NHS
North of England

INDEPENDENT

INVESTIGATION

INTO THE CARE AND TREATMENT PROVIDED TO MR SU BY MERSEY CARE NHS TRUST

CONSEQUENCE UK LTD

January 2013

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

Undertaken by Consequence UK Ltd

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

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The Independent Investigation Team wishes to thank:

- Mr SU (the mental health service user whose care and treatment is the subject of this report);
- the family of Mr SU;
- staff employed by Mersey Care NHS Trust;
- Mr SU's care co-ordinator (retired);
- the managers of two independent supported housing providers who assisted with information regarding Mr SU and the service they provided to him;
- the development manager, mental health, Liverpool City Council;
- Dare to Care, a voluntary agency providing support to persons recovering from substance misuse;
- the Spider Project, a voluntary agency providing support to people recovering from substance misuse; and
- the substance misuse service at Mersey Care NHS Trust;

all of whom assisted in the provision of information for the investigation.

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

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ACRONYMS USED IN THIS REPORT

Acronym	Full Title
A&E	Accident and Emergency
GP	General Practitioner
CPA	Care Programme Approach
LASSL	Local Authority Social Service Letter
NHS	National Health Service
NPSA	National Patient Safety Agency
SHA	Strategic Health Authority

EXECUTIVE SUMMARY

Incident overview and intention

On 31 March 2008, a mental health service user, subsequently referred to in this report as 'Mr SU', went to his parent's home and attacked them. Both of his parents died as a consequence of the attack. The attack was unexpected and unpredicted. The impact of the incident on Mr SU's remaining family has been significant and lasting. For Mr SU, the consequence of what occurred was the loss of his liberty and compulsory admission to a secure hospital under section 37/41 of the Mental Health Act.

At the time of the incident Mr SU had a diagnosis of paranoid schizophrenia and had been adequately maintained in the community for ten years.

Purpose of the investigation

The purpose of the investigation was to conduct an analysis of the care and treatment provided to Mr SU by Mersey Care NHS Trust to determine:

- whether the care and treatment was reasonable and in keeping with local and national standards at the time;
- whether the violence displayed by Mr SU was predictable;
- whether the violence displayed by Mr SU was preventable on the day that it occurred.

To deliver its intent, the Independent Team determined what it considered to be a reasonable antecedent period to the incident (2001-2008), and agreed the following questions as the framework for setting out its findings:

- Overall, was the care and management of Mr SU appropriate (in relation to CPA, Risk Assessment, and Medication)?
- Did Mr SU receive appropriate medical input from the medical team involved with him?
- Mr SU's parents were Carers to him until the time of their deaths. Did his community mental health team engage appropriately with them?
- Was the incident in which Mr SU was involved predictable on the basis of information that was known to, or should have been known by, mental health services? And, was it preventable?

Conclusions

The deaths of Mr SU's parents have been immensely upsetting and shocking to his family and the local community in which they lived. As a consequence of what happened, Mr SU, previously a well-liked member of his community, has lost his liberty and his family continue to come to terms with what has happened.

Section 4.5 of this report clearly states that:

- the act of violence conducted by Mr SU was not predictable; and
- the deaths of Mr SU's parents were, on the balance of probabilities, not preventable on the day that they occurred.

This conclusion does not mean there was no scope for improvement in the care and treatment provided to Mr SU by Mersey Care NHS Trust. Neither does it mean that there was no scope for improvement in the treatment of Mr SU's parents as Carers of Mr SU in the last three years of their lives. It is the perspective of the Independent Team that the care and treatment of Mr SU and the involvement of, and communication with, his parents could and should have been much improved.

The aspects of Mr SU's care and treatment that could and should have been better were:

- Standards of nursing practice in relation to:
    - documentation;
    - care planning;
    - risk assessment; and
    - accurate representation of the range of services Mr SU was receiving, e.g. from the supported housing providers.
- Medication management:

  There should have been a more robust process in place for renewing the prescription for a service user. In this case, the consultant psychiatrist referred to the last recorded prescription in the medical notes some two years previously. However, this differed from what was written on the prescription chart itself. Because the system at the time relied on what was recorded in the medical records, there was no reliable mechanism for identifying this error. The system relied on staff raising a concern if they considered a prescription warranted this.
- Medical Review:

  The frequency of medical reviews for Mr SU was insufficient throughout his contact with Mersey Care NHS Trust in all years between 2001 and 2008, except for 2003 and 2004. The main contributor to the insufficiency was the non-attendance of Mr SU to planned reviews. Nevertheless, in 2006, when Mr SU was two years post his last medical review, his community mental health team should have made an effort to try and achieve a medical review for him. This is, with the benefit of hindsight, recognised and accepted by the community mental health team.
- Support for Carers:

  Although there appears to have been a hiatus in the relationship between Mr SU and his parents between 2002 and 2005, in the two to three years preceding their deaths they did fulfil a carers' role for their son, doing his laundry, and supporting him financially. The level of support being provided to Mr SU by his parents was not known about by his care co-ordinator, as Mr SU consistently told him that he was not having contact with his parents; consequently, he saw no requirement to continue communications with them, especially as Mr

SU is reported to have expressed to him that he did not want any communications between Mersey Care NHS Trust staff and his family. That Mr SU's care co-ordinator respected the wishes of Mr SU was not unreasonable. Neither was the fact that he took at face value what Mr SU told him regarding his lack of contact with his parents. Nevertheless, in view of the longevity of the relationship between the care co-ordinator and Mr SU's parents, and his good relationship with Mr SU, the Independent Team suggests that it may have been possible for the care co-ordinator to have negotiated with Mr SU to have at least invited the input of Mr SU's parents into the CPA reviews, even if this was via written or telephone communication.

- Systems and Processes:

  With regards to systems and processes, the core system that could and should have been better at the time was the supervision of staff. It was recognised that the standard of documentation for Mr SU's care co-ordinator did not meet with expected standards at the time. Although the care co-ordinator's line managers identified this as an issue requiring improvement, assessment of the care co-ordinator's standard of record-keeping did not form a component of his supervision. Furthermore, owing to periods of time where he was absent from work, and the work pressure of the managers at the time, his supervision did not occur on a monthly basis.

Recommendations

Since the deaths of Mr SU's parents, Mersey Care NHS Trust has implemented a number of significant organisational changes and has also addressed a number of the areas for improvement highlighted via its own retrospective analysis of Mr SU's care and treatment.

A summary of some of these changes and improvements are:

- A key performance indicator for the Trust is the percentage of service users who are not attending for annual medical review;
- Specific development work is underway or under development so that the Trust meets the recommendations of the NICE Schizophrenia Guidance, including:
  - Joint working with primary care to ensure that service users on anti-psychotic medication receive an annual physical health check; and
  - Community mental health team managers audit the ePEX system to monitor the reliability with which care co-ordinators are notating when Cognitive Behavioural Therapy is offered to Service Users. The audit conducted in September 2011 indicated 100% compliance with policy expectations.
- A revised protocol for the running of Depot clinics has been ratified and distributed, with audits undertaken of the depot clinics within Liverpool Clinical Business Unit.
- New CPA documentation was launched on 14 April 2010.

- Each professionally trained member of staff within acute services is undergoing training in the use of the START. The training includes the most recent evidence base of risk vulnerability factors for suicidality. At the time of publication, approximately 5% of staff have attended this training.

As a consequence of the work already undertaken in Mersey Care NHS Trust, the Independent Team has few recommendations to make. The summary recommendations presented to Mersey Care in December 2011:

Recommendation 1: Professional staff interviewed by the Independent Team identified a gap in their knowledge and understanding of alcohol and drug misuse. Interviewees also highlighted a gap in their knowledge base about the available resource in Liverpool to enhance this.

The Independent Team is mindful of the restrictions on public spending, and the impact this will have on education and training budgets. However, Liverpool is well serviced with a range of charitable organisations and self-help groups that would, if approached, provide opportunity for Mersey Care NHS Trust staff working in general adult community services to enhance their knowledge and understanding of addictions.

Examples of these organisations are:

- Action on Addiction;
- Addaction;
- Alcoholics Anonymous (AA);
- Narcotics Anonymous (NA); and
- Cocaine Anonymous (CA).

AA, NA and CA will all have ‘open’ meetings which professionals can attend, and/or most AA, NA, and CA groups will have members who are willing to attend at local work premises to share their addiction experience, and their recovery. The insights these individuals provide can be very illuminating for health professionals.

The family self-help groups of Al-Anon and Families Anonymous will also have members who will come and speak to health professionals so that they can have a better understanding of the impact another’s addiction has on family life and the type of information and support families might need if caring for a person with a dual diagnosis or addiction.

Contact details for all of the above are available on the World Wide Web, and are easily located via a simple internet search.

Target audience: Medical Director; Nursing Director; Clinical Directors for each adult service CBU; Business Managers for each adult service CBU; the manager of the Patient Advice and Liaison Service; Mersey Care NHS Trust’s Training and Education Manager.

Timescale: The Independent Team considers that Mersey Care NHS Trust should be able to produce a strategy for enhancing the knowledge and understanding of its staff in the field of substance misuse prior to the publication of this report.

Recommendation 2: All clinical business units in Mersey Care NHS Trust need to implement a more dynamic approach to how it audits and reviews the quality of clinical documentation.

The quality of documentation was not of the standard expected in Mr SU's community mental health records. In particular, there was no depth of information about how his mental state was being assessed, little about communications with other involved agencies such as supported housing, and a complete lack of up-to-date care plans.

Although Mersey Care NHS Trust conducts audits of CPA and risk assessment documents via standardised audits, information gathered during the investigation process suggests that it does not sufficiently or consistently interrogate the quality of what has been recorded. Consequently, the Independent Team recommends that a peer review process is implemented where:

- A randomised selection of CPA and Risk Assessment documents and progress notes are selected from the professionals participating in the peer review process;
- The group of peers reviews the documents selected and provides constructive feedback on their completeness and also usefulness.

The Independent Team suggests that a peer review of clinical records could be facilitated on a three- to four-monthly basis.

The Independent Team also recommends that each professional's supervisor reviews the record-keeping for each of its supervisees across the professional's entire caseload on a rolling basis. Because documentation review is time-consuming, the Independent Team anticipates approximately two to three sets of records being reviewed at each monthly supervision session.

To make delivery of this recommendation achievable, the following principles will be required:

- An agreement of what aspects of the clinical record should be subjected to scrutiny;
- An agreement as to what proportion of each record needs to be scrutinised. For example, would it be acceptable to review a contemporary CPA care plan in one set of records, and a risk assessment and crisis intervention plan in a different service user's records?

To achieve the principle of proactive records review does not mean that for each set of records reviewed in a supervision session, the same documents need to be reviewed for each service user.

Target audience: The Clinical Director and Business Manager for Liverpool CBU.

Note: This recommendation could and should apply to all Clinical Business Units in Mersey Care NHS Trust.

Timescale: Accurate clinical records are essential to the delivery of safe and effective care and treatment. They are also essential for staff to show the standard of their practice and the delivery of a defendable standard of care.

The Independent Team can think of no reason why this recommendation could not be implemented in advance of the publication of this report.

Recommendation 3: Where a long-term service user ceases to have regular contact with his or her Carers, their needs do not simply end. As part of its ongoing commitment to supporting Carers, Mersey Care NHS Trust needs to find a way of ensuring that, if it becomes inappropriate for a care co-ordinator to maintain contact with the Carer for a service user, then the Carers are provided with an alternative source of contact and support, as well as information about how to make direct contact with the Service User's care team if there are any concerns.

Mersey Care NHS Trust has had *in situ* a robust approach to meeting the needs of carers with a Carers' Support Worker (Officer) working in all community mental health teams. These individuals have developed effective working relationships with local Carer Support agencies. The future of the Carers' Support Officer is uncertain following the removal of funding from Liverpool City Council. Mersey Care NHS Trust will need to give careful consideration as to how the support needs of Carers are not forgotten when a service user does not agree to his/her care co-ordinator having contact with his/her family.

In the case of Mr SU, such a situation arose which was compounded by the fact that the care co-ordinator did not know that his family continued to provide substantial support to him in the years immediately preceding their deaths.

The Independent Team is aware that Mersey Care NHS Trust is already taking measures to resolve the potential service gap should its own funding of the Carers' Support Officer post not be sustainable beyond this financial year.

Target audience: Mersey Care NHS Trust's Director with responsibility for Carer Support and the Patient Liaison and Advice Manager.

Timescale: This recommendation is for discussion and consultation, the outcome of which may be that Mersey Care NHS Trust and its partner

agencies consider that they are delivering as much support as they can to carers of mental health service users at Mersey Care NHS Trust.

The Independent Team therefore recommends that by 1 January 2012 it should be able to provide NW Strategic Health Authority with a position statement on this issue, and its rationale for any decision for 'non-action', if it feels that further advancements in carer support are not currently achievable.

1.0 INTRODUCTION

The purpose of the HSG (94)27 investigation is to ensure that appropriate lessons are learnt where shortcomings in the care and treatment of service users involved in mental health homicide are identified.

When the Independent Team conducted its initial analysis, it identified a range of questions to which it could not find the answer in either Mersey Care NHS Trust's investigation report, or the Mersey Care NHS Trust interview records. In view of the level of investigation commissioned by NHS North West, the seriousness of the incident that had occurred, and the impending Inquest, a decision was made by the Independent Team to re-interview the staff involved in the care and treatment of Mr SU between 2005 and 2008. The Independent Team also elected to interview a range of management staff who it believed were in a position to inform it about the development of core systems and processes in Mersey Care NHS Trust, such as supervision of professional staff, the Care Programme Approach (CPA), and risk assessment (RA).

To the mind of the Independent Team, it was essential that the investigation was sufficiently fearless and searching to meet the expectations of article 2 of the Human Rights Act. Mr SU was a patient of Mersey Care NHS Trust at the time he killed his parents. Determining whether or not there was any contribution to what happened by those responsible for his care and treatment was therefore essential.

1.1 An Overview of Mr SU's contacts with Mental Health Services

Mr SU was first referred to Adult Mental Health Services by his GP in December 1993. He was subsequently admitted to hospital under section 3 of the Mental Health Act on 13 January 1994. He absconded from hospital and his section expired. He was subsequently re-admitted to hospital on 16 May under section 3 of the Mental Health Act. He was diagnosed with Schizophrenia at this time. He was subsequently managed in the community until March 1997, when he was again admitted under section 3 of the Mental Health Act. Following his discharge, he was again managed in the community on depot medication.

On 13 January 2000 it was recorded that Mr SU told his care co-ordinator that he had been arrested the previous month for drug dealing and was due in court in February 2000. The initial hearing was adjourned until 22 February. The records also note a second court hearing planned for 25 February for a different matter, which was subsequently dropped.

Mr SU's community psychiatric nurse continued to monitor him in the community whilst Mr SU was awaiting trial. It was noted that he remained stable and received his depot injections, as required.

On 27 April 2000 it was noted that Mr SU was unable to be contacted. He had left his parents' home and it was not known where he was staying. His parents believed that their son was heavily involved with illicit drugs.
The clinical record also noted that Mr SU had 'skipped bail' and that he had not reported to the Police in connection with his forthcoming court case.

21 June 2000: Mr SU was in custody, having surrendered to the Police on a warrant issued by the court. His care co-ordinator wrote to the Criminal Justice Mental Health Liaison Team and advised them that Mr SU's prescription was for Depixol, 90mg I.M. fortnightly, and that his next depot injection was due on 26 June 2000.

29 June 2000: Mr SU received a two year and three month custodial sentence for supplying drugs. The expected release date was 3 August 2001.

3 July 2000: Mr SU was discharged from section 117 aftercare.

29 June 2000 to 25 July 2001: Mr SU's Depixol medication was reduced to 90mg three-weekly, with no adverse effects. He also received regular reviews from the Criminal Justice Liaison Team.

3 August 2001: Mr SU was released from HMP Liverpool and returned to his parents' address. His care co-ordinator remained the same and there had been a multi-disciplinary discharge CPA prior to his release. His medication had been reduced to 50mg Depixol every two weeks by this time.

August 2001 to September 2002: Mr SU was successfully treated in the community with fortnightly Depixol medication. He obtained a tenancy during this time and moved out from his parents' home. However, in September 2002 he was evicted from his accommodation and returned to live with his parents. (He did so until April 2003.)

September 2002 to 18 March 2003: Mr SU remained stable with no episodes of psychosis. His medication was administered on a reasonably reliable basis every fortnight. There was no evidence of illicit drug use during this period.

22 April 2003: Mr SU was rehoused and again lived independently.

June and July 2003: Mr SU was supported in applying to Network Employment to assist him in obtaining work.

24 July 2003: CPA Review: No concerns noted. Mr SU was settled with a supported living tenancy. Medication of Depixol 50mg fortnightly continued.

Mr SU had an uneventful course through 2003 and the spring of 2004. He remained stable and there were no concerns about his mental state.

4 May 2004: Mr SU was noted to have requested to come off his depot medication. A detailed discussion was carried out with Mr SU about the risk associated with his previous history of non-compliance. Mr SU felt he had matured since then and that he recognised the importance of his medication. Arrangements were therefore made for him to move to oral anti-psychotic medication.

24 August 2004: Mr SU was being treated with 15mg Aripiprazole and 50mg Depixol medication monthly rather than fortnightly.

9 September 2004: The above regime continued with Mr SU experiencing no apparent side effects. The plan was for Mr SU to be reviewed by the clinical assistant in psychiatry in six months' time.

20 October 2004: Mr SU attended at the depot clinic and requested to return to Depixol medication only and to stop the Aripiprazole as it was not agreeing with him. This request was agreed to and Depixol 50mg was administered by his care co-ordinator after the meeting.

November 2005 to May 2005: Mr SU remained stable on his medication, receiving most doses with some periodic missed appointments. There were no noted concerns.

In May Mr SU was advised that his tenancy with his then supportive accommodation provider was to end. His care co-ordinator contacted Mr SU's social worker with regards to finding alternative accommodation for him.

19 May 2005: Mr SU attended at A&E, accompanied by his mother and sister, complaining of suicidal feelings. This assertion was not confirmed on assessment. Mr SU was not considered suicidal. During the assessment he reported a five-month daily drug habit of heroin and crack cocaine. He requested admission to the local rehabilitation unit, but was appropriately provided with the details for the substance misuse service. His family were also provided with this information. Mr SU was discharged home.

26 May 2005 to August 2005: It is not entirely clear where Mr SU was living over this period. The community mental health nurses continued to attend to administer his depot medication on a fortnightly basis, but there were a number of occasions where he was not available. When one of the community mental health nurses was eventually able to speak with him, he refused to

attend at the community mental health team base, requesting a home visit. At this time a home visit was agreed and also that he would attend for medical review at the depot clinic. Mr SU's mental state was stable throughout.

September 2005: Mr SU commenced a supported living tenancy with a new provider. Subsequent records noted that he was happier with this tenancy than his previous one.

14 September 2005: Mr SU's care co-ordinator and social worker made a joint home visit, and undertook an Effective Care Co-ordination review. At this time, it was recorded that Mr SU was mentally very well; he was accepting his depot medication; he was noted to no longer be using illicit drugs.

14 October 2005: The records note that Mr SU is now living with his parents, having left his supported tenancy following a physical attack on him.
His social worker was noted to be reviewing again his housing.

October 2005 to March 2006: New supported living accommodation was acquired for Mr SU. He remained well throughout this period. He was continuing to receive his Depixol medication as frequently as his availability and/or attendance at the Depot clinic or his community mental health team base would allow.

End January 2006: Mr SU's medication was changed from 50mg fortnightly to 50mg monthly. This occurred as a consequence of a discrepancy between the medical records and the prescribing charts. The prescribing clinician referred to the medical records as his guide as to what to prescribe.

16 March 2006: A CPA review was held. Mr SU did not attend for this. At this review it was concluded that Mr SU had good insight, was doing well and living in supported accommodation. The plan, at that time, included continuing with his depot injection, that his CPA level was enhanced and that he would be reviewed, on a regular basis, in the depot clinic.

30 June 2006: It was noted that complaints had been made that Mr SU was causing a nuisance at his accommodation, including playing music at 4 am, slamming doors and intimidating younger residents. A meeting was consequently planned with his supported living provider. This, however, appears not to have occurred.

7 March 2007: Mr SU is noted to have made a complaint about his then support worker. The clinical records say that, following investigation, this was partially upheld and that the services of the support worker were removed at Mr SU's request.

With regards to his mental health, Mr SU was continually noted to be stable, and receiving his depot injection on a now monthly basis with reasonable reliability.

7 June 2007: Mr SU did not attend his CPA review. This was the second year he had not attended. The community nursing staff reported continual stability in his mental state and behaviours. As a consequence, a decision was made to review him in the depot clinic in twelve months' time. Monthly administration of Depixol medication was to continue, which it did.

30 October 2007: Mr SU attended for his depot injection. He was noted to have apologised for his body odour.

November 2007 to 25 February 2008: Mr SU received his depot medication in every month except December. He was noted to be stable and there were no identifiable concerns about his mental state.

25 March 2008: Mr SU did not receive his depot medication, but attended at the community mental health team base for this on 28 March 2008. However, he attended at 8.30 am, when there was no staff on duty to administer this for him. Because of an existing appointment, Mr SU did not wait for a qualified member of staff to arrive but asked if his care co-ordinator could come and administer it to him at home on Monday 31 March. A message was left in the community mental health team message book to this effect. (Mr SU's care co-ordinator was on annual leave on 28 March 2008.)

31 March 2008: The community mental health team message book noted that Men's Direct contacted the community mental health team. Mr SU had visited their premises, reporting that he was being harassed. Men's Direct did not report any behaviours arising from Mr SU that triggered any concern in the community mental health team deputy team manager who took the call. A message was left in the message book for Mr SU's care co-ordinator. (This individual was on annual leave that afternoon.)

1 April 2008: Mr SU's care co-ordinator attended at his flat to administer his medication. Mr SU was not at home. Later that same day the community mental health team were notified that Mr SU had been arrested on suspicion of murdering his parents.

2 April 2008: Mr SU was detained under section 2 of the Mental Health Act and admitted to a medium secure unit. He was subsequently reassessed and admitted to a high secure unit.

Appendix 1 of this report contains a more detailed chronology of Mr SU's contacts with Mersey Care NHS Trust.
Also, relevant aspects of the chronology are set out in detail in certain parts of the 'findings' section (section 4.0) of this report.

2.0 TERMS OF REFERENCE

A generic terms of reference was provided by North West Strategic Health Authority as follows:

To examine:

- the care and treatment provided to the service user at the time of the incident (including that from non-NHS providers, e.g. voluntary/private sector, if appropriate);
- the suitability of that care and treatment in view of the service user's history and assessed health and social care needs;
- the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies;
- the adequacy of risk assessments to support care planning and use of the Care Programme Approach in practice;
- the exercise of professional judgement and clinical decision-making;
- the interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs;
- the extent of services engagement with carers; use of carer's assessments and the impact of this upon the incident in question; and
- the quality of the internal investigation and review conducted by the Trust.

To identify:

- learning points for improving systems and services; and
- development in services since the user's engagement with mental health service and any action taken by services since the incident occurred.

To make:

- realistic recommendations for action to address the learning points to improve systems and services.

To report:

- findings and recommendations to the NHS North West Strategic Health Authority Board, as required by the SHA.

Following its initial analysis of Mr SU's clinical records, the Mersey Care NHS Trust internal investigation report, and Mersey Care NHS Trust interview records, the Independent Team agreed that the above terms of reference would be addressed in the provision of answers to the questions formulated and set out in i) the executive summary, and ii) the start of section 4.0 (page 21) of this report.

3.0 COMMUNICATIONS AND CONTACT BETWEEN THE INDEPENDENT TEAM, MR SU AND HIS FAMILY

The Independent Team initially attempted to make contact with the family of Mr SU via his current care team on 10 October 2010. Once communication was established, the Independent Team engaged in direct communication with the family on 15 November 2010.

Face-to-face contact was achieved between the Independent Team and Mr SU's family on 25 January 2011. At this time it was clear that Mr SU's family remained distressed by what had happened to Mr SU's parents.

As a consequence of the meeting, it was clear that Mr SU's family had a range of reasonable questions that they hoped this investigation process would answer for them. The key questions were:

- Why was Mr SU's medication reduced from 50mg Depixol fortnightly to 50mg monthly in January 2006?
- Why did Mr SU not receive a home visit on 31 March as he requested?
- Why was there no contact with Mr SU's parents by mental health services after their son moved out of their home in 2002? The family recalled meeting with Mr SU's care co-ordinator prior to this, and that he was in evidence prior to this. They did not understand why the contact and relationship stopped when Mr SU was provided with his own accommodation (April 2003).
- What happened with Mr SU's support package after May 2005? They had heard that it had been stopped due to funding issues.
- Whether Mr SU had been taking drugs and alcohol prior to the death of their parents?

The Independent Team advised Mr SU's family that it expected to be able to address all of their questions in the investigation, except the issue of his supportive accommodation. This would be dependent on the Independent Team being able to identify who the supported living providers were and their willingness to participate in the investigation. Mr SU's family were advised that the boundaries of the investigation are focused on the care and treatment delivered by specialist mental health services and not services provided by other agencies.

During the discussions with Mr SU's family, it was revealed that to their knowledge neither of the deceased were informed of support networks available in the local community to provide support in relation to their son's illicit drug use and chaotic lifestyle. The Independent Team discussed with them the range of support avenues available in Liverpool. The family

members present believed that had Mr SU's mother known of these she may have made use of them. They did not believe that his father would have done.

At the end of the meeting it was agreed that the preferred form of communication for Mr SU's family was email. Between January 2011 and the completion of the draft investigation report, emails were exchanged between the Independent Team and Mr SU's family at regular intervals. Communications by email and telephone continued up until August 2012.

On 9 August a representative of the Strategic Health Authority and the Independent Team met with the family to discuss the draft investigation report and to talk through the publication of the report.

With regards to contact with Mr SU himself, communication was initially sent to his Consultant Psychiatrist on 20 October 2010. Direct communication with Mr SU occurred on 8 and 17 February 2011. This was followed by a face-to-face meeting with the Independent Team on 15 February 2011.

As a consequence of this meeting, it was clear that Mr SU was deeply remorseful for what he had done to his parents. He told the Independent Team that he had loved them and would not have knowingly harmed them. He had not realised that his drug usage would ever have affected him in the way that it did. He expressed remorse also for the damage he had caused to his family. He told the Independent Team that he had changed his attitude completely concerning illicit drugs and was receiving help with regards to this and his mental illness in the mental health hospital in which he resides.

With regards to questions about his mental health care and treatment, his only question was in relation to the reduction of his Depixol medication in 2006.

The Independent Team did ask him about his illicit drug use. The information he provided was illuminating. He told the Independent Team that his drug usage was always periodic. He would have long periods of being drug free and then binge. In 2006 and 2007 he accessed two voluntary support groups in Liverpool and received acupuncture. He found this helpful. He did not tell his care co-ordinator about his drug usage as he did not want to. It was something he preferred to deal with outside of the mental health services.

Mr SU told the Independent Team that he had been drug free at the end of 2007 and in January and February 2008. He started using again in March 2008. He knew it was making him unwell and this did frighten him. He said it was his intention to get himself 'clean' again and re-engage with the agency that had provided him with acupuncture.

The draft report was sent to Mr SU on 7 August 2012 and his consent for publication sought.

4.0 FINDINGS OF THE INVESTIGATION

This section of the report sets out the Independent Team's findings in relation to the following questions:

4.1 Overall, was care and management of Mr SU appropriate?

- Was he on a reasonable CPA level and did his care package/care plan reflect his needs?
- Did he have appropriate and timely risk assessments and was there an acceptable risk management and relapse prevention plan?
- Was there appropriate consideration of his substance misuse?
- Was his medication managed appropriately and was he on the right medication at the right dosage?
- Was there an acceptable level of engagement between specialist mental health services and Mr SU's supportive housing providers?

4.2 Did Mr SU receive appropriate medical input from the medical team involved with him?

4.3 Mr SU's parents were Carers to him until the time of their deaths.

- Did his community mental health team engage appropriately with them?
- Were they offered a Carer's Assessment in keeping with local and national policy?

4.4 Was the incident in which Mr SU was involved predictable and/or preventable based on information that was or should have been known to his mental health team?

In setting out its findings, the Independent Team is very mindful of the tragic outcome when Mr SU attacked both of his parents and the impact the deaths of his parents has had on his remaining family as well as on himself.

In assessing the adequacy of the care and treatment provided to Mr SU, it was the responsibility of the Independent Team to avoid hindsight bias[1] and to analyse the appropriateness of decisions made on the basis of the information available to clinicians at the time the care and treatment was provided, and the circumstances in which they acted. It was also the responsibility of the

[1] Hindsight bias: this is the inclination to see events that have occurred as more predictable than they in fact were before they took place. Hindsight bias has been demonstrated experimentally in a variety of settings, including politics, games and medicine. In psychological experiments of hindsight bias, subjects also tend to remember their predictions of future events as having been stronger than they actually were, in those cases where those predictions turn out correct. This inaccurate assessment of reality after it has occurred is also referred to as "creeping determinism".

Independent Team to apply the principles of the NPSA's substitution test[2] to its assessment of the care and treatment afforded Mr SU.

4.1 Was care and management of Mr SU appropriate?

4.1.1 Was he on a reasonable CPA level and did his care package/care plan reflect his needs?

4.1.2 Did he have appropriate and timely risk assessments and was there an acceptable risk management and relapse prevention plan?

4.1.3 Was there appropriate consideration of his substance misuse?

4.1.4 Was his medication managed appropriately and was he on the right medication at the right dosage?

4.1.5 Was there an acceptable level of engagement between specialist mental health services and Mr SU's supportive housing providers?

At the time of the incident, Mr SU had been in receipt of specialist mental health services since 1993, a period of fifteen years. The period of time most closely analysed during this investigation was the three-year period prior to the incident, as this was considered to be a sufficient length of time to be able to determine the reasonableness of his care and treatment in the antecedent period to the incident and to form a view with regards to the incident's preventability. However, because of Mr SU's long history with secondary mental health services, historical information predating 2005 and as far back as 1997 is incorporated so that the Independent Team's findings are presented in a way that is factually and contextually correct.

It is the overall perspective of the Independent Team that the actual service delivered to Mr SU over the years of his contact with the specialist mental health service in Liverpool was reasonable because:

- He experienced continuity in his care co-ordinator throughout;
- He was offered regular contact with his consultant psychiatrist (Consultant Psychiatrist [1]) in the period leading to his detention under the Mental Health Act in 1997 and for a number of years after this;

[2] http://www.msnpsa.nhs.uk/idt2/(jg0xno55baejor55uh1fvi25)/index.aspx. The substitution test is where one asks whether a similarly qualified group of professionals would have acted in a similar way as the professional did in caring for and treating Mr SU. In many cases this principle can be applied by an investigation team without seeking input from others. However, sometimes it is necessary to apply the principle using a larger sample group of professionals. This was not the situation for this case.

- He was treated with depot medication, a decision made after the relapse of his mental illness in 1997;
- The clinical notes and interviews show that a decision was made to keep Mr SU with his regular community mental health team even when he moved out of the area because it was considered that for him a change in community mental health team would exacerbate the challenges of effectively engaging with him;
- A flexible arrangement was agreed with Mr SU's care co-ordinator and his community mental health team which enabled him to attend at the community mental health team base for his depot injection if he missed a scheduled appointment for the administration of his anti-psychotic medication;
- He had a plan of care which required regular home visits for the administration of his medication because he was not reliable in attending at the depot clinic for this. Indeed, when he had moved outside of the boundary for his community mental health team, to have had to have attended at the depot clinic would have required a considerable journey for him, which his care co-ordinator did not believe he would regularly undertake;
- The interviews consistently indicate that the community mental health team staff were socially supportive of Mr SU; for example, giving him lifts to Garston from his flat if they were returning there, making multiple visits to his accommodation if he was out at the time of the first visit;
- In June 2000, when Mr SU had 'skipped bail', his care co-ordinator persisted in trying to make contact with him to ensure that his medication was administered and to persuade him to 'turn himself in';
- On 5 July 2001 Mr SU's care co-ordinator attended for the prison discharge CPA meeting, as is the expected practice;
- The notes and interviews showed that, during Mr SU's care co-ordinator's sick leave, cover for Mr SU's case management was always provided in a timely way by his colleagues.

What was also consistently evident from the interviews conducted with Mersey Care NHS Trust staff was that Mr SU was not a person about whom there had ever been concerns regarding violence and aggression. Mr SU's care co-ordinator excepting, none of the community psychiatric nurses that the Independent Team spoke with had ever experienced anything other than appropriate behaviour from Mr SU. He was described as a 'loveable rogue', a 'cheeky chappie', always trying 'to bum a pound here and there' and to 'cadge a lift'. These are terms that Mr SU's family also identified with him.

A community psychiatric nurse, who had contact with Mr SU over a number of years, told the Independent Team that she had never felt at risk from him at any time following his discharge from hospital after his admission under section 3 of the Mental Health Act in March 1997. She also said that had there been any identified risk her male colleagues would not have supported her in visiting Mr SU on her own. There was never a circumstance that she experienced to prevent this. Mr SU's care co-ordinator also told the Independent Team that he would not have asked a female colleague to visit Mr SU if he had been at all concerned about a risk of violence.

The above being said, the care management of Mr SU did fall below some of the standards the Independent Team understands to have been in place between 2000 and 2008. The following sections address these areas as they relate to each of the questions posed. However, to summarise, practice was not as it should have been in relation to:

- Care planning;
- Risk assessment and contingency planning;
- Medical review;
- Carer/family communication and support;
- Information-sharing within the team.

4.1.1 Was Mr SU on a reasonable CPA level and did his care package/care plan, reflect his needs?

Mr SU had a diagnosis of paranoid Schizoprenia and he was on enhanced CPA which was the appropriate level for him. However, although much of the care/service provided to him by Mersey Care NHS Trust is considered to have been appropriate, he did not have a documented care plan that reflected his needs or that met with the documented policy standards at the time. In this respect his care and treatment did not meet the internal standards of Mersey Care NHS Trust nor in the latter years the national CPA standards.

The following information sets out the detail of the Independent Team's assessment in relation to 4.1.1.

Between 2000 and 2008 the dates for Mr SU's CPA reviews were:

- 29 June 2000, with a review summary also documented on 10 July 2000;
- 12 November 2001;
- 24 July 2003;
- 12 February 2004;
- 14 September 2005;
- 16 March 2006;
- 7 June 2007.

Prior to the CPA review of June 2000, Mr SU had been on *"level 1"* CPA. However, on 29 June his level was changed to *"enhanced".* This was documented on the *"Review summary section 2"* form on 10 July 2000 and met the newly revised CPA standards published by the Department of Health in 1999.[3]

The care plan summary in July 2000 stated that Mr SU *"requires depot medication to maintain his mental stability"*. The depot was to be given fortnightly and the responsible clinicians were noted as *"CPN/Prison nurse".* Mr SU had been sentenced to a 27-month custodial sentence for the possession and supply of class A drugs.

In 2001 Mr SU was discharged on licence from HMP Liverpool. By this time the CPA and risk assessment documentation had been changed, with the risk assessment elements being contained in a dedicated risk assessment form that had been adapted from *"clinical risk management – Sainsbury Centre for Mental Health 2000".*

The features of his care package at this time were:

[3] Effective Care Co-ordination in Mental Health Services Modernising the Care Programme Approach.

- Mr SU *"to receive depot medication as prescribed for mental state, to be monitored by regular visits from CPN".*[4]
- *"Regular medical review by Consultant Psychiatrist."*
- *"To maintain contact with the probation service whilst on licence."*
- Mr SU *"requires assistance with re-housing, social services, probation, health and voluntary sector to work together to achieve this".*

There was also a summary of Mr SU's compliance with the terms of his licence within this CPA document. Important elements documented in relation to the delivery of effective care and treatment by the specialist mental health service were:

i. *"Accommodation is a concern for both him and his mother as, whilst he presents no serious problems in the family home, his socialising and late hours to his parents is disruptive to them. Seeking alternative accommodation is posing a problem for a number of reasons – Mr SU himself is restricting his choice of locations to the immediate area of his family home..... His offences of supplying drugs will preclude him from local authority tenancy consideration and because of this MPS accommodation providers are reluctant to offer him temporary tenancies as a move on into local authority or the housing association sector will probably be impossible.* However, one tenancy provider was noted to be considering his application for a twelve month tenancy. *... Mr SU was noted to have been advised "to explore the private sector but"* he was *"hard to motivate to take some action/responsibility for this."*

In keeping with good practice, the CPA review document was reviewed and signed by Mr SU. The plan was for further review in six months. This would have been in May 2002. However, there is no evidence that this review occurred, or that it was planned for. The community psychiatric nurse records do, however, point to regular contact with Mr SU through to August 2002.

The next documented CPA review was 24 July 2003. This is approximately nineteen months after the previous CPA of November 2001. The passage of time and the significant change in record-keeping systems in Mersey Care NHS Trust has meant that determining whether or not the 2002 CPA review was ever booked has not been possible. Understandably, staff do not have a memory recall of such discrete historical events.

The next documented CPA review was 24 July 2003. This was approximately nineteen months after the previous CPA of November 2001. At this time Mr SU had moved to accommodation two miles from where he had been living in

[4] CPN = community psychiatric nurse.

2001 and approximately five and a half miles from his parents. Previously, in 2001, he had been living approximately four miles from his parents. It would appear therefore that he had been successful in securing accommodation in the *"immediate location of his parents' home".*

Furthermore, the CPA document states that at this time Mr SU was living in *"supported accommodation"*, but does not say who was providing this. The CPA document also noted that Mr SU continued to receive his anti-psychotic medication every two weeks (50mg Depixol) and that he had also been referred to Network Employment as he had *"expressed a wish to find work".* It is this CPA review that identifies that Mr SU now lives outside of the catchment area for his community mental health team. (Mr SU is now residing seven miles from the team base, whereas previously he lived four miles away.) It is notable that his consultant psychiatrist (Consultant Psychiatrist [1]) determined that *"it would be detrimental to* [*Mr SU's mental health*] *to transfer him; therefore he will remain under our care".*

As in 2001, the CPA document design had again changed. In 2003 it allowed specific space for:

i. Family/Carers' views;
ii. A description of the current situation and views of those involved in supporting the service user;
iii. Main points of Review;
iv. Change of need identified (new care plan to follow if necessary).

Sections ii and iii only were completed. The content of section iii did not differ from the points identified in 2001. The plan for Mr SU was in all respects the same.

Although Mr SU's then GP did not attend at the 2003 CPA review, he did return the 'response form' attached to his invitation to attend. This response form informed secondary mental health services that he (the GP) had *"not seen* [*Mr SU*] *for more than two years".* This meant that he had not received his annual physical health check, as recommended in the NICE 2002 guidance.

For the 2004 CPA review there was no CPA paperwork, only an entry into the medical records that lists the persons invited to the review meeting, but no other detail. There is also a return slip provided by Mr SU's GP at the time which says: *"I am unable to attend the review regarding ... but would like to make the following comments: Not seen recently but when last seen in October 2003 with back pain and in May 2003 with back pain looked stable."*

The next fully documented CPA review was on 14 September 2005. This CPA review was attended by:

- Mr SU;
- his then support worker, which was good practice;
- Mr SU's care co-ordinator;
- a social worker; and
- the care manager from Natural Networks.

There was no consultant psychiatrist present at this CPA review and no documented reason why. The newly appointed consultant psychiatrist was unable to advise the Independent Team at this length of time after the fact why he was not there.

Mr SU's then situation was described as:

- *"domestic help – 2 hours on weekdays. 2-4 hours on weekends;*
- *Gym and training;*
- *Financial management needs work;*
- *Preparing own meals;*
- *Spider Project referral."*

Medication remained Depixol at 50mg per fortnight.

The outcome of this CPA review was:

- *"service user to register with local GP;*
- *Natural networks assisting application for a community care grant;*
- *no change to care plan."*

This CPA document also identified that section 117 aftercare continued for Mr SU.

This was the last CPA review that Mr SU attended. Although CPA reviews were scheduled for March 2006 and June 2007, Mr SU did not attend either. However, his then consultant psychiatrist and community psychiatric nurses attended both of the planned reviews in 2006 and 2007.

The Independent Team understands that in 2006 there were no reports of problems with Mr SU. Furthermore, because he had been relatively stable in the community for about ten years (following his last relapse in 1997), a decision was made not to follow him up in outpatients as it was believed he was being reviewed *"on a regular basis in the depot clinic"*. Mr SU's consultant, who was new to the team and had not met Mr SU before, did, however, review *"volume two"* of his case records (2000-2008).

A further CPA review meeting was booked for 12 months hence. The content of the medical notes reflects what is documented in the CPA review document in all respects except the notation to *"cancel OPA".*

When, in June 2007, Mr SU again did not attend for his CPA review, a decision was made by the same Consultant Psychiatrist to *"book OPA with"* the GP practitioner who covered the depot clinic, and *"No ECC"* (Effective Care Co-ordination, meaning no CPA review). This was documented on 7 June 2007.

4.1.1.1 Commentary by the Independent Team

The level of CPA

CPA was revised and integrated with Care Management in 1999 to form a single care co-ordination approach for adults of working age with mental health needs. It was to be used as the format for assessment, care planning and review of care by health and social care staff in all settings, including in-patient care (NHSE & SSI, 1999). Standard CPA was described as being for those people whose needs can be met by one agency or professional or who needed only low-key support from more than one agency or professional, who were more able to self-manage their mental health problem, who posed little danger to self or others, and who were more likely to maintain contact with services. People on the enhanced CPA level were likely to have multiple care needs which required inter-agency co-ordination, more frequent and intensive interventions, to be at risk of harming themselves or others, and to be more likely to disengage with services. (*Back on Track? CPA care planning for service users who are repeatedly detained under the Mental Health Act.* Extract from the chapter *"Review of the literature on the care programme approach". 2005 ISBN: 1 870480 65 1.)*

Mersey Care NHS Trust's own 'Effective Care Co-ordination Policy' 2006, on page 16, said:

"The characteristics of those service users requiring Standard ECC [*CPA*] *will include some of the following:*

a) They require the support or intervention of one agency or discipline, or require only low key support from more than one agency or discipline
b) They are more able to self manage their mental health/learning disability problems
c) They have an active informal support network
d) They pose little danger to themselves or others
e) They are more likely to maintain appropriate contact with services."

In relation to enhanced Effective Care Co-ordination it said:

"a) All service users admitted to in-patient or Crisis Resolution and Home Treatment care

b) *They may be in contact with a number of agencies (including the Criminal Justice System)* [***Mr SU met this criteria***]

c) *They have complex/multiple needs which in general require the input of two or more professionals/agencies* [***Mr SU met this criteria***]

d) *They are only willing to co-operate with one professional or agency but have multiple care needs, including: housing, employment, etc, requiring inter-agency co-ordination* [***Mr SU met this criteria***]

e) *They have a high level of social disability that reflect agreed joint criteria*

f) *They are more likely to disengage from services* [***Mr SU met this criteria***]

g) *They are more likely to have mental health problems coexisting with other problems or substance misuse* [***Mr SU met this criteria***]

h) *They are more likely to be at risk of harming themselves or others* [***Mr SU met this criteria***]

i) *They are more likely to be at risk of serious self-neglect and/or highly vulnerable*

j) *They are likely to require more frequent and intensive interventions, perhaps with medication management."*

Other possible Enhanced Level Characteristics were identified as:

"a) Section 117, Section 49 and Section 41 apply [***Mr SU met this criteria***]

b) The service user is subject to a Guardianship Order

c) The service user is on the Supervision Register

d) The service user is subject to supervision under Section 25A-J (Supervised Discharge)

e) They are prone to relapse

f) The service user has sole responsibility for dependent children and there are child protection/welfare issues

g) The above represent indicators and do not replace reasoned clinical judgement in relation to deciding what level of ECC (CPA) a person should be placed on. Risk and case complexity should be the key identifiers."

In 2000 Mr SU was placed on enhanced CPA. However, initially, in many respects he met the Department of Health's then criteria for standard CPA. He was predominantly seen by his care co-ordinator with follow-up in outpatients; he more often than not attended for his medication administration and remained in contact with services. He was independent in his day-to-day activities, and had a supportive family.

However, by 2001, and on release from HMP Liverpool in November 2001, Mr SU clearly met the guidelines for enhanced CPA. The features that required this were:

- his substance misuse;
- his accommodation needs after his discharge from HMP Liverpool in November 2001;
- his need for support in regaining employment;
- the erratic nature of his compliance with his prescribed medication and the relapse risks associated with this; and
- his ongoing contact with the probation service.

It is clear from the Mersey Care NHS Trust Effective Care Co-ordination Policy in use in 2006, which we believe had similar criteria in 2001, that Mr SU met six out of the ten suggested criteria listed.

Frequency of CPA (Effective Care Co-ordination) reviews

With regards to the frequency of his CPA reviews, bar an unexplained gap between 2001 and 2003, he received CPA reviews at a reasonable frequency, though not as often as was sometimes indicated at the previous CPA, nor as often as Mersey Care NHS Trust's Effective Care Co-ordination Policy (2006) suggested for service users on enhanced CPA. There has been no forthcoming explanation as to why, when a six-monthly CPA review was noted as required, it did not happen. The significant passage of time will have impacted on staff's memory recall. However, the Independent Team does not believe that the lack of the above CPAs had any negative impact on the care and treatment of Mr SU between 2005 and 2008.

With regards to the frequency of CPA reviews between 2006 and 2008, the Mersey Care NHS Trust Effective Care Co-ordination Policy in 2006 said:

"It is essential that the care plan is reviewed as often as is required to ensure it continues to meet the service user's assessed needs. A maximum frequency of 6 months is indicated as good practice, although this can be extended to annual reviews for certain service users where appropriate, such as care home residents" (page 28 point *d*).

When the Independent Team asked Mersey Care NHS Trust staff working in Mr SU's community mental health team, and other staff engaged with CPA, about the frequency of CPA reviews for enhanced service users, all said that six-monthly was good practice, but that the Trust's policy document required a minimum frequency of 12-monthly reviews. The impression given to the Independent Team was that the best practice guideline of six-monthly CPA reviews was established practice and pre-dated the 2006 Effective Care Co-ordination (CPA) Policy.

It was also clear to the Independent Team that it had become custom and practice for CPA reviews to be conducted on an annual basis for service users considered to be stable and not only those such as *"care home residents"*. Four Mersey Care NHS Trust staff members, two of which had been involved

in the development of the approach to CPA at Mersey Care NHS Trust, told the Independent Team that it was never intended that 12-monthly reviews would be applicable to community-based enhanced CPA service users. They also agreed that the Mersey Care NHS Trust policy was not as clear as it could have been in relation to its expectation that reviews would usually be conducted six-monthly. The staff interviewed were aware that the day-to-day interpretation of the Mersey Care NHS Trust policy document was that 12-monthly reviews was acceptable. Consequently, the Independent Team does not consider that the planned time period of twelve months in between CPA reviews can be criticised.

The Independent Team did, however, have a concern that Mr SU was without any medical assessment at all between November 2004 and the day of the incident, 31 March 2008. Because this factor has received particular attention:

- from Mersey Care NHS Trust in its internal investigation; and
- from the family of the deceased and Mr SU;

the Independent Team addresses the issue of the medical input into Mr SU's care and treatment in section 4.2 of this report (page 61).

Setting aside the medical issue, the Independent Team considers that it would have been prudent for Mr SU's care team and in particular his care co-ordinator to have arranged for another CPA review, after Mr SU's non-attendance in March 2006. It does accept, however, that Mr SU was considered to be stable, and that, although Mr SU was erratic from time to time with his medication, generally he did engage, albeit on a superficial level, with the mental health service provided by Mersey Care NHS Trust. The community psychiatric nurse providing care co-ordination to Mr SU at this time was community psychiatric nurse [4]. He was one of a cluster of staff who provided care co-ordination cover when Mr SU's own care co-ordinator was on sickness absence.

An acceptable alternative to this would have been for his own care co-ordinator to have arranged to meet with Mr SU for a substantial period of time to enable a more detailed exploration of his mental state, rather than the more frequent but superficial assessments which were all that could realistically be achieved when administering Mr SU's monthly depot medication. With the benefit of hindsight, this idea was something that Mr SU's own care co-ordinator volunteered to the Independent Team during interview. He told the Independent Team that Mr SU did not share his thoughts freely, but that taking him out for breakfast would have been an effective inducement for Mr SU to spend time with his care co-ordinator, and thus possibly have enabled a more meaningful exchange of information between them, the outcome of which would have either confirmed that Mr SU was as well as he appeared to be, or that his stability was not as robust as it appeared and a medical review could have been arranged.

Again setting aside the medical review element, when in 2007 Mr SU did not attend for his second CPA review, an outpatient appointment should have been booked for him in the first instance, followed by an attempt to see him at home if he did not attend this. Simultaneously, efforts could have been made to achieve an assessment of Mr SU by the doctor who covered the depot clinic.

The reasons as to why none of the above suggested actions occurred appear to have been as follows:

- Mr SU was considered to be stable, requiring very little input from mental health service;
- there were no identifiable changes in Mr SU's behaviours at all;
- Mr SU was being seen on a regular basis for the administration of his depot;
- There were ten contacts with Mr SU between 15 September 2005 and 16 March 2006, of which only two were with his own care co-ordinator. A total of four other staff had contact with Mr SU over this period. The main reasons for this were:
  - The care co-ordinator being off sick;
  - Mr SU not being at home on the designated days for his depot administration.
- Mr SU's own care co-ordinator was not at the CPA review in March 2006; a colleague who had been asked to *"act as care co-ordinator"* was present. Consequently, there was no-one present with a real depth of knowledge about Mr SU.

Mr SU's own care co-ordinator did not have contact with Mr SU again until 23 June 2006, some three months later.

A key reason why there should have been more assertive action taken at this stage is, six months previously, Mr SU had been receiving a substantial amount of input from other agencies and it would have been important to have reviewed how these inputs were progressing and whether any planned interventions had been successful, including his engagement with the Spider Project.[5]

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[5] The Spider Project is an award-winning relapse prevention and aftercare service offering a range of creative, cultural and physical activities for people who have come to terms with their substance misuse and want to move forward with their lives.

The deputy and acting deputy team manager for Mr SU's community mental health team told the Independent Team that in 2006 there was no mechanism for flagging service users who had not been seen by a medical practitioner for a period of greater than 12 months. Now (2011) there is such a system and where medical review cannot be achieved the ongoing management of a service user is discussed within the weekly clinical team meetings so that a strategy to try and achieve this can be agreed.

Quality of documentation
The completion of the CPA paperwork could have been very much improved over the time period on which the Independent Team concentrated. Between 2000 and 2006 there were a number of significant changes in the design of the CPA paperwork within Mersey Care NHS Trust. It was agreed that for all new service users the new paperwork would be used and that for existing service users the documentation of CPA care plans, etc, would 'move over' at the time of the next review. Clearly, this was time consuming. Furthermore, during this period the mode of recording changed from handwritten CPA forms to those that had to be completed electronically. For staff that were not computer literate, and/or did not possess reasonable typing skills, creating the CPA documents could, the Independent Team is advised, be anxiety-inducing for staff.

For Mr SU's care co-ordinator, the quality of his documentation was a perpetual problem that cropped up in his management supervisory sessions. There were, however, no concerns about the quality of the clinical care he provided, nor about his clinical judgement.

4.1.1.2 Did Mr SU have a care plan that clearly identified his needs and how mental health services were to address these?

The short answer to this question is no; after November 2001 Mr SU did not have a care plan that clearly identified his needs.

A service user's care plan is informed as a consequence of undertaking a range of assessments and for longer term service users like Mr SU, by the regular contacts a care co-ordinator has with him/her.

In the case of Mr SU, although he did have CPA reviews between 2000 and 2005, he only had one documented care plan. This was written in November 2001 following his release from HMP Liverpool.

That Mr SU had no other documented care plan represents a lapse in the CPA practice standards required by Mersey Care NHS Trust and nationally over the subsequent years.

For a service user like Mr SU, one would reasonably have expected to have seen care plans setting out the range of needs of Mr SU, how they were going to be addressed and updates on how the plan was progressing at least on the same time basis as the CPA reviews.

Elements the Independent Team would have expected to have seen for Mr SU were that:

- Mr SU had a significant illicit drug history and what activities, groups, resources were available to him to support his commitment to remaining well and drug free. (This commitment was documented in 2001 and 2005.)
- Mr SU had a diagnosis of paranoid Schizophrenia and that the potential usefulness of psychological therapies such as Cognitive Behaviour Therapy (CBT) needed to be explored with him[6] (NICE Guidance 2002).
- Mr SU was living at his parents' home on release from HMP Liverpool, and that this was not an ideal situation for him or his parents.
- in the first instance, the probation service were providing the main support to Mr SU in searching for suitable accommodation.

The particular significance of the lack of care plan for Mr SU was that he was often seen by a range of community mental health team staff partly because of his tendency to just 'pitch up' for his depot, and also because his care co-ordinator had frequent periods of sick leave. The lack of:

- an up-to-date comprehensive care plan; and
- incomplete CPA documents;

meant that there was no easily accessible information for staff to be well informed about Mr SU. It was all housed in the memory of his regular care co-ordinator, which in his absence was not conducive to the delivery of effective care and treatment. It is fortunate that the actual care and treatment of Mr SU does not appear to have been adversely affected by this lack of documentation.

Staff acting as 'foster care co-ordinator' need to know what things to ask a service user about when they meet with him/her. They need to know what types of responses to questions might be cause for concern, and what

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[6] In this case the Independent Team does not believe that Mr SU would have engaged with CBT, even had this been offered. Generally speaking, when offering CBT a professional needs to know that the service user will commit to the CBT process and undertake the necessary level of engagement required. There is nothing that the Independent Team has read or heard which suggests that Mr SU would have made this level of commitment.

represents normal for a service user. In the case of Mr SU, staff needed to know:

- the extent of Mr SU's illicit drug taking and how he presented when in relapse;
- that when unwell he expressed anger towards his family; and
- that when unwell he displayed signs of grandiosity.

Two of the community psychiatric nurses who did act as 'foster care co-ordinators' told the Independent Team that they felt disadvantaged in the completeness of their knowledge about Mr SU as a consequence of the lack of an up-to-date care plan, and risk assessment, etc. This lack of knowledge about Mr SU would have been exacerbated by the fact that Mr SU was a 'depot' patient. Consequently, his case would have been distributed along with a number of other service users receiving contact primarily via the depot clinic.

Only the more complex service users would have been 'handed over' to the 'foster care co-ordinator' on a one-to-one basis by the team manager. The Independent Team understands this and considers that the system was reasonable. Indeed that (in 2006) Mersey Care NHS Trust specifically addressed the issue of 'fostering' within a team was good practice.

The various managers for Mr SU's community mental health team were asked about the review of care plans within the context of case management supervision. The Independent Team was told that care plans would be reviewed if there was time. The overall impression of the Independent Team, formed on the basis of information provided at interview, was that usually there was no time to reliably undertake care plan assessments as a component of case management supervision.

4.1.2 Did Mr SU have appropriate and timely risk assessments and was there an acceptable risk management and relapse prevention plan?

The analysis of Mr SU's clinical records revealed only two formal risk assessments to have been undertaken between 2000 and 2008. One was conducted in 2001 and one in 2006. Today (2011) it is expected that risk assessments are conducted on an annual basis if there is no trigger to conduct them more frequently. However, standards of practice in relation to risk assessment have changed significantly over the last 11 years and local and national expectations in 2000 were not as clearly defined as they are now. Nevertheless, it is the contention of the Independent Team that there was a lack of formalised risk assessment for Mr SU.

With regards to any risk management or relapse prevention plan, these were lacking throughout. This was and remains an unacceptable lapse in practice.

The remainder of this section sets out the Independent Team's analysis in relation to 4.1.2 in more detail.

As noted above, Mr SU had formalised risk assessments in 2001 and in 2006. Risk was also specifically referenced in two other contacts Mr SU had with mental health professionals between these dates. The first of these was in 2004 in a letter from the Consultant Psychiatrist at the time (Consultant Psychiatrist [1]) to the Citizens Advice Bureau regarding Mr SU's claim for disability living allowance. This letter said the following: *"because of paranoid thoughts, he can get anxious, tense, aggressive and violent, both physically and verbally, and he needs constant support to avoid self neglect and to maintain an appropriate level of hygiene and nutrition."*

There is nothing that the Independent Team can see in Mr SU's records prior to 2000 or between 2000 and 2004 that suggests this level of vulnerability in Mr SU, or that he could become physically violent. Mr SU's regular care co-ordinator told the Independent Team that Mr SU did not have a history of physical violence, even when in relapse in the mid-1990s. The Independent Team checked this professional's perspective with another community psychiatric nurse who had regular contact with Mr SU and she also reported no knowledge of any history of violence in Mr SU. When the Independent Team spoke with the family of Mr SU, they did not report any history of violence in Mr SU. Furthermore, the arrest record of Mr SU prior to the incident does not indicate behaviours of violence. The Independent Team was not able to interview Consultant Psychiatrist [1]; however, it is aware that it is not uncommon for mental health professionals to over-state the situation of the service user to try and ensure that they receive the level of state support they need. On the balance of probabilities, this is what happened here.

The second occasion where risk was specifically referenced, outside of a formalised risk assessment, was in May 2005 when Mr SU attended at the Royal Liverpool Hospital A&E department. During the course of Mr SU's assessments in A&E, it is recorded in the nursing notes, *"no suicide ideation or thoughts of harm to self or others. This presentation was related to his daily use of drugs (Heroin/Cocaine use)".*

The mental health A&E fast track form identified that Mr SU used not only *'illegal drugs'* but also *'alcohol to excess'.* This had not been identified as an issue for Mr SU previously.

With regards to the *'brief MSE'* (mental state examination) that was conducted on 19 May, no evidence of paranoid ideation was detected. Mr SU was appropriate in speech and was also noted to be *'stable on medication'*.

Finally, the 'threshold assessment grid' assessed risk across four criteria: safety, risk, needs and disabilities. Under risk *'from others'*, the criterion *"no concerns about risk of abuse or exploitation from other individuals or society"* was ticked. Under *'risk to others', "antisocial behaviour*" was ticked.

The outcome of the mental health assessment in A&E was succinctly communicated to Mr SU's GP in May 2005, including the assessed lack of risk to self or others.

4.1.2.1 What did the risk assessments of 2001 and 2006 say?

With regards to the risk assessments that were conducted in 2001 and 2006, the following were identified:

In 2001:

- That there were risk factors for suicide. These were misuse of drugs/alcohol. Major psychiatric diagnosis, expressing high levels of distress and unemployed.
- That there were two issues that constituted a risk of neglect. These were financial difficulties and that Mr SU *"denied problems perceived by others"*.
- There were four issues that constituted a risk of violence and aggression. These were misuse of drugs; that Mr SU was under the age of 35 and male;[7] paranoid delusions about others; and signs of anger and frustration.
- There was one issue noted under 'other'. This was exploitation by others.

Under *"situational context of risk factors"*, the assessment states that Mr SU had *"been non-compliant with oral medication in the past and requires depot medication to maintain mental health. Lacks insight when unwell."*

Under *"summary of current protective factors"*, the assessment stated that Mr SU *"currently lives with his parents. He requires a depot injection every 2/52 and is compliant with this."*

Under *"summary of risk assessment"*, it says Mr SU *"does not present a risk to himself or others as he is compliant with medication at present".*

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[7] From the BMA online: Violence and Health.
"A number of sources provide information on the prevalence of different types of interpersonal violence in the UK. These data are not directly comparable and in the majority of cases are under-representative due to under-reporting.

The 2005 Centre for Public Health report *Violent Britain: People, Prevention and Public Health* provides the most comprehensive overview of the levels of collective violence in the UK. The following is a summary of the key data from this report:
Youth violence
• Youth violence committed by or against young people (aged 10 to 30 years) accounts for an estimated 60 per cent of all violence committed in England and Wales.
• Nearly three-quarters of firearms offences (71%) and incidents of alcohol-related violence (72%) are committed by youths under the age of 30.
• Over 5 per cent of all 12-30 year olds report fighting in the previous year and almost half of 10-14 year olds have been bullied at school at some time.
•Those most likely to be involved in youth violence are males between the ages of 14 and 17.
Reference:
http://www.bma.org.uk/health_promotion_ethics/domestic_abuse/vioheal.jsp?page=5.

It did not set out what the risks are if Mr SU were to be non-compliant with medication.

The 2006 Risk Assessment:
This risk assessment identifies almost identical risk factors to the 2001 assessment document. It is not an exact replica, as the design of the form and its content had changed in the intervening five years.

The three suicide risk factors identified were:

- Misuse of drugs and/or alcohol;
- Major psychiatric diagnosis;
- Unemployed/retired.

"History of habitual use of narcotics, principally cocaine but also heroin. Not physically dependent. Long standing diagnosis of schizophrenia."

The six factors for neglect identified were:

- previous history of neglect;
- living in inadequate accommodation;
- pressure of eviction/repossession;
- lack of positive social contacts;
- difficulty in maintaining hygiene;
- experiencing financial difficulties.

"Residual negative symptoms of schizophrenia."

The three factors for aggression/violence were:

- misuse of drugs/alcohol;
- male gender, under the age of 35 years of age;
- known personal trigger factors.

"History of habitual drug use. Narcotic use can precipitate relapse."

The headings relating to the situational context of risk factors was not completed; neither was the section entitled *'historical and/or current context of factors'.*

Under the heading *'summary of current protective factors'*, it was recorded that:

"personality intact – sociable, warm and engaging. No history of risk to others. Receiving day support."

Under the heading *'summary of risk assessment'*, it was recorded:

"Risk of relapse from narcotic use and/or non-compliance with prescribed medication."

The risk assessment form was signed by the service user and the assessing community psychiatric nurse, who was not the care co-ordinator. Neither did the signature of the assessor resemble any of the staff who had provided a 'foster care co-ordination' service to Mr SU. The risk form in use by Mersey Care NHS Trust did not require the assessor's designation to be recorded, nor their name to be printed.

4.1.2.2 Comment by the Independent Team on the 2001 and 2006 risk assessments

The 2001 risk assessment identifies a number of issues; however, none of them are described in terms of how they present in Mr SU and under what circumstances. In this respect the risk assessment conducted was of limited use to anyone who did not have a prior detailed knowledge of the service user. The only person who held this depth of knowledge was the service user's regular care co-ordinator, who had been assigned to Mr SU since he first engaged with specialist mental health services in 1995.

The early-warning symptoms for Mr SU known to his regular care co-ordinator were:

- expressions of anger towards his family;
- that Mr SU would become delusional talking about his Russian uncle who had a tank and would come to kill them all;
- that Mr SU would also refer to his body being a temple and would become very particular about the food he ate.

Mr SU's regular care co-ordinator also told the Independent Team that when Mr SU *"became psychotic he couldn't hide it ... there were no subtle changes with him and he could play the game well, so would be able to blag that he was ok for a half hour visit, but once psychosis had taken hold he couldn't hide it."*

To determine how well or unwell Mr SU was, his regular care co-ordinator told the Independent Team that he would *"ask general questions and those that I knew would push buttons; for example, asking after his parents, asking what he had been doing. Asking direct questions about taking drugs or hearing voices. He would always deny that he was taking drugs."* However, he did not ask Mr SU about his diet. The other issues he considered to be more indicative of Mr SU's mental state.

With regards to risks to others, Mr SU's care co-ordinator told the Independent Team that *"If I had felt that the MSHU was a risk to anyone I would not have let my* [*female*] *colleague visit him, as I said earlier. She was happy to visit him if she was in the area and she knew him very well too."*

It would therefore have been helpful to other community mental health team staff if this information had been recorded on the risk assessment documentation, along with the measures Mr SU's regular care co-ordinator took to determine whether or not there were identifiable signs of relapse. Ideally, these actions would have been notated in Mr SU's care plan. However, in 2001 the practice of risk assessment as a formalised and documented process was not fully embedded across mental health services, and practice did vary within Trusts and across Trusts at the time. Mersey Care NHS Trust's then policy documents did not require staff to set out the plan for managing identified risks, or to record the early-warning signs for emerging risks. This was not at all unusual in 2001.

With regards to the 2006 risk assessment overall, the document was somewhat better completed than that in 2001. However, as with the 2001 risk assessment, there is no information about what happens when Mr SU relapses, becomes paranoid or uses illicit drugs.

Furthermore, there was no trigger in the Mersey Care NHS Trust 2006 risk assessment form for the documentation of:

- a service user's early-warning signs;
- a risk containment plan;
- a crisis intervention plan.

In 2006 these should have been routine features of a comprehensive risk assessment.

With regards to Mr SU's 2006 risk assessment, staff responsible for the delivery of risk assessment training in Mersey Care NHS Trust observed that:

- the risk form was the *"older style risk form"*;
- there was the identification of some risks but no evidence of a care plan arising from that;
- risks should be reflected in a care plan; and
- there were a significant number of data fields that are not completed. One of the trainers said: *"If there was nothing to say then this should have been indicated with a 'NA'; that at last evidences that the practitioner has considered the issue."*
- One trainer said that they would have liked to have seen more fulsome documentation about the risks - one knows that there are

risks, but not much about them. This lack of recording leaves vulnerability clinically.

The opinion expressed by Mersey Care NHS Trust's training staff mirror those of the Independent Team.

The same staff also told the Independent Team that: *"There was 1/2 day RA and 1/2 day CPA for unqualified staff. There was a full day RA and a full day CPA for qualified staff. Then there was a 5 day care co-ordinators training which a care co-ordinator had to have done the 1 day course to gain entry to. Risk assessment was also a thread through this. The training addressed how information is gathered from a service user, the consequences of not asking for information, and passing the information on, and working in partnership with a service user and his/her family."*

The workshop also addressed *"the importance of the qualitative description of risks, their triggers, their known consequences etc on the ePEX system".*

This information shows that Mersey Care NHS Trust complies with the recommendation in *Safer Services – The Report of the National Inquiry in Homicide and Suicides 1999*, that all mental health staff should receive risk assessment training at least on a three-yearly basis.

4.1.2.3 The consequence of the incomplete risk assessment forms

In this case, it is unlikely that better completed risk assessment forms would have made any difference to what subsequently happened. The service user was seen by his regular care co-ordinator, who knew him well, on 25 February 2008 and Mr SU was not displaying any of his early-warning signs of relapse. However, staff who acted as 'foster care co-ordinators' told the Independent Team that they didn't really know very much about Mr SU other than that he was on depot medication and used illicit drugs. The staff told the Independent Team that they did look for information that would normally be contained within the Effective Care Co-ordination (CPA) documents and/or the risk assessments conducted over the years and found them to be uninformative. This meant that they did not know what sort of questions to ask Mr SU when they had contact with him to help them determine how stable he was mentally. In this particular case, having reviewed the clinical records between 2000 and 2008, and interviewed staff and family members, the Independent Team does not believe that the reported knowledge gaps in community psychiatric nurse [4] and community psychiatric nurse [5] had a negative impact for Mr SU. His care co-ordinator was around sufficiently enough for risk factors, had they been discernible, to have been raised with colleagues and addressed. Furthermore, the consultant psychiatrist between 2005 and 2008 told the Independent Team that he was confident that had the team had any concerns regarding Mr SU they would have brought them to the weekly multi-disciplinary clinical team meeting. This consultant told the Independent Team that staff actually reported *"concerns even before the weekly meetings, if they had them and the concern could not wait".*

In this case, the issue is more one of incomplete record-keeping rather than the care co-ordinator not being aware of a service user's risks. However, the omission in documentation could have had a serious negative impact and it is therefore incumbent on Mersey Care NHS Trust and all clinical business units to ensure that the quality of risk assessment documentation is now sufficiently robust to ensure that all staff referring to such documents are as fully informed about:

- the known risks associated with a service user;
- the context of how those risks manifest;
- the consequences of the risk behaviours when 'active';
- the early-warning signs that the risk behaviours may be emerging;
- any remedial actions that can be taken to reduce risk;
- the crisis intervention plan should a service user be in 'full relapse'.

4.1.2.4 What were the standards required in Mersey Care NHS Trust in relation to risk assessment between 2000 and 2008?

In 2001 a document entitled *"Mersey Care NHS Trust Community Mental Health Teams*" said:

"CMHTs[8] are a specialist resource and will work in partnership with other services and agencies to ... assess and manage risk in order to reduce self harm, violence and harm to others and severe self neglect."

In 2002 the 'Operational Policy for Community Mental Health Teams' said that community mental health teams would *"assess and identify risk, developing risk management strategies as part of individual care plans. This will be in accordance with the guidance provided by the* [*Effective Care Co-ordination*] *process."*

The 2002 *"Effective Care Co-ordination in Mental Health Services in Liverpool and Sefton"* under *'Responsibilities of a care co-ordinator'* (page 3), says:

"the care coordinator will be responsible for co-ordinating the multi-disciplinary assessment of risk" and "be responsible for maintaining an up to date risk assessment and management plan. It is however the whole team's responsibility to ensure timely and accurate information is communicated to the care coordinator to up-date the risk assessment and management plan."

The Mersey Care NHS Trust Effective Care Co-ordination policy (2006) in section 2, which summaries the key policy points, says at 2.1 and 2.2 page 6:

"All service users will have an assessment of risk (5.12, 5.14) & (Appendix 4).

All service users will have a care plan detailing interventions and anticipated outcomes and which contains a risk management plan (Appendix 6)."

In section 8.4.8 (page 18), entitled *'Responsibilities of the Care Co-ordinator'*, the policy says:

"To be responsible for maintaining a current risk assessment document and a risk management plan which is contained within the care plan. It is however, the whole team's responsibility to ensure timely and accurate information is communicated to the Care Co-ordinator for updating risk assessment."

In none of the above documents is any guidance given to staff on the maximum time lapse between reviews of a service user's risk assessment. One doctor interviewed during this investigation told the Independent Team that *"risk assessment should be carried out at every care review. Review of care plan of service users should occur annually as a minimum."*

[8] CMHTs = Community mental health teams.

The clinical director for the Liverpool clinical business unit (adult services) told the Independent Team that: *"clinical risk is embedded in all practice and was within but also beyond policy. Risk is always being considered; it is just something that is done all the time. The Effective Care Coordination (CPA) policy states that a risk assessment must always be done when a patient is transferred within CPA or to hospital. Risk assessment is embedded in practice within the CPA process."*

Those responsible for the delivery of risk assessment training in Mersey Care NHS Trust told the Independent Team that in any service user's clinical record they would expect to see a:

- initial assessment;
- risk assessment document;
- risk management plan;
- history of risk;
- current risk.

For an uncomplicated service user these professionals also told the Independent Team that they would have expected to see reviews of risk at least once a year.

The Independent Team agrees with all of the above interviewees. Risk assessments should be reviewed for service users on CPA at least annually, or more frequently if there are changes in the circumstances for the service user.

The Independent Team was curious as to how risk assessment plans were audited within the context of clinical/case management supervision. This is something all qualified community mental health team practitioners should receive on a monthly basis.

Managers working in Mr SU's community mental health team at the time told the Independent Team that: *"Systematic reviewing was sadly missing and a recurrent concern."* It was something they would have liked to have done, but time pressures meant that it usually did not occur. The Independent Team was also told that there was a certain level of frustration in staff who felt that even the most perfect of risk assessments could not be guaranteed to prevent significant adverse events from happening. The Independent Team empathises with such feelings, because they do reflect the reality of the limitations of good risk management practice in mental health services. However, a good quality risk assessment, risk management plan and crisis intervention plan can evidence that the mental health services were appropriately aware of a service users risks and had done all they could to

mitigate these. The risk assessment documents for Mr SU do not indicate such a standard of practice.

With regards to the knowledge and skills of Mr SU's regular care co-ordinator, the lack of completeness in the 2001 risk assessment was not considered to be due to a lack of these. One of his managers told the Independent Team that he *"seemed to have a good grasp of the essentials",* and that she had not had any concerns about his clinical competency.

When the Independent Team interviewed this individual he was able to articulate knowledgably and confidently about Mr SU and clearly had a detailed knowledge of him, and hitherto a reasonable relationship with Mr SU's family who did, prior to 2000, contact Mr SU's care co-ordinator if they were concerned.

The main contributors to the lapses in record-keeping in relation to Mr SU were:

Organisational issues:

- A persistent lack of review of the quality of staff record-keeping via the supervision process because of time constraints.
- No system to enable and ensure the review of the standard of record-keeping across an individual community psychiatric nurse's caseload on a rolling basis.
- An alteration to the Trust plan that for each community psychiatric nurse the team manager would audit the standard of risk assessment/CPA document against a pre-designed audit tool. This task was delegated to CPA co-ordinators who, although able to assess the quantitative criteria, would not have been alert to the qualitative aspects of an individual community psychiatric nurse's records.

Team Issues:

- The personal ill health of Mr SU's own care co-ordinator which resulted in regular periods of time off work and the consequence of a backlog of record-keeping tasks.
- That the depth of historical information about Mr SU was held by Mr SU's care co-ordinator only.
- The number of community psychiatric nurses engaged in 'fostering' Mr SU when his own care co-ordinator was off sick.
- The lack of skill in using a computer by Mr SU's care co-ordinator.
- A conflict between what Mr SU's care co-ordinator saw as of most importance in his work (i.e. making contact with the clients on his caseload) and the need to ensure that the records he made

accurately reflected the care/service he provided. Mr SU's care co-ordinator was not able to reconcile the conflict because of the previously mentioned issues.

The most significant contributory factors, in the opinion of the Independent Team, were:

- The lack of systematic review of Mr SU's care co-ordinator's records, even though his managers knew there were significant issues over his record-keeping.
- Mr SU's care co-ordinator's own conflict between care provision and record-keeping that he did not resolve.

4.1.3 Was sufficient attention given to Mr SU's substance misuse?

The Independent Team considers this to be a difficult question to answer. The whole area of addictions management is complex and requires there to be a commitment on the person suffering from an addiction to want to address this. There is no convincing information available that suggests that Mr SU was ever willing to seriously address his addictive tendencies.

It is well understood in the mental health professions that individuals who make their own appointments with drug and/or alcohol services, and are self-motivated to attend for therapy and group work designed to promote recovery from substance misuse, have the best chance of success. Individuals who attend such meetings under obligation, or because someone else has booked the appointment for them, generally have a lesser chance of success.

Consequently, although the Independent Team agrees with the sentiment of the Mersey Care NHS Trust internal report that there could and should have been greater documentary evidence of his care co-ordinator and others encouraging Mr SU at times where he expressed motivation to address his substance misuse problem, on the balance of probabilities the Independent Team does not believe it would have resulted in engagement of Mr SU with the services and groups who could have helped him achieve recovery.

As Section 3.0 highlights, Mr SU told the Independent Team that he did not want to work with specialist mental health services to address his drug habit. He wanted to find his own way with this. Furthermore, his own testimony that he had significant 'clean' periods followed by time-limited binges explains why staff detected no physical signs of dependency. It was the Independent Team's impression on speaking with Mr SU that he was able, when using drugs, to maintain a reasonable degree of functionality. The length of his appointments was relatively short, and he would have been able to maintain a front of wellness when meeting with professionals. That this was possible for him was confirmed by him to the Independent Team.

Liaison with the substance misuse service provided by Mersey Care NHS Trust revealed that Mr SU never engaged with any of their services at any time, even though he was encouraged to do so, in 2001 and in 2005.

Liaison with the Spider Project revealed that, prior to the current organisation of the project, no *"proper records were kept".* However, the centre manager recalled that Mr SU had contact with the project prior to and after 2005. . He had been referred initially to their acupuncturist, and latterly to Dare to Care. The centre manager also recalled that Mr SU did attend some sessions for acupuncture. Mr SU was always 'clean' when he attended at the Spider Project. It is a requirement of the project that service users are clear of drugs and alcohol. The centre manager recalled that Mr SU was never interested in engaging in any of the structured activities that might have enabled him to

maintain his abstinence from drugs. The team manager at the Spider Project also told the Independent Team that they were not at all aware that Mr SU had a care co-ordinator or a serious mental illness. He did not reveal this to them. Had he done so, then they would have wanted to obtain permission from him to speak with his care co-ordinator. However, they can only work with the information a service user is prepared to share with them.

Liaison with “Dare to Care”[9] revealed that Mr SU had attended at their centre for acupuncture in 2006 and 2007. He received acupuncture therapy. He had been referred by the Spider Project as Mr SU said he found acupuncture helpful in addressing his substance misuse and it helped him with feelings of calmness.

The Independent Team Comment

Dual Diagnosis (i.e. a mental health illness and a substance misuse problem) is an ever increasing challenge in mental health services. On the basis that one cannot impose a desire to address a drug habit on a service user, the Independent Team considers that one can only reasonably expect a mental health care provider to:

- Provide opportunity for its staff to be well educated about substance misuse and the addictive personality;
- Provide all service users who express a desire to ‘kick their habit’ with an information sheet of all the relevant support groups and services within the locality, so that they can explore what is on offer and choose what is right for themselves;
- Offer to accompany a service user to their first appointments or meetings if the service user would find this helpful;
- Make sure that the service user knows that they are not judged on the basis of their addiction;
- Provide opportunity for a service user who wants to ‘kick their habit’ to talk with a service user ‘in recovery’ from their habit.

In this case, Mr SU accessed the recovery services he wanted when he wanted. Furthermore, the Independent Team is satisfied that Mr SU’s care co-ordinator did make reasonable and regular efforts to ask Mr SU about his illicit drug usage over the years he was his care co-ordinator. That Mr SU did not want to speak with his care co-ordinator about his illicit drug usage does not reflect poorly on the care co-ordinator. It was a choice Mr SU made and had a right to make.

The only thing that the Independent Team considers Mr SU’s care co-ordinator could have done differently was to have been more diligent in his

[9] Dare to Care is a holistic therapy centre that accepts clients on a self-referral basis.

record keeping, or to have at least stated periodically what his standard of practice was, and the range of issues he routinely explored with Mr SU when he met with him to administer his depot.

4.1.4 Was his medication managed appropriately and was he on the right medication at the right dosage?

The management of Mr SU's medication was reasonable throughout his contacts with Mersey Care NHS Trust until January 2006, when his medication was reduced from 50mg Depixol fortnightly to 50mg Depixol monthly. The change in medication occurred when Consultant Psychiatrist [3] re-stated Mr SU's prescription in the medical notes. It was not known to him at the time that what had been written by the clinical assistant who covered the depot clinic in 2004 differed from what he had actually prescribed in the period 2004 to 2006.

The reduction in medication occurred 27 months prior to the incident, with no apparent deterioration in Mr SU's mental state being observed. The Independent Team therefore concurs with the independent psychiatric opinion sought by the Coroner that, although 50mg Depixol was at the lower end of therapeutic effectiveness, one cannot say there was a causal link between the reduction in medication and the incident that subsequently occurred.

Set out below is a more detailed analysis of the medication management of Mr SU.

During the period of Mr SU's last in-patient episode he was prescribed Depixol (an antipsychotic medication), 150mg every fortnight. By November 1997 the dosage had reduced to 100mg a fortnight. It then reduced as follows:

- 90mg a fortnight in 1998;
- 90mg a fortnight in 1999;
- 90mg a fortnight in 2000.

On 10 September 2001 the dosage was reduced to 50mg every fortnight.

An analysis of the administration records between 2001 and 2004 showed that Mr SU received his depot medication on a reliable basis and that two community psychiatric nurses predominantly administered this to him. These community psychiatric nurses were Mr SU's care co-ordinator and community psychiatric nurse [2].

The occasions on which Mr SU did not attend for his medication were noted as:

- 9 October 2002;
- 11 November 2003.

On 10 August 2004 the ‘prescription and administration card’ stated that Mr SU’s Depixol had been reduced to monthly. This followed a review by the clinical assistant in psychiatry (a GP with a special interest in psychiatry) who noted that Mr SU had been *“expressing a desire to stop depot medication and substitute this with oral antipsychotic treatment”.* The clinical records noted that Mr SU expressed that his life was more stable and that he then had a better insight into his illness. At the time of this request Mr SU was seven years post his last relapse in 1997. Initially, a decision was made to commence Olanzapine, but following Mr SU’s concerns about weight gain this medication was changed to aripiprazole, which, at the time was a recently licensed antipsychotic without any of the side effects Mr SU wanted to avoid.

The change in medication was monitored by the clinical assistant in psychiatry on:

- 26 August 2004; and
- 9 September 2004;

when it was noted that he was doing well with the change of medication and that he had no side effects.

However, on 20 October 2004 Mr SU was reviewed at the community mental health team base by one of the medical staff and his care co-ordinator. He was at this time complaining of side effects of his medication aripiprazole and it was agreed that he would switch back to his previous medication, which was Depixol 50mg a fortnight. This was also administered to him the following day by community psychiatric nurse [2].

He was booked an appointment for follow-up by the clinical assistant in psychiatry for 4 November, but Mr SU did not attend for this. The clinical assistant did, however, speak with Mr SU’s community psychiatric nurse. In his letter (dated 17 November 2004) to Mr SU’s then GP he said, *“This man did not attend today but I understand from his community psychiatric nurse that he is now well stabilised back on Depixol 50mg every four weeks.”*

A review of the medication prescribing and administration card shows that Mr SU was in fact being prescribed Depixol every two weeks.

On 16 November 2004, when community psychiatric nurse [2] attended the home of Mr SU to administer his depot, she noted:

- His mental health was stable;
- He appeared to be sleeping in the lounge, which looked *“quite dirty and untidy”*.

As a consequence of her observation, community psychiatric nurse [2] asked the company providing ‘supported living’ to Mr SU if his support worker would work with Mr SU to *“improve daily living skills to include domestic chores and personal hygiene”.*

Between 16 November 2004 and 13 May 2005 Mr SU missed three of his depot injections. The longest time he was without this was four weeks. Furthermore, except between 15 February 2005 and 15 March 2005, when Mr SU was not available on the day his community psychiatric nurse or community psychiatric nurse [2] attended to administer his depot, further attempts were always made to make contact with him to administer this.

Throughout the remainder of 2005 the electronic patient record (ePEX) shows that when Mr SU was not at home for his depot, or he did not attend at the depot clinic as planned, staff did try and make contact with him, and would make further home visits to try and catch him in. There was one period where the gap between depot injections was significant. This was between 10 June 2005 and 11 August 2005. During this period, community psychiatric nurse [2] did manage to make contact with Mr SU and asked him to attend to meet with a doctor in the depot clinic the following week. A review of Mr SU’s medical records showed that that there were no medical entries after 4 November 2004, suggesting that Mr SU did not appear at the medical follow-up he had been requested to attend.

Mr SU next attended on 7 September for his depot injection. Thereafter for the remainder of 2005 he attended more regularly. On the subsequent occasions he did not attend, for example on 4 November 2005, the Epex records indicate that community psychiatric nurse [2] did try and make contact with Mr SU via his mobile phone. Although successful contact was not achieved, Mr SU attended at the community mental health team base on 7 November 2005 for his medication.

He subsequently missed his December dose.

In January 2006 the prescription for Depixol every fortnight was changed to Depixol every four weeks. This change came about when the new consultant psychiatrist to the community mental health team wrote up a new prescription for Mr SU. This consultant could not recall whether he was given the previous prescription card or only a new blank card. However, it would have been his practice to refer to the last recorded dose in the medical records, which was Depixol 50mg every four weeks, before writing the new prescription. As already stated above, the last medical record about Mr SU’s dosage of

Depixol was stated to be 50mg every four weeks. Consequently, the prescription was made for Depixol 50mg every four weeks. The independent psychiatric report provided to HM Corner for the City of Liverpool, dated 5 February 2010, stated, "*According to the Maudsley Prescribing Guidelines, suggested dosages and frequencies for flupentixol deconate are between 12.5 – 400mg per week (and between 204 weeks). Therefore a dose of 12.5mg every 4 weeks is at the lowest end of the advisory range."*

The independent consultant also highlighted that as a consequence of Mr SU not attending for his depot injections when required he was sometimes receiving less than the lowest therapeutic dose. The Independent Team reviewed the frequency with which Mr SU missed his depot injection it found between January 2006 and April 2008 Mr SU:

- missed one depot injection in 2006. This was the December dose;
- missed one depot injection in 2007. This was the December dose;
- was due his medication in the last week of March 2008. Mr SU had attended at the community mental health team base for this on 27 March (Thursday) at 8.30 am. He left after 30 minutes, as he had an appointment with his bank manager. He asked if his care co-ordinator would *"go to his on Monday morning"*, 31 March. The message was left for Mr SU's care co-ordinator on Friday 28 March. However, on this day Mr SU's care co-ordinator was on annual leave and was not at work. He therefore would not have seen this. Mr SU's care co-ordinator returned to work on 31 March, but only worked the morning, having already booked annual leave for that afternoon. Consequently, he attended at Mr SU's home to administer this on Tuesday 1 April 2008. However, Mr SU was not at home.

In the context of mental health services and in the context of the behavioural traits of Mr SU he had a remarkably low miss rate.

Because 31 March 2008 is the day Mr SU's parents died, the timing of the sequencing of events at this stage is of significant interest to the remaining family of the deceased.

What is known is that on Monday 31 March 'Men's Direct Access' (a men-only hostel) contacted Mr SU's community mental health team asking that his care co-ordinator contact them. The ePEX record for this day noted that the deputy team manager returned the call to 'Men's Direct Access' at 11.35 am. The ePEX record noted that Mr SU had *"turned up at their office saying he is being harassed and they were concerned that he may make himself intentionally homeless. Mr SU is known to them. Message left in message book for Mr SU's care co-ordinator to contact them. No other immediate concerns expressed by them."*

The next ePEX record related to the unsuccessful attempt by Mr SU's care co-ordinator to see him at home on the morning of 1 April.

Commentary by the Independent Team

As stated at the start of the above, Mr SU's medication management was reasonable overall.

Because of his history of non-compliance with medication, Mr SU had been on depot medication following the last relapse of his mental illness as a consequence of non-compliance with oral medication in 1997. This was appropriate.

Since that time Mersey Care NHS Trust staff had consistently been diligent in following up Mr SU if he did not attend at the depot clinic, or was not available at home to administer his medication. Furthermore, a decision had been made in March 1999 after a run of 'did not attend' at his outpatients appointments for Mr SU to be followed-up at home. This was good practice. It is notable that this decision required an additional commitment from the community mental health team staff after 2001 as Mr SU had moved out of the geographical patch for the team when he was placed in supported accommodation.

The only aspect of Mr SU's medication management that was cause for concern was the lack of correlation between the dosage of Depixol recorded on Mr SU's prescription charts between 2004 and 2006, and that recorded as being required in his medical records. The conflict between these documents caused an actual reduction in Mr SU's Depixol dosage in 2006, though no clinical decision had been made to actively reduce this. The Independent Team is satisfied that it was the sincere belief of the prescribing consultant in 2006 that the dose of Depixol Mr SU had been receiving prior to him prescribing had been 50mg every four weeks. Had he become aware of the conflict in the documents, the Independent Team are satisfied that the reduction in dosage would not have occurred. There was no reason to have consciously done this.

The discrepancy in the records seems to have come about as a consequence of i) the initial reduction in Depixol from 50mg every two weeks to 50mg every four weeks when Mersey Care NHS Trust were trialling a change of medication with Mr SU; ii) the re-prescribing of Depixol when it became clear that Mr SU preferred to take his Depixol. The last recorded dosage of Depixol in the medical records was 50mg every four weeks, and it seems that this was inadvertently continued even though what was prescribed on the medicines chart was 50mg Depixol every two weeks.

That there is more than one place for recording dosage and the fact that at the time medical staff relied on the medical records being correct were the most significant factors to the error that occurred.

Although the actual reduction in medication that occurred in 2006 was not necessary, it did not seem to have any adverse impact on Mr SU. There was no apparent or sustained deterioration in his mental state and there was no evidence of any of Mr SU's early-warning signs. The clinical records consistently note that Mr SU was well and appeared stable throughout 2006 and 2007. He was seen monthly by a community psychiatric nurse every month bar two, December 2006 and December 2007. The Independent Team therefore agrees with the assessment of the Forensic Consultant Psychiatrist who considered that the reduction in medication between 2006 and 2008 was not a causal factor in the incident that subsequently occurred.

The only other aspect of medication management that the Independent Team feels should have been different was the lack of questioning by the community mental health team staff. Mr SU had been on depot injections every fortnight for a number of years. A trial of oral medication did not suit him in 2004 and he returned to Depixol 50mg every fortnight. Mr SU's care co-ordinator was absent from work when the change in medication occurred. By the time he returned to work, he not unreasonably assumed that the decision had been a reasoned one. None of the other community psychiatric nurse staff the Independent Team interviewed have been able to articulate why no-one questioned Mr SU's consultant psychiatrist in 2006 about the reduction in Depixol dosage, especially as the consultant had not seen or assessed the patient and there had been no requests by Mr SU to reduce his medication. Reasonably, one would have expected staff to have raised the unplanned change in medication with the clinical assistant in the depot clinic or with the consultant psychiatrist himself.

The impact of the reduction in Depixol from 50mg every fortnight to 50mg every month

The most significant impact the reduction in medication had was that it reduced the frequency of contact between Mr SU and the community mental health team staff. Although Mr SU was seen monthly in 22 out of 24 months, this may not have been frequent enough to observe any subtle changes in him. Had fortnightly injections continued in the four to five weeks prior to the incident, there would have been opportunity for staff to have assessed him twice prior to the incident's date. However, the fact that these contact opportunities were removed cannot be extrapolated to determine incident preventability, or that the community mental health team staff would have noted features of such concern that Mr SU would have required assessment under the Mental Health Act. The Independent Team has also learnt that Mr

SU was very good at masking his symptoms and, unless floridly psychotic, was capable of presenting well for 30 minutes or more. This means that even had he been seen by mental health practitioners more frequently in January, February and March, it is unlikely that the deterioration occurring in him would have been detectable. This is especially so as he presented as rational on 28 March when he attended at the community mental health team base, and Men's Direct Access reported nothing odd about him when he attended at their offices on 31 March.

At the time of his last relapse (1997) Mr SU had been without medication for at least eight weeks before presenting as floridly unwell and requiring a hospital admission. Since that relapse Mr SU was without medication for a period of three months between June and August 2005 and did not become unwell. On 31 March 2008 Mr SU was only six days overdue in relation to his prescribed regime. It was a comparatively short period of time, and not sufficient on its own to have precipitated the relapse that occurred.

It is the contention of the Independent Team that the dramatic change in Mr SU's behaviour is more likely linked to the reported illicit drug use of Mr SU in the period immediately prior to the incident. This it considered is especially so on the basis of the recollection of his family that Mr SU had spent a short period of time, on 31 March 2008, with his father prior to the death of his parents and the impression was that Mr SU did not behave any differently to that which he normally did. The Independent Team is also mindful that when admitted to a medium secure unit on 2 April Mr SU tested positive for Cannabis and reported using it when assessed for his fitness for interview on 2 April 2008 when still in custody.

4.1.5 Was there an acceptable level of engagement between specialist mental health services and Mr SU's supportive housing providers?

Between 2003 and 2005 Mr SU received a service from Trimar Care Ltd, a professional independent support agency. Trimar Care provided Mr SU with support with independent living as well as his accommodation.

The Trimar records show that daily, and sometimes twice daily, visits were made to Mr SU's flat between 3 April 2003 and 29 July 2005. The records consistently show that Mr SU posed no management problem to the Trimar support workers between April 2003 and May 2005. He was consistently at home when the support workers called around to his flat, he maintained a tidy home, interacted socially with them, and accepted the support provided to him with regards to the management of his financial affairs. The Trimar Care records also confirm that his support workers accompanied Mr SU to the GPs from time to time, and that they accompanied him to visit his mother. The records also show that from time to time one of the community psychiatric nurses attending to administer Mr SU's depot injection would be in attendance

at the same time as the Trimar support worker. Trimar's records show that interaction between the two services occurred.

With regards to the need for a joint professionals meeting, there is nothing in Mr SU's Trimar records that suggests that there would have been any reason for the Trimar staff to have contacted mental health services about him until 20 May 2005, the day following Mr SU's attendance at the Royal Liverpool Hospital's A&E department, asking to be detained in hospital following his starting to use heroin and crack cocaine again.

The Trimar records indicate that the general manager of Trimar Ltd contacted Mr SU's social worker and also the team leader at Moss House community mental health team about what had happened, and to seek assistance from the mental health services, as it had been reported to them that Mr SU was without money for food and electricity. The Trimar record states:

"[*The general manager for Trimar Care Ltd*] *was informed by* [*the team leader for the community mental health team*] *that Mr SU had chosen his path and no help was available.* [*The leader of the community mental health team*] *also informed* [*the general manager at Trimar Care Ltd*] *that if Mr SU wants help he needs to take himself to Rodney Street (Hope House) to get himself off drugs.* [*The leader of the community mental health team*] *then explained to Trimar that the crisis team from the Royal Liverpool Hospital had written to her saying that he* [*Mr SU*] *was not ill enough to be sectioned and that any mental health issues were drug induced."*

The record made by Trimar also shows that Trimar had contacted Mr SU's social worker two weeks prior to Mr SU's presentation at A&E raising concerns about Mr SU's behaviour, and suspicions that he had again recommenced illicit drug taking, even though Mr SU reported to the general manager and the director at Trimar Care that he had not.

Although the Independent Team can understand the position of Mr SU's community mental health team with regards to his social situation as reported by Trimar, the Independent Team considers that, as Mr SU had a named care co-ordinator, the community mental health team manager could and should have asked this individual to make contact with Trimar and to have tried to make contact with Mr SU about his situation and offered support to him in engaging with substance misuse services.

Reviewing Trimar's records between 21 June and 29 July 2005, it seems as though Mr SU was never at home. There was a chance communication with him on 25 July 2005, when he reported he was leaving his flat in R Road and moving to an alternative location.

At no time between 21 June and 25 July is there any indication that the Trimar Care staff communicated with Mr SU's community psychiatric nurse to determine whether or not they had achieved any contact with him. Mr SU was in fact seen on 29 June for the administration of his depot injection. However, then there was a period of no contact between Mr SU and the community mental health team (30 June 2005 to 10 August 2005). The Independent Team has not received any explanation from Trimar regarding the gap in the records provided. As already highlighted in this report, in addition to the lack of contact initiated by Trimar, there was no initiation of contact from the community mental health team to Trimar over this six-week period to determine the whereabouts and/or well being of Mr SU.

After July 2005 it is completely unclear what happened to the provision of supported housing for Mr SU. It seems that he was offered a tenancy with Natural Networks but that this was terminated after one month, for reasons that the Independent Team is not privy to.

Extensive research undertaken by the Development Manager, Adult Services (Mental Health), Integrated Adult Health & Social Care, Commissioning Unit, Liverpool City Council, did not reveal a clear audit trail of what had happened to the provision of a support package to Mr SU. This individual also tried to determine what had happened by reviewing the then social workers' records; however, this was not successful. Contact with the social worker involved at the time was not possible as his current whereabouts are not known.

4.2 Did Mr SU receive appropriate medical input from the medical team involved with him?

For the majority of his contact with the mental health service Mr SU received reasonable medical input. However, in the three years preceding the incident he was not assessed by a doctor at any time. In each of these years, 2005, 2006 and 2007, provision had been made for contact between Mr SU and a doctor as a component of his annual medication review and/or the annual Effective Care Co-ordination review. Mr SU did not attend for any of the planned appointments. As a consequence of his non-attendance, there was no plan to try and effect a medical assessment of him via alternative arrangements. On the basis of the reports received from the community mental health nurses, it was not considered as necessary by Mr SU's consultant psychiatrist.

A mental health service user with a severe and enduring mental illness on long-term psychotropic medication requires medical input at two levels:

- the management and review of physical health;
- the management of their mental illness.

All mental health service users should have a physical health check. The 2009 *"NICE clinical guideline 82 – Schizophrenia"* document says *"GPs and other primary healthcare professionals should monitor the physical health of people with schizophrenia at least once a year".* This requirement was included in the 2002 guidance document. It also says that *"healthcare professionals in secondary care should ensure, as part of the CPA, that people with schizophrenia receive physical healthcare from primary care as described in recommendations 1.4.1.1–1.4.1.4"* (page 25). The emphasis on a care co-ordinator's responsibility for ensuring that a physical health check was performed, although not stated as plainly, was contained in the 2002 guidance,. This said:

"The higher physical morbidity and mortality of service users with schizophrenia must be considered in all assessments. Particular attention should be paid to the risk of metabolic and cardiovascular disease, and attention should be given to the promotion of lifestyle and dietary changes that may promote better health outcomes. Whilst this would normally be expected to be the role of primary care services, secondary care services should nevertheless monitor these matters, especially where they believe a service user may have little regular contact with primary care. Primary and secondary care services, in conjunction with the service user, should jointly identify which service will take responsibility for assessing and monitoring the physical health care needs of service users. This should be documented in both

primary and secondary care notes/care plans and clearly recorded by care co-ordinators for those on enhanced CPA."[10]

It was generally expected and accepted in the field of secondary mental health care that a service user on enhanced CPA would be seen by a doctor at least once a year if there were no indicators for this to occur more frequently.

In the case of Mr SU it is unclear when his last physical health check was prior to the incident, although this is not something that one would have expected to have gleaned from mental health records prior to 2009. The Independent Team understands from Mr SU's care co-ordinator that Mr SU did not attend at his GP's as he was never ill.

With regards to medical input from a psychiatrist, or appropriately qualified medical practitioner, until the end of 2004 Mr SU was seen at minimum on an annual basis and sometimes more frequently. However, in 2005, 2006 and 2007 Mr SU was not seen by a member of the medical team at all. There was opportunity for Mr SU to meet with his consultant psychiatrist (consultant psychiatrist [3]) during the CPA reviews in March 2006 and June 2007; however, he did not attend either of the meetings planned. Consultant psychiatrist [3] was invited to the 2005 CPA review, but did not attend. It is the Independent Team's understanding that this was because he was very new in post at the time. As noted above, because the community psychiatric nurses involved with Mr SU over this period reported consistent stability in his mental state with no variation in his behaviours over a number of years, a decision was made in 2006 and 2007 respectively that there was no need for Mr SU to be followed-up in outpatients or for there to be an attempted medical review at Mr SU's home. Consultant psychiatrist [3] considered that the community psychiatric nurses working with Mr SU would bring to his attention any issues of concern that emerged in the intervening period and would organise a medical assessment as and when it was required. His analysis of Mr SU's retrospective clinical records meant that in his clinical opinion this approach was reasonable for Mr SU. However, consultant psychiatrist [3] was not aware of the level of support Mr SU required in the community. This information was not communicated to him and neither was the agency providing this support in attendance at the 2006 or 2007 CPA reviews. A review of Trimar Care's records between 2003 and 2005 did not reveal any invitations received from Mr SU's community mental health team inviting them to attend at Mr SU's CPA reviews.

The following table sets out the medical contacts between Mr SU and Mersey Care NHS Trust-employed doctors between 2000 and 2004.

[10] In 2008, following the launch of *"Refocusing CPA"*, the requirement for service users to be on two levels of CPA changed. Now service users are either CPA or non-CPA.

The Medical Assessments of or medical contact with Mr SU between 2000 and November 2004

Date	Type of planned Contact	Successful?	Grade of medical staff
2000 – No contact			
10 May 2000	OPD	No. Mr SU did not attend	Consultant Psychiatrist [1]
10 July 2000	OPD	Mr SU in HMP Liverpool	
29 June 2000	Planned CPA review	Mr SU in HMP Liverpool	
2001 – No contact			
Mr SU was discharged from HMP Liverpool in August 2001.			
9 September 2001	Discussion between care co-ordinator and the consultant	NA	Consultant Psychiatrist [1]
2002 – No contact			
2003 – One contact			
24 July 2003	CPA review	Yes	Consultant Psychiatrist [1]
2004 – Five contacts			
15 January 2004	Letter to the CAB	NA	Consultant Psychiatrist [1]
12 February 2004	CPA review	No medical record made	Locum Consultant Psychiatrist [2]
20 May 2004	OPD	Yes	Locum Consultant Psychiatrist [2]
17 June 2004	Depot clinic	DNA	Clinical Assistant in Psychiatry
12 August 2004	Depot clinic	Yes	Clinical Assistant in Psychiatry
26 August 2004	Depot clinic	Yes	Clinical Assistant in Psychiatry

Date	Type of planned Contact	Successful?	Grade of medical staff
9 September 2004	Depot clinic	Yes	Clinical Assistant in Psychiatry
24 October 2004	Depot clinic	Appears, Yes	Clinical Assistant in Psychiatry
4 November 2004	Message from community psychiatric nurse	No	Clinical Assistant in Psychiatry
17 November 2004	Depot clinic	DNA	Clinical Assistant in Psychiatry
2005-2007– No contacts			
10 March 2005	Depot clinic	DNA	Clinical Assistant in Psychiatry
3 March 2006	CPA review	DNA	Consultant Psychiatrist [3]
June 2007	CPA review	DNA	Consultant Psychiatrist [3]

On the basis of the medical records provided to the Independent Team by Mersey Care NHS Trust, the above table shows that Mr SU was not assessed by a medical practitioner in:

- 2002;
- 2005;
- 2006;
- 2007.

Of the above, the only year where the provided records do not contain any evidence that a medical assessment was offered was in 2002.

2004 was a notable year, because of the enhanced contact with the clinical assistant in psychiatry. The medical notes of this period show that due care and attention was given to Mr SU's request, including an exploration of Mr SU's contemporary attitude to illicit drugs, medication and his mental illness. The clinical record also indicates that the clinical assistant in psychiatry was

sensitive to the side effects Mr SU wanted to avoid and prescribed a newly licensed anti-psychotic medication, as is already described in section 4.1.3 a-b. This was good practice and complied with the 2002 NICE guidance.

Commentary by the Independent Team regarding the lack of medical contact with Mr SU between November 2004 and April 2008

It is unquestionable that Mr SU should have been provided with the opportunity to be assessed by a medical practitioner on at least an annual basis. However, 2004 excepting, although opportunity was provided for Mr SU to meet with a member of the medical team in the five years preceding the incident, more often than not he was not seen by a doctor.

He was a service user who, judging by the 2004 contact, attended when it suited him. The question therefore is, was it reasonable for Mr SU's mental health team to be satisfied with the fact that opportunities had been offered and not taken up, or should they have been more assertive in trying to achieve a medical assessment for Mr SU? Because of the length of time that has elapsed, the Independent Team has contained its exploration of this to the period of time 2005 to April 2008.

Mr SU's regular care co-ordinator told the Independent Team that he thought that, with the benefit of hindsight, they should have been more assertive, although he did not consider that being so would have impacted on the incident that subsequently occurred. The Independent Team agrees with this.

The Independent Team can, however, understand why the team did not have any sense of urgency with regards to obtaining a medical assessment for Mr SU.

He had been stable in the community since his last relapse in 1997, some nine to ten years earlier. Over this period he had presented consistently with:

- no usage of illicit drugs except over a five-month period in 2005;
- no exhibition of his known early-warning symptoms;
- no report of having been inappropriate with staff throughout;
- no neglect of his hygiene needs; and
- no signs of neglect, except on one occasion in 2005.

Mr SU was adequately maintained by regular depot medication. He was, as far as the staff could ascertain, stable and functional.

However, the Independent Team believes that Mr SU's mental health team should have been more mindful of a small number of contemporary issues that it feels should have prompted the team to achieve a medical assessment of Mr SU. These issues were:

- Mr SU's attendance in A&E in May 2005 following a self-reported sustained period of illicit drug usage;
- The changes to his supported housing package in June 2005 and the loss of his subsequent tenancy in October 2005;
- The changes to Mr SU's support package provision in September 2005. This was reduced from a previous six hours a day to two hours a day, with two to four hours support provided at the weekends. In spite of extensive enquiries, the Independent Team has not been able to trace any information relating to Mr SU's supported living packages after 8 June 2005, when his then social worker completed a community approval form for four hours support per day, to be delivered by Trimar Care Ltd.

Mr SU's ability to present 'as well' to the community psychiatric nurses administering his depot injection and also 'drug free' over the five-month period preceding his attendance at A&E should, the Independent Team suggests, have alerted the mental health professionals to Mr SU's ability to mask symptoms and his drug use. His regular care co-ordinator told the Independent Team that Mr SU was very able to hold his own for the period of time a depot appointment usually lasted, between 20 and 30 minutes. Consequently, provision for a more detailed mental state examination with a medical practitioner on at least an annual basis would have been prudent. The effective care co-ordination meeting would not have provided for a detailed mental health examination of Mr SU; they are not designed for this. Whether such assessments, if they could have been achieved, would have revealed anything different to the day-to-day impressions gained by the community psychiatric nurses is not possible to say.

4.3 Mr SU's parents were Carers to him until the time of their deaths.

- **Did his community mental health team engage appropriately with them?**
- **Were they offered a Carer's Assessment in keeping with local and national policy?**

Mr SU came from a close-knit family. He lived with his parents up to 2000 and then lived independently for a period of time, staying at his parents in between tenancies. Although there was a belief that Mr SU was estranged from his parents for a period, his family report that this was not the case and that he enjoyed regular contact with his parents and his wider family.

With regards to Mersey Care NHS Trust's consideration of Mr SU's parents although it is clear that Mr SU's care coordinator did have a relationship with Mr SUs family prior to his residency in HMP Leeds and in the months after his release, when Mr SU resided at his parents, it is the contention of the Independent Team that insufficient attention was given to the needs of Mr SU's parents, and that there should have been some ongoing contact with them after Mr SU moved into his own flat, and particularly after his attendance in A&E in June 2005.

A carer's assessment was not offered to Mr SU's parents; this was a policy expectation after 2002.

The importance of family and/or carer's cannot be underestimated in relation to the support they can provide to a service user suffering from a severe and enduring mental illness, or any mental health illness. Neither can the impact of providing support be underestimated, even if that support constitutes something as low key as daily telephone contact.

Generally, a carer is defined as someone who provides care to another person and is not paid for providing that care.

Care can be defined as being any task relating to assistance needed to ensure the well being of an individual and their home environment. This would include tasks such as washing, dressing, attending to toilet needs, food preparation, cleaning, laundry, shopping, paying bills, etc.

The above represents a common understanding of 'care' and 'a carer'. Based on this understanding, Mr SU's parents delivered a 'carer' function to their son for significant periods of time and in particular in the immediate period prior to their deaths. Consequently, their son's care co-ordinator, or foster care co-ordinators, should have had periodic contact with them, offered them a carer's assessment and, with the permission of Mr SU, invited their input into his CPA reviews. Even if Mr SU did not want information divulged to them, this was not

an impediment to the Mersey Care NHS Trust staff from asking his parents if they had anything they wanted to ‘tell them’, i.e. the mental health professionals.

Prior to Mr SU moving into his own flat in 2002, it seems that his care co-ordinator had a good relationship with Mr SU’s parents, and that they did contact him if concerned, and he responded appropriately. This relationship, however, pre-dated the launch of the National Service Framework and CPA in 1999, and pre-dated Mr SU living independently from his parents.

Once Mr SU was living independently from his parents there is little evidence of contact between Mr SU’s parents and his care co-ordinator. However, Mr SU was noted to be residing at his parents in 2003, when in between tenancies. Mr SU’s care co-ordinator has confirmed that contact between him and Mr SU’s parents did reduce after 2002. He reported finding no reason to be in contact with them once Mr SU was living independently. To his understanding, Mr SU was self-caring, having little contact with his parents, and was a grown man. That he believed Mr SU to be estranged from his parents, for a period of time, underlined the situation as he saw it. The reported lack of parental contact was endorsed by the supported housing provider for Mr SU between 2002 and mid-June 2005. They reported that Mr SU had no contact with his parents for the entire time they were providing him with a service. He did, however, have contact with his grandmother. However, Mr SU’s family have a different memory. They recall Mr SU always being in contact with his parents, and that they were always providing him with support financially and with daily living activities such as doing the laundry.

Mersey Care NHS Trust’s internal investigation report has criticised the fact that Mr SU’s parents were not offered a carer’s assessment. However, what needs to be clarified is:

- Whether, on the basis of information known to Mr SU’s care co-ordinator(s), a carer’s assessment was required in relation to Mersey Care NHS Trust’s and national policies and procedures; and
- Whether, based on the longer term relationship between Mr SU, his care co-ordinator and his parents, it is reasonable to have expected Mr SU’s care co-ordinator to have remained in touch with Mr SU’s parents, after Mr SU moved into his own home.

The Policy Framework
1995/1996
The Carers 1995 Recognition and Services Act:
This act came into force in 1996. This act said that if:
“(b) an individual (‘the carer’) provides or intends to provide a substantial amount of care on a regular basis for the relevant

person, the carer may request the local authority, before they make their decision as to whether the needs of the relevant person call for the provision of any services, to carry out an assessment of his ability to provide and to continue to provide care for the relevant person; and if he makes such a request, the local authority shall carry out such an assessment and shall take into account the results of that assessment in making that decision."

1999

The National Service Framework for Mental Health (Department of Health) was published. This document spelt out the national standards for mental health, what they aimed to achieve, how they should be developed and delivered, and how to measure performance in every part of the country.

One of the guiding principles of the National Service Framework for Mental Health (1999) was to *"involve service users and their carers in the planning and delivery of care".* Standard Six specifically addressed the needs of carers and said:

"All individuals who provide <u>regular and substantial care</u> for a person on CPA should:

- ❒ *have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;*
- ❒ *have their own written care plan which is given to them and implemented in discussion with them."*

Effective Care Co-ordination in Mental Health Services (1999) – Department of Health

The 1999 Department of Health CPA guidance document (page 8) underlined the importance of a carer's needs when it said:

"*The process of the CPA is clearly intended to deliver care to meet the individual needs of service users. However, those needs often relate not just to their own lives, but also to the lives of their wider family. The CPA should take account of this, in particular the needs of children and carers of people with mental health problems, and must comply with the Carers (Recognition & Services) Act 1995 and the National Service Framework standard on caring for carers."*

It then reiterates the standards detailed under Standard Six of the National Framework for Mental Health Services.

Mersey Care NHS Trust's internal policy and procedures:
Mersey Care NHS Trust's "Effective Care Co-ordination Policy" 2002
In 2002 under *"Responsibilities of the Care Co-ordinator*" (page 3) it was stipulated that *"the care co-ordinator is responsible for sharing relevant information with carers".* In addition, under a heading *"Carer's Needs"* (page 4), it says:

- *"The prime focus of an assessment must continue to be the needs of the service user. If these are satisfactorily met, the needs of the carer may be too."*
- Where it is found that the carer of someone with a mental health illness is providing a substantial amount of care on a regular basis, then they should be advised that they are entitled to a carer's assessment under the Carer's (Recognition and Services) Act 1995.
- Where this is not the case, or where a carer requests a separate assessment, there should be an assessment of the carer's own needs.

It also says, *"throughout the process, carers should be fully aware of their entitlement within the constraints of confidentiality, to be involved and to be consulted".*

In Appendix 1 of this policy document Mersey Care NHS Trust provides further information about the carer's assessment. In this it sought to further clarify *"regular and substantial care"*. Mersey Care NHS Trust's policy says:
"This is not defined in legislation or in subsequent guidance and it has been left to each local area to agree a definition. The guidance refers to the sustainability of the caring role and it is not the time each week spent caring that has an impact on Carers. Guidance to the 2000 Act specifically excludes from the definition of carer someone who just 'keeps an eye on the service user'. Regular and substantial care is therefore more than this. Reference is made to those caring for the severely mentally ill person for whom the caring role is cyclical or sporadic responsibility."

Mersey Care NHS Trust's Effective Care Co-ordination Policy 2006
The substance detailed in the 2002 policy document in relation to Carers remains in the 2006 policy. However, there is in the 2006 policy document a dedicated chapter for Carers.

The significant difference between the 2002 and the 2006 position was the decision by Mersey Care NHS Trust to appoint designated Carer's Assessment Workers to each community mental health team. Consequently, there was in 2006 a dedicated component to section 8 of the policy on *"Who Undertakes Carers' Assessments?"* This section said:

“Designated Carers’ Assessment Workers have been appointed to each CMHT.[11] *However, it is not envisaged that all, or perhaps most, carer assessments will be undertaken by these staff. In many instances it would be preferable for the service user’s care co-ordinator to carry out the carer’s assessment and care plan.”*

Where a carer had no identified needs requiring a personalised care plan, it was the expectation at Mersey Care NHS Trust that a ‘standard carers care plan’ would exist. This would *“as minimum contain factual information, including:*

a) *Contact details of the assessor, psychiatrist, general practitioner and care co-ordinator responsible for the cared-for person.*
b) *Telephone numbers of who to contact in the event of a crisis.*
c) *Details of the mental health needs of the person cared for, including medication, possible side effects, etc (with the agreement of service user).”* (8.10.8, page 36 of Mersey Care NHS Trust’s 2006 Effective Care Co-ordination policy document).

Observation by the Independent Team

The national and local policies clearly highlight the fact that individuals providing substantial care and support to a service user should be offered a carer’s assessment. The issue of relevance to this case is the interpretation of the word ‘substantial’. Some local authorities have defined what this is. For example, in Northamptonshire from the local authority’s perspective a minimum of twelve hours per week ‘care support’ on a non-paid basis is required to qualify an individual for a ‘statutory’ carer’s assessment. Generally speaking, within mental health trusts such a clear definition has not been applied. The lack of stringent definition in mental health services is appropriate because care and support covers such a broad base and is not confined only to practical help. It also includes emotional support which in many respects cannot be quantified. Furthermore, the type of Carer’s Assessment offered within a mental health trust is not the same as a Statutory Carer’s Assessment. It is a voluntary assessment of needs as they relate to the relationship with the service user and the impact this has on a carer’s life. It may, however, result in a referral for a statutory local authority assessment.

Nevertheless, the above being said, the benchmark of ‘substantial’ is used by Mersey Care NHS Trust in its determination of whether a local Carer’s Assessment is required. Unfortunately, in neither the 2002 nor the 2006 policy document is the term ‘substantial’ defined in any way, leaving it open to individual care co-ordinator or community team interpretation.

[11] CMHT = Community Mental Health Team.

Although the Independent Team appreciates how difficult it is to provide boundaried guidance on something as qualitative as ‘caring’, an example list of what Mersey Care NHS Trust considered to have constituted ‘caring activities’ included:

- washing;
- dressing;
- attending to toilet needs;
- food preparation;
- cleaning;
- laundry;
- shopping;
- paying bills, etc;

followed by greater clarification of what Mersey Care NHS Trust considered to constitute ‘substantial’ caring support, such as:

“Substantial care support in Mersey Care NHS Trust includes, but is not limited to:

- *situations where a service user is living with family members;*
- *situations where a service user is having his/her laundry done by family managers on a regular basis;*
- *situations where a service user is regularly (multiple times per week) having meals with family members, or is in receipt of ‘food parcels’;*
- *situations where a service user is regularly (weekly/monthly) seeking financial support from family members;*
- *situations where a service user is receiving regular ‘at a distance support’ from the same family member/members, e.g. daily telephone contact”*;

would have been helpful to its staff, especially as nationally the implementation and interpretation of the legislative requirements, and those detailed in the National Service Framework, were known to be variable.

Such refinement within Mersey Care NHS Trust’s policy documents would have clarified its expectations of its staff, and fostered a uniform interpretation of its policy document. It would have also enabled staff to more clearly make the distinction between an ordinary level of contact a family might have with a family member, e.g.:

- meeting for Sunday lunch as a family each week;
- talking on the phone once a week; and
- the occasional lending of money, rather than the regular lending of money;

and that which must be considered as over and above this.

Did Mr SU receive support from his parents that constituted 'caring' in a way and to a degree that meant they should have been offered a Carer's Assessment?

Evidence of support provided by Mr SU's parents

The Independent Team understands from the family of the deceased that Mr SU's parents provided him with regular support in the form of:

- ❐ doing his laundry for him;
- ❐ regularly lending him money when he ran out of it;
- ❐ providing him with food.

In addition to the above, the Independent Team believes that it was customary for Mr SU's family to gather together on Sundays for lunch. From the information made available to the Independent Team, it appears that Mr SU's parents provided support to their son over and above that which might normally be provided to a family member prior to April 2003 and after October 2005. Between April 2003 and October 2005 Mr SU was supported by independent living providers every day of the week.

With regards to evidence of parental involvement detailed in Mr SU's clinical records, there is little evidence of this, reflecting perhaps the lack of contact between Mr SU's care co-ordinator(s) and his family after 2002:

Date	Circumstance
11 February 2002	Mr SU's mother agreed with his care co-ordinator that she would *"arrange with her son for him to be available for his depot".*
11 September 2002	Depot injection administered at Mr SU's parents. It was noted that Mr SU has *"been evicted from his flat and is currently staying with friends whilst looking for other accommodation".*
26 September 2002	Mr SU is seen at his parents for the administration of his depot.
8 October 2002	Mr SU is seen at his parents for the administration of his depot.
4 April 2003 to 29 July 2005	Mr SU was in supported living accommodation and was not receiving support from his family over this time that would have been interpreted as requiring a carer's assessment.

Date	Circumstance
19 May 2005	Attended A&E accompanied by his mother and sister. Reporting to be suicidal. This was determined not to be the case. Information about the drug dependency unit in Hope Street Liverpool provided to Mr SU and his sister. (Note: Mr SU was given notice to quit his supported accommodation in the previous weeks. New accommodation was, however, secured for him, but this appears to have been terminated in October 2005.)

The Independent Team cannot comment on whether Mr SU's parents met the criteria of the local authority for a statutory formalised carer's assessment. However, as they were regularly providing their son with support, including activities of daily living and financial support, then they should have been offered a carer's assessment by mental health services and signposted to voluntary and self-help groups in the locality where they may have found additional support for themselves. Furthermore, the conduct of a carer's assessment by the carers' support officer working with the community mental health team would have clarified whether a statutory social services assessment was needed.

4.4 Was the incident in which Mr SU was involved predictable and could the deaths of his parents have been prevented, on the day they occurred, by different management by mental health services that could or should have been delivered?

Based on its review of the evidence (clinical records, interviews with staff, the Trust's own investigation's findings and interview records arising from the Trust's own investigation), the Independent Team does not believe that Mr SU was a person about whom one would or should have had serious concerns about his potential risk of harm to others.

The information gathered throughout the investigation process, including information from third sector and supported housing providers, has been consistent. Mr SU was well liked, was considered to be a bit of a 'jack the lad', would try and scrounge a few pounds here and there, but was neither physically nor verbally aggressive. His family had not reported any concerns about violence, and they too had no experience of him displaying the level of violence he inflicted upon his parents on 31 March 2008. This came as a 'bolt out of the blue' for everyone.

When making a judgement about preventability, the following questions need to be applied:

- Were staff knowledgeable that an incident was both likely and imminent?
- Did staff have the legal means to prevent it?
- Did staff have the opportunity to prevent it?

In this case it cannot be argued that staff were knowledgeable that an incident involving Mr SU was likely and imminent. On the day it occurred Mr SU had reportedly visited his father, who had communicated to other family members that Mr SU was his usual self. The only change was the refusal of his father to provide Mr SU with money.

The circumstances of the incident were such that mental health services had neither the legal means nor opportunity to prevent what occurred.

The only thing that could have prevented the incident on the day it occurred was the compulsory admission of Mr SU under the Mental Health Act in the day, or days, preceding it. The Independent Team does not believe, on the balance of probabilities, that this would have occurred, although it does accept the family's perspective that, because no-one saw or assessed Mr SU

between the day his medication was due (25 March) and the day of the incident (31 March 2008), any opportunity for this to have occurred, or for there to have been identification of any deterioration in Mr SU's mental state, was lost.

The Independent Team also accepts that it is indisputable that, when Mr SU was assessed on 2 April 2008 following his arrest, he was assessed as suffering from *"a mental disorder of a nature and degree that warrants admission for assessment to a secure setting".*

The report arising from this assessment also made clear that Mr SU:

- ❒ had no violent history;
- ❒ said he had *"taken two 20 pound (£) bags of skunk"*;
- ❒ reported not sleeping the night before.

With regards to Mr SU's medication, an issue that is of particular importance to Mr SU's family, the Independent Team acknowledges the fact that at the time the incident occurred Mr SU's medication was suboptimal. However, as had been determined by previous independent forensic opinion, it is not possible to make a causal link between this and the incident because Mr SU had been on a half-dose of medication for the two years preceding the incident without any discernible adverse impact on his mental state or any displays of violence that were known about by any authority.

To conclude, therefore, on the balance of probabilities, and acknowledging the fact that there was no mental health assessment of Mr SU in the four days preceding the incident, the Independent Team considers that the deaths of Mr SU's parents were neither predictable nor preventable by the mental health service in Liverpool.

5.0 ACTIONS TAKEN BY MERSEY CARE NHS TRUST FOLLOWING ITS OWN INVESTIGATION IN 2008

Mersey Care NHS Trust has undertaken extensive work to address the weaknesses and lapses identified across a range of serious incidents investigated across the Trust. Encouragingly, the Trust does have a system for aggregating the recommendations made in individual investigations and addressing issues on a corporate basis where appropriate. The following represents actions taken as a consequence of the internal investigation following the care and treatment of Mr SU and other serious incidents.

Mersey Care NHS Trust recommendation 1: A warning should be placed on ePEX (the electronic record-keeping system) for any service user who has been subject to a Multi-Agency Protection Panel Arrangement (MAPPA).[12] The MAPPA policy should be amended to reflect this.

Contemporary situation: Mersey Care NHS Trust could not amend the MAPPA policy as it does not have the jurisdiction to do this. However, it has included the use of the Red Flag system to identify Service Users on MAPPA within the HRAMM[13] policy. Because this had the potential to cause confusion, the criminal justice liaison team are the service which manage all MAPPA involvement and therefore remove and place the red flags. Co-ordinating this via one team has aided implementation of the new process.

Mersey Care NHS Trust recommendation 2: Clear guidelines and information should be provided to assist clinical teams to appropriately obtain and protect forensic history, MAPPPA details, etc.

Contemporary situation: The use of HRAMM has now been established across the organisation, and the criminal justice liaison team (CJLT) co-ordinates the use of both HRAMM and MAPPA meetings across the Trust. A database is maintained by the CJLT which identifies all services users who

[12] MAPPA – 'Multi-Agency Public Protection Arrangements' are formal arrangements set down by the Criminal Justice and Court Services Act 2000 and which are co-ordinated at a local level by the police, probation and prison services. They are aimed at sharing relevant information regarding high-risk individuals with the aim of reducing their level of risk to society.

[13] HRAMM is a health co-ordinated risk assessment and management framework for those service users at risk of displaying dangerous behaviour, who would not meet the criteria for MAPPA. The process involves multi-agency partnerships with the aim of sharing reasonable and proportionate information, in line with established data protection principles, identifying risks and co-ordinating a multi-agency action plan.

are part of the MAPPA or HRAMM process (see footer). The CJLT also provides guidance to staff on how to access the criminal records of Service Users and will process the request for clinical teams; they will attend CPA meetings to provide advice and guidance.

In addition to the above:

- Police Liaison meetings are now held in all in-patient units, with the aim of improving communication and the management of offenders.
- The Trust has invested in a Mental Health Police Liaison Officer which is a shared post between this organisation and Merseyside Police. The post holder's focus is on developing policy and procedure regarding joint working. They also have involvement in providing guidance for the joint management of complex and high-risk service users.
- The Trust has developed an information-sharing protocol with the Police to ensure that information about a person's Mental Health and the actions that should be undertaken can be held on the Police database.
- The Trust also has an information-sharing protocol regarding the information that On Call Managers can provide to the Police.

Mersey Care NHS Trust recommendation 3: The CPA assessment process should ensure that a service user's criminal history is part of the assessment.

Contemporary situation:
The present CPA assessment documentation does include a section on past criminal history.

Mersey Care NHS Trust recommendation 4: Arrangements are established for the routine review of complex cases on a periodic basis, specifically including those cases repeatedly seen by a single practitioner.

Contemporary situation: This recommendation was made following a case specifically related to a junior staff doctor. All junior doctors now have specific clinical supervision with their lead consultant.

Mersey Care NHS Trust recommendation 5: To address the problems of clinicians knowing of the existence and whereabouts of old files from the same and other parts of the Trust. A policy that old paper records be routinely requested for all new referrals and re-referrals should be considered. When a new case file is opened, there must be a mandatory search made for previous

records and any archived. (Information from Day Hospitals must also be incorporated.)

Contemporary situation: The issue highlighted above is a common problem across mental health services, and is not unique to Mersey Care NHS Trust. To try and effectively address the problem in Mersey Care NHS Trust, an alert system has been included in the body of the current health records policy since the *"Integrated record"* has been in place to highlight the existence of other records held within the Trust. The following guidance is also integral to the integrated record:

"It is essential to provide a high standard of care and to reduce the element of risk for the Trust and Service Users and that identification is made of any 'other' sets of records that may be in existence within Mersey Care NHS Trust. The search process must be performed upon a service user being referred to the Services within Mersey Care NHS Trust. A thorough search should be undertaken on the Patient Information System. If a Service User has attended another Service, then it must be recorded on the Alert sticker which must be completed and stuck onto the inside Alert notification located inside the front cover of the health record folder, identifying that other records exist and the site they are located at. It is the decision of the Healthcare Professional who the service user has been referred to to make a decision to request records from other internal services."

Mersey Care NHS Trust recommendation 6: Guidance to be made available on the role that ePEX plays in documenting care and which records (either paper and/or electronic) have primacy.

Contemporary situation: ePEX (the electronic record-keeping system) is now the major form of documentation within the Trust and all professional groups are expected to use this. A process is currently underway to make all paper records electronic – termed the EDMS project. Furthermore, the clinical business units are moving towards being paper light where it is feasible to achieve this.

Mersey Care NHS Trust recommendation 7: Psychological assessments should always be considered to aid assessment and diagnosis.

Contemporary situation: Psychological assessments are considered as part of the assessment process for all service users. Although availability of specialists is not at an optimum, the Trust recognises this as a deficit and is working to increase the number of Clinical Psychologists available, as well as enhancing the availability of the existing professionals to give advice and guidance about psychological treatment.

NICE guidelines are now used to direct the way staff work with service users with a Psychotic illness; the adherence to the guidance was first audited in 2007 and a new audit was completed in the first quarter of 2011. The Trust's *"NICE Guidance in Schizophrenia"* Implementation Group oversees the implementation of the guidance and highlights challenges in provision to the relevant clinical business unit Director. At present the key gaps are in the level of psychology within community mental health teams and the acute care team to deliver the required 16 sessions of cognitive behavioural therapy and family engagement.

A business case/protocol has been developed within Liverpool clinical business unit to increase the level of assistant psychologist posts to deliver more intensive individual work within the acute care team. Furthermore, the role of an acute care psychologist has been developed for both Liverpool and Positive Care Partnerships' clinical business units with the aim of providing increased psychological care to people in the acute phase of their illness and to champion and lead the development of therapeutic interventions within an acute care setting. The first post holder is now in place in Liverpool CBU. Appointment to the position in Positive Care Partnerships is anticipated in the near future.

RECOMMENDATIONS SPECIFIC TO THE CARE AND TREATMENT OF MR SU

Mersey Care NHS Trust recommendation 8: The Clinical Directors and Service Manager will consider the issues raised with specific reference to the working practices of the Care Co-ordinator, Consultant Psychiatrist and medical practitioner leading the Moss House Depot Clinic involved in the care and treatment of Mr SU, and, with the support of HR, consider any issues of concern in respect of their personal practice in this case.

Action taken: Mr SU's care co-ordinator's personal practice was reviewed by his service manager. The practice of Mr SU's consultant psychiatrist was reviewed by two independent senior clinicians. Both practitioners were found to be competent in their knowledge and skill base; however, both were provided with focused supervision and ongoing monitoring for a period of approximately 12 months.

Mersey Care NHS Trust recommendation 9: That consideration be given to establishing, within Multi-Disciplinary Teams, a discussion forum to evaluate the principle of a staff rotation scheme, within and across Mental Health Teams.

Action taken: Following discussion, it was agreed that 'peer evaluation' will take place when service users have been with a single practitioner (i.e. care co-ordinator) for 5 years. There will also be reviews yearly as part of the CPA review. It was agreed that changing or rotating service users and care co-ordinators would not always be in the best interest of the service user. However, where indicated as necessary, the principle of the original recommendation will be considered on a case-by-case basis.

Mersey Care NHS Trust recommendation 10: Consider the introduction, within ePEX, of an electronic system which automatically generates an indicator when CPA reviews are due for each patient/service user.

Action taken: As a consequence of this recommendation, the above was placed on the agenda at the ePEX users' group. As a consequence of subsequent discussions, it was agreed that the principle of the recommendation would be set as a 'standard'.

The facility to highlight that a CPA review/medical review is required is now up and running on ePEX. Because the reliability of the system is dependent on staff ensuring that there is a review date projected and also that a member of the team is identified as the care co-ordinator, managers have the facility to independently audit the system, as does the clinical services manager.

Mersey Care NHS Trust recommendation 11: There needs to be a protocol with standards developed to ensure there is a robust system in place in regard to how often, when and by whom patients are reviewed medically. Each team must have a system in place as a 'safety net'.

Action taken: Meetings have taken place with Mersey Care NHS Trust Information Services. An implementation plan has been developed, a part of which is a medical review component as a minimum every 12 months, unless there is a written entry documenting why a medical review is not necessary.

6.0 CONCLUSIONS

The deaths of Mr SU's parents have been immensely upsetting and shocking to his family and the local community in which they lived. As a consequence of what happened, Mr SU, previously a well-liked member of his community, has lost his liberty and his family continue to come to terms with what has happened.

Section 4.5 of this report clearly states that:

- the act of violence conducted by Mr SU was not predictable; and
- the deaths of Mr SU's parents were, on the balance of probabilities, not preventable on the day that they occurred.

This conclusion does not mean there was no scope for improvement in the care and treatment provided to Mr SU by Mersey Care NHS Trust. Neither does it mean that there was no scope for improvement in the treatment of Mr SU's parents as Carers of Mr SU in the last three years of their lives. It is the perspective of the Independent Team that the care and treatment of Mr SU and the involvement of, and communication with, his parents could and should have been much improved.

The aspects of Mr SU's care and treatment that could and should have been better were:

- Standards of nursing practice in relation to:
  - documentation;
  - care planning;
  - risk assessment; and
  - accurate representation of the range of services Mr SU was receiving, e.g. from the supported housing providers.
- Medication management:

  There should have been a more robust process in place for renewing the prescription for a service user. In this case the consultant psychiatrist referred to the last recorded prescription in the medical notes some two years previously. However, this differed from what was written on the prescription chart itself. Because the system at the time relied on what was recorded in the medical records, there was no reliable mechanism for identifying this error. The system relied on staff raising a concern if they considered a prescription to warrant this.
- Medical Review:

  The frequency of medical reviews for Mr SU was insufficient throughout his contact with Mersey Care NHS Trust in all years between 2001 and 2008, except for 2003 and 2004. The main

contributor to the insufficiency was the non-attendance of Mr SU to planned reviews. Nevertheless, in 2006, when Mr SU was two years post his last medical review, his community mental health team should have made an effort to try and achieve a medical review for him. This is, with the benefit of hindsight, recognised and accepted by the community mental health team.

- Support for Carers:

  Although mental health professionals believed there to have been a hiatus in the relationship between Mr SU and his parents between 2002 and 2005, in the two to three years preceding their deaths they clearly fulfilled a carer's role for their son, doing his laundry, and supporting him financially. The level of support being provided to Mr SU by his parents was not known about by his care co-ordinator, as Mr SU consistently told him that he was not having contact with his parents; consequently, he saw no requirement to continue communications with them, especially as Mr SU is reported to have expressed to him that he did not want any communications between Mersey Care NHS Trust staff and his family. That Mr SU's care co-ordinator respected the wishes of Mr SU was not unreasonable. Neither was the fact that he took at face value what Mr SU told him regarding his lack of contact with his parents. Nevertheless, in view of the longevity of the relationship between the care co-ordinator and Mr SU's parents, and his good relationship with Mr SU, the Independent Team suggests that it may have been possible for the care co-ordinator to have negotiated with Mr SU to have at least invited the input of Mr SU's parents into the CPA reviews, even if this was via written or telephone communication. The family of Mr SU feel strongly that he would have acceded to this.

- Systems and Processes:

  With regards to systems and processes, the core system that could and should have been better at the time was the supervision of staff. It was recognised that the standard of documentation for Mr SU's care co-ordinator did not meet with expected standards at the time. Although the care co-ordinator's line managers identified this as an issue requiring improvement, assessment of the care co-ordinator's standard of record-keeping did not form a component of his supervision. Furthermore, owing to periods of time where he was absent from work, and the work pressure of the managers at the time, his supervision did not occur on a monthly basis.

7.0 RECOMMENDATIONS

Mersey Care NHS Trust has already implemented a raft of improvements that have addressed the concerns the Independent Team had when it commenced this investigation. Therefore, its recommendations are less far-reaching than they might have been.

The recommendations the Independent Team has for Mersey Care NHS Trust are:

Recommendation 1: Professional staff interviewed by the investigation identified a gap in their knowledge and understanding of alcohol and drug misuse. Interviewees also highlighted a gap in their knowledge base about the available resource in Liverpool to enhance this.

The Independent Team is mindful of the restrictions on public spending, and the impact this will have on education and training budgets. However, Liverpool is well serviced with a range of charitable organisations and self-help groups that would, if approached, provide opportunity for Mersey Care NHS Trust staff working in general adult community services to enhance their knowledge and understanding of addictions.

Examples of these organisations are:

- Action on Addiction;
- Addaction;
- Alcoholics Anonymous (AA);
- Narcotics Anonymous (NA); and
- Cocaine Anonymous (CA).

AA, NA and CA will all have ‘open’ meetings which professionals can attend, and/or most AA, NA, and CA groups will have members who are willing to attend at local work premises to share their addiction experience, and their recovery. The insights these individuals provide can be very illuminating for health professionals.

The family self-help groups of Al-Anon and Families Anonymous will also have members who will come and speak to health professionals so that they can have a better understanding of the impact another’s addiction has on family life and the type of information and support families might need if caring for a person with a dual diagnosis or addiction.

Contact details for all of the above are available on the World Wide Web, and easily located via a simple internet search.

Target audience: Medical Director; Nursing Director; Clinical Directors for each adult services CBU; Business Managers for each adult services CBU;

the manager of the Patient Advice and Liaison Service; Mersey Care NHS Trust's Training and Education Manager.

Timescale: The Independent Team considers that Mersey Care NHS Trust should be able to produce a strategy for enhancing the knowledge and understanding of its staff in the field of substance misuse by 31 December 2011.

Recommendation 2: All clinical business units in Mersey Care NHS Trust need to implement a more dynamic approach to how it audits and reviews the quality of clinical documentation.

The quality of documentation was not of the standard expected in Mr SU's community mental health records. In particular, there was no depth of information about how his mental state was being assessed, little about communications with other involved agencies such as supported housing, and a complete lack of up-to-date care plans.

Although Mersey Care NHS Trust conducts audits of CPA and risk assessment documents via standardised audits, information gathered during the investigation process suggests that it does not sufficiently or consistently interrogate the quality of what has been recorded. Consequently, the Independent Team recommends that a peer review process is implemented where:

- A randomised selection of CPA and Risk Assessment documents and progress notes are selected from the professionals participating in the peer review process;
- The group of peers reviews the documents selected and provides constructive feedback on their completeness and also usefulness.

The Independent Team suggests that a peer review of clinical records could be facilitated on a three- to four-monthly basis.

The Independent Team also recommends that each professional's supervisor reviews the record-keeping for each of its supervisees across the professionals' entire caseload on a rolling basis. Because documentation review is time-consuming, the Independent Team anticipates approximately two to three sets of records being reviewed at each monthly supervision session.

To make delivery of this recommendation achievable, the following principles will be required:

- An agreement of what aspects of the clinical record should be subjected to scrutiny;

- An agreement as to what proportion of each record needs to be scrutinised. For example, would it be acceptable to review a contemporary CPA care plan in one set of records, and a risk assessment and crisis intervention plan in a different service user's records?

To achieve the principle of proactive records, review does not mean that for each sets of records reviewed in a supervision session, the same documents need to be reviewed for each service user.

Target audience: The Clinical Director and Business Manager for Liverpool CBU.

Note: This recommendation could and should apply to all Clinical Business Units in Mersey Care NHS Trust.

Timescale: Accurate clinical records are essential to the delivery of safe and effective care and treatment. They are also essential for staff to show the standard of their practice and the delivery of a defendable standard of care.

The Independent Team can think of no reason why this recommendation could not be implemented in advance of 1 January 2012.

Recommendation 3: Where a long-term service user ceases to have regular contact with his or her Carers, their needs do not simply end. As part of its ongoing commitment to supporting Carers, Mersey Care NHS Trust needs to find a way of ensuring that if it becomes inappropriate for a care co-ordinator to maintain contact with the Carer for a service user, then the Carers are provided with an alternative source of contact and support, As well as information about how to make direct contact with the service user's care team if there are any concerns.

Mersey Care NHS Trust has had *in situ* a robust approach to meeting the needs of carers with a Carers' Support Worker (Officer) working in all community mental health teams. These individuals have developed effective working relationships with local Carer Support agencies. The future of the Carers' Support Officer is uncertain following the removal of funding from Liverpool City Council, so Mersey Care NHS Trust will need to give careful consideration as to how the support needs of Carers are not forgotten when a service user does not agree to his/her care co-ordinator having contact with his/her family.

In the case of Mr SU, such a situation arose which was compounded by the fact that the care co-ordinator did not know that his family continued to provide substantial support to him in the years immediately preceding their deaths.

The Independent Team is aware that Mersey Care NHS Trust is already taking measures to resolve the potential service gap should its own funding of the Carers' Support Officer post not be sustainable beyond this financial year.

Target audience: Mersey Care NHS Trust's Director with responsibility for Carer Support and the Patient Liaison and Advice Manager.

Timescale: This recommendation is for discussion and consultation, the outcome of which may be that Mersey Care NHS Trust and its partner agencies consider that they are delivering as much support as they can to carers of mental health service users at Mersey Care NHS Trust.

The Independent Team therefore recommends that by 1 January 2012 it should be able to provide NW Strategic Health Authority with a position statement on this issue, and its rationale for any decision for 'non-action', if it feels that further advancements in carer support are not currently achievable.

APPENDIX1 CHRONOLOGY, FEBRUARY 2000 TO 1 APRIL 2008

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
28/2/2000	Criminal Justice MH Liaison Nurse	Mr SU attends at magistrates' court. Appearing in court due to theft and violent conduct. Also possession of Class A drugs with intent to supply.	
March 2000		Between March and April 2000, regular contact with Mr SU occurs. There is evidence of community support being provided. On 27 April Mr SU's care co-ordinator visited his parents as he was unable to meet with Mr SU for his depot injection. There is a clear record of the discussion between the care co-ordinator and Mr SU's parents.	**Contact with Mr SU's parents**
5/6/2000	Care co-ordinator	Mr SU remains non-compliant with his depot medication. His father believes him to be heavily involved with illicit drugs at this time.	
12/6/2000	Care co-ordinator	It becomes apparent that Mr SU has skipped bail. However, he did agree to meet with his care co-ordinator for the administration of his depot. He did, however, remain 'at large' until 21 June 2000, when he gave himself up to the police. He was subsequently sentenced on 23 June 2000 for a term of two years and three months.	
29/6/2000	Consultant psychiatrist [1], care co-ordinator and GP	No info on form.	
3/7/2000	Care co-ordinator	Visits Mr SU in jail.	**Good Practice**

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
25/7/2000	Care co-ordinator	Care co-ordinator attends prison discharge CPA.	**Good Practice**
Some time in 2001	Care co-ordinator, HMP Liverpool probation officer - CJLN (Criminal Justice Liaison Nurse Specialist)	CPA review HMP Liverpool: Mr SU was convicted on 23 June 2000 for two years and three months for the supplying of drugs. Release date 3 August 2001 (to have served 50% of sentence). Plan: - Enhanced CPA on release. - Consultant psychiatrist [2] to follow-up. - Care co-ordinator to remain the same. - Depixol 50mg three weekly (recently reduced from 90mg, even though no prodromal features). - Mr SU noted to be well. - HoNos (Health of the Nation Outcome Scale) noted to not identify any major problems. - Noted that there are no major issues of violence, aggression, suicide, self-harm or neglect on the 'Worthing Risk Assessment'. - Released on conditions and therefore 'on licence'. Licence expiry date was set as 26 February 2002. - Released to his parents' address.	**Good Practice – multi-disciplinary, multi-agency CPA**

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
12/11/2001	Care co-ordinator	Care Plan: The care plan contains all the features as detailed in the post-relapse CPA for Mr SU. Probation officer provided a report as she was unable to attend the care planning meeting. She reported that Mr SU had been reporting to her as required and showed *"commitment to lead an acceptable life style and not to jeopardise his liberty"*. Noted to be living with his parents, this is a situation that both parties want to change owing largely to Mr SU's lifestyle – *"socialising and late hours"*. It is also noted that securing 'non-private' accommodation will be challenging owing to the previous drug dealing.	
7/8/2001 to August 2002		The nursing records show regular contact with Mr SU and it is also clear that his parents are providing social contact and support to Mr SU.	
11/9/2002		Mr SU evicted from his flat. Mr SU was noted to be staying with friends and that he was seen by the community mental health team staff at his parents' home.	**Continued evidence of parental support**
March 2003	Care co-ordinator	Contact with care co-ordinator by parents: Mr SU's parents contact the care co-ordinator as they are concerned about Mr SU. The care co-ordinator agrees to meet with Mr SU and his father at the Law Courts on 21/3/2003.	**Evidence of engagement and support of parents by care co-ordinator**
4/4/2003		Mr SU is asked to leave his parents: Mr SU's parents have asked him to leave their home. The care co-ordinator is noted to have advised Mr SU that he would contact the social worker on his behalf to find alternative accommodation.	

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
22/4/2003		Mr SU re-housed and supported by Trimar.	**Very good timescales in terms of achieving supported accommodation for Mr SU**
3/6/2003		The community psychiatric nurse commenced discussions with Mr SU about Network Employment, as he was keen to work.	**Proactive effort to try and engage Mr SU**
15/7/2003	Care co-ordinator	Invitations sent for CPA meeting for 24 July 2003.	
No date	Consultant psychiatrist [1], care co-ordinator, Mr SU's support worker and her Manager	Effective Care Co-ordination Meeting: - Mr SU is noted to live out of 'patch', but consultant psychiatrist [1] felt it would be detrimental to transfer his mental health at that time. - Depot every 2 weeks 50mg Depixol. - Network Employment to explore employment opportunities with Mr SU. - 'Regular reviews' of mental state.	**Good Practice – Mr SU's key worker from supportive housing was present and this individual's manager** **Also the decision to maintain Mr SU in the same community mental health team**
23/12/2003	Consultant psychiatrist [1]	Citizens' Advice seek info from the community mental health team to assist Mr SU in contesting the reduction of his disability living allowance.	
13/1/2004		Letter to Mr SU enclosing his CPA form.	

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
15/1/2004	Consultant psychiatrist [1]	Responded to CAB letter: The letter to CAB confirms that: - Mr SU has a diagnosis of Schizophrenia. - That he has little to no insight into his mental illness. - Requires constant monitoring of his mental state. - Requires encouragement to comply with his medication and activities of daily living. - Mr SU, as a result of his paranoia, can get aggressive, tense, violent - physically and verbally. - Needs constant support to avoid self-neglect and to maintain an appropriate level of hygiene and nutrition. Consultant psychiatrist [1] confirms that Mr SU meets the disability living allowance criteria.	
4/2/2004	Locum consultant psychiatrist	Letter informing Mr SU about his CPA from the Effective Care Co-ordination administrator: The letter was sent on 4 February 2004 for a CPA review on 12 February 2004 (8 days' notice).	
4/5/2004		The nursing records show careful discussion with Mr SU by the community psychiatric nurse about his request to move from depot to oral medication.	
1/6/2004		Mr SU has started working in a gym.	
26/8/2004	Clinical assistant in psychiatry	Modecate Clinic: No problems noted so far. Depixol reduced to 50mg every four weeks. No agitations. Form signed for exemption of council tax.	

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
16/8/2004	Clinical assistant in psychiatry	OPA – Mr SU attended. The medication aripiprazole (Abilify) 15mg daily was prescribed. The subsequent letter to the GP stated that *"I have been reviewing this man recently in the clinic and for some time he has been expressing a desire to stop depot medication and substitute it with oral antipsychotic treatment"*. The letter sets out the discussions with Mr SU, and states that he did explore previous non-compliance with medication. Mr SU is noted to have reported *"he is now much more mature in his attitude and would not do so again*". It is also noted that the staff in his supported accommodation would "*dispense his treatment for him*". **Good Practice**	
9/9/2004	Clinical assistant in psychiatry	Modecate Clinic To continue with 15mg of aripiprazole. No side effects noted. Asymptomatic. To give Depixol 4-weekly.	
22/9/2004	Clinical assistant in psychiatry	OPA – Mr SU attended: Mr SU is noted to be doing well with *"no symptoms of his illness".* He continues 15mg of aripiprazole with no reported side effects. Depixol 50mg continues every four weeks, last administered on 9 September 2004. The plan is to review the situation in Mid-October and decide whether to stop his depot injections altogether.	**Adherence to NICE Guidelines**
20/10/2004	Consultant psychiatrist [2]	The nursing records note that Consultant psychiatrist [2] saw Mr SU about his request to return to depot as his regular medication and to stop the aripiprazole as he could not tolerate it.	

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
16/11/2004	Community psychiatric nurse [2]	The nursing records note that Mr SU appears well and continues to comply with his medication. He is, however, also noted to be sleeping in his lounge, which looked dirty and untidy. The visiting community psychiatric nurse suggested to the housing provider that Mr SU needed a support worker.	
17/11/2004	Assistant in psychiatry	Mr SU did not attend the outpatient appointment: The clinical assistant noted in his subsequent correspondence to Mr SU's GP that he believes Mr SU to be well stabilised on his Depixol medication 50mg every two weeks. It is also noted that *"his sexual problems did not improve with aripiprazole and he felt physically unwell".*	
13/5/2005		Mr SU was given notice to quit his flat as, following an assessment of his needs by Supporting People, the provider was no longer going to be delivering the service he required. The nursing records noted that Mr SU did not appear to be worried about this. The notes also said that his social worker was believed to be finding alternative accommodation for him.	
19/5/2005		Mr SU attended A&E: Mr SU was accompanied by his sister and mother to A&E, saying he was depressed and suicidal.	

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
20/5/2005	Mental health nurse in the A&E mental health team	Letter to Mr SU's GP (GP[2]) following his attendance at A&E: The letter noted that: Mr SU attended at A&E feeling depressed and suicidal and wanting to go to 'Broadoak' for a few weeks. Following assessment it was determined that he was not depressed or suicidal and therefore was not admitted. He attended A&E with his mother. Impression formed - that Mr SU was bored, at a loose end, and was 'fed up' with his use of drugs. He had admitted to a daily habit of Crack Cocaine and Heroin for at least five months. No evidence of deterioration in Mr SU's mental health was noted. It was also noted that he appeared motivated to address his drug usage. Information about the local Drug Dependence Unit was provided, also to his mother. Mr SU was encouraged to attend this centre as soon as possible. Note: Mr SU's drug use was not apparent to the providers of his supportive accommodation or his care co-ordinator. His supported housing provider told the Independent Team that Mr SU was not using illicit drugs at all during the bulk of the time he had resided with them (2003 up to April 2005).	**Information about the Drug and Alcohol Service given to Mr SU and his mother** **No evidence of information given to the mother about support networks for her and her husband regarding her son's drug misuse**

Date	Staff member involved	Event/chronology	Identified good practice / significant concerns
26/5/2005		Change in community psychiatric nurse in Mr SU's care co-ordinator's absence	**No evidence of follow-up by the community mental health team staff about Mr SU's re-use of illicit drugs, or enquiry about whether he had attended the drug and alcohol service or not** **No liaison with Mr SU's family to make sure that they were OK, given the known difficulty they have had with their son's drug misuse and behaviours in the past**
10/6/2005		Depot administered	
22/6/2005	Community psychiatric nurse [3] and community psychiatric nurse [2]	22/6/2005 - No access. 24/6/2005 - Unable to locate.	
29/6/2005	Community psychiatric nurse [3]	Home visit. Depot administered.	

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
30/6/2005 to 11/8/2005		No visits	**No clinical records made of attempts to visit Mr SU**
11/8/2005	Community psychiatric nurse [2]	Depot Clinic Did not attend. Record notes contact with Carer/support worker who advised that Mr SU wanted his depots 'at home'. The community psychiatric nurse, however, felt that, as there had been a significant gap in the administration of this, a clinical review was required. A subsequent home visit was made and the depot administered.	**Good Practice. The community psychiatric nurse recognised and organised medical follow-up for Mr SU**
7/9/2005	Care co-ordinator	Mr SU was seen at Moss House following failed access visit the day previously: Depot administered. Mr SU's mental state was noted to be well; very happy with new accommodation and support package. No longer taking illicit drugs; has lost weight and feels well. Has agreed to attend the depot clinic two-weekly.	**Evidence of substance misuse being discussed with Mr SU**

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
14/9/2005	Care co-ordinator, Mr SU, his support worker, his social worker, the Care Manager at the supported housing provider [2]	1. Drug-free (self-reported). 2. New tenancy which he prefers and feels supported by tenancy provider. 3. Good relationship with support worker. 4. Receiving domestic help. 5. Depixol - 50mg two-weekly. 6. Spider Project Referral. 7. Tenancy provider to assist with community care grant application. 8. Plan for next review in six months.	**Multi-agency EEC review. Evidence that drug usage was discussed** **Referral to the Spider Project – for support with structured activity and staying drug-free**
14/10/2005	Care co-ordinator	Successful contact for depot. Mr SU was noted to have been severely beaten following a local dispute. He is no longer at his tenancy and is living with his parents until he can be re-housed.	**No reason why Mr SU is no longer at his tenancy which a month ago he was noted to have preferred**
January 2006		Medication changed from 50mg every two weeks to 50mg every four weeks.	**Discrepancy between the medical note made in 2004 and the prescription chart**

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
14/2/2006	Community psychiatric nurse from Moss House	Risk Assessment. This data is set out in the relevant section of the report.	
3/3/2006		Letter of Invitation *re.* Care Co-ordination Meeting for 16 March 2006.	
20/3/2006	Consultant psychiatrist [2]	Letter to GP following Care Co-ordination Meeting on 16 March: The letter notes: - Mr SU did not attend. - Consultant psychiatrist [2] has not met Mr SU before, but has reviewed volume two of his case records. - Significant past history. - That Mr SU did not tolerate oral anti-psychotics and returned to Depixol, which he continues to have ever four weeks. - Confirms community psychiatric nurse [4] as the care co-ordinator. - A clear management plan of: continuation with his depot injection, to remain on enhanced CPA, for follow-up in depot clinic but not outpatients, for next Effective Care Co-ordination (CPA) review in 12 months.	**Mr SU had more than ten years of mental health history at this stage. Compilation of a case summary using all records might have been considered** **A new consultant psychiatrist and a care co-ordinator who has limited knowledge of Mr SU. No medical review in 2005. It would have been prudent for a medical review to have been booked, albeit in the depot clinic**

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
30/6/2006	Care co-ordinator	Mr SU noted to be causing a nuisance at his tenancy - music at 4 am, slamming doors and intimidating younger residents. D/W support worker from Croxteth and a meeting was arranged for 3 July 2006.	**No information about which supported housing provider was involved or the detail of Mr SU's support package**
3/7/2006		NO MEETING	**Nothing in the records as to why no meeting was held**
20/7/2006	Community psychiatric nurse [5]	Home Visit – Depot. The community psychiatric nurse attended to administer depot in the care co-ordinator's absence.	
July 2006 to May 2007		Depot largely administered as prescribed, no social incidents. Mr SU's mental state noted to be stable.	
30/5/2007		Letter of Invitation *re.* Care Co-ordination Meeting for 7 June 2007. Care co-ordinator and community psychiatric nurse [4] are on the attendance list, along with consultant psychiatrist [2] and Mr SU's GP.	**Good Practice for the foster care co-ordinator (community psychiatric nurse [4]) and the regular care co-ordinator to attend the EEC (CPA) review**
7/6/2007		Effective Care Co-ordination (CPA) Review.	

Date	Staff member involved	Event/chronology	Identified good practice/ significant concerns
14/6/2007	consultant psychiatrist	Letter to GP following Care Co-ordination Meeting on 7 June 2007 advising of Mr SU's non-attendance, confirming that depot medication continues and that consultant psychiatrist will book Mr SU to be seen at the clinical assistants/GP clinic.	
21/6/2007	Care co-ordinator	Attempts to administer depot: 21/6/2007 and 22/6/2007 (x2).	
25/6/2007	Care co-ordinator	Attends at Moss House for Depot. Mr SU noted to appear stable.	
30/10/2007		Attends at Moss House for Depot. Mr SU was noted to be quiet and apologetic; he was noted to be quieter in mood and apologised for his odour. He was going home to wash.	**Note:** No odour at all detected by the community psychiatric nurse.
27/11/2007 to 25/2/2008		Depot Administration. Attends at Moss House for Depot, missing only the December dose. The last dose received was 25 February.	
25/3/2008		Mr SU did not receive his depot on this day.	**No medical records made following Mr SU's missed depot appointment**

Date	Staff member involved	Event/chronology		Identified good practice/ significant concerns
28/3/2008		Mr SU apparently attended at Moss House for his depot: Mr SU attended at 08.30 am and no nurses were available. It is stated in the Trust's internal investigation report that he left a message for his care co-ordinator asking him to come and give him his depot later that day. (This was recorded in the message book for 31 March 2008, which was the Monday).		Note: Mr SU's care co-ordinator was on annual leave.
31/3/2008	Men's Direct	Phone call from Men's Direct Access.	Saying that Mr SU was being harassed. Also noted that Mr SU may be endeavouring to orchestrate a change of accommodation.	Note: Mr SU's care co-ordinator was on a ½-day annual leave.
1/4/2008		Attempted home visit.	Unsuccessful; then there was a phone call at 4 pm advising of incident.	

APPENDIX 2: INVESTIGATION METHODOLOGY AND SOURCES OF INFORMATION TO INFORM THE INDEPENDENT TEAM'S FINDINGS

The investigation methodology for this case followed recognised investigation practice using systems-based thinking in keeping with the National Patient Safety Agency's approach.

The activities conducted comprised a range of core activities, which were:

- The construction of an analytical timeline of Mr SU's contact with mental health services.
- The identification of questions the Independent Team had about Mr SU's care and treatment.
- A re-analysis of the information (evidence) collected by the Trust's own investigation team to determine the extent to which it provided answers to the Independent Team's questions.
- Face-to-face interviews with staff.
- Review of relevant policies and procedures.

Face-to-face interviews and meetings:

- The family of Mr SU
- Mr SU himself
- The Consultant Psychiatrist for Mr SU (2005 to 2008)
- Mr SU's care co-ordinator
- Two AO mental health nurses
- The then team leader for Mr SU's community mental health team
- The then deputy team leader for Mr SU's community mental health team
- The then acting deputy team leader for Mr SU's community mental health team whilst the deputy manager was on maternity leave
- The Service Director, Adult Mental Health Liverpool
- The Clinical Director, Adult Mental Health Liverpool
- A Community Mental Health Team manager unrelated to the care and treatment of Mr SU
- Principal Officer, Learning & Development
- Senior Training Officer
- Deputy Director of Social Care
- CPA Implementation Manager.

Telephone communication with:

- Natural Networks supported housing
- Trimar Ltd (supported housing provider)
- The Spider Project (substance misuse service).

Other documentary information used:

- Mr SU's mental health records
- The original internal investigation report commissioned by Mersey Care NHS Trust
- All interview records arising from the Trust's investigation
- Dare to Care records (Dare to Care is a holistic healthcare provider)
- Trimar Care Ltd records
- Independent Consultant Psychiatric report compiled by Dr J McKenna, Consultant in Forensic Psychiatry, Lancashire Care Foundation Trust
- Mersey Care NHS Trust's relevant CPA policies
- Mersey Care NHS Trust's Effective Care Co-ordination policies
- Mersey Care NHS Trust Supervision policies 2007 and 2008
- Mersey Care NHS Trust's Effective Care Co-ordination Audit 2006
- National Service Framework for Mental Health (DH, 1999)
- Appleby, L. *Safer Services: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (Department of Health, London, 1999)
- Best Practice in Managing Risk (DH, June 2007).

The investigation tools utilised were:

- Structured timelining
- Triangulation and validation map
- Investigative interviewing
- Qualitative thematic content analysis
- Application of human factors analysis principles
- Semi-structured survey using 'survey monkey' and qualitative analysis.

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