist: • "AT may have adult ADHD" • Community psychiatrist planned to see AT again in 1 month to discuss his childhood • AT had been given an appointment with psychologist.	
13.02.07		Appointment letter from Clinical Psychologist for 22.02.2007.	
13.02.07		AT arrested on suspicion of murder – later charged with murder of Miss S	
14.02.07		CPA 1a Record of Referral to CRS Contacted by Exeter police: "AT brought in 6.12 am" Dr ... requesting MHA assessment "due to the nature of the offence and recent previous contact with mental health services.	
14.02.07		CMHT worker received phone call from SW informing her that AT had been arrested for "murder". Mental Health Act Assessment completed and AT not detainable under MHA	
15.02.07		Incident Report form completed by CMHT manager: AT Arrested, MHA assessment: • ASW • Sec 12 Dr • FME	

		• "[Mr. A.T.] was not sectionable" • Not psychotic or depressed • "He appeared calm and collected and in control of the situation"	
16.02.07		AT arrives at Long Lartin Prison	
06.03.07		3 Day Report completed by CMHT manager • List contacts Diagnosis: • Depression, alcohol addiction, personality disorder.	
07.03.07		Fax from HMP Long Lartin • Informed that AT had arrived at Long Lartin on 16.2.2007 • requesting information on AR's "interventions".	
07.03.07		Letter to HMP Long Lartin confirming that: • AT was being assessed by CMHT, "Referred to addiction" • "the overwhelming feeling of the team was that this young man had an antisocial personality disorder."	
07.03.07		Letter from Community Psychiatrist to GP reporting meeting of his assessment of 12.2.2007.	
20.11.07		AT convicted of murder and sentenced to serve a minimum of 15 years imprisonment. Exeter Crown Court	

Appendix 2 – Care Pathway

DoB: 18/05/83

Date	Actual care pathway of Mr AT	Met/partially met/not met	Agreed formal care pathway
	First recorded incident of self harm		
2001	Age 18 – minor cuts to wrist, no medical intervention required and not reported to health services; reported during history taking at a later date		
	First indication of suicidal thinking		
2003	Age 20 Drove to Beachy Head and considered jumping off; reported during history taking at a later date		
	Second incident of suicidal thinking		
19.10.06	Drove to New Forest with the intension of CO poisoning – under influence of alcohol. 8 cans larger and ½ bottle of vodka. Presented to A&E, accompanied by his mother, the following day asking for help. He was referred to the crisis team.		Appropriate referral from A&E
	First referral CRT		
20/10/06	The crisis team were informed that Mr AT was experiencing thoughts of wanting to kill people and goats and that he appeared psychotic. The crisis team noted that Mr AT in A&E experienced thoughts of killing people, thoughts of wanting to end his own life and that it was not worth living, having a shallowness of affect, appeared not to empathise with mother's anxiety. He was judged to be at low risk of self harm although this was exacerbated by alcohol. • Plan: ○ Taken on to CRS		There is no standard within the CRS Operational Policy 2006 to indicate how soon a psychiatrist should see a person after they have been taken onto the CRT case load. The completion of form CPA 2a is in keeping with the Trust CPA policy 2006. Mr AT's mother provided at history but there is no indication in the assessment that considers his mother's view, nor was

	cases load ○ Monitor mental state ○ Re-assess when alcohol free. He was seen at home on the same day. The plan was for CRS to liaise with GP re anti-depressants. They recommend private CBT therapist. Mr AT was not seen on the 21 or 22. 23 the GP prescribed Citalopram 20mg and agreed with the CRT that Mr AT have a consultant psychiatrist assessment. 4 days later home visit: CRS Psychiatrist and CPN. CPA 2 form was completed it is noted that Mr AT was talking/fantasying about killing people. . There were three further phone contacts between CRS and Mr AT. Mr AT appeared to want to pursue help via primary care and his employer. The case was discharged on 30/10 The GP increased Citalopram to 40 mgs on 14/11		she asked for corroborative information This was a missed opportunity and not in keeping with best practice. Mr AT was immediately recommended to seek private CBT. If this need is identified it should be offered in a timely and effective manner by the Trust/NHS There are no records from the consultant psychiatrist's visit nor was there a letter was written to the GP (cross referenced with GP file) so it is not possible to make a comment about the fullness of an assessment that would be expected at a point of first contact with a consultant psychiatrist. This is an issue about data protection and governance. Mr AT was prescribed anti depressant medication on the 23/10 as suggested by the CRS. The CRS did not then see Mr AT again to monitor the effects of the medication. Contact was maintained by phone, apart from the assessment by the psychiatrist. Mr AT declined home visits. It is unusual although appropriate for a GP to increase an SSRI as a first port of call when treating a depression.
	Change in medication		
27.11.06	GP changes medication to Venlafaxine		This medication is associated with increased agitation and suicidal thoughts when first taken.

			This should have been taken into account in monitoring Mr AT's mental state.
	Referral to primary care mental health team		
08.12.06	Referral by locum GP to "Primary Care Mental Health Team" • Suicidal thoughts - isolated and worthless • Drinks heavily • Feels unable to work • Started on Venlafaxine 75mg "nine days ago" Mr AT was not seen in primary mental health services		There are no operational policies for the CMHT to guide referrals or protocols available in 2006 so not possible to determine what the care pathway should have been. This should have been an urgent referral to the CMHT (cf Trust policy on re-referrals) as Mr AT was experiencing suicidal thoughts, was within the window for increased suicidality in relation to his medication and had increased his risk by his episodic drinking heavily which would have reduced the potency of the anti-depressant medication. Mr AT might have been referred to alcohol services The service structure and relationship between primary mental health and secondary mental health systems, along with protocols are not known so it is not possible to comment. The referral suggests that this was internal to the medical practice.
	1st referral to CMHT		
21.12.06	The GP referral arrives at the CMHT 27 an opt in letter was sent to Mr AT following which an appointment letter was offered for13.2.2007		The referral took 13 days to arrive at the CMHT. This suggests that care pathways and protocols were not clear or efficient. The protocol for an opt in service delays people

			being seen The Trust standard for a routine assessment was 4 weeks. Mr AT's referral should have been treated as a priority (cf Trust CPA policy).
	First incident of criminal behaviour **2nd referral to CRT**		
25.01.07	Arrested for driving car into Barclays bank. His blood alcohol was initially recorded as "normal". He was referred by the custody nurse to the crisis team and assessed at home the same day. He was judged to be at low risk of suicide in short term, o Risk is increased with alcohol o Impulsive and disinhibited with alcohol o No symptoms of "severe mental illness" o Mr AT felt medication was not "particularly beneficial" o Taken on to CRS case load to "monitor mental state" It was later noted that Mr AT did not want to kill himself but wanted to be removed from society, and that his blood alcohol level was twice the legal limit. Mother and GP were concerned and felt that Mr AT should be admitted to hospital. Mother believed that Mr AT's mental state was deteriorating. The consultant did a home visit on the 30 and a letter was sent to the GP indicating that Mr AT was depressed with dissocial personality difficulties. There was no further face to face contact with the crisis team but they phoned on 4 occasions and discharged him on the 5th February. The CRT did not think that Mr AT was suicidal but noted that alcohol increased the risk.		CRS were aware of mother's concerns but they did not consult with her as good practice would indicate - poor practice There are lots of comments about his being fatuous, immature, inappropriate, lacking in empathy, supercilious. Had they spoken to Mrs. T they may have given more weight to these factors and interpreted his immediate symptomatology rather differently, possibly leading to a different intervention. Mr AT's behaviour was becoming more dramatic and dangerous, he told those assessing him that he wanted to be removed from society; his mother believed that his mental state was deteriorating. Those assessing Mr AT's risk should have (i) attended to this history (ii) initiated a fuller (level 2) risk assessment (iii) consulted with his mother. Given the importance that alcohol was identified as playing in Mr AT's presentation a risk management plan should have been put in place. This might have included referral to the alcohol

			services rather than waiting for the CMHT to do this. Here are inconsistencies in the clinical notes. There is no evidence that these were noted or reflected on. Though the crisis team discharged Mr AT on the 30th they do not close the case until he had been seen at the CMHT Appropriate to refer and liaise with CMHT. Good that his appointment brought forward
	CMHT Initial assessment		
01.02.07	Seen by CMHT worker for initial assessment **Plan** • Refer to addiction services • Copy of assess to GP • OP appt with community psychiatrist. • Waiting list for Care Co-ordinator. Level 1 risk assessment completed. Mr AT was seen again by the same worker on the 6th February and by the Psychiatrist CMHT on 12.02.2007. He was discussed at the CMHT meeting on 6th February. Mr AT was advised: • to stay on medication • to stop drinking • to see addiction services • anger management, psychological assessment To see mother ADHD?" Appt letter from Clin. Psychologist for 22.02.2007		Standards of documentation are poor. There was no written transfer, and no written handover of assessments or care plans. As there was no operational policy assessments were undertaken without reference to eligibility criteria for CMHT or care co-ordination. There appears to be a lack of clarity with respect to care co-ordination. The CMHT worker was not the care co-ordinator but did co-ordinate Mr AT's care. She was referred to as the care co-ordinator in the notes of the CRS. Current standards should be those of *Re-focusing the CPA.* (2008) . Given Mr AT's history a fuller assessment (including risk assessment should have been

			undertaken). This should have included input from his family. There is no evidence of a clear formulation of the case to inform further assessment or intervention. The assessment did not result in a plan of care but rather a list of actions to be completed and an opinion..
13.02.07	**Incident**		