An independent investigation into the care and treatment of service user Mr SUA

December 2011

A report for NHS London
Undertaken by Consequence UK Ltd

NHS London

This is the report of an independent investigation commissioned by NHS London to conform with the statutory requirement outlined in the Department of Health (DH) guidance *"Independent investigation of adverse events in mental health services"*, issued in June 2005. The guidance replaces paragraphs 33-36 in HSG (94)27 (LASSL(94)4) concerning the conduct of independent inquiries into mental health services.

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.

The Investigation Team members were:

- Ms Maria Dineen – Director, Consequence UK Ltd
- Ian Petch – Consultant Clinical Psychologist, South West London and St George's Mental Health Trust
- Nicholas Chamberlain-Kent – Team Leader, Early Intervention Services, Wandsworth. South West London and St George's Mental Health Trust

Acknowledgements

The Investigation Team wishes to thank:

- The family of the deceased;
- Staff employed by East London Foundation NHS Trust (formerly East London and the City Mental Health Trust);
- The Service User's previous GP surgery,

all of whom assisted in the investigation conducted.

Note

For the purposes of clarity and to avoid possible confusion with the "Trust Team", throughout this report the Independent Investigation Team will be 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
CMHT	Community mental health team
CPA	Care Programme Approach
CPN	Community psychiatric nurse
GP	General practitioner
LASSL	Local Authority Social Service Letter
MDT	Multi-disciplinary team
NHS	National Health Service
SHA	Strategic health authority
THEIS	Tower Hamlets Early Intervention Service

EXECUTIVE SUMMARY

Incident overview

On 9 June 2007, a Service User of the then East London and the City Mental Health Trust , subsequently referred to in this report as Mr SUA, attacked and unlawfully killed his mother's partner (Mr D). At the time of the incident, Mr SUA was a patient of the Early Intervention Service in Tower Hamlets, referred to in this report as the early intervention service.

Purpose of the investigation

The purpose of the investigation was to provide answers to the following questions:

- Was the care and treatment of Mr SUA reasonable and compliant with relevant local and national policy guidelines?
- Was the incident predictable and/or preventable based on information the Tower Hamlets EIS knew, or reasonably should have known?

The full terms of reference are tabled in section 2 of this report.

Main conclusions

The incident in which Mr SUA was involved was tragic, and its impact has been enormous for all concerned. The Independent Investigation Team's (Independent Team's) conclusions are based on an objective and detailed analysis of Mr SUA's care and treatment in the then East London and the City Mental Health NHS Trust in the 10 months preceding the incident.

With regards to the question "Was it predictable that Mr SUA would act in the way that he did?", the Independent Team does not believe that the incident of violence that occurred on 9 June 2007 was predictable.

With regards to the question "Was the death of Mr D preventable by virtue of different mental health care and treatment?", it is the perspective of the Independent Team that, although there was a clear lapse in care standards in the month preceding the death of Mr D, it cannot be said with any degree of certainty that the incident would have been prevented had the service delivered to Mr SUA been of the standard expected between 8 May and 9 June 2007. However, the Independent Team is mindful that there were missed opportunities for the sequencing of events to have been different, and it is mindful that for the family of Mr D the missed opportunities will always represent missed opportunities for incident avoidance and thus the avoidance of the death of Mr D.

With regards to the specific terms of reference, these have been addressed throughout the findings section of this report (section 4). To summarise:

- Although the concerns identified by the Trust's internal investigation team were mostly validated by the independent investigation process, the depth of analysis of these by the Trust's team was less than that required for an incident of this severity.
- The clinical records do evidence that the mother of Mr SUA was appropriately involved in the care management of her son up to 20 February 2007, and was provided with appropriate support after the incident.
- The information provided by the family of the deceased does not evidence that the Trust handled the situation with them very well.
- In the 10 months Mr SUA was a patient of the early intervention service, the care he received did meet the expectations of local and national policy as it related to the Care Programme Approach (CPA). However, compliance with the local traffic light system was not as good as it should have been in November 2006 and May 2007. Furthermore, although the face-to-face meetings with Mr SUA were well documented when this was undertaken by assistant psychologist [1] and the trainee psychologist, this robustness was lacking from 2 April 2007, and there was no record made of any discussions held in the clinical team meetings about Mr SUA after 4 October, even though these discussions are reported to have occurred.
- The care plan for Mr SUA was appropriate, and up to 8 May 2006 he received a good level of input from the assistant psychologist [1], the trainee psychologist and his care co-ordinator. Furthermore, as one would expect, Mr SUA's care co-ordinator attended at all home visits conducted by the assistant psychologist, an unqualified team member.
- With regards to the effectiveness of inter-agency working in this case, up to May 2006 this appeared to be of a reasonable standard. In the month preceding the incident, although calls to the supported living/housing provider were reported at interview, only one such contact was recorded on 8 June. There should have been more careful communications with the supported living/housing provider over this period. Optimum communication would have been achieved via a face-to-face meeting where the quality of contact the housing provider was having with Mr SUA could have been better explored.

RECOMMENDATIONS

Since the incident occurred, and the recommendations made by the then Trust's own internal investigation team, the systems in the Tower Hamlets early intervention service have been tightened up. Under the new team leadership, systems for documentation have improved, the wording in the traffic light system is more explicit, and is therefore less vulnerable to mis-interpretation, and management supervision is robustly carried out. As a consequence of the above, recommendations addressing these issues are no longer required. However, there are four recommendations for East London Foundation NHS Trust to consider and implement.

Recommendation 1: East London Foundation NHS Trust must ensure that all mental health teams using a Traffic Light System for clinical management purposes, rather than resource management, audit the system on an agreed periodic basis to provide assurance that it is working as intended and to the expected standard of reliability.

With regards to priorities, it is essential that the Tower Hamlets early intervention service conducts such an audit as soon as possible, as to date there has been no audit of system reliability since its implementation in 2006. This is not good governance.

In formulating an appropriate audit process, the Independent Team recommends that at least the following factors are incorporated:

- The appropriateness of the traffic light level/zone.
- The quality of documentation when a decision is made to manage a service user outside of the protocol guidelines.
- The quality of documentation when a decision is made to move a service user to a lower-risk tier of the traffic light system.
- Whether the documented frequency of medical review evidences protocol compliance, and where the frequency does not meet this, do the notes provide a reasonable explanation as to why? (For example, a decision has been made for less frequent reviews and is a documented component of the management plan, or the service user has DNA'd for appointments.)
- Appropriateness and frequency of medication review.
- Appropriateness of actions planned, following consecutive periods of non-attendance for planned contacts, that the traffic light system says requires action.

Target audience: The Medical Director, The Clinical Leads and Team Managers for all Early Intervention Services, The Clinical Lead for adult services.

Timescale: The need for the above was highlighted to East London Foundation NHS Trust in May 2011. Consequently, within twelve weeks of the publication of this report it should be in a position to present the findings of its audit across all of its early intervention services to NHS London.

Recommendation 2: When a considerable change is made to a service, and the role expectations of the staff working in that service, East London Foundation NHS Trust must ensure that it has appropriate processes in place to ensure the following issues are considered and addressed, where appropriate. In this case, the early intervention service responsible for Mr SUA's care and treatment had, almost immediately prior to him becoming a patient, been the Early Psychosis Service operating on a psycho-social model and not a care co-ordination model. There was no effective transition period for staff and neither were the role changes and staff development needs given sufficient attention in the way the transition was managed. For at least one member of staff, there was little to no resemblance between the job he had been doing and his newly expected role.

In designing a system to ensure that appropriate consideration is given to staff development and supervision when there are notable changes made to the functionality, and purpose, of a clinical team, the following components are recommended for inclusion:

- Clarity about the critical success factors for the 'new' or 'revised' service.
- A map of existing systems and processes within 'the existing' team and the degree to which they meet the new expectation.
- A knowledge and skills map of what is required to reliably deliver achievement of the new/revised service's critical success factors.
- For safety-critical activities, a Failure Modes and Effects map (control map) and/or Task Analysis should be conducted in the planning phases for significant service change.
- Where significant alteration to an individual practitioner's job description is required, the individual should be advised of this and its implication.
- A training needs analysis and/or self-assessment against an appropriate knowledge and skills map.

The Independent Team is aware that, although East London Foundation Trust has more robust processes in place for managing service change and re-design than it did in 2007, these systems and processes do not meet the specific requirements set out above.

Target audience: Deputy Chief Executive and Director of Performance and Business Development, Director of Nursing and Quality, Director of Operations.

Timescale: East London Foundation NHS Trust should be able to advise NHS London on how it plans to address this recommendation within four weeks of the publication of this report.

Recommendation 3: The Clinical Lead and Team Manager for Tower Hamlets early intervention service must assure themselves that there is a detailed clinical review prior to a planned CPA meeting and that the content of this is comprehensively documented in the relevant service user's records. In this case, although both involved medical staff reported such a review occurring, both also reported no knowledge of the extent to which Mr SUA had not been present for planned assessments in November 2006 and January 2007.

The Independent Team suggests that determining the extent to which pre-CPA meetings are being recorded could sensibly be incorporated into the traffic light system audit.

Timescale: On the basis that the records assessment is incorporated into the traffic light system audit, completion should be possible within 12 weeks of publication of this report.

Recommendation 4: Following the death of Mr D, an executive director of East London and the City Mental Health Trust met with the relatives of Mr D to share with them the findings and recommendations of the internal investigation. The family of Mr D found the Trust's representative to be insufficiently informed about Mr D, the circumstances of the care and treatment of Mr SUA, and over protective of the Trust's investigation report. Consequently it is essential that East London Foundation NHS Trust ensures that when serious untoward incidents occur and there is a decision to meet with the family of a service user and/or the family of 'the victim' the person tasked with meeting with the family:

- **Knows the name of the service user.**
- **Knows the name of the victim.**
- **Is fully conversant with the care the service user received and in particular the antecedent period to the incident.**
- **Has given careful consideration as to his/her response if the family ask to read the report, and/or to be provided with a copy of it at the time of the meeting.**
- **Considers seeking a legal opinion on the content of the Trust's internal investigation report before a meeting with the family is arranged so that any issues in how the information is presented can be appropriately addressed.**
- **Is accompanied by a senior member of the clinical team responsible for the patient where it is possible and reasonable to achieve this.**

The Independent Team is mindful that East London Foundation NHS Trust currently appoints named investigators and/or Panel Chairs for all of its serious untoward incident investigations and that a component of their role is to be fully conversant with the incident, its antecedents and the identity of affected family members/victims. Because it now has this system in place the

Independent Team recommends that the Trust assure its commissioners that :

- the lead investigator/panel chair leads the feedback process to families in all cases; and
- the lead investigator/panel chair is accompanied by a senior member of the clinical team when meeting with families.

In addition the Trust must:

- Finalise its policy and practice guidance on the process on sharing of reports and activities that must be completed in advance of this.

This policy guidance must meet the standards of 'Being Open' as espoused by the National Patient Safety Agency and the principles listed above.

Target audience: Deputy Chief Executive and Director of Performance and Business Development, Director of Nursing and Quality, Director of Operations, Medical Director.

Timescale: The principle of 'Being Open' is an established concept within the NHS regarding communications with patients and families adversely affected by an untoward incident. Because East London Foundation NHS Trust already has in place a process it believes meets the above listed principles it should be in a position to provide assurance with regards to the reliability of its practice and its completed policy document along with an audit and monitoring framework within two to three months of the publication of this report.

1.0 INTRODUCTION

This investigation was commissioned by NHS London to determine:

- whether the quality of care and treatment afforded Mr SUA was reasonable and in keeping with local and national standards; and
- whether, or not, the incident on 9 June 2007 could have been prevented by different management and/or actions by the specialist mental health services in East London and the City Mental Health Trust.

On 9 June 2007, Mr SUA had spent the day with his mother and her partner. In the early evening, Mr SUA's mother went to work, and then out with friends until the early hours of the morning. At approximately 1.45am (10 June), she missed a call from her son. When she returned home she could not get in to her home. She called her partner, with no response, and then she called her son, who told her not to go into her home, and that he and her partner had had a fight. Mr SUA's mother then called the police, who entered her home and discovered the body of her partner.

The incident, shocking in itself, was all the more so because there had been no indicators that Mr SUA was of any significant risk of harm to others.

1.1 Background to Mr SUA

Mr SUA is of Cuban origin. He moved to England aged 12. He had a "normal childhood development" and his performance at school was unremarkable. Of relevance are his history of substance misuse from the age of 12, and his usage of cannabis between the ages of 15 and 17 and during his period of contact with the Tower Hamlets Early Intervention Service (the early intervention service).

With regards to his forensic history, there was no record of violence that the Independent Team is aware of and Mr SUA's only criminal act was stealing a bike – no charges were brought as a consequence of this.

1.2 Overview of Mr SUA's contacts with specialist mental health services in East London and the City Mental Health Trust

Mr SUA first came into contact with specialist mental health services on 25 July 2006, when he was referred from A&E to the Tower Hamlets Home Treatment Team (TH HTT, or the home treatment team).

The home treatment team assessment identified:

- *"several weeks insomnia;*
- *auditory and ? tactile hallucinations;*
- *suspicion and paranoia that unidentified others were going to stab him; and*
- *difficulties* [*with*] *concentrating."*

The plan made was for daily visits, and an 'as soon as possible' medical review, referral to the early intervention service, a carer's assessment and psycho-education for Mr SUA and his mother.
The home treatment team assessment was conducted over the course of one week. Deterioration in Mr SUA's behaviour and symptoms resulted in an assessment under the Mental Health Act (1983) and an informal admission to hospital on 9 August 2006.

11 August 2006: The first early intervention service assessment was undertaken by the consultant psychiatrist (and clinical lead) for the team. He was accompanied by an assistant psychologist (a person with a psychology degree who is gaining experience before engaging in formal training as a psychologist).

The result of this assessment was:

- a diagnosis of schizophrenia;
- the prescribing of Olanzapine 15mg (increased prior to the EIS assessment);
- a continuance of feelings of paranoia that someone was going to stab him;
- distraction, poor eye contact, but no hostility in manner;
- mood was noted to be perplexed and he had a reactive affect (i.e. an appropriate response);
- no evidence of suicide or homicide ideation;
- no depression;
- no evidence of impulsivity or grandiosity; and
- Mr SUA reported loud and disturbing auditory hallucinations.

The plan was to allocate a care co-ordinator to Mr SUA at the next early intervention team meeting and, in the intervening period, Mr SUA was requested to remain an in-patient, which he agreed to do.

16 August 2006: Mr SUA was discharged from hospital into the care of the TH HTT, and was living in semi-supported living accommodation.

17 August 2006: A joint home visit occurred between the TH HTT and the EIS. A key piece of information elicited at this assessment was that Mr SUA was not using illicit drugs, but had been placed in a room with someone who did. The mental health professionals therefore requested that this issue be addressed.

It was also noted that Mr SUA's mother was very supportive of her son.

6 September 2006: A home visit occurred, attended by the home treatment services, the staff-grade psychiatrist for the early intervention service and the assistant psychologist. This meeting constituted the formal handover of clinical responsibility between the home treatment team and the early intervention service. As a consequence of this home visit, the medication for

Mr SUA was changed from Olanzapine to Risperidone (6mg per day), as Mr SUA had reported putting on weight with Olanzapine.

Mr SUA was also assigned a clinical psychologist as his care co-ordinator in view of his psychological needs.

September 2006 to December 2006: There were 17 attempted face-to-face assessments of Mr SUA by the early intervention service between September and 21 December 2006, of which 12 were successful: i.e. a face-to-face meeting was achieved. The focus of Mr SUA's care plan over this period was the exploration of, and devising coping strategies for, the voices he was experiencing. The assistant psychologist devised a voice content table in October 2006 which set out clearly the number of voices experienced by Mr SUA, their names, and the nature of the voices.

At his medical review on 26 September 2006, Mr SUA was noted, by his mother, to be 50% improved. She also informed the early intervention staff that her son was experiencing excessive salivation and tears. Consideration was given to changing his medication to Clozapine; however, it was agreed to try a higher dose of Risperidone in the first instance. Risk was noted to remain low.

The management plan following the medical review was:

1. Risperidone increased to 8mg.
2. To see the clinical psychologist (i.e. his care co-ordinator) on a regular basis.
3. To review in 3-4 weeks.

January 2007: There was no face-to-face contact with Mr SUA in January 2007. This was as a consequence of him not being available for planned assessments. One telephone contact was achieved on 16 January only. However, the early intervention staff were aware from staff at the semi-supported living accommodation that Mr SUA had been seen and that no concerns had been expressed. Telephone contact was also achieved on two occasions with Mr SUA's mother.

13 February 2007: This was the first face-to-face contact achieved with Mr SUA by the early intervention service since 21 December 2006. The trainee psychologist (who had replaced the assistant psychologist) attended at Mr SUA's residence. This trainee noted a positive reaction from Mr SUA and that he was friendly and chatty. His symptoms were recorded as unchanged, the voices being at the same frequency and volume. The records also noted that Mr SUA found the voices easier to cope with when in company, but more difficult when alone. Two new voices were reported by Mr SUA and were noted to have made him feel angry and annoyed.

20 February 2007: Mr SUA's risk assessment was updated by his care co-ordinator. This and the previous risk assessment both identified no history of harm to self or others. A Care Programme Approach (CPA) review meeting also occurred on this day. This was attended by Mr SUA, his mother, the early

intervention staff-grade psychiatrist, the consultant psychiatrist, Mr SUA's care co-ordinator and the trainee psychologist.

Significant improvements in Mr SUA were reported by his mother. Mr SUA also reported that he no longer believed that "people would try and kill him". Specific attention was given to Mr SUA's motivation and how he could work on this.

The management plan agreed was:

- to continue with Risperidone;
- blood tests – routine;
- weekly contact with trainee psychologist;
- maintaining contact with clinical psychologist;
- to liaise with the key worker at the semi-supported living provider about courses; and
- a review in one month.

28 February 2007: Mr SUA received a home visit from the trainee psychologist. He was noted to be bright and cheerful and that the voices had improved and were quieter. The records note that Mr SUA reported having taken "a spliff" with friends, and that he was warned of the dangers of this behaviour.

7 March 2007: It was noted that Mr SUA's mother had now moved to Stratford, approximately 2-3 miles from Tower Hamlets. The records also noted that Mr SUA had been staying with his uncle, as he considered Stratford too far to visit. Cannabis use was again noted as discussed and that Mr SUA gave an assurance that he would not use it again, although the trainee psychologist recorded that this was "notably without conviction".

Of significance was the information that Mr SUA had learnt that he was a father to a child born two days previously and that he was contemplating a paternity test and visiting the child and its mother, accompanied by his uncle.

13 March 2007: A multi-disciplinary meeting was convened between the early intervention service and the semi-supported living provider. Mr SUA was noted to be low in mood, lethargic and preoccupied. Mr SUA was noted not to be meeting the programme requirements of the semi-supported living provider and that his tenancy was therefore at risk. Mr SUA reported not being able to think clearly "or in colour".

2 April 2007: Mr SUA was visited at home by the clinical psychologist, his care co-ordinator. Mr SUA was noted as denying the presence of any symptoms except auditory hallucinations. He continued to spend substantial time at his uncle's, which was noted to be less lonely for him and allowed him to save money. It was also noted that he had sent an application form for a training course. Mr SUA was noted to have seen the child he believed he was a father to, and that he would see the child again. Mr SUA told the clinical psychologist that he hoped for limited contact approximately once a fortnight.

The records also noted that Mr SUA's voice content was now influenced by the presence of a child in his life.

Two days after this home visit, Mr SUA agreed to participate in a study into "Understanding cannabis use in 1st episode psychosis".

13 April 2007: The planned appointment with the clinical psychologist was cancelled by him and rearranged for 18 April. A message was left for Mr SUA with staff at the semi-supported living accommodation to this effect.

18 April 2007: Mr SUA was not at home for the rearranged appointment.

30 April 2007: Telephone contact was achieved by the new assistant psychologist [2], the purpose of which was to invite Mr SUA to join the psycho-education group. This assistant psychologist noted that Mr SUA was at college on Mondays and Wednesdays, but that he agreed to join the group on Tuesdays. A face-to-face meeting was arranged for 3 May 2007 to complete necessary paperwork and to discuss the group further.

3 May 2007: Mr SUA did not attend for the planned face-to-face meeting and did not respond to texts or telephone calls from the assistant psychologist [2].

8 May 2007: Mr SUA did not attend at the psycho-education group.

8 June 2007: The clinical psychologist telephoned the semi-supported living provider and determined that Mr SUA had been seen by staff recently and they reported no concerns about him. He also noted that Mr SUA's key worker was on annual leave until 13 June.

9 / 10 June: The Incident Occurred.

Section Four of this report sets out relevant aspects of Mr SUA's chronology in more detail.

2.0 TERMS OF REFERENCE

The terms of reference for this independent investigation, set by NHS London, were as follows:

- A review of the Trust's Internal Investigation to assess the adequacy of its findings, recommendations and action plans.
- Reviewing the progress made by the Trust in implementing the action plan.
- Involving the family of Mr SUA and the family of the deceased as is considered appropriate.
- Compiling a chronology of events to assist in the identification of any care delivery concerns leading to the incident.
- An examination of the mental health services care provided to Mr SUA and a review of relevant documents.
- The extent to which Mr SUA's care was provided within statutory obligations and relevant national guidance from the Department of Health, including local operational policies.
- The appropriateness and quality of assessments and care planning.
- The effectiveness of inter-agency working – in this case the Home Treatment Team, Semi-Supported Living Provider and the Early Intervention Service.
- To consider such matters as the Public Interest may require.
- To provide NHS London with an investigation Report.

3.0 CONTACT WITH THE FAMILY OF THE DECEASED, THE FAMILY OF MR SUA AND MR SUA HIMSELF

The Family of the Victim

The Independent Team first wrote to the daughter of the deceased, via the family solicitors, on 23 September 2010. This correspondence was followed by telephone communication with the deceased's daughter and then further written correspondence on 7 October 2010.

The first face-to-face meeting occurred on 21 October 2010. This was subsequently followed up with written correspondence on:

- 22 November 2010;
- 4 January 2011;
- 19 February 2011; and
- 11 July 2011.

The main issues for the family were that:

- an open and honest investigation was conducted;
- the findings of the investigation were shared with them fully;
- if at all possible the Independent Team was to meet with the mother of Mr SUA to find out more about the days leading to the incident; and
- respect was shown to the family and the memory of their father. The family did not consider that this was achieved when a representative of East London and the City Mental Health Trust (ELCMHT) attended at their home to gather feedback on the Trust's internal investigation process.

The Mother of Mr SUA

The Independent Team has not been able to meet with Mr SUA's mother. Four letters were sent to her at her last known addresses. No response has been received to any of the Independent Team's communications and none of the signed-for letters have been returned to the offices of Consequence UK. A further letter was also sent via her son's legal advisors, who agreed to ask him to pass the correspondence to his mother. This he did not agree to do. The Independent Team again wrote to Mr SUA's mother on 13 July, seeking her input into the investigation and specifically seeking her support with information about the prevailing circumstances in the four- to six-week period immediately pre-incident.

Mr SUA

The Independent Team communicated with Mr SUA via his forensic consultant psychiatrists and also his legal advisors. The Independent Team were informed that he did not wish to meet with them, but that he did want a copy of the draft report sent to his legal advisors for reading pre-publication.

4.0 FINDINGS OF THE INVESTIGATION

The terms of reference for this investigation required an analysis of the then East London and the City Mental Health Trust's own internal investigation and Mr SUA's care and treatment.

The findings of the Independent Team with regards to the care and treatment of Mr SUA are set against a contextual background of a service that up until January 2006 was an early psychosis service, which was psychology-led, and held no care co-ordination responsibility for the service users it engaged with. Clinical management responsibility remained with the referring community mental health team, who were responsible for:

- ❒ care planning;
- ❒ risk assessment;
- ❒ medication management;
- ❒ carers' assessments; and
- ❒ medical reviews.

In 2006 the Trust decided that the team needed to evolve into a more formalised early intervention service to meet the standards set out in the Department of Health's Policy Implementation Guidance for Mental Health Services, March 2001. This meant that the existing service had to change significantly, including the roles and responsibilities of the staff working within it, because to deliver a service with fidelity to the model set out in the Department of Health's guidance document required the evolved Early Intervention Service to embrace complete clinical responsibility for its service users. This meant professionally qualified staff adopting care co-ordination responsibility for service users on their caseload. In July 2006, when the transition fully occurred, some staff working in the previous Early Psychosis Service had no previous experience of being a care co-ordinator, and no training in this role.

4.1 East London and the City Mental Health Trust's Internal Investigation Report

The Health Circular Guidance (94) 27,[1] entitled *"Independent investigation of adverse events in mental health services"*, says that an initial 72-hour review will be undertaken by the NHS Trust whose patient has been involved in the homicide and that this will be followed by an internal Trust-led investigation, *"using an approach such as root cause analysis (RCA). This investigation should establish a clear chronology of events leading up to the incident; determine any underlying causes and whether action needs to be taken with respect to policies, procedures, environment or staff."*
In the introduction to the Trust's report, it says:

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1 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4113574.pdf

"The purpose of the report is to give an account of the events leading up to the incident, the incident itself and subsequent actions taken. The report will provide recommendations for action to be taken by the Trust to minimise the risk of a similar incident re-occurring. The report will also discuss if the incident could have been prevented.
The inquiry/review is aimed at identifying any areas of current practice, which can be improved within or without the current resources. This is a critical review and is focussing on the defects of care, but also on aspects of good practice."

The Trust's report did set out the chronology of Mr SUA's contacts with the early intervention service between 2006 and 2007; it also identified a number of concerns about Mr SUA's management, including:

- The allocation of *"two successive assistant psychologists to work with Mr SUA".*
- The lack of attention to medication compliance.
- *"the fact that* [*Mr SUA*] *had failed to attend appointments and had not been seen by a professional for 26 days should have triggered the traffic light system operational in the EIS. This did not happen."* (This refers to the period January 2007 to February 2007.)
- That the care co-ordinator who did not see Mr SUA for the 11 weeks prior to the incident should have made more assertive attempts to have seen him. (Referring to the period prior to February 2007.)
- That those attending at the February 2007 Care Programme Approach meeting did not adequately appreciate the lack of contact Mr SUA had been having with the service in the months preceding this review.
- That the care co-ordinator did not adhere to expected Safeguarding (Children) practice when it became clear that he had fathered a child whom he wished to see.
- The lack of contact between Mr SUA and the early intervention service after 2 April and the date of the incident should have triggered more assertive follow-up and contact with Mr SUA's mother.

It is unfortunate, having identified a range of concerns which the Independent Team considers to have been appropriate, that the Trust's investigation report did not indicate that these had been explored systematically using effective information analysis techniques such as affinity mapping. The information gathered by the Trust's investigation team was set out against the National Patient Safety Agency's Human Factors framework. However, the information presented was relatively superficial and was not specifically linked to each of the identified concerns. This meant that evidence of a sufficient exploration of each concern was lacking. However, the approach taken by the then East London and the City Mental Health Trust was not all that uncommon. This aspect of the investigation process is, in the experience of Consequence UK, one of the least understood by those tasked with investigating serious untoward incidents in the NHS.

Because of the gaps in the understanding of the victim's family following their reading of the report, and the gaps in the understanding of the Independent Team, which were not addressed on reading the original interview records, it was agreed that it was appropriate to conduct further independent analysis of Mr SUA's care and treatment by the early intervention service responsible for him.

Recommendations made as a consequence of the Trust's internal investigation report are set out in Section 5 of this report (page 82).

4.2 The Independent Team's Findings Regarding the Care and Treatment of Mr SUA

To deliver the terms of reference identified by NHS London in a logical format, and to meet the needs of the family of the deceased, the Independent Team determined that presenting its findings in response to the following questions was the logical approach. These questions are:

- Was the care and treatment of Mr SUA reasonable in respect of:
  - medical review;
  - medication;
  - level of CPA, and his associated care plan and policy compliance; and
  - risk assessment?

- Was the care actually delivered to Mr SUA of a reasonable standard in terms of:
  - the frequency and quality of contacts;
  - compliance with the early intervention escalation policy (traffic light system);
  - communication with other agencies; and
  - communication and involvement with Mr SUA's mother?

- Was the incident that occurred on 9 June predictable and/or preventable on the basis of information the early intervention service was, could or should have been aware of?

In assessing the adequacy of the care and treatment provided to Mr SUA, it was the responsibility of the Independent Team to avoid, as far as it is possible to do so, hindsight bias[2] and to analyse the appropriateness of Mr

[2] 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".

SUA's care and treatment on the basis of information available to clinicians at the time the care and treatment was provided. It was also the responsibility of the Independent Team to determine whether a broader range of clinical opinion was required than that contained within the Independent Team so that proper consideration could be given to what a reasonable group of similarly qualified clinicians would have done in similar circumstances. This is what the National Patient Safety Agency refers to as the "substitution test" in its incident decision tree.[3]

In this case, a decision was made that it was necessary to obtain the input from professionals working in the early intervention service at the time but who were not directly involved in the care and treatment of Mr SUA. However, it was not considered necessary to seek the input of EIS staff outside of this team. The Independent Team also considered it appropriate to ask an independent consultant psychiatrist to review the Independent Team's report and the evidence on which it is based as part of its validation process. This decision was supported by NHS London.

4.2.1 *Was the care and treatment of Mr SUA reasonable in respect of:*

- medical review;
- medication;
- level of CPA, and his associated care plan and policy compliance; and
- risk assessment?

Summary: For the most part, Mr SUA did receive reasonable care and his management plan was mostly appropriate. He was managed in line with enhanced CPA principles, having a CPA review within six months of his acceptance onto the early intervention caseload. He was also assigned to an appropriately qualified professional who had the necessary skills and experience to meet his identified needs. However, there were aspects of the care co-ordination role with which the assigned professional was not familiar, having not fulfilled care co-ordination duties before. This did impact adversely on the completeness of the service provided to Mr SUA. However, this point made, Mr SUA had two risk assessments conducted between August 2006 and February 2007 and an appropriate care plan. With regards to medical review, initially it was frequent and of a good standard. However, after September 2006 the frequency of medical review did not occur in line with the documented medical management plan

The specific aspects of the management plan for Mr SUA that could and should have been improved were:
☐ the documentation of enquiries about Mr SUA's medication compliance;
☐ enhanced focus in the documented risk assessments in relation to Mr SUA's reactions to his paranoia;

[3] http://www.msnpsa.nhs.uk/idt2/(jg0xno55baejor55uh1fvi25)/index.aspx

☐ the documentation of the medical involvement in the review of Mr SUA's management plan, and the medical perspective about him in February 2007.

The following sets out the Independent Team's findings in more detail in relation to the above.

4.2.1.1 *Medical Review*
The first medical assessment of Mr SUA occurred on 26 July 2006 by the Psychiatric Senior House Officer (SHO) on call. This doctor noted that Mr SUA:

- was not previously known to services;
- reported "live ants inside my head";
- was experiencing second-person auditory hallucinations;
- had no command hallucinations;
- had no risky content to his hallucinations;
- was experiencing reduced sleep;
- had smoked 9+ joints of cannabis a day until two months previously;
- lived with his mother;
- had no risk to self or others
- had no thoughts or plans.

The SHO's records further show that he explored the auditory hallucinations with Mr SUA, noting:

- there were many people, male and female;
- that Mr SUA did not recognise any of the voices; and
- that the voices said funny things and made him laugh.

With respect to the tactile hallucinations, the SHO identified that:

- Mr SUA experienced a *"crawling sensation in his legs and head ... live like ants".*

The SHO also determined that Mr SUA felt safe, though he had *"vague thoughts that people may be watching me".*

The SHO's records also evidence that he explored risk of harm to self and others. With respect to the latter, the SHO noted:

- *"No aggression towards others;*
- *No acts of violence;*
- *Sometimes irritable with people;*
- *Not carrying weapons."*

The overall conclusion of the SHO was: *"drug-induced psychosis – schizophrenia".*

The documented management plan stated:

- *"continue to stop cannabis;*
- *leaflet for community drug team;*
- *start Olanzapine 10mg at night;*
- *referral to the home treatment team for daily visits* [*starting 26/07/06*] *and? referral to the 'EPS'* [*early psychosis service*]*;*
- *aware can return to A&E whenever feels concerned/worried."*

The 2nd medical review occurred on 9 August 2006. This was conducted by the consultant psychiatrist for the early intervention service on the in-patient ward in which Mr SUA was resident. In the subsequent letter to a consultant psychiatrist at the Royal London Hospital, the early intervention consultant noted:

- There was no history of violence to others.
- There is no hostility in his manner.
- His speech is hesitant but spontaneous.
- He had thought broadcasting and insertion and has passivity of actions.
- He denied any suicidal or homicidal ideation.
- He reported having loud, disturbing auditory hallucinations, but did not want to explore this further during the consultant's assessment.
- He was uncertain of the need for medication and did not think cannabis was causally linked.

This consultant also wrote: *"*[*Mr SUA*] *appears to have had a first presentation of a Paranoid Schizophrenic illness and is currently at high risk due to his positive and cognitive symptoms. There is a genetic loading and a DUP* [*Duration of Untreated Psychosis*] *= approx. 3-4 months. It would be in the interest of his health and with regard to the risk to himself to continue treatment."*

On 17 August 2006 there was a discharge review and a typed summary of this was dictated. This summary reiterated the content of previous medical reviews conducted by the home treatment team and the early intervention service.

In particular, the discharge summary sent to the early intervention service said:
"No evidence of formal thought disorder. Denied any thought interference. Preoccupied with the voices. Denied any delusions or paranoid feelings."
And
"Admitted to hearing voices sometimes talking to him, for example calling his name. Sometimes talking about him. Doesn't know who the voices are or really what they say, suggesting both second and third person auditory hallucination. Also evidence of tactile hallucinations."

With regards to his progress during his in-patient stay (a period of seven days), the discharge summary noted that Mr SUA appeared to settle well on the ward. It was noted that *"he did not appear to respond to any auditory hallucinations or present any other psychotic symptoms".* When he was asked about this, he said he continued to hear voices, but didn't seem too disturbed by them.

No significant risks of harm to self or harm to others were identified.

The 3rd medical review occurred on 6 September 2006, and was conducted by the staff-grade psychiatrist for the early intervention service at Mr SUA's place of residence.

The documented assessment is comprehensive, appropriately identifying how Mr SUA has been referred to the early intervention service. It also noted:

- That Mr SUA had reported *"feeling ok initially"* and lately that he feels *"numb/didn't feel like doing things".*
- That Mr SUA was experiencing anhedonia (no enjoyment from life).
- Early insomnia (i.e. broken sleep, rising early).
- That Mr SUA's hallucinations continue.
- That Mr SUA's *"voices don't ask him to hurt himself but sometimes ask him to hurt others".* The medical record also noted that Mr SUA *"doesn't listen to them. Talks back - helps dealing with them."*
- That Mr SUA continued to deny cannabis use.
- That Mr SUA *"does not go out because people irritate him, also when on public transport voice got worse".*
- That no side-effects of medication were reported.

The documented plan was:

- To *"Transfer care to THEIS;*[4]
- *Continue Risperidone 6mg at night;*
- *Home treatment team to dispense two weeks' medication and GP to continue;*
- *Assistant psychologist to continue input – weekly contacts;*
- *Medical review in two weeks' time;*
- *Gradual encouragement with college, but needs lots of work around motivation."*

The fourth medical review occurred on 26 September 2006, approximately three weeks after that of 6 September. Also present at this assessment were the assistant psychologist and Mr SUA's mother.

The medical record noted that Mr SUA was:

[4] Tower Hamlets early intervention service.

- “Feeling better than before;
- Still having problems with sleeping;
- Feels bored a lot;
- Voices are still the same, worse at night;
- No command hallucinations, voices of a derogatory nature saying ‘I’ll kill you’;
- Not had any cannabis;
- Some paranoia, sometimes feels somebody will kill me; and
- Going out more, even public transport, voices don’t get worse - are there though.
- Starting college by end October;
- Enjoys swimming, cinema.”

The staff-grade psychiatrist also noted that Mr SUA’s mother reported that her son was:

- “Better than before;
- 50% improved;
- Still has memory problems;
- Tears and increased salivation; possible SEs [side-effects];
- Better for accommodation.”

Medication was discussed at this review and a decision made to increase Mr SUA’s Risperidone to 8mg at night, due to his residual symptoms.

Other features of the plan were for the assistant psychologist to continue her input and for further medical review in 3-4 weeks’ time.

There is no documentary evidence that the planned medical review occurred.

20 February 2007: The next medical review occurred at the planned CPA meeting, at which the staff-grade psychiatrist and the consultant psychiatrist and clinical lead for the early intervention service were present. The Independent Team understands that, prior to this meeting, it was routine practice for the early intervention service to have a detailed discussion about the situation for a service user and to consider the ongoing relevance of the management plan and any changes required.

The notes of the CPA review, made by the staff-grade psychiatrist, show that:

- Mr SUA’s mother felt her son had improved so much more. He was communicating more, interacting more, making jokes, and his memory was better.
- Mr SUA himself reported finishing his plastering course, but not getting through to the 2nd level, that he was filling in application forms for a construction course, that he sometimes woke up and did not feel like “doing things”, at times he also reported being happy.

- Mr SUA also reported continuing experiences of “voices”. But that the voices “were not as bad as before”, they were “decreased in intensity”. He reported that he was less scared than before. Mr SUA also reported speaking to his uncle about his experiences, but not to his friends.

The medical notes also reported that:

- Mr SUA wanted to think about courses and wanted to get rid of the voices;
- there was a discussion “about contacts”, and that Mr SUA was encouraged to take on more responsibility, to be less dependent on his mother, and that “appointments” were discussed with him; and
- Mr SUA reported that he “can’t be bothered” for missing appointments.

Importantly, the staff-grade psychiatrist noted that Mr SUA no longer believed that anyone wanted to kill him.

With regards to medication, it is noted that Mr SUA reported that they help him feel relaxed, and that his mother reported “tears excessive”.
Overall, Mr SUA believed that he was 65-70% back to normal.

With regards to Mr SUA’s reported ambitions, it was noted that:

- He wanted to have his own flat;
- He wanted to go to Cuba for approximately two months to enjoy himself, but had no immediate plans to do so.

Mr SUA’s mother was also noted to be supportive of her son’s independence.

With regards to risk, these were noted to be low.
The Plan documented was:

- To continue with Risperidone 8mg at night;
- To have a range of blood tests taken (FBC, LFTs, Lipid Profile, AbAic, Renal Function);
- For weekly contact to continue with the trainee psychologist working on motivation, coping strategies, symptoms and activities.
- To liaise with his key worker at the semi-supported living accommodation regarding courses;
- The review in one month.

There is no documentary evidence that the recommended medical review took place.

Comment by the Independent Team
Mr SUA received four medical reviews within a six-month period:

- A pre-assessment by the consultant psychiatrist for early intervention in August 2006;
- Two specific medical reviews in September 2006 by the early intervention staff-grade psychiatrist;
- Medical attendance at the CPA review in February 2007.

The records show that the range of issues one would normally expect to be addressed was included in these reviews. That is, medication, prevalence of symptoms, engagement, and the ongoing medical plan. The only original presenting feature for Mr SUA not referred to in the medical documentation was Mr SUA's reported tactile hallucinations. The Independent Team presumes that this is because there were no further reports of these after Mr SUA's discharge from hospital.

The Independent Team also noted that the documented "as required" medical reviews did not occur as they should after September 2006.

Because of the incident that occurred, it is important that i) the reason for the lack of subsequent medical reviews is understood; and ii) whether there is any reason to suggest that the day-to-day management of Mr SUA (February to June 2007) would have been markedly different had the medical reviews occurred.

The interventions and frequency of medical review and care co-ordinator contacts were guided by a clinical protocol referred to as the 'Traffic Light' system. This framework is outlined here.

For 'Red' patients, the protocol said:

- *"Medical Review* [*every*] *1-2 weeks*
- *Care co-ordinator review 2-3 per week*
- *Daily handover*
- *MDT* [*multi-disciplinary team*] *weekly*
- *EXIT ONLY AFTER MEDICAL REVIEW."*

For 'Amber' patients, the protocol said:

- *"Medical review every 4-6 weeks*
- *Care co-ordinator review every 1-2 weeks*
- *Multi-disciplinary review every 12-14 weeks*
- *EXIT ONLY AFTER Multi-Disciplinary Review."*

For 'Green' patients, the protocol said:

- *"Medical review every 8-12 weeks*
- *Care co-ordinator review every 2-4 weeks*
- *Multi-disciplinary review every 24-26 weeks."*

Although the then consultant psychiatrist for the early intervention service has been able to say what retrospectively he believes was appropriate for Mr SUA, not one member of staff has provided a reasonable explanation as to why the recommended medical review did not occur, other than identifying that all of the responsibility for this rested with Mr SUA's care co-ordinator.

Contributory Factors to the insufficient number of medical reviews between September 2006 and February 2007, and after February 2007
As a consequence of the Independent Team's investigation and the information made available to it, it suggests that the following all contributed in some way to the non-booking of medical reviews after 26 September 2006.

Policy and Procedural Issues
The traffic light system had been introduced in July/August 2006, following the arrival of the consultant psychiatrist into the team. This professional had been appointed to the team in January 2006, but was unable to actively commence in post until his contractual obligations to his existing post had been discharged. The system was therefore new to the team. A number of early intervention staff told the Independent Team that, in the last quarter of 2006 and early 2007, it was a system that they were getting used to.

Notably, the four qualified members of staff interviewed (two occupational therapists, one mental health nurse and one psychiatrist) all told the Independent Team that the traffic light system was understood by them, and that guidance was readily available about it and clearly displayed on the traffic light board.

The care co-ordinator for Mr SUA also told the Independent Team that he was aware of the system and recalled that the consultant psychiatrist had given a presentation on it and that further guidance was also available.

Practice Issues
As a consequence of interviewing a range of staff working within early intervention in the antecedent period leading to the incident, the Independent Team understood that there was an expectation that a service user's care co-ordinator was responsible for booking medical reviews.

The staff-grade doctor told the Independent Team that:
"The reviews were arranged by care co-ordinators and if they had any doubts/were unsure, they could always check the notes, letters or check directly with us." And "If for some reason the care co-ordinator was not present (off sick, leave, etc), someone else would be delegated this responsibility [*may include the medic*] *of weekly contact, but this was decided at the Traffic Light meeting and not presumed to be the medic."*

He also told the Independent Team that:
"by 2007, I would say it would be rare to see the reds protocol not being implemented. It may be that the amber and greens were not that closely scrutinised, but the reds always were."

Other non-medical but professionally qualified mental health staff working in early intervention in the antecedent period leading to the incident told the Independent Team that it was the role and responsibility of a care co-ordinator to organise and book routine medical reviews, and any other that were considered necessary.

However, these staff, and the care co-ordinator for Mr SUA, told the Independent Team that the care co-ordination role was new to most of them. Prior to the formation of the early intervention service, none of the occupational therapy staff or the Clinical Psychologist had been expected to, or trained to, take on the role and responsibility of a care co-ordinator. It is the impression of the Independent Team that the clinical psychologist (care co-ordinator) did not fully appreciate it was his role to ensure that medical reviews were booked, and neither did he impress upon the assistant psychologist [1] or the trainee psychologist that this needed to occur.

When asked what training had been delivered to prepare staff for their new role, Mr SUA's care co-ordinator told the Independent Team that:
"As a service we received arguably little training. I recall a presentation on service policy and the Care Pathway by [*the consultant psychiatrist*]*; a session familiarising ourselves with CPA documentation, and a session on negotiating the Benefits system. Given my own specialist professional training and the job description of the post I had been appointed to, I was extremely confused: about my role as a care co-ordinator; about whether or not I was supposed to be attempting also to engage in Clinical Psychology work when care co-ordinating service users – and how; and about whether or not I could/should delegate any tasks to others."*

Other early intervention staff told the Independent Team that they recalled some low-key training prior to the new consultant psychiatrist joining the team, and some afterwards, but it was all low-key.

One OT told the Independent Team that: *"you could pick it up as one went along and she felt that the CPN* [*on the team*] *was there if she needed help. It was a role where you had to learn as you went along as new needs came up with different service users."*

The current team leader for the early intervention service told the Independent Team:
"I think most people understood the role, what they lacked was experience in certain aspects of the role, particularly complex social care needs. This cannot always be taught. Sometimes it's about where to look for help, i.e. benefits advice, housing, etc. Staff always came to discuss complex situations with me. This is the same today." [Note – this individual only commenced in post in May 2007].

Supervision Issues
It is usual within a community mental health and specialist mental health team for the case management of a service user to be reviewed within the context of supervision. One might reasonably expect, therefore, a frequency of

medical reviews, and the delivery of the agreed management plan for a service user to form a component of these. In the early intervention service, supervision was provided to care co-ordinators by the then team leader.

A range of staff interviewed highlighted that, although the team leader was knowledgeable and supportive, when asked for input his lack of availability due to significant periods of time off work was problematic. Also problematic were his reported assurances to the then service manager that he was on top of supervision requirements, when he was not.

The Trust's standard for supervision in 2006 was as follows:
"As an absolute minimum, staff will receive a minimum of one hour's supervision each month and the length and frequency should be determined on an individual basis, taking into account the supervisee's needs, experience and length of time in the Trust." Supervision Policy 2002.

This policy also defined three types of supervision:

- Management supervision;
- Clinical supervision; and
- Professional supervision.

Management supervision was intended to enable review of an employee's management/administrative tasks, to set priorities and objectives, to identify specific management/administrative tasks, e.g. time management, budget skills, and to identify training and development needs.

Clinical supervision was to provide opportunity to reflect on and review their clinical practice; to discuss individual cases in depth; to provide support to clinicians to change/modify their clinical work; and to support the development of clinical skills in assessment and treatment.

Professional supervision was to review professional standards and to enable a practitioner to keep up to date with developments of their particular profession; identify professional development needs; and be clear that they are working within professional boundaries.

The difficulty in this case was that the appointed care co-ordinator for Mr SUA was not working in the professional capacity he had originally been employed post-qualification as, i.e. as a clinical psychologist. He was (2006 to June 2007) working as a care co-ordinator, a role for which his training had not prepared him. Consequently, it was essential that his management and clinical supervision was provided by his line manager and someone experienced in care co-ordination and caseload management, and that it met with the Trust's then stipulated standard of being carried out monthly for at least one hour. This did not occur for Mr SUA's care co-ordinator. It seems to the Independent Team that confusion arose for non-nursing staff about who was providing supervision and what type of supervision.

The CPN interviewed recalled receiving regular supervision delivered in line with his expectations; this contrasted with recollections of Mr SUA's care co-ordinator and also with one of the occupational therapists. Both of these professionals recalled sporadic supervision.

The care co-ordinator told the Independent Team that he:
"received supervision from [*the team leader*] *and* [*professional supervision*] *from* [*a consultant psychologist*]*. While initially there could possibly have been more helpful distinctions drawn between the nature and content of the two supervisions, the comfortable arrangement gradually arrived at was that* [*the team leader*] *provided Management supervision (caseloads, service issues, etc.) and* [*the consultant psychologist*] *provided Clinical supervision (actual cases and clinical practice* [*as it related to psychology*]*). Supervision with* [*the team leader*] *was infrequent in the context of his regular absence; supervision with* [*the consultant psychologist*] *was always fortnightly. I was always extremely happy with the supervision provided by* [*the consultant psychologist*]*: it was regular, efficient, organised and very helpful. ...* [*T*]*he infrequency of supervision from* [*the team leader*] *... some of my supervision with* [*the consultant psychologist*] *necessarily concerned those more general matters of caseload and service issues that would otherwise have been addressed in supervision with* [*the team leader*]*."*

The occupational therapist told the Independent Team that she:
"only remembered seeing [*the team leader*] *twice for case management supervision.* [*She*] *received her clinical supervision from* [*a senior OT colleague*]*. This was regular. Not much management supervision/professional supervision from* [*the team leader*] *– in fact,* [*I*] *did not recall any."*

It is the working hypothesis of the Independent Team that how supervision was to be delivered within the early intervention service was given insufficient consideration when the decision was made to evolve the pre-existing early psychosis service into a more formalised Early Intervention Service.

Working Environment Issues (workload, etc)
It is clear that the staff employed by the early intervention service were in the early stages of getting to grips with their new roles and responsibilities and the change this required from their previous way of working (no care co-ordination responsibility and a psycho-social model of work). The Independent Team understands that, in the initial months of the early intervention service, there was a limit to the caseloads that staff were asked to manage. However, the information provided by interviewees is inconsistent about this and no qualified information has been produced. It seems that caseloads ranged from 8 to 12 persons for each of the '7.5' care co-ordinators.

Mr SUA's care co-ordinator told the Independent Team that there were additional components of his role which added a layer of complexity and created a certain degree of time pressure. He outlined the following activities:

- *"My having to complete the PgDip in order to justify my position as Psychologist in THEIS;*

- *My working only a four-day week (attending the PgDip on the fifth), while my caseload appeared not to be reduced commensurately;*
- *...* [*T*]*he initially sanctioned Study Day per week stipulated by the PgDip* [*not being possible for the THEIS to provide*]*;*
- *My supervising an Assistant Psychologist at any given point, and also* [*the trainee psychologist*] *during her placement;*
- *In addition to my existing caseload, my having to seek work at another service during this time so as to secure sufficient referrals to pass the PgDip."*

The impact the above had on the care co-ordinator's capacity to fulfil his care co-ordination role were compounded by a range of significant life events for him and his family during the antecedent period to the incident.

The occupational therapists told the Independent Team that they did not consider that caseloads *per se* had increased, but the workload had, as the following indicates:
"There were more assessments needed for [*service users*]*, there was no help with liaising with the police, etc. Generally, they had to do more, that care co-ordinators had done before, now it was* [*our*] *role."*

Interestingly, both of these professionals told the Independent Team that holding care co-ordination responsibility did have its advantages; for example, knowing what was going on for a service user rather than having to chase other professionals to find out. They also told the Independent Team that, similarly, they considered that having a resident consultant psychiatrist on the team was beneficial.

Conclusion of Independent Team regarding the lack of medical reviews
It is clear from the information provided by the early intervention service professionals that 2006 and early 2007 represented a period of significant change in the way the team operated and also in the range of responsibilities required of staff.

With regards to the booking of medical reviews, taking into account the above, the lapse in this element of Mr SUA's care and treatment seems to have arisen simply as a consequence of:

- a booking system that was overly reliant on care co-ordinators, not all of whom were used to these elements of their role;
- Mr SUA's care co-ordinator not properly appreciating that this was a part of his role and responsibility; and
- a lack of control mechanisms to either prevent lapses in the expected process, or to flag up lapses. One could argue that the CPA review process could have functioned in this way, but it did not.

It is the contention of the Independent Team that it is not reasonable to expect a professional:

- who is trained in a specialism that does not usually require the professional to care co-ordinate; or
- who hitherto has been working solely in his/her professional capacity

to have assimilated all aspects of the care co-ordination function and to be delivering the task to the standard of the competent community mental health nurse or another professional who has received specific training and/or has experience in the role.

4.2.1.2 *Medication Management*

Summary: Between September 2006 and April 2007 the Independent Team considers that the management of Mr SUA's medication and his compliance with this was reasonable. However, at some point between 2 April 2007 and 9 June 2007, Mr SUA became medication non-compliant. The early intervention service was unaware of this. It is the perspective of the Independent Team that the service could and should have made more assertive efforts to determine the medication status of Mr SUA during this period of time.

Mr SUA was prescribed anti-psychotic medication; initially Olanzapine and subsequent to this Risperidone. Both of these medications were appropriate for him.

The previous section confirms that at the medical reviews the staff-grade doctor was attentive towards medication on 6 September, 26 September and 22 February. It is also clear that he directed the assistant psychologist towards having regular contact with Mr SUA to encourage Mr SUA with his medication as a specific component of his care plan.

The clinical record also shows that Mr SUA reported finding his medication to be helpful in calming him. There is no indication that he was ambivalent towards his medication.

The Independent Team is satisfied that from the medical perspective the management of Mr SUA's medication was reasonable.

The internal investigation (conducted by EL&C MHT) found that the medication management from a care co-ordination perspective was not reasonable. This was because there was no reference in the day-to-day progress notes of follow-up with Mr SUA about this. Although the Independent Team agrees that the lack of comprehensive contemporaneous records is not good practice, it does not agree that there is evidence to support the internal report's assertion that medication issues were not attended to. The lapse in the antecedent period September 2006 to April 2007 appears to have been one of documentation rather than a lapse in the actual practice of those involved.

During interviews with the assistant psychologist and Mr SUA's care co-ordinator, the following emerged:

The assistant psychologist [1] confirmed that she did ask questions about medication. Questions about this would have been asked as part of the general well-being questions she routinely asked. She told the Independent Team that:
"[*Her*] *previous experience in other support roles had enabled* [*her*] *to work alongside nurses and* [*she*] *knew that it was the normal component of conversation with someone on medication."*

However, in spite of this experience, the assistant psychologist is an untrained support worker and, over and above the general well-being questions, she did not and would not have had the requisite skills or knowledge to undertake a more searching exploration of how Mr SUA was managing his medication.

Mr SUA's care co-ordinator believed that the
"aim was to provide [*the MHSU*] *with traditional EI service input, including fostering medication compliance and monitoring medication".*
He also told the Independent Team that:
"It may not be evident from the notes, but at every contact medication compliance is asked. [*Mr SUA*] *informed* [*me*] *that he was compliant with medication on each occasion he was asked.* [*The trainee psychologist*] *was seeing him*[5] *and would have asked this of him as a matter of course – this is probably why it was not documented."*

In response to the questions *"How else would you and the psychology trainees have assessed whether or not* [*Mr SUA*] *was medication compliant?"* and *"What is the range of approaches you would employ to try to verify what you are told about compliance?"*, the care co-ordinator told the Independent Team:
"Unless there were clear indications that a service user might be fitfully compliant or non-compliant with medication, or that their personal accounts were not to be trusted, then we would respectfully trust self-reports. In the case of [*Mr SUA*]*, he had always presented as open and honest in his engagement with us and we trusted his repeated reports of medication compliance."*

What appears to have been lost in the report arising from the Internal Inquiry is that medication compliance was always asked about – as a matter of course – at every substantial contact with a service user.

The care co-ordinator also told the Independent Team that:
"in the context of [*his*] *Clinical Psychology training I was not in the habit of recording this unless I had suspicions of non-compliance and/or a service user had acknowledged such. I contributed to the inculcation of this approach (i.e. always to ask about medication compliance) in both* [*the assistant psychologist*] *and* [*the trainee psychologist*] *– but they might also have followed my lead in recording only incidents of suspected/self-reported non-compliance. If there had been suspicions of non-compliance, then options would have included to contact significant involved others/the GP to check."*

Mr SUA's care co-ordinator also told the Independent Team that it was his understanding that all staff had a responsibility to ask service users about medication compliance and to report back to the care co-ordinator any identified concerns. Other staff told the Independent Team that, once the team had a consultant psychiatrist, there was a significant shift in the philosophy of

[5] The trainee psychologist was seeing the MHSU in 2007.

the team to one that focused on treating service users with medication as the primary intervention.

On the basis of the interviews conducted with early intervention staff and in particular with assistant psychologist [1] and Mr SUA's care co-ordinator, the Independent Team has no reason to disbelieve their testimony of regularly asking Mr SUA about medication and regularly not recording that they had done this.

The Independent Team is satisfied therefore that, during the periods where there was active contact with Mr SUA (i.e. up to early April 2007), the early intervention staff attending to meet with him did ask him about his medication and his level of compliance with this. The Independent Team, based on its collective experiences, does not believe that, had Mr SUA been visited by a mental health nurse, a person with this qualification would have asked of Mr SUA more searching questions about medication, unless there were indications of non-compliance.

4.2.1.3 *Was the level of CPA, and associated care plan and policy compliance reasonable?*

Summary: Mr SUA was placed on standard CPA. The Independent Team considers that Mr SUA should have been on enhanced CPA, as he met the local and national criteria for this at the time. However, it accepts that his care management plan met with enhanced CPA standards, so that his care and treatment was not compromised by being on standard CPA.

With regards to risk assessment, the Independent Team considers the assessments undertaken to have been adequate. It agrees that Mr SUA was not an identifiable source of risk to others; however, it does not consider that the documented risk assessments were as robust as they could and should have been. This is specifically in relation to the exploration of his potential responses to the voices that angered and annoyed him.

CPA

The then East London and the City Mental Health Trust's CPA policy, dated February 2006, said that a person on standard CPA would:

- *"Require the support or intervention of one agency or discipline; OR*
- *Require low key support from more than one agency or mental health worker"*;

and would

- *"Be more able to self-manage their mental health problems;*
- *Have an informal support network;*
- *Pose little danger to themselves or others;*
- *Be more likely to maintain contact with services."*

Of Enhanced CPA it said:

- *"All service users who fulfil the criteria for Section 117 aftercare will automatically be included on Enhanced CPA (i.e. service users who have been detained in hospital under Sections 3, 7, 37, 37/41, 47/49 and 48/49 of the Mental Health Act 1983).*
- *For those not subject to Section 117 aftercare the following are the criteria for Enhanced CPA:*

  A diagnosis of a severe and persistent major mental illness

  and

  A requirement for multi-agency involvement and co-ordination.

  NB Individuals with a history of substance misuse; or with evidence of a significant physical illness/disability; or with learning difficulties should not be excluded from services if they meet the above criteria."

Mr SUA, whose care and treatment is the subject of this report, required:

- the care and support of a care co-ordinator;
- the care and support of a supported-living provider; and
- medical input.

He also required considerable support from his mother.

In the mind of the Independent Team, he met the Trust's criteria for enhanced CPA.

Although there was no adverse impact on the management plan for Mr SUA as a consequence of being placed on standard CPA, the Independent Team did ask the consultant psychiatrist for the early intervention service about this.

He told the Independent Team that:
"Standard CPA was routine for all patients in THEIS; we had a clinical protocol which required a review at 3 months and thereafter 6-monthly. The 'EIS level of Standard CPA' is meant to indicate that there was no reason for patients not to have a high degree of MDT input. Often CPA's levels are based on historical events, and in EIS we are at the starting point of an illness and have to have a higher index of care, and cannot rely on the standard risk instruments which rely on historical risk."

The operational policy for the early intervention service at the time did not set out with any clarity the position of the service in relation to existing local and national policy guidance. The only aspects of the operational policy indicative of the intent of the clinical lead and author of the early intervention service operational policy were:

"5.4 Allocation of Primary THEIS worker
...
The Primary THEIS worker will be the Care Co-ordinator in line with CPA guidelines. (See the Trust's policy as to the role of the Care Co-ordinator.)
...

7.2 Monitoring Intervention and Outcomes
THEIS will meet the requirements of the Trust and aim to complete audit cycles in both clinical and operational standards.
• CPA monitoring of individual care plans is a priority."

Mr SUA's care co-ordinator said:
"The Psychiatrists in THEIS typically stated in their initial assessment letters what level of CPA (i.e. Standard or Enhanced) they were placing a service user on, with Standard being the default status when Enhanced was not stated. [*The consultant psychiatrist's*] *letter (11th August 2006) and* [*the staff-grade's*] *letters (6th September 2006 and 27th September) do not indicate* [*Mr SUA's*] *CPA Status.* [*Mr SUA's*] *Standard status was known within the service and not revised.*

I clearly recall there being some confusion and discussion among care co-ordinators as to the principles operating by which psychiatrists placed service users on particular levels of CPA and the clinical features distinguishing between Standard and Enhanced. (It is interesting to note that in my current work within a TH CMHT, distinctions have long since ceased to apply: individuals are now simply on CPA or not.)"

This individual also recalled that Mr SUA *"was on standard CPA and there* [*was*] *a protocol on how often they are reviewed".*

It was the element of potential confusion for staff working to Trust policy that the Independent Team had a concern about. However, following interviews with staff, although it remains unclear as to why the early intervention service could not simply have placed all of its service users on enhanced CPA in keeping with the then East London and the City Mental Health Trust's policy, it is satisfied that the distinction of 'standard' did not negatively impact on Mr SUA's care and treatment.

The CPA Care Plan
A review of Mr SUA's clinical records revealed the following care planning documents:

- Care Programme Approach Care Plan, completed by the Home Treatment Team, dated 1 August 2006.
- Care Programme Approach Care Plan, completed by Mr SUA's care co-ordinator on 2 February 2007.

The care plan dated 1 August 2006 was a comprehensive plan and set out clearly the issues for Mr SUA and the interventions and actions required to deliver the care plan to him. These actions included:

- Daily home treatment visits to monitor mood, mental state and risk.
- Referral to the Tower Hamlets Early Intervention Service (THEIS)
- Exploration of Mr SUA's cannabis use, including frequency of use, amount used and the effect it has on him.

- Providing Mr SUA with 'Harm Minimisation' information about "cannabis use and links to specialist services, i.e. Lifeline".
- Opportunity to explore his concerns about "unprotected sex".
- To ensure that Mr SUA understood the importance of taking "some time off" his plastering course. The Consultant psychiatrist to the home treatment team is also noted to have written to Mr SUA's college explaining the need for this.
- To provide opportunity for Mr SUA's mother "to ventilate any issues/concerns she may have and is supported accordingly".
- To discuss medication with Mr SUA daily and to ensure that he was aware of potential side-effects of Olanzipine. It was also noted that Mr SUA and his mother were to be advised of how to access medication within and "out of hours".

Mr SUA's records show that the home treatment team carried out its plan with him.

The Care Plan dated 2 February 2007

The August 2006 care plan was reviewed and updated as part of the CPA Review process. At the start of the care plan it stated: "The following items of the care plan have all been discussed with [Mr SUA]. While his insight and ability to provide insight into the CPA is limited, he has clearly understood and agreed with the following in discussion."

The February 2007 care plan outlined six individual care needs relating to his auditory hallucinations, lack of sleep, lack of motivation, past cannabis use, lack of insight, and the need to achieve less dependence on his mother.

The documented interventions were:

- *"To provide* [*Mr SUA*] *with psycho-education within his weekly sessions.*
- *To provide* [*Mr SUA*] *with opportunity to discuss his symptoms each week and explore possible meanings or interpretations of these.*
- *To explore with* [*Mr SUA*] *any symptom patterns or strategies he can use to ease symptoms/prevent exacerbation of symptoms.*
- *To teach* [*Mr SUA*] *relaxation techniques to assist him in getting to sleep more easily.*
- *To use Activity Scheduling, breaking down goals into manageable stages and exploring any factors impacting on lack of motivation.*
- *To assist* [*Mr SUA*] *in claiming and receiving his benefits as soon as possible.*
- *To provide support in abstaining from cannabis. To invite* [*Mr SUA*] *to attend a group concentrating on cannabis use and psychosis in THEIS.*
- *To encourage* [*Mr SUA*] *to become more independent of his mother whilst not increasing his cannabis use."*

This 2007 care plan was of good quality. It identified almost all of the activities necessary to provide effective care and treatment to Mr SUA. The only omission in this 2007 care plan was any reference to Mr SUA's medication management. This should have been a component of the plan. However, as detailed in the previous sub-section 4.2.1.2 (page 34), the Independent Team is satisfied that Mr SUA's care co-ordinator was appropriately mindful of the need to monitor Mr SUA's medication and that this did happen as far as one can reasonably expect non-nursing and non-medical staff to monitor medication.

Independent Team Commentary on the February 2007 Care Plan
The 2007 care plan was documented some six months after the plan created by the home treatment team. Although in terms of time-scales this time period is not unreasonable and meets CPA standards, the care plan of 1 August 2006 should have been reviewed and updated by the early intervention service when it took over responsibility for Mr SUA's case management in September 2006. Although some elements of the home treatment plan retained relevance after the transfer of care responsibility to the early intervention service, it did not reflect the early intervention management plan for Mr SUA. However, it is clear from the clinical records that Mr SUA received regular contact from early intervention staff and that there was an appropriate care strategy for him. The following provides a commentary on this.

Part 1 of the care plan
This section of the care plan was intended to provide an overview of the service user, and evidence that the care plan and care planning options have been discussed with the service user. Commonly, this section is also used to provide a historical overview of the service user's historical and contemporary situation.

Although what was documented was reasonable and provided an overview of how Mr SUA came to be on the early intervention caseload and his situation at that time, it did not detail a précis of the situation for Mr SUA in 2007, nor did it set out in brief what had changed for Mr SUA, if anything, since August 2006. It is the perspective of the Independent Team that it would have been helpful to other practitioners involved with Mr SUA if this had been recorded.

Part 2 of the care plan
Overall this was a good care plan. All of the care plan goals noted were relevant for Mr SUA. Psycho-education was a prominent feature of the planned intervention for Mr SUA and this was appropriate for him.

The three issues that the 2007 care plan did not address were i) the position with regards to Mr SUA finding a new GP; ii) medication management; and iii) working arrangements and communications with Mr SUA's semi-supported housing provider, with whom he had an identified Key Worker.

All of these issues were important and should have been noted. With regards to medication management, this has been addressed at 4.2.1.2. With regards

to the issue relating to the GP and the semi-supported housing provider, it is the Independent Team's understanding that the care co-ordinator simply did not think to put these issues into the care plan. His focus was on the interventions required by the early intervention service. However, the day-to-day records of the team's contact with Mr SUA show that there were regular communications with the housing provider. Section 4.2.2.3 addresses this in more detail (page 75).

Contingency Planning and Crisis Planning

The Contingency Plan:
The contingency plan for Mr SUA was not as complete as it could or should have been.

It said: *"Ongoing regular input aimed at addressing the above items; discussion with* [*Mr SUA*] *re. warning signs of relapse.* [*Semi-supported housing provider*] *also to provide ongoing monitoring and support according to their remit and to remain in close liaison with THEIS."*

This aspect of the plan should have provided more detail about Mr SUA's early warning signs of relapse and measures to be taken once these were in evidence and before a crisis emerged. The early warning signs appeared to have been:

- An increase in the distress caused to Mr SUA by his voices.
- Re-emergence of confrontational behaviour.
- An increase in cannabis use.
- A decrease in medication or disengagement with medication.
- Non-attendance at planned contacts with the early intervention service.
- Non-availability with regards to phone contact.
- Long periods of absence from his residence, and him not residing with his mother or uncle.
- Increasing concern raised by Mr SUA's mother.
- Any notable change in behaviour.

The crisis plan should have set out clearly what actions were required if a collection of the above features materialised. Such a plan should have included Mr SUA's mother and what she was to do if she identified any of the above. The then East London and the City Mental Health Trust's CPA policy in use at the time set out clearly the intent of contingency and crisis plans. In this case, a component of any contingency or crisis plan would have been escalation of the service user through the early intervention service traffic light system and discussion at the weekly clinical team meeting.

The Crisis Plan:
Mr SUA's crisis plan was set out in two parts: the signs constituting a crisis and the agreed service response.

The signs of what was expected were documented as:

- increase in frequency and severity of Mr SUA's symptoms;
- increased social withdrawal and isolation; and
- increased lack of motivation.

The omission as above was disengagement from the early intervention service.

As stated, the documented service response to the above was not adequate. It constituted a list of services to contact, but no contact numbers; and also to contact Mr SUA's mother and uncle, but no contact numbers. The documented service response does not show that Mr SUA's care co-ordinator had thought through what to do if Mr SUA relapsed, or was not available for assessment.

Overall Comment on the quality of Mr SUA's Care Plans
Although the Independent Team has identified aspects of Mr SUA's 2007 CPA care plan that could and should have been more complete, overall it constituted a reasonable plan. The level of detail for the most part was good and the Independent Team knows that if a cross-section of care plans was taken from a range of mental health providers and assessed for completeness and usefulness that Mr SUA's care plan would, on the balance of probabilities, be with those care plans considered to be of better quality. However, in hindsight, had the document been more complete and thoroughly thought out, it may have prompted different actions by Mr SUA's care co-ordinator when he (Mr SUA) disengaged from the early intervention service in May 2007.

4.2.1.4 *Was the care and treatment of Mr SUA reasonable in respect of the quality of risk assessments undertaken?*

Summary: Mr SUA's risk of harm to others and harm to self was assessed to be low. On the basis of the information contained within the clinical records and interviews conducted with early intervention staff, the Independent Team considers the risk level associated with Mr SUA by staff to have been reasonable. In terms of the risk assessments undertaken, there were three in total: two assessments prior to Mr SUA's acceptance by the early intervention service and one at the end of Mr SUA's first six-month period as an early intervention service patient. The Independent Team considered that an interim risk assessment should have been undertaken in September 2006 when Mr SUA reported feelings of persecution and the voices he experienced telling him to harm others. The Independent Team also considered that, although adequate, the risk assessment of February 2007 should have reported on risk issues identified in the 2006 assessments and set out in more detail the assessment of risk in relation to Mr SUA's voices and his likely response to these. However, the Independent Team does not believe that, had the assessment been more complete, it would have made a material difference to the management plan for Mr SUA.

A review of Mr SUA's clinical records showed that the following assessments were undertaken between July 2006 and June 2007:

- a full needs assessment - 27 July 2006;
- a risk screening was completed - 27 July 2006;
- a risk 'checklist' form was completed - 1 August 2006; and
- a Clinical Risk Assessment and Management Part 1 was completed - 20 February 2007.

The Full Needs Risk Assessment (July 2006)
This contained good quality information and identified that Mr SUA:

- was suspicious;
- had tactile and auditory hallucinations. (Tactile hallucinations were noted as *"things moving inside my head, blood gushing"*; audio were noted as *"several female voices telling him weird things - nothing of a command nature".)* Both symptoms were noted to reduce after 10mg of Olanzapine and a good night's sleep;
- had no thoughts of suicide, but had isolated himself from friends
- had identified that there had been some reference to *"head butting"* on the referral form to the home treatment team;
- had plans to return to college;
- had reported stopping cannabis 2 months ago; prior to this he was smoking 9 joints per day. He had used from the age of 12 years. Mr SUA also reported smoking a joint a few days prior to his A&E attendance. A urine drug screen showed no evidence of illicit substances (25 July 2006);
- had first presented for home treatment on 25 July 2006 and stated that he was living in a *"temporary hostel/bedsit"*, sharing with another who used cannabis and played loud music. (The loud music was evident at the assessment);
- Mr SUA had a good relationship with his mother; and
- had no history of trouble with the police.

The Risk Screening document dated 27 July 2006
This identified that:

- there was no known history of violence and aggression for Mr SUA;
- this was Mr SUA's first contact with mental health services and his history was largely unknown.

The risk screening form also identified that there were *"active symptoms that indicated increased risk of harm to self or others".* These factors were noted to be:

- first presentation;
- distracted;
- preoccupied; and
- guarded.

The assessor noted that the risk assessment needed to be reviewed when Mr SUA was more settled, and when more information was available.

This Risk Checklist also noted that Mr SUA's mother had concerns about her son, but not in relation to risk of harm to self or others but with regards to his symptoms and his potential prognosis.

The Independent Team noted that the assessor did not tick either of the boxes that directed whether or not further risk assessment was required. However, the content of the risk screening strongly suggested that further assessment was required.

The Risk Checklist dated 1 August 2006
This second Risk Checklist was completed as planned, three days earlier. Its content reflected that recorded on 27 July. However, there were a number of notable differences.

These were:

- Mr SUA's mother reported that he was suspicious towards strangers and had confronted three people in the week prior to 28 July.
- That female staff had reported that Mr SUA stared at them for an uncomfortable length of time - they reported feeling uneasy with this.

The assessment also repeated the earlier information that Mr SUA denied *"any past history or current concerns regarding violence and aggression".*

This form did not indicate whether a more detailed risk assessment was required, in all probability because:

- at this stage all available information had been elicited;
- the plan was for daily home treatment contact and ongoing assessment; and
- the plan was for transfer of care to the early intervention service.

The Risk Assessment of 20 February 2007
This risk assessment was completed as part of the Care Programme Approach review process.

This assessment was undertaken by Mr SUA's care co-ordinator and noted:

- No known history of violence and aggression;
- No known arrests;
- No known history of preoccupation/obsession with weapons;
- No known history of arson;
- No known history of threats to kill or harm others;
- No present or past suicidal ideas, planning or intent;

- A previous history of head banging, but that Mr SUA reported that *"he stopped this behaviour in November 2006".*
- A history of heavy cannabis use since *"12 years of age. Stopped using at 15 years when he returned to Cuba for 9 months. Resumed use back in the UK. ... Has consistently denied use for the past 9 months. Drug use vague and slightly contradictory."*
- No known history of disengagement from mental health services, but Mr SUA *"frequently forgets about arranged appointments and is not present when visited at his flat by health care professionals."*

In response to the specifically posed question "Are there any active symptoms that indicate an increased risk to self or others?", the care co-ordinator noted: *"*[*Mr SUA*] *is frequently troubled by auditory hallucinations which at times cause him to feel angry. However, he has no history of harm to himself or others and no history of intent."*

The risk form also noted that Mr SUA *"has consistently denied use of cannabis for approximately 9 months.* [*Mr SUA*] *has an extremely supportive mother with whom he spends a great deal of his time."* It was also noted that his mother had *"recently acquired a full-time job, the impact that the inevitable reduction in time she has available to spend with* [*Mr SUA*] *is as yet unclear."*

The Management Plan stated that Mr SUA:

- *"has been receiving weekly visits from THEIS*[6] *and will continue to do so.*
- *will be monitored and assessed as part of his CPA agreement.*
- *will be encouraged and assisted in his desire to find a suitable training course/job."*

Independent Team comment

The brief risk assessments undertaken by the home treatment team in 2006 were reasonable and accomplished all that could be expected when Mr SUA was a relatively unknown entity to mental health services. The decision to repeat the brief assessment after Mr SUA had received a few days of anti-psychotic medication was a good one, and did reveal further significant information about Mr SUA's deterioration in behaviour when unwell, namely the confrontation with three individuals. All of this information was available to the early intervention service.

With regards to the more fulsome risk assessment documented in February 2007, the Independent Team considered this to be adequate. It did identify key issues about which all staff providing care and/or treatment to Mr SUA needed to be aware and it also referred to the previously reported 'head

[6] Tower Hamlets Early Intervention Service.

banging' behaviour which Mr SUA reported having stopped in November 2006.

However, there were gaps in the risk assessment document.

It is the contention of the Independent Team that it should have:

- been updated as early as September 2006, following Mr SUA's report that he feared someone might stab him;
- set out the situation in relation to the previously reported incident of verbal aggression towards others in July/August 2006;
- set out the change in Mr SUA's demeanour towards women. When he was an in-patient, female staff had reported that he stared at them for an uncomfortably longer period of time. This behaviour had not continued following discharge from in-patient services;
- focused more on Mr SUA's reported voices and the potential reactions he may have to these. It is documented in the records that Mr SUA's voices did cause him anger and irritation. For completeness, the perceived risk associated with the voices and the potential response of Mr SUA to these, based on the care co-ordinator's knowledge of this, could and should have been set out.

Because of the gaps in the risk assessment document, and the lack of updated risk profile in September 2006, the Independent Team did explore risk perception and risk management with the early intervention service staff directly involved in the care and treatment of Mr SUA. It was clear from all interviews that Mr SUA was considered by all staff to be of low risk of harm to others and self. The team's then consultant psychiatrist considered him to be sufficiently low risk that a 'green' traffic light rating was considered appropriate in February 2007, even though Mr SUA remained symptomatic.

Mr SUA's care co-ordinator provided open and detailed information about how his risk impressions were formed.

With specific regard to the record risk assessment dated 1 August 2006 and the reference to Mr SUA confronting three other persons, Mr SUA's care co-ordinator told the Independent Team that, to his knowledge:
"the confrontation was mentioned only in the Risk Assessment completed by the home treatment team CPN on 01/08/06 and was received by 'THEIS', and [*also*] *noted on a continuation sheet dated 28/07/06.* [*The CPN*] *noted that* [*Mr SUA's*] *mother reported that '*[*Mr SUA*] *appears suspicious towards strangers and confronted three people in the week prior to the 28/07/06'."*

The care co-ordinator told the Independent Team that the specifics of the incident were never clear. For example, did Mr SUA confront three individuals on one occasion? The Independent Team accepts this; however, if the early intervention service staff had been unclear about the significance of Mr SUA's behaviour, as reported by his mother, then they should have further explored this with her and made sure they properly understood what she had told them.

Mr SUA's care co-ordinator also informed the Independent Team that, subsequent to the report by Mr SUA's mother, there was no confirmed actual physical aggression shown by Mr SUA or that he had ever caused anyone any harm. In fact, 'no harm' is consistently noted on all risk-related documentation.

The perceived low risk associated with Mr SUA is also confirmed by the in-patient Discharge Summary. This noted that, prior to this episode of mental ill health, *"*[*Mr SUA*] *was very easy-going, always laughing and smiling, had lots of friends, was very popular, and was 'never aggressive or argumentative'."*

The early intervention service consultant psychiatrist's initial assessment letter dated 11 August 2006 also stated: *"There is no history of violence to others. … There is no hostility in his manner. … He denied any suicidal or homicidal ideation …".*

Mr SUA's care co-ordinator told the Independent Team: *"in the absence of any specificity about the kind of risk he* [*the consultant psychiatrist*] *was highlighting, I took his concluding comment, that* [*Mr SUA*] *'is currently at high risk due to his positive and cognitive symptoms', not to refer to any risk for aggression or violence (because this would have constituted a contradiction), but to refer to a risk for deterioration in mental state."*

The then early intervention service consultant psychiatrist during the Trust's internal investigation is reported to have said:
"I thought [*Mr SUA*] *was risky because he was young, known to misuse substances, aggressive towards mother, passivity and thoughts of harming others. Based on all this information, he should have been in the red. How he got to green is questionable."*

However, when his perspective was explored by the Independent Team, it appears that these thoughts were early formulations based on his August 2006 assessment. Furthermore, there is no evidence in any other 'Trust' interview, and no data in Mr SUA's records, to support the assertion that Mr SUA was aggressive towards his mother. Following the CPA review in February 2007, it is clear that the consultant psychiatrist no longer considered Mr SUA to be 'high risk'. This is evidenced by the following extract from the Independent Team's validated interview record:
"Mum gave information at the CPA review. She revealed that [*Mr SUA*] *felt more optimistic, he said the medication was helpful and he was keen on taking it. At that point there was no indication that there was any high risk element for* [*Mr SUA*]*. To best of* [*the consultant psychiatrist's*] *recollection, the care co-ordinator indicated that* [*Mr SUA*] *was being seen regularly, that accommodation was suitable, that he was hoping to go to college, etc – the road to recovery seemed to be going in the right direction. From that review – it did not appear that there were high risk issues on the basis of the information he had."*

The early intervention service consultant psychiatrist was asked about the voices that Mr SUA continued to experience and the extent to which these

would have been explored in the CPA review and in relation to risk. He told the Independent Team that:
"This is not the forum for detailed examination, but they would have been discussed with a focus on how much distress resulted and how much they impaired functioning."

Further clarity was sought in relation to risk from the early intervention service consultant, which revealed that the consultant psychiatrist had a view that Mr SUA was "high risk when unwell" as a consequence of reported assaultive behaviour. However, when not in relapse he did not have this consideration.

The letter written by the consultant after his assessment of Mr SUA on 9 August states:

- "No risk of violence to others";
- "There is no hostility in his manner";
- "He denied any suicidal or homicidal ideation";
- "There is no evidence of impulsivity or grandiosity".

Nowhere does the consultant refer to assaultive behaviour, and nowhere in the records is such behaviour recorded. The Independent Team, in its effort to ascertain whether or not there was an evidence base for the consultant psychiatrist's memory recall, therefore asked the care co-ordinator for his perspective.

Mr SUA's care co-ordinator told the Independent Team that:
"In the process of my own initial joint assessments of [*Mr SUA*]*, conducted with* [*the assistant psychologist*] *and with* [*Mr SUA's*] *mother present, the latter (*[*Mr SUA's*] *mother) reported one incident, occurring (as far as I can recall) as she and* [*Mr SUA*] *made their way to A&E, of* [*Mr SUA*] *engaging in a verbal altercation with three males, with no violence arising and the situation abating quickly. My impression at the time was that* [*Mr SUA's*] *mother had mentioned this sole item as an example of how out of context the behaviour was and in the context of concernedly agitating for Care."*

Mr SUA's care co-ordinator also told the Independent Team that:
"My own impression when translating the [*home treatment CPN's*] *(and others' prior) assessment(s) into the Care Plan I then produced was as follows:* [*Mr SUA*] *was a young male from an ethnic minority working-class background, growing up in the adverse social environments of east London; that these sole references to an instance of possible Risk behaviour were vague; that the incident itself appeared limited to a verbal altercation only in which* [*Mr SUA*] *apparently was not the instigator and simply responded to culturally normative barracking from peers in the street; that it occurred in the context of apparent onset of illness, and was outweighed by several other professionals' references to a premorbid absence of Forensic history, a historic lack of aggression and hostility, and an oft-reported generally easy-going, friendly personality – appeared quite remarkable and to indicate, if anything, a very lack of risk when compared with the history and personality of*

many other of our service users who had gone on to present as low risk throughout their careers with the service. I deliberated over whether or not to include this feature of [*the home treatment team's CPN's*] *assessment in the Care Plan I produced, and decided that, given the above, it would seem unnecessary and inaccurate to contribute to having* [*Mr SUA*] *viewed thereafter as a risky individual in the context of the above-reported available information and professional impressions."*

Mr SUA's care co-ordinator also said: *"With hindsight, and following further Risk training since, I have come to recognise that it would nonetheless have been helpful if I had reported verbatim* [*the home treatment team CPN's*] *observation, while also contextualising it – albeit I genuinely believe that my reporting such, then, would not have changed the actual Care Plan in any way."*

The Independent Team also interviewed the staff-grade psychiatrist who took over the medical management of Mr SUA from September 2006. This professional confirmed to the Independent Team that, in his opinion, Mr SUA was of low risk of harm to self and harm to others. The staff-grade doctor also told the Independent Team that, when he assessed Mr SUA on 6 September 2006, he would not *"admit or deny harm to others at this stage. He was in the Red zone at this time, as are all new service users to THEIS."*

Letters he wrote included: *"the risks are currently low"* (in his letter of 6 September 2006); *"risk remains low"* (in his letter of 27 September 2006); and *"*[*Mr SUA*] *is in late recovery from his schizophrenic illness … and the risks are low"* (in his letter of 20 February 2007, documenting the CPA Review led by the consultant psychiatrist).

With regards to Mr SUA's voices, the staff-grade psychiatrist told the Independent Team that:
"[*Mr SUA told him that*] *the voices were a mixture of funny things and bad things, the voices were male and female.* [*Mr SUA*] *said the voices were worse outside;* [*Mr SUA*] *felt safe with his mother."*

The Independent Team asked the staff-grade psychiatrist whether he asked Mr SUA "*how he was keeping himself safe from the voices when they were threatening, and/or persecutory?".* The staff-grade told the Independent Team that:
"We did explore the voices and the paranoia with him. Initially, he only spoke of the voices and said his paranoia was better, but subsequently told us that the paranoia was still there but not as much and it was the same with the voices. His way of dealing with both was avoidance and he told us specifically that he did not have any arguments or confront anyone and his way of dealing with it was staying at home mainly."

Mr SUA's care co-ordinator, when asked about the exploration of Mr SUA's voices in the context of risk assessment and risk management, said:
"Risk was assessed generally. ... Risk around voices was assessed through regular exploratory discussion of voices at appointments with [*Mr SUA*]*, and*

he reported no command hallucinations and [*was*] *not engaging in altercations with people in the context of voice material. Strategies for managing the voices were explored."*[7]

When asked about Mr SUA's voices, the consultant psychiatrist told the Independent Team that:
"someone who hears voices can be in late recovery and can be in the green zone. It depends on what else is going on. On balance [*for Mr SUA*] *there was sufficient information for* [*Mr SUA*] *at the February 2007 CPA review for him to be in the green zone. He was functional and in recovery, he was not acutely unwell and non-functional."*

Overall Opinion of Independent Team with regards to Risk
On the basis of all of the information contained in Mr SUA's clinical record, the Trust's original interview data, the pre-interview information provided to the Independent Team by the then early intervention service staff, and the information gathered via the Independent Team 's interviews with staff, the strength of documented evidence regarding Mr SUA's pre-early intervention service behaviours rests with the perspective of the care co-ordinator and other early intervention staff who reported an assessment of low risk associated with Mr SUA, and not the recollection of the early intervention consultant psychiatrist who recalled assaultive behaviour by Mr SUA. There is no provided evidence to support this.

Consequently, the Independent Team considers that the consultant psychiatrist should have stated more clearly what he meant when he wrote: *"*[*Mr SUA*] *appears to have had a first presentation of a Paranoid Schizophrenic illness and is currently high risk due to his positive and cognitive symptoms".*

The wording is ambiguous and open to interpretation, particularly as there was no documented evidence of potentially high-risk behaviours.

[7] Note: the following section 4.3 sets out in more detail the quality and scope of the care contacts with Mr SUA, including work undertaken with him on his voices.

4.2.2 *Was The Care Actually Delivered To Mr SUA of a Reasonable Standard In Terms Of:*

- the frequency and quality of contacts;
- compliance with the early intervention escalation policy (i.e. the traffic light system);
- communication with other agencies; and
- communication and involvement with Mr SUA's mother?

Summary: The Independent Team found that the frequency of contacts with Mr SUA was reasonable up to and including 13 April 2007; thereafter followed a prolonged period of no face-to-face contact that was not followed up assertively enough. With regards to the quality of contacts, the contents of the clinical records and the verbal information provided at interview suggest a reasonable to good quality of contact with Mr SUA.

With regards to the adherence to the Traffic Light policy, the Independent Team found a lack of documentation supporting claims of adherence to this. Furthermore, from May 2007 there was a complete lack of adherence to the principles of the Traffic Light system.

Communication with the semi-supported living provider was, in the opinion of the Independent Team, adequate up to end April 2007. From May to June 2007 it could and should have been more assertive.

Communication with Mr SUA's mother was good up to and including February 2007. Between April and June 2007 it was notably absent.

4.2.2.1 *The frequency and quality of contacts between the early intervention service and Mr SUA*

The following table sets out the contact the early intervention service had with Mr SUA in the period 17 August 2006 through to 9 June 2007:

Date	Nature of contact	Successful or unsuccessful	Grade of staff
17 August	Face-to-Face	Successful	care co-ordinator and assistant psychologist [1]
25 August	Face-to-Face	Successful	care co-ordinator and assistant psychologist [1]
31 August	Face-to-Face	Successful	care co-ordinator and assistant psychologist [1]
6 September	Face-to-Face	Successful	Staff-grade psychiatrist, the home treatment team, social worker and assistant psychologist [1]

Date	Nature of contact	Successful or unsuccessful	Grade of staff
11 September	Telephone	Unsuccessful – Mr SUA had given his phone to a friend	assistant psychologist [1]
15 September	Face-to-Face	Successful	care co-ordinator and assistant psychologist [1]
19 September	Telephone	Successful	care co-ordinator
20 September	Face-to-Face	Successful	care co-ordinator and assistant psychologist [1]
26 September	Face-to-Face	Successful	Staff-grade psychiatrist, assistant psychologist [1] and Mr SUA's mother
21 October	Face-to-Face	Successful (unplanned)	care co-ordinator and Mr SUA's mother
3 October	Face-to-Face	Successful	care co-ordinator
10 October	Face-to-Face	Successful	care co-ordinator and an early intervention service student nurse
16 October	Face-to-Face	Successful	care co-ordinator and assistant psychologist [1]
25 October	Face-to-Face	Successful	assistant psychologist [1] and a trainee psychologist
3 November	Face-to-Face	Successful	assistant psychologist [1] and a trainee psychologist
10 November	Face-to-Face	Unsuccessful	trainee psychologist
17 November	Face-to-Face	Unsuccessful	trainee psychologist and care co-ordinator
22 November	Telephone	Unsuccessful	trainee psychologist
24 November	Face-to-Face	Unsuccessful	care co-ordinator

Date	Nature of contact	Successful or unsuccessful	Grade of staff
29 November	Face-to-Face	Successful	care co-ordinator and trainee psychologist
6 December	Face-to-Face	Successful (following phone call)	trainee psychologist
12 December	Face-to-Face	Successful	trainee psychologist and Mr SUA's uncle
21 December	Face-to-Face	Successful	trainee psychologist
3 January 2007	Face-to-Face	Unsuccessful	trainee psychologist
10 January	Face-to-Face	Unsuccessful (reported to be in Cornwall)	trainee psychologist
16 January	Telephone	Successful – home visit rearranged	trainee psychologist
23 January	Face-to-Face	Unsuccessful	trainee psychologist
30 January	Telephone contact with mother	Successful	trainee psychologist
7 February	Face-to-Face	Unsuccessful (in Manchester)	care co-ordinator and trainee psychologist
9 February	Telephone	Successful	care co-ordinator
13 February	Face-to-Face	Successful	trainee psychologist
20 February	CPA	Successful	Staff-grade psychiatrist, consultant psychiatrist, care co-ordinator, trainee psychologist, Mr SUA's mother and Mr SUA
7 March	Face-to-Face	Successful	trainee psychologist
13 March	Face-to-Face	Successful	trainee psychologist, care co-ordinator, key worker from housing provider
2 April	Face-to-Face	Successful	trainee psychologist
13 April	Face-to-Face cancelled by care coordinator	NA	care co-ordinator
18 April	Face-to-Face	Unsuccessful	care co-ordinator

Date	Nature of contact	Successful or unsuccessful	Grade of staff
30 April	Telephone to invite Mr SUA onto a psycho-education group	This contact is not treated as a 'successful contact' as no therapeutic content	assistant psychologist [2]
3 May	Face-to-Face	Unsuccessful	assistant psychologist [2]
8 May	Face-to-Face	Unsuccessful	assistant psychologist [2]
8 June	Telephone	Unsuccessful	care co-ordinator

Note: The planned contacts of 3 May and 8 May were not components of the required 'weekly' contacts as stated as required at the end of Mr SUA's CPA review on 20 February 2007. The psycho-education group was 'in addition to' and not 'instead of' these contacts.

Before setting out the Independent Team's perspective about the frequency and quality of contacts between Mr SUA and the early intervention service, it is important that the reader understands the following:

- In 2006 the qualified early intervention staff, including the clinical psychologist, became care co-ordinators as defined within the context of the Care Programme Approach.
- Assistant psychologist [1] and assistant psychologist [2] were unqualified staff with a degree in psychology but no specific mental health qualification. They held no accountability for service user management and worked under the direct supervision and instruction of a service user's care co-ordinator.
- Assistant psychologist [2] was not, as far as the Independent Team can deduce, assigned to work on a 1:1 basis with Mr SUA after the trainee psychologist left the team. It is the understanding that the clinical psychologist, Mr SUA's care co-ordinator, was to deliver the required components of Mr SUA's care plan.
- The trainee psychologist was a graduate psychologist, undertaking a period of formal doctoral-level study and training at an accredited training organisation. Undertaking clinical placements, as in this instance, required supervised practice under the direction of a qualified clinical psychologist. This post-holder worked under the direct supervision of Mr SUA's care co-ordinator. A trainee psychologist would not be expected to take on any care co-ordination responsibilities.

Frequency of contacts

Care Co-ordinator Attendance

Where a care co-ordinator is assigned to a service user, generally one expects this individual to be present at a significant proportion of planned contacts with the service user.

In this case, between September 2006 and June 2007 Mr SUA's care co-ordinator was present at 68% of all successful face-to-face contacts with Mr SUA. Although the Independent Team is not aware of any specific guidance regarding the ratio of visits a care co-ordinator should be undertaking when other team members are engaged with a service user, it had expected the ratio to be higher than it was. The Independent Team recognises that there may be different models of care co-ordination. One such model is that the care co-ordinator acts as a 'broker' for the care the individual patient receives, reviewing this periodically and re-assessing the needs of that patient. This does not necessarily require that the care co-ordinator does all or even most of the face-to-face work with the patient. However, the Independent Team found no evidence that the clinical service operated this model of care co-ordination, and noted that the expectations of the care plan were that the majority of the care objectives would be the responsibility of the care co-ordinator.

When the Independent Team looked at the ratio of care co-ordinator attendance when the assistant psychologist (i.e. an untrained worker) was working with Mr SUA, the care co-ordinator was present at all, bar three, face-to-face meetings with Mr SUA. Of the three meetings the care co-ordinator was not present, two of these were medical reviews attended by the staff-grade psychiatrist for the early intervention service. The Independent Team considers that this was acceptable and constituted a percentage attendance rate by the care co-ordinator of 75% over this specific period of time.

The gap in care co-ordinator attendance arose after 25 October, when a trainee psychologist took over from the assistant psychologist. Of the 11 successful face-to-face contacts achieved between 3 November and 2 April (approximately 20 weeks), Mr SUA's care co-ordinator was present at four of these, i.e. 36.3%. This was not acceptable. The care co-ordinator carried total responsibility for the case management of Mr SUA and should have been present at more of the face-to-face meetings with the trainee psychologist. The Independent Team appreciates that ordinarily a clinical psychologist does expect more from a trainee psychologist, and part of the supervision role is to prepare them for the range of work they are likely to undertake post-qualification. However, the care co-ordination role was new to Mr SUA's care co-ordinator and consequently he should have exercised an enhanced level of diligence when working with the trainee psychologist between November and the end of March 2007.

The Independent Team did ask Mr SUA's care co-ordinator what the normal expectation was in relation to joint visits to a service user on the trainee's caseload. He told the Independent Team:
"I would always expect to allocate to a Trainee only service users who I and the team have deemed sufficiently low risk, and to accompany the Trainee on some of the visits, both to reassure myself about any safety issues and as part of my ongoing monitoring and assessment of the Trainee. Prior to his/her taking on a case, I would always discuss the case in detail and assess the Trainee's thoughts and feelings about the allocation; thereafter I would always discuss in supervision her/his thoughts and feelings about ongoing contact with the service user and about conducting home visits."

The Independent Team did request access to the trainee psychologist's supervision records; however, in keeping with good governance practice, the Independent Team was informed that these records had been destroyed when the trainee concluded her trainee placements with East London and the City Mental Health Trust. There would have been no good reason to store them as they did not form a component of the patient record. For the purposes of this investigation, it did mean that the Independent Team could not validate the robustness of the trainee psychologist's supervision.

General commentary on the frequency of contacts with Mr SUA
It is clear from the table above that, between September and 3 November 2006, contact with Mr SUA was good. There then followed a series of three planned appointments that Mr SUA did not attend. In line with the Traffic Light System in place at the time, Mr SUA should have been placed on the 'Red' level and his management discussed at the next discussion of 'code Red' service users (there was daily opportunity for this) and again at the next available weekly clinical team meeting. There is no evidence that any such discussion occurred or that Mr SUA was escalated by the care co-ordinator on 24 November. Adherence to the traffic light system was not dependent on individuals; it was expected that all staff adhered to the policy guidelines. (Section 4.2.2.2 (page 68) sets out in more detail how the traffic light system worked.)

Between 24 November and 21 December, contact with Mr SUA was again good, followed by a period of four unsuccessful visits between 3 January and 7 February. During this period of unsuccessful face-to-face contacts, two telephone contacts were achieved that informed staff that Mr SUA was in Cornwall on holiday on one missed contact and in Manchester with his mother visiting family on the other (7 February). Mr SUA was also noted to have apologised for forgetting his planned appointment on 7 February. Successful contact was then achieved on 9 February.

Technically, the recurrence of non-contact with Mr SUA should have resulted in him being escalated through the Traffic Light System and discussed at the daily traffic light meeting and the weekly early intervention service clinical meeting. As previously, there is no evidence that such discussions were conducted. The Independent Team, however, does note that now (2011) the Traffic Light Policy does not automatically include missed appointments

caused by holiday and family visits, etc, as 'missed appointments' contributing to automatic escalation through the traffic light zones.

After 9 February there were six successful contacts with Mr SUA, ending on 2 April 2007. Thereafter, there were no face-to-face contacts with Mr SUA, and only one telephone contact on 30 April. The incident occurred on 9 June 2007.

The lack of contact with Mr SUA, and the lack of evidence of assertive effort to make contact with Mr SUA, appears to have coincided with the trainee psychologist leaving the early intervention service, presumably for her next training placement. Assistant psychologist [2], who is recorded as making successful telephone contact with Mr SUA, was an unqualified worker and there is no available information to suggest that she had been assigned to Mr SUA's care. In contrast to the handover between assistant psychologist [1] and the trainee psychologist, there is no evidence of a formalised handover of care to any professional when the trainee psychologist left the service after 13 March 2007. There should have been a clearly documented handover between this professional and the care co-ordinator at this time, and the ongoing management plan, including frequency of face-to-face visits, notated.

It is the Independent Team's perspective that the lack of assertive follow-up of Mr SUA by his care co-ordinator after 8 May represents a significant lapse in Mr SUA's care.

Why was Mr SUA not more assertively followed up?
Mr SUA's care co-ordinator told the Independent Team that he:
"was not unduly concerned until the final month of [*Mr SUA's*] *absence. This was a service user with a history of erratic contact, a very laid back approach and had not as yet presented with any apparent risks. He also appeared to be significantly improving at the CPA in Feb. He was going to be engaging in a college course a couple of days a week. His* [*the care coordinator's*] *concern was therefore deferred. He was, however, relieved when* [*assistant psychologist [2]*] *made contact with him. The creeping anxieties were appeased to some extent by this. However, in the final month he was more concerned – he was aware that he really needed to have some contact. He was leaving messages for* [*the semi-supported housing provider's key worker*] *–* [*The care co-ordinator*] *wanted to know how and where* [*Mr SUA*] *was."*

The care co-ordinator also told the Independent Team that:
"his documentation [*had*] *slipped off – and in this case it was the less substantive contacts and activities he was doing,* [*that*] *didn't get recorded. He was under tremendous pressure at the time re end of his* [*CBT*] *Diploma course.*
He [*did*]*, however, recall that he brought* [*Mr SUA*] *up at the team meeting, that he hadn't seen* [*Mr SUA*] *for some time – there was no particular alarm in the team that he could detect. However, he now knows that he should have used the traffic light system and ramped his concern up through that.* [*The care co-ordinator*] *acknowledges that he should have been using it more dynamically. However, at the time he saw it more as a tool for mapping*

historical risk and how it is reflected in the present. He accepts he could definitely have used it better – he is sorry with hindsight that he didn't."

The Independent Team accepts the explanation provided by the care co-ordinator, and the team's usage of the traffic light system is explored more fully in the following sub-section (4.2.2.2 (page 68)). However, the Independent Team was surprised that Mr SUA's care co-ordinator did not make better use of the relationship he had built with Mr SUA's mother, in the month preceding the incident. When asked about this, he told the Independent Team that:
"The service's experience was that [*Mr SUA's*] *mother was closely involved in his* [*Mr SUA's*] *care, saw him very regularly, had a very good relationship with our service and had agreed always to contact us if there were concerns. I am not aware of our ever having contact details for* [*the uncle*] *or his ever contacting us. In addition,* [*Mr SUA's*] *Key worker at* [*the housing provider*] *and other Staff at* [*the housing provider*] *were aware of our ongoing involvement, and* [*the key worker*] *had agreed to liaise with us closely, and to contact us if he had any concerns."*

The Independent Team does believe that the care co-ordinator attempted to make meaningful contact with the supported housing provider; however, it considers the rationale for not making proactive contact with Mr SUA's mother and uncle insufficient. The care co-ordinator had a duty to satisfy himself that Mr SUA was not relapsing and that this was not the cause of his lack of contact. To take assurance from a lack of contact made by Mr SUA's family is not what one expects from a highly qualified professional. The extent to which Mr SUA would or could relapse remained an unknown quantity. It does not appear to have entered into the care co-ordinator's thinking that the reason for the lack of contact could have been a re-emergence of Mr SUA's drug usage and mental health relapse.

It was established after the incident that this is precisely what had occurred in the four to six weeks pre-dating the incident. It transpired that Mr SUA had been resident with his mother for a significant portion of this time. The implications of this information, coupled with how the early intervention service, on the balance of probabilities, would have managed Mr SUA over this period had he been escalated through the traffic light system as he should have been, are detailed in section 4.2.2.3 (page 75).

The Independent Team could not find any evidence of the care co-ordinator having raised his concern about Mr SUA at any clinical team meeting. However, this is not altogether surprising; the Independent Team was informed by other staff not involved with Mr SUA's case management that the documentation of cases discussed was not as rigorous then as it is now and discussions were often not documented. The care co-ordinator himself told the Independent Team:
"I suspect that it was a combination of several factors, including: i) my likely delivery of the point (perhaps I could have been more emphatic and urgent), and ii) diverse expectations and practice when it came to the recording of those discussions held towards the end of the Meeting (i.e. those discussions

about service users who were not foregrounded as being in 'red'/'amber'). I am sure that some care co-ordinators were duly diligent and always recorded in the files any discussion they engaged in re. service users on their caseload, whether the discussions were formal/urgent or not. Possibly my understating of the case led to the discussion's not being minuted; possibly the expectation was that the onus was on me to be noting the points in the case file. Because of the pressure of my workload at the time, something had to 'give', and I had to afford priority to recording more-formal discussions and appointments with service users."

Although the Independent Team is quite clear in its thinking about what reasonably should have happened after 8 May 2007 in terms of Mr SUA's case management, it did note the sincerity of the care co-ordinator's reflections on his practice and that he fully embraced his professional accountability for any mistakes he made in the care co-ordination of Mr SUA. The Independent Team did, as alluded to in the Trust's own internal investigation, hear a certain degree of frustration from Mr SUA's care co-ordinator regarding the change in model of work, in particular with regards to the impact that this had on his own day-to-day work. Once the previously named Early Psychosis Service became a formalised Early Intervention Service, with fidelity to the Department of Health's Policy Implementation Guidance, the changes necessary to achieve fidelity and the model introduced by the new clinical lead for the team led to an erosion of the care co-ordinator's professional role as a clinical psychologist, and under-usage of his professional skills. However, the Independent Team did not hear anything that suggested that Mr SUA's care co-ordinator did not take his role seriously, or that he felt inhibited in raising concerns about service users, or that the professional tensions between him and the consultant psychiatrist got in the way of his delivering what he believed was appropriate care and treatment to service users on his caseload. Other staff working in the early intervention team at the time all spoke highly of Mr SUA's care co-ordinator, his normal standard of practice, and his engagement with them as a colleague. His presence and his clinical support to colleagues were valued. Furthermore, the staff-grade psychiatrist was unaware of any professional tensions until after the incident of 9 June. None were detectable by him at any team meeting he attended, which (bar annual leave) was almost all of the meetings.

Issues, however, that did interfere with this were:

- The previously reported lack of appropriate training/supervision to equip the clinical psychologist to embrace his new role as care co-ordinator to the standards required.
- The requirement for him to complete a specialist CBT diploma in order to deliver cognitive behavioural therapy to early intervention service users and the amount of specific case management work this entailed over and above his early intervention caseload.
- His responsibility to deliver professional supervision to the assistant psychologists and trainee psychologists on a frequency of one hour weekly to the assistant psychologist and one and a half hours weekly to the trainee psychologist (with other *ad hoc* supervision of her

as/when required/possible). His responsibilities also included liaising/meeting with the trainee's Course Supervisor to assess/reflect on her progress over the placement. (Note: the requirement for supervision in psychological therapies far exceeds that required in non-psychology disciplines.)

- His lack of clarity about his role and responsibility as a care co-ordinator.
- His inaccurate understanding about how the traffic light system worked.
- His selective approach to the documentation of his interventions with service users on his caseload.
- The ill health of close family.
- A distinct lack of management supervision provided by the then team manager. The care co-ordinator recalls between four and five supervision sessions with him.

With regards to the most significant influencing factors ('root causes'[8]) the Independent Team considers that in this case the most significant influencing factors to the lapse in assertive efforts to achieve contact with Mr SUA after 18 April 2007 were:

- A significant change in model of work for a professional who had been specifically trained as a clinical psychologist and not a care co-ordinator, with an insufficient period of induction into the new role to assure a smooth transition of role, and role expectation (systemic cause).
- The lack of effective management (caseload) supervision (systemic cause).
- The misinterpretation by the care co-ordinator of the traffic light system and how it should be applied. The Independent Team considers this to be unique to Mr SUA's care co-ordinator, as consistency of interpretation was elicited from other interviews in a similar position to Mr SUA's at the time (proximal cause).
- That Mr SUA's care co-ordinator was distracted by other responsibilities and the completion of his CBT diploma (proximal cause).

[8] A root cause is a contributory factor considered to be of greater significance to a problems' causation than others. This 'problem' may be 'the incident' e.g. the wrong medicine was administered to the patient, or it may be a specific issue, or issues, of concern in the care and treatment of the patient that may or may not be linked to the incident that occurred. It is not uncommon to find a cluster of 'root causes', or 'significant influencing factors, that need to be remedied to prevent problem recurrence.

Quality of contacts between the early intervention service and Mr SUA
The clinical records show good quality contacts with Mr SUA. The records made by the care co-ordinator, assistant psychologist [1] and the trainee psychologist were detailed, and set out clearly what had been explored during the face-to-face contacts achieved, including:

- The auditory hallucinations (15/9/06; 20/9; 26/9; 2/10; 10/10; 16/10; 25/10; 3/11; 29/11; 21/12; 13/2/07; 7/3; 13/3; 2/4);
- Mr SUA's experience of paranoia (15/9; 2/10; 3/10; 25/10; 21/12);
- Mr SUA's feelings (15/9; throughout October; 3/11; 29/11; 13/2/07);
- Homicide ideation (15/9; no evidence of any such thoughts after this date);
- Medication (15/9; 20/9);
- Cannabis use (20/9; 29/9; 2/10; 10/10; 29/11; 7/3/07);
- Sleep issues (15/9; 20/9; 26/9; 16/10; 25/10; 3/11; 29/11; 21/12/ 7/3/07; 13/3);
- Activity level (3/11; 29/11; 12/12; 13/2/07; 7/3/07; 13/3); and
- Independence (29/11; 12/12; 21/12; 7/3/07).

The following information provides more detailed examples of the quality of contacts achieved with Mr SUA.

6 October 2006: The care co-ordinator visited Mr SUA at home following a distressed call. Mr SUA had experienced an increase in the intensity of his voices and the voices had become *"highly distressing and louder in volume than he* [*Mr SUA*] *had ever experienced".* The clinical record states clearly that the care co-ordinator and Mr SUA *"contextualised the deterioration. Voices in context of skunk – and I provided* [*Mr SUA*] *with further psycho-education about using skunk, effects on MH, especially after abstinence. We then focused on voices. I provided* [*Mr SUA*] *with psycho-education about voices and we discussed practical strategies for management. ...* [*Mr SUA*] *was very agreeable to experimenting with possible strategies to reduce voices, distress there at."*

The documented plan was to continue with the arranged visit the next day and to continue to work on Mr SUA's experience of voices. The clinical record of 3 October highlights that particular attention was given to discussing and exploring Mr SUA's voices and activities that were beneficial for him in quietening and/or blocking them.

Ongoing work with Mr SUA's voices was detailed in a voice chart that the assistant psychologist completed under the direction of the care co-ordinator.

10 October 2006: The care co-ordinator noted that there were a number of *"notable antagonistic voices ('x-mas tree man', and 'Blanco's bro')"* that had gone, but that two new voices had been introduced. *"Female, approximately 21 years, who was experienced as a low mumble for long periods; male,*

similar age, insulting and swearing. Voices were less frequent in the morning on getting up; still frustrating when trying to get off to sleep."

Interventions to assist Mr SUA manage his voices included the use of his Walkman, going jogging, conversing with others, computer games, music. A "new tactic" was also introduced. The care co-ordinator encouraged Mr SUA to stay up until midnight, rather than going to bed at 9/10pm, so that he was more tired. Once in bed, Mr SUA was to practise relaxation exercises. Going to the library to get "*light graphic novels to read (esp before sleeping)"* was also encouraged.

16 October 2006: The care co-ordinator's and assistant psychologist's record of their meeting with Mr SUA noted the volume of the voices to be 5/10 and the distress caused was around 6-7/10. They also noted that Mr SUA *"engaged well in discussing the context and personal meaning of the voices he"* had been hearing recently. Consequently, it was recorded that Mr SUA *"was finding it disturbing when voices were shouting and insulting him".*
Mr SUA reportedly told both professionals that he was able at times to switch off the voices.

To achieve this, he used a combination of:

- *"concentrating on something;*
- *Stopping breathing;*
- *Tensing (forehead)."*

The clinical record also noted that Mr SUA remembered all of the strategies agreed on at previous meetings with his care co-ordinator and that Mr SUA had found additional strategies of his own. In addition, it was noted that Mr SUA reported taking the care co-ordinator's advice of joining the library.
Mr SUA was encouraged to replace the "stopping breathing" with "slow breaths".

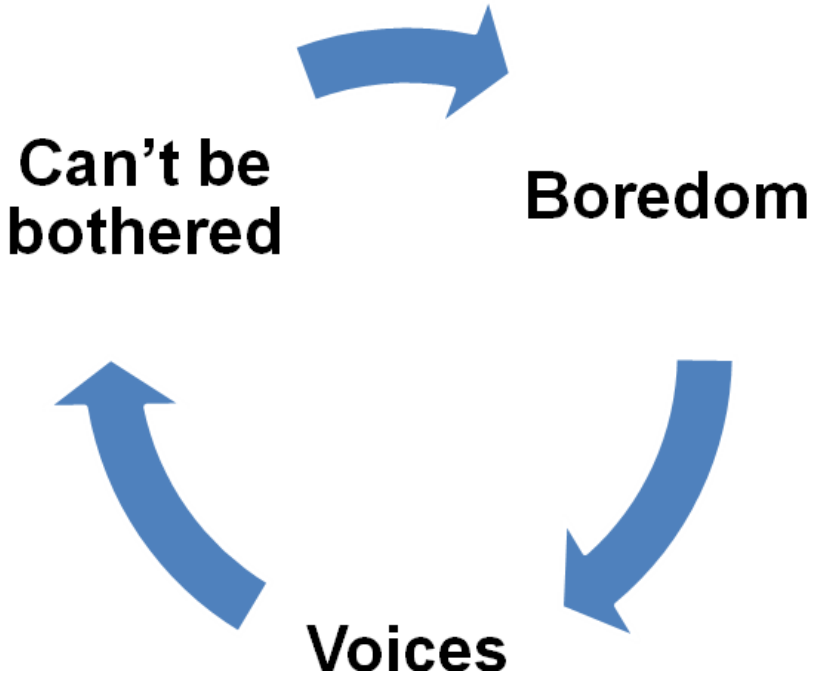
At this visit Mr SUA was advised that assistant psychologist [1] was leaving the early intervention service in the December and that a trainee psychologist would be replacing her. They arranged for Mr SUA to meet the trainee psychologist at their next meeting.

25 October 2006: The clinical records again note that Mr SUA was experiencing no paranoia, and that Mr SUA continued to use a range of distraction techniques to manage his voices. He was noted to have reported as previously that some of the voices made him angry. His main problem otherwise appeared to be boredom during the day. Consequently, a list of activities was complied with him and displayed in his room.

29 November 2006: The record made on this day shows discussion with Mr SUA about his missed appointments and the context of these. It is clear that Mr SUA had a) forgotten the previously planned appointments; and b) had been spending a lot of time at his mother's home. He told the trainee psychologist and the care co-ordinator that he had been applying for courses but was not always getting a response. He also told the trainee psychologist

and his care co-ordinator that he had applied to do a cookery course and was hoping to get some experience in the cafe nearby. He also told these professionals that he enjoyed being at his mother's and described being in his own flat as *"difficult and irritating and linked this to the voices he hears which are easier to deal with at his mum's".* The clinical record sets out at length an ensuing conversation between Mr SUA, the trainee psychologist and his care co-ordinator about managing the voices, and also includes a diagram depicting the *"vicious cycle"* of:

DIAGRAM:



Mr SUA was noted to have told the trainee psychologist and his care co-ordinator that the above was changing and that he was keen to commence a course. The record also noted that *"pros and cons of the level of help he was receiving from* [*his*] *mum"* were discussed. Weekly contact was agreed to enable ongoing exploration of Mr SUA's feelings, level of activity and voices.

21 December 2006: The ongoing frequency and content of Mr SUA's auditory hallucinations was explored. Mr SUA reported no longer hearing three voices; it has increased to five voices. The most frequent is "Chesita". "Chesita" was the only voice noted to cause Mr SUA's distress, because of its frequency and that it disturbs his sleep. *"Blanko he hears every day, but is not bothered by it*". 'Christmas Tree', 'Blanco's Bro', and 'Blue' were all noted to be less frequent. Mr SUA is reported to have said that these voices could be irritating, *"but do not cause stress"* **.**

The trainee psychologist with Mr SUA *"put together a 'tip sheet' of ways to improve sleep"*.

13 February 2007: The record made on this day indicates that some considerable time was spent talking with Mr SUA about his auditory hallucinations, strategies for dealing with these, his emotions and his activity level. At the visit he was noted to be positive, chatty and friendly.

Of particular note was further evolution of his auditory hallucinations and the introduction of "visual perceptual disturbances".

The record noted that:

- Mr SUA's symptoms had not changed: the voices were at the same frequency and volume.
- Mr SUA found the voices easier to deal with when in company.
- Mr SUA had identified two voices he had not heard before – both in their mid-thirties, both sounding angry; but Mr SUA could not recall any specific content.
- The voices made Mr SUA feel angry and annoyed, but they did not frighten him.
- Mr SUA reported *"seeing a blurred dark shape like a tall man every day – sometimes standing up, sometimes lying down. It is usually close to him and sometimes grabs at him."* The record noted that Mr SUA could feel this when he closed his eyes.
- Mr SUA also described seeing a broken bottle, a hanger and a couple of girls coming towards him.
- Importantly, *"all of these images disappear when he looks at them".*
- Mr SUA also reported *"only being able to see things in his mind in shades of grey"* and that he wished *"he could imagine things in colour".*
- Mr SUA had not socialised with any of his friends, but had spent most of his time with his mother and her brother-in-law, commonly referred to as 'Uncle' by Mr SUA.
- Mr SUA was *"notably keen"* to receive information on courses about practical vocational activities such as plastering and provided information that his key worker in his supported housing accommodation was assisting him in accessing opportunities.

Independent Team comment

At this meeting, a distinct change in Mr SUA's auditory hallucinations and the introduction of visual hallucinations was noted. Although it is evident that his experiences were explored with him, there is no evidence that how he might respond to his feelings of anger and irritation were explored. The Independent Team was not able to interview the trainee psychologist, as she was no longer working at the now East London Foundation NHS Trust. However, at interview, neither the assistant psychologist nor Mr SUA's care co-ordinator could recall any explorations at any time with Mr SUA about his possible

reactions to his anger and irritation. They were satisfied by his articulation of how he managed them and his continued efforts (when he remembered) to use distraction techniques. Furthermore, Mr SUA was spending considerable time with his mother and his uncle and the professionals considered that if there had been any deterioration in his behaviours then the early intervention service would have been informed of it. Mr SUA was also considered to be of low risk and his care co-ordinator did not consider it necessary to directly explore further with Mr SUA how he might 'potentially respond' as he was telling him, and the trainee psychologist, that he was managing his voices. Mr SUA revealed nothing to suggest that he had any ongoing thoughts of causing harm to others or that he would behave violently.

The care co-ordinator told the Independent Team that:
"In our ... supervision we would discuss approaches to the voices, and strategies that [*Mr SUA*] *might use to alleviate distress and by which he might come to understand and manage his voices better. To my knowledge, then and now, there was never any indication that* [*Mr SUA's*] *voices led him into altercations with others or to behaving in ways suggestive of risk in the period of our providing care, until that period of disengagement prior to the homicide, when, ... later reports indicated, he became floridly unwell in the weeks immediately prior to the incident."*

The care co-ordinator also told the Independent Team that most of the information he had about Mr SUA after November 2006 was *"by proxy"*, as the main member of staff meeting with Mr SUA was the trainee psychologist.

The Independent Team's Consultant Clinical Psychologist suggests that, for risk and risk management, it can be helpful to involve a service user in considering potential risk scenarios based upon the clinical data that is obtained from the service user. In this instance, this could have included asking Mr SUA to consider his likely emotional and behavioural responses to voices that were perceived as threatening or demeaning, given that it appears that this was his perception of the voices he had heard. Moreover, in at least one instance Mr SUA had attributed a threatening voice to an identified person who visited the accommodation. The potential risk to this individual could have been explored with Mr SUA, and thereby illustrate his possible reaction to such experiences in other contexts. There is no evidence to suggest that Mr SUA's care co-ordinator or the trainee psychologist involved him in the consideration and exploration of risk scenarios.

13 March 2007: This contact involved the trainee psychologist, Mr SUA's key worker at his supported living accommodation and Mr SUA's care co-ordinator. A fulsome record of the range of issues discussed with Mr SUA included:

- This is the first time it is recorded that he did not spend much time with his mother in the preceding week.
- His mother is noted to have moved to a different part of London a few miles away. Mr SUA was noted as having decided that she was too far away to visit.

- That Mr SUA had not completed any of the activities he agreed to last week (not unusual) because he *"couldn't be bothered".*
- The record infers that Mr SUA had smoked cannabis. It says: *"discussed use of cannabis again ...* [*Mr SUA*] *said he wouldn't use it again, but this was said noticeably without conviction".*
- With regards to his symptoms, Mr SUA reported no change, except that when he 'now' heard voices he *"felt compelled to look up at the ceiling".* (There is no explanation why he felt compelled to do this.)
- Mr SUA told the trainee psychologist that he was pre-occupied during their meeting because he had learnt that he was father to a new-born child. He also told the trainee psychologist that he planned to visit the child with his uncle during the coming week.

Independent Team comment
As with previous contacts, it is clear from the record that the trainee psychologist exercised diligence during her meeting with Mr SUA, addressing all key aspects of his care plan. This meeting also constituted a handover of care from this professional back to Mr SUA's care co-ordinator, as 13 March was the last time the trainee psychologist would be attending to meet Mr SUA, as she had reached the end of her placement with the early intervention service.

A number of significant changes for Mr SUA were recorded, namely:

- His mother moving home, resulting in less contact between her and her son.
- Mr SUA believed that he had become a father.

The Independent Team has neither seen nor heard any information that suggests that the impact of these changes for Mr SUA were explored with him. It considers that Mr SUA's feelings about these changes should have been more carefully explored and/or that the trainee psychologist or care co-ordinator made it clear in the record that Mr SUA did not want to discuss the issues in any depth. Furthermore, it would have been good practice for the ongoing management plan and planned frequency of visits to have been clearly documented at this time. The last time this had been recorded was on 20 February 2007, when a frequency of weekly visits was noted as required.

2 April 2007: This visit was conducted by Mr SUA's care co-ordinator. The depth and breadth of documentation is notably less than when the trainee psychologist or assistant psychologist [1] had conducted the visits. There is limited evidence of exploration of Mr SUA's voice content, but the records do show that Mr SUA's auditory hallucinations were discussed with him and that Mr SUA *"denied any symptoms except AHs: 'sometimes really bad, sometimes normal' (ie vol 7-8/10 or 3-4/10). Occasionally AHs criticise him re. preoccupations."*

Mr SUA's care co-ordinator also noted in his record that Mr SUA had been to see the mother of his child and that he planned to see her again the coming Wednesday. His longer-term hope was to have limited contact with the child: for example, once a fortnight. The documented plan was:
"*next HV on Friday 13 April at 2pm:*

- *Focus on reiteration or psycho-ed*
- *Attentional switching techniques as part of strategy to manage voices."*

Independent Team comment
At the time of this visit, the care co-ordinator had last conducted a face-to-face assessment of Mr SUA one calendar month previously (13 March 2007). During this time there had been a number of significant changes in Mr SUA's life and also some changes in the number of voices he was hearing. It is the contention of the Independent Team that the care co-ordinator should have made more careful documentation of the extent to which he explored with Mr SUA the impact these changes had brought about, and the impact the voices were having on him. For example, when the voices *"were really bad"*, what did that mean for Mr SUA? Also, how was he coping on *"really bad"* days?

In terms of the child, the care co-ordinator's notes do suggest that Mr SUA was positive in his thinking about this. The Independent Team does not consider that Mr SUA's care co-ordinator was errant in not activating child protection procedures. At the time, there was no evidence that Mr SUA posed a risk to the child or to its mother. The diagnosis of a mental health disorder is not a sufficient reason to presume that there are safeguarding concerns. However, it would have been prudent had Mr SUA's care co-ordinator documented clearly that he had considered the issue of safeguarding and that ongoing monitoring of Mr SUA's attitude and response to fatherhood was now a feature of his care plan.

Ideally, the care co-ordinator should have conducted a revised risk assessment, and also formally updated Mr SUA's CPA care plan accordingly.

After 2 April there were no contacts with Mr SUA. This time period is addressed in section 4.2.2.2 (page 68) of this report, which addresses the care co-ordinator's compliance with the early intervention service's traffic light system, and section 4.2.3 (page 80), which addresses the question of preventability of the incident.

4.2.2.2 *Compliance with the early intervention service escalation policy (traffic light system)*

Summary: In this case, there was no evidence of compliance with the early intervention service traffic light system after October 2006. There were, in the opinion of the Independent Team, two clear occasions where the management and treatment of Mr SUA should have been reviewed under the auspices of this. The first was on 22 November, when Mr SUA should have been escalated to Amber and then to Red on 24 November, following four unsuccessful planned contacts with Mr SUA; and the second was on 8 May 2007, when there had been four consecutive unsuccessful contacts with Mr SUA. He should at this time have been escalated to the red zone of the early intervention service traffic light system, resulting in a detailed discussion about his management and a clear plan of assertive outreach to make contact with and assess Mr SUA. That Mr SUA was not escalated on either occasion represents a clear breach of practice protocol.

Before setting out the Independent Team's analysis of Mr SUA's care and treatment in respect of the traffic light system, the early intervention protocol for this is set out below.

The Traffic Light System

In 2006 the then clinical lead and consultant psychiatrist for the early intervention service set out the aims and purpose of the traffic light system.

In his paper[9] he states that, although traffic light systems have been widely used in a range of health arenas, the only published work about the use of such a system in mental health was in relation to the management of case work and the management of resources (Ryrie *et al*., 1997)[10]. With regards to the traffic light model to be used in the team, the clinical lead stated that it was to be *"more specific to the risk management in community teams and has a system of responsibility for the whole team. This whole team approach fits very well in the accountability structure for a large community team and with the development of 'New Ways of Working for Everyone', in mental health teams (Department of Health 2007). This way of working and monitoring risk allows for understandable clinical governance and with each care co-ordinator sharing their responsibilities. The Traffic Light system used by THEIS[11] provides a simple and clear method of managing patients who are at risk or pose risk. It enables the team to prioritise reviews and interventions to changing risk and for those with the greatest need, even if it is non-attendance for reviews."*

[9] Mohammed Ashir & Karl Marlowe (2009). 'Traffic Lights: A practical risk management system for community early intervention in psychosis teams.' *Clinical Governance: An international Journal*, Vol 14 Issue 3, pp 226-235.

[10] Ryrie, I., Hellard, L., Kearns, C., *et al.* (1997). 'Zoning: A system for managing case work and targeting resources in community mental health teams'. *Journal of Mental Health* 6, pp 515-523.

[11] The Tower Hamlets Early Intervention Service.

The aim was that at any time a service user would be in any one of three risk categories of the traffic light system: Red, Amber or Green. The system also set out "a clearly defined set of clinical and operational characteristics" which determined in which category a service user was placed. The intention of the traffic light system was that, if the behaviour of a service user changed (for example, recurrent non-attendance at planned meetings), then the service user would be moved into a greater risk category and consequently a different traffic light zone, resulting in increased frequency of review and team discussion about the service user and in which zone the service user should be managed. The identified change in behaviour did not mean automatic retention of a service user in a higher risk category, but it did mean that the service user could not be moved out of the higher risk category without the agreement of the clinical lead and a multi-disciplinary team discussion.

The principles of the traffic light system were encapsulated in a simple poster that was displayed on the wall in the team's office, and on the white board that listed all early intervention patients. The current poster looks like this:

Colour	Criteria	Clinical Expectation
RED	▪ All in-patients ▪ Increasing risk to self or others ▪ Non-engagement with no contact in 4 weeks ▪ 6 weeks post-natal ▪ EWS[12] apparent ▪ Concerns from Key Worker/Carer/Family/Health professional ▪ Safeguarding Adult concerns ▪ Safeguarding Children concerns ▪ If abroad (see policy) ▪ Newly allocated referrals without CPA transfer	▪ Medical RV **1-2** weeks ▪ KW RV **2x** per week ▪ MDT RV **1x** week ▪ Discussed **daily** in handover ▪ For Clinical Discussion at MDT **EXIT <u>ONLY</u> AFTER MEDICAL RV**
AMBER	▪ Within 12 weeks of initial contact ▪ Concerns of medication change/discontinuation ▪ 2x DNA/poor engagement ▪ Within 4 weeks of Deliberate Self-Harm ▪ During pregnancy ▪ Accommodation change ▪ High Expressed emotion	▪ Medical RV **4-12** weeks ▪ KW RV **1-4** weeks ▪ MDT RV **12-14** weeks **EXIT <u>ONLY</u> AFTER MDT RV**

[12] EWS means Early Warning Systems.

Colour	Criteria	Clinical Expectation
GREEN	▪ Engaged & Compliant ▪ In Remission ▪ Chronic residual symptoms ▪ "Watch and Wait" ▪ OFF CPA	▪ Medical RV **12-16** weeks ▪ KW RV **4-6** weeks (minimum of monthly telephone contact) ▪ MDT RV **24-28** weeks
ANY MDT MEMBER CAN PLACE A PATIENT IN RED		

What early intervention staff interviewed by the Independent Team said
The Independent Team considered it essential to gain an insight around the clarity of thinking about the traffic light system so that it could form a judgement about the reasonableness of Mr SUA's management through it.

Staff not involved with the care and treatment of Mr SUA told the Independent Team that, generally, they felt it was understood well. They confirmed that the criteria sheet was stuck on the wall for reference and it was easy to see. They also confirmed to the Independent Team that there was a good understanding of it and that they felt it would come out quickly in team meetings if it was being used incorrectly.

These staff (two occupational therapists and one registered mental health nurse) were asked about their understanding of the RED criteria of "3x DNA" as it was stated in 2006 and 2007, and all demonstrated clarity of understanding about what 3 missed contacts meant. They did not believe that the "3x DNA" referred only to outpatient appointments, but to any missed planned contact. All three were uncertain as to how Mr SUA was missed being put into the RED zone prior to the incident.

With regards to the documentation of a service user's movement across traffic light zones, the staff-grade psychiatrist told the Independent Team that movement of a service user *"is discussed at the next traffic light meeting and documented by the care co-ordinator in the notes. It is still practised this way, but now, in addition, the admin staff member who takes the minutes of traffic lights makes a note of this."*

He also confirmed to the Independent Team that he considered himself to have a good understanding of the system, which he obtained from the clinical lead (the consultant psychiatrist).

The staff-grade said that he felt that the RED zone worked really well and that he felt the system was good. However, "AMBER/GREEN" were not talked about as frequently. The Independent Team considers this to be reasonable and that the minimum frequency of discussion was clearly set out in the one-page easy-reference protocol set out above.

The then clinical lead, and consultant psychiatrist, for the early intervention service told the Independent Team that the traffic light system had to be intrinsic to the team and used on a daily basis. With respect to what happened

with Mr SUA (i.e. not managed in accordance with the traffic light system), he said:
"the process of the traffic lights was closely managed and all staff knew from daily experience how it worked, and there was no reason not to follow it."

When the Independent Team interviewed Mr SUA's care co-ordinator, he told it that:
"As far as I remember, [*the consultant psychiatrist*] *gave us a presentation on the traffic lights system, and there was an e-version in the service's database."*

However, he could not recall ever discussing caseload management from the perspective of a service user's traffic light status during any of the management supervision he received from the then team leader, which in itself was infrequent.

With regards to the extent to which it was embedded in practice, Mr SUA's care co-ordinator told the Independent Team that:
"it was to hand for people and they adhered to it. However, they might all have had slightly different interpretations of how it operated. [*His*] *interpretation was such that* [*he*] *didn't appreciate that it was to also capture non-engagement."*
At the time of Mr SUA's disengagement, the criteria for RED was not as explicit about non-engagement as the contemporary version set out above. In 2007, the one-page protocol did not refer to non-engagement, but only to 'DNA' (i.e. 'did not attend').

The Independent Team therefore enquired as to what this term meant to Mr SUA's care co-ordinator. He told the Independent Team that:
"At the time, I interpreted 'a DNA' to mean a service user's non-attendance at a specifically arranged and mutually agreed (whether at the conclusion of the previous face-to-face meeting or, thereafter, by one-to-one telephone conversation) formal appointment with the care co-ordinator. I did not interpret its meaning to include a service user's non-attendance at a non-mandatory Activity/Group. That is, my interpretation remained domain-specific (i.e. specific to care co-ordinating duties), not across domains."

Independent Team comment
The Independent Team can understand the care co-ordinator's interpretation of DNA, and considered it to be reasonable. However, what is not understandable is the care co-ordinator's interpretation in relation to the lack of contact with Mr SUA after 18 April. His last face-to-face assessment was achieved on 2 April; Mr SUA was not available for the planned meeting on 18 April, and was not available thereafter. The care co-ordinator reported leaving a series of messages for Mr SUA on his mobile phone, none of which elicited a response. The Independent Team accepts that Mr SUA did speak with assistant psychologist [2] about the psycho-education group, but this was not a "domain-specific" interaction, and did not constitute a therapeutic contact: it was a process-oriented contact.

The care co-ordinator also told the Independent Team that, on the few occasions he had spoken with staff at the supported housing provider, they had told him that Mr SUA seemed OK.

The Independent Team considers the response by the care co-ordinator to the lack of contact with Mr SUA between 18 April and the date of the incident (9 June 2007) to have constituted a significant lapse in standards and in practice.

The Independent Team accepts that:

- Mr SUA's care co-ordinator was under considerable pressure trying to complete the necessary requirements for the CBT diploma;
- he was new to the role and function of a care co-ordinator;
- the traffic light system was in the early months of its implementation;
- the care co-ordinator did in all probability on one occasion mention Mr SUA at a multi-disciplinary team meeting in the weeks prior to the incident;
- Mr SUA's care co-ordinator had made an honest error in his interpretation of the traffic light system.

However, Mr SUA's care co-ordinator was a qualified clinical psychologist responsible for the supervision of assistant psychologists and trainee psychologists. He also had experience of working with service users presenting with first-episode psychosis; he was not new to the field of work, and would therefore have been aware that this type of service user often presents with an unclear risk picture because it has not fully developed. Notable changes in behaviour should trigger a response from the mental health service. It is the perspective of the Independent Team therefore that Mr SUA's care co-ordinator could and should have raised concerns about the non-engagement of Mr SUA (i.e. his non-response to telephone calls, his non-attendance at planned meetings, his lack of presence at the supported living provider), regardless of the presence or not of any traffic light system. Mr SUA's care co-ordinator knows this, and recognises that he should have been more assertive with regards to Mr SUA and worked harder to achieve concrete information about his whereabouts and well-being.

What the impact of a different action by the care co-ordinator would have made to the subsequent course of events is set out in section 4.2.3 (page 80), which addresses preventability.

The Independent Team's overall comment about the traffic light system
It was clear from the information provided by the eight staff interviewed that the traffic light approach was a valued system and that all staff believed that they understood it at the time. However, the review of the weekly clinical team meeting minutes between September 2006 and June 2007 revealed that there were only records relating to Mr SUA on the following dates:

- 18 August 2006;
- 23 August 2006;

Mr SUA was not a patient of the early intervention service at this stage.

- 30 August 2006;
- 6 September 2006;
- 4 October 2006.

The record of 4 October says: *"RED* – [*Mr SUA*] – *smoked skunk at the weekend and went to A&E. Seen on Monday (2) and seemed okay – compliant with meds."*

This was the last evidence of Mr SUA being discussed at the weekly clinical team meeting between this date and 13 June 2007, four days after the incident.

There are no references in the clinical records at all to Mr SUA's traffic light zone. Consequently, it is not at all clear on 4 October whether Mr SUA was moved out of the red zone, to amber or green. No staff member has been able to tell the Independent Team what happened with regards to Mr SUA's traffic light category between October and the CPA review of 20 February 2007. At this time the clinical lead for the team was confident that Mr SUA would have been in the green category, as he was engaging with the service. Based on his own review of Mr SUA's clinical records, he considers that, in February 2007, 'Green' would have been the correct zone for Mr SUA.

The clinical lead also told the Independent Team that:
"Every RED [*was*] *discussed, but at that time there was not always a record of the discussion and who* [*was*] *on the board (there is now a snapshot of the board recorded, but the care co-ordinator needs to write in the notes and subsequent discussion)."*

The Independent Team considers that the lack of attention to the accurate minuting of service users discussed at the clinical team meeting constituted a lapse in good standards of governance.

With regards to the lack of compliance with the traffic light system, the clinical lead was keen that the Independent Team did not misunderstand the protocol. The clinical lead told the Independent Team that:
"It is important to correctly read the protocol. There are CRITERIA and then CLINICAL EXPECTATION. This tool allows a process/framework for discussion and review to be followed in certain situations. Remember, this process fills a void compared to other community teams, where there are no such tools and no process to have risk criteria being responded to. There were still reviews done within the statutory minimum of 6 monthly, which we were doing via the CPA process. In 2006 any patient falling out of the system was a learning for the Care Co-ordinators and as staff used the tool they found the process very supportive and an iterative process."

He also told the Independent Team:
"At that time the staff were using the tool rigidly to place patients into the correct zone, but then after the discussion patients could be re-zoned (with a management plan noted), even if they had initially met the criteria (this flexibility would deviate from what is written on the tool). So there is clinical

flexibility in the management plan and flexibility in zoning, both after the discussion being noted."

His assertion is validated by the information provided by the staff-grade doctor, two occupational therapists and a registered mental health nurse, all of whom were working in the early intervention service between 2006 and 2007.

Therefore, as the Independent Team understands it, although for a RED patient the protocol called for a medical review every one to two weeks as a '*clinical expectation'*, this did not mean that all service users on RED were seen every one to two weeks as a matter of course. The frequency of medical review was based upon the individual circumstances of the service user and what was agreed at the weekly team meeting. In the case of Mr SUA, the clinical lead considered that neither weekly nor fortnightly visits were required after September 2006, largely because of his mother reporting at the end of that month a 50% improvement in his symptoms. The clinical letter following the medical review at the end of September stated that follow-up was to occur between three and four weeks later. This, the clinical lead considered, was appropriate for Mr SUA at the time. (This report has already set out how the planned-for medical review did not take place.)

With regards to Mr SUA's non-engagement in November 2006, the clinical lead told the Independent Team that:
"You are correct that the discussion should have happened and that he was having a psychological therapy and if discussed with me as the clinical lead, that there was regular telephone contact, was improving in his functioning and he was generally engaging, then I would have suggested he remain in AMBER. ... There is little to indicate he should be in RED, despite the DNAs."

The clinical lead also highlighted that the level of contact with Mr SUA indicated that he was in fact meeting with the clinical expectation in terms of frequency of contact with the key worker, or care co-ordinator (in this case the majority of contact was with the trainee psychologist, supervised by the care co-ordinator).

The Independent Team agrees that the frequency of contact with Mr SUA did meet the stated clinical expectation for an Amber service user in so far as contact with his key worker was concerned. There was a period of approximately 18 weeks between his CPA review of 20 February and the last recorded multi-disciplinary team review on 4 October 2006, which was a period of four weeks outside of that expected.

Looking at the contact with Mr SUA after the CPA in Review in February 2007, when he is reputed to have been classified as a GREEN service user, his level of planned contact up to and including 18 April met with the clinical expectation; indeed, planned contact continued on a fortnightly basis. There was no expectation of medical review between 20 February and 20 June (16 weeks), unless concerns with Mr SUA were identified. Similarly, the expectation for discussion within the context of the multi-disciplinary weekly

clinical meeting was every 24 to 28 weeks, unless concerns about Mr SUA's care and treatment required discussion sooner.

On the basis of the above, although the Independent Team considers that Mr SUA should have formally been presented for discussion somewhere around 24 November 2006, it accepts that the frequency of contact by the identified key workers, supervised by the care co-ordinator, was in keeping with the protocol. It also accepts that presentation of him would not at this stage have materially altered Mr SUA's management.

The Independent Team also accepts that in February 2007 Mr SUA was reasonably treated as a Green-rated service user.

All parties accept that from 8 May, at the latest, Mr SUA should have been escalated to the Red zone of the traffic light system.

4.2.2.3 *Was the care and treatment of Mr SUA reasonable in respect of communication with other agencies and communication and involvement with his mother?*

Summary: There were two relevant agencies for the early intervention service. These were the supported housing/living provider and the voluntary drugs misuse service Mr SUA had been referred to in June 2006.

It is the contention of the Independent Team that overall the communication between the early intervention service and the voluntary substance misuse provider was appropriate and ceased at the end of October 2006, when it became clear that the voluntary agency was not going to be able to provide support to Mr SUA. With regards to the supported housing/living provider, contact and communications with this agency was appropriate up to and including May 2007. After 8 May, when Mr SUA's care co-ordinator was achieving no response from him, it would have been prudent if he had met on a face-to-face basis with the staff at the housing provider to try and elicit as much information as they could regarding the quality of their contact with him.

With regards to the communication with and involvement of Mr SUA's mother, up to and including 20 February 2007 this was of a very good standard. Mr SUA's mother was clearly involved at all appropriate times, her perspective about her son was sought and she was considered to be a key supportive person to Mr SUA. She was a person who had a good insight into her son's level of well and ill health. Consequently, it is hard to understand why Mr SUA's care co-ordinator did not make contact with her when he could not achieve successful contact with her son at any time after 18 April 2007. The rationale that the care co-ordinator relied on the mother to contact him if she was concerned about her son is not commensurate with the qualification, experience and professional opinion held of the care co-ordinator by his colleagues.

The evidence base for the above conclusion is as follows:

Contact with the voluntary substance misuse service
The first contacts with this service were on 29 September and 3 October. The plan agreed following these telephone contacts was:

- For Mr SUA to recommence meetings with the agency;
- For Mr SUA to continue with the early intervention service;
- For a professionals meeting with the agency in the forthcoming weeks.

On 23 October 2006 a professionals meeting occurred, attended by Mr SUA's care co-ordinator and the assistant psychologist. The clinical record makes it clear that at this stage the voluntary agency had reservations about providing a continuing service to Mr SUA because of:

- his current mental health situation;
- his demonstrated lack of motivation to address his substance misuse; and
- his age. The voluntary agency was a young persons' substance misuse service providing a service for young persons up to the age of 19 years. Mr SUA was to be 19 years old shortly after the face-to-face meeting.

On the basis of the above, a decision was made to withdraw from providing Mr SUA with a service.

The final contact with this agency was on 30 October 2006.

The Independent Team understands that at the time it was customary for the early intervention service to provide its own substance misuse support to its service users and not to refer on to the dual diagnosis service.

Contact with Mr SUA's supported living/housing provider
The clinical records show regular contact with this provider, commencing on 17 August 2006. There were subsequent documented contacts on:

- 25 August 2006;
- 30 October 2006;
- 31 October 2006;
- 3 January 2007;
- 10 January 2007;
- 23 January 2007;
- 7 February 2007;
- 7 March 2007;
- 13 March 2007;
- 18 April 2007;
- 8 June 2007.

The purpose of the early contacts was to establish a relationship with the supported living/housing provider and to establish the extent of the service

and support they could offer Mr SUA. The notes of the meeting are comprehensive and show that the meeting was substantial. The contact at this point was also useful in achieving the relocation of Mr SUA into a self-contained flat rather than shared accommodation, so that his contact with other substance misusers was reduced. This was an issue for Mr SUA and his mother, particularly as the person he had been allocated to room share with actively used cannabis.

Normally, a client of the supported living/housing provider had to have completed the first stage of the programme with the provider before self-contained living accommodation was offered.

The contacts in January and early February were largely related to Mr SUA's non-response to calls from the early intervention service, and the trainee psychologist seeking information about him, and trying to locate his whereabouts. Consequently, the contacts were appropriate. It would, however, have been best practice if the clinical records set out more clearly how the supported living/housing provider found Mr SUA in terms of attitude, habits, mood, etc, rather than simply reporting *"no concerns".* Slightly more recorded detail, when Mr SUA was non-contactable, would better indicate that the nature of the trainee psychologists, and the care co-ordinator's enquiries, were of the standard expected.

In March 2007 there was a face-to-face professionals meeting, including Mr SUA, where a detailed review of progress occurred and issues threatening Mr SUA's ongoing tenancy were raised; for example, Mr SUA's complete non-engagement with the activities schedule in which he was expected to engage in by the supported living/housing provider.

After March 2007, there were only two recorded contacts. One was to change the date of a pre-planned appointment with Mr SUA and the other the day before the incident. This was in an effort to find out what was happening with Mr SUA because of his non-response to messages left for him over the previous weeks by his care co-ordinator.

Independent Team comment

The Independent Team noted that the supported living/housing provider was not invited to the CPA review of 20 February 2007. There has been no explanation as to why this did not happen. Although the invitation of the supported living/housing provider to the CPA review would constitute expected and good practice, the Independent Team was reassured that soon after this, on 13 March, there was a professionals meeting with Mr SUA's key worker where a detailed review of Mr SUA's progress and management plan occurred.

The Independent Team also wishes to highlight that, although the above listed dates represent the occasions where there is documentary evidence of communication with the supported living/housing provider, the majority of Mr SUA's contacts occurred on the premises of the supported living/housing provider and it is inconceivable that there were not ongoing communications

between the services that would have been considered informal and would not have been recorded.

Communication and involvement of Mr SUA's mother

The Independent Team was persistent in its effort to engage Mr SUA's mother in this investigation. However, it was clear to the Independent Team by her non-response to any of its correspondence that she preferred not to be involved. This, the Independent Team considers, was very understandable. Consequently, the only evidence the Independent Team had to draw on was Mr SUA's clinical records.

There is evidence in Mr SUA's clinical records of contact between the early intervention staff and Mr SUA's mother on the following dates:

- 17 August 2006 (home visit at supported living/housing provider);
- 25 August 2006 (planned meeting with mother and son);
- 15 September 2006 ('home visit', mother in attendance at her request);
- 26 September 2006 (medical review);
- 2 October 2006 (at supported living/housing provider for Mr SUA);
- 22 November 2006 (attempted contact with mother via telephone);
- 6 December 2006 (telephone contact with mother, and a face-to-face meeting with her and her son);
- 12 December 2006 (uncle (mother's brother-in-law) present);
- 30 January 2007 (visit of 7 February 2007 for Mr SUA confirmed with mother);
- 9 February 2007 (telephone call with mother to confirm contact details and also her attendance at the planned CPA review);
- 20 February 2007 (mother present at CPA review meeting).

This was the last contact with Mr SUA's mother pre-incident.

After the incident, contact with Mr SUA's mother occurred on:

- 11 June 2007;
- 12 June 2007;
- 13 June 2007;
- 15 June 2007;
- 18 June 2007;
- 26 June 2007;
- 2 July 2007; and
- 13 July 2007.

Independent Team comment

It was encouraging to see the extent to which Mr SUA's mother was engaged by the early intervention service, and that staff were accommodating of her need to be involved, even though it was clear from the clinical records that the staff were concerned at the level of over-reliance Mr SUA had on his mother, and in some respects her over-caring for her son. The records show that this sensitive issue was discussed openly with Mr SUA's mother and that, for her son's recovery, enhancing his levels of independence would be important.

The only area prior to May 2007 where the Independent Team considered that there could have been greater evidence of exploration with Mr SUA and his mother was the potential impact of 1) Mr SUA's commencing a full-time vocational training course; and 2) moving out of the immediate area. The Independent Team gets a sense from the records that generally both of these changes were considered to be positive for mother and son. However, it would have expected greater evidence of how this might impact on Mr SUA's mental health, given the central importance of Mr SUA's mother to his stability. Evidence of reiteration of the early intervention contact details and that Mr SUA's mother could make contact with them at any time would also have been advantageous in light of the circumstances that subsequently arose.

Finally, as stated above, there has been no sensible explanation as to why Mr SUA's care co-ordinator did not contact his mother after 18 April, when he (Mr SUA) missed his planned appointment. The above list of dates shows that to call Mr SUA's mother when he was not contactable was a usual thing to do. To not have contacted her after sequential unsuccessful telephone contacts with him simply constituted a lapse in the previously demonstrated standard of practice in such circumstances by the early intervention service staff.

With regards to the most significant contributory factors to this identified lapse, the Independent Team considers that these were a combination of system and proximal causes.

System Causes

- A lack of effective management and caseload supervision**;** and
- A lack of recognition in the clinical and management leaders that Mr SUA's care co-ordinator was not delivering his work to his usual high standards, owing to the pressure of the essential diploma course he was completing**.**

Proximal Causes (i.e. individual practitioner)

- Mr SUA's care co-ordinator did not set out a clear management plan when Mr SUA was non-contactable on 18 April 2007. It is the contention of the Independent Team that Mr SUA simply fell off his radar because of his low-risk status and that, on all other occasions where he had not been in contact with the team, he had been OK.
- Mr SUA's care co-ordinator simply did not think about contacting Mr SUA's mother.

4.2.3 *Was the incident predictable and/or preventable on the basis of information the early intervention service could or should have been aware of?*

On the matter of predictability, the Independent Team does not consider that the incident of violence that occurred on 9 June 2007 was predictable. Mr SUA did not have a history of violence, and even though in September 2006 he did report that the voices told him to hurt others, he also said that he would not do this. There was nothing in his behaviours, or in anything he told the staff, that suggested that Mr SUA posed a notable risk of harm to anyone over and above that associated with the unpredictability associated with illicit substance misuse.

On the matter of preventability, this is more complex. The Independent Team is of the opinion that the lack of assertive follow-up of Mr SUA from early May 2007 did remove the opportunity for the early intervention staff to have been informed about Mr SUA's complete disengagement from their service, non-compliance with medication and also his reactivated usage of illicit substances. Consequently, the lack of follow-up removed the opportunity for the care co-ordinator to act appropriately on information he could and should have been aware of in the weeks leading to the incident. On the balance of probabilities, a telephone call to Mr SUA's mother could have elicited this information and enabled the early intervention service to make a plan to attend at her home to conduct an assessment of Mr SUA. It would also have enabled the service to obtain important information from Mr SUA's mother about her son's mental state, and his behaviours. Even if Mr SUA was not prepared to allow the early intervention team to assess him, this information would have enabled an informed decision about the feasibility of conducting a Mental Health Act assessment.

The Independent Team is aware that after the incident Mr SUA's mother met with the early intervention service and there is nothing in the information she shared with them that suggests that her son was displaying overt signs of psychosis, or overt signs of aggression. The Independent Team is also aware that on the day of the incident Mr SUA had spent time with his mother and her then partner (the victim). The day reportedly went without incident. The Independent Team is also aware that in the immediate aftermath of the incident he was assessed in the cells by an Approved Social Worker, who noted: *"he showed no discernible signs of being psychotic"*. Two days after the incident, he was assessed by the consultant psychiatrist for early intervention and was deemed 'fit for interview'; again, no notation is made about any psychotic symptoms or command hallucinations. Furthermore, Mr SUA's voices were noted to have reduced from four to one in the antecedent period to the incident and it recorded that there had been *"no recent aggression or recent confrontation"*.

The Independent Team noted from the post-incident records that Mr SUA's mother had taken her son to a GP, who reportedly encouraged him to re-commence his anti-psychotic medication. The Independent Team contacted Mr SUA's then GP surgery and was informed by the now senior partner that Mr SUA's mother telephoned them on 25 May 2007. The GP records noted

that she informed them that her son had been medication non-compliant for approximately two months, had started to use cannabis again and was relapsing. The GP record also noted that Mr SUA's mother told the GP practice that her son was agreeable to re-commencing his medication. She was advised that he should re-start his Risperidone at 4mg for a week and then increase this to 8mg. (Note: the Independent Team believes that the early intervention service may have been prescribing this, although in September 2006 it was noted that the home treatment team and the GP were responsible for prescribing.) The Independent Team have assumed that the GP provided a prescription for Mr SUA's mother, or that she already had a stock of medication for him at her house.

The Independent Team asked the GP surgery if they were aware that Mr SUA was under the care and management of the early intervention service. The now senior partner responded by telling the investigator that it was stated in the discharge summary provided by the in-patient service that the plan was for Mr SUA to be referred to the early intervention service. However, he could see no indication that they had received any direct correspondence from the early intervention service at any stage. Reviewing Mr SUA's mental health records, it had been identified that the staff-grade for the early intervention service had sent correspondence to a GP surgery in September 2006. However, this GP surgery told the Independent Team that the last time they had seen Mr SUA was in September 2004 and the local Family Health Services Authority had requested Mr SUA's notes from them on 31 August 2006. This surgery advised the Independent Team that the staff-grade's letter of 26 September 2006 arrived with them on 27 September 2006. They did not say what happened to this correspondence. Further review of Mr SUA's records revealed that the in-patient discharge letter was sent to a different GP surgery than that to which the staff-grade had written. It had been sent to the GP surgery Mr SUA was registered with at the time of the incident. It is unclear at this length of time after the incident how this error occurred. Now, all adult services in East London Foundation Trust share a common information system, so the chances of such an error occurring now are remote.

On the basis of the information to which the Independent Team has had access, although there was lost opportunity to assess and to try and re-engage with Mr SUA, the Independent Team cannot say that, had the early intervention service delivered the standard of care that it should have done in the month preceding the incident, the incident would not have occurred. The only circumstance that would have guaranteed preventability was if Mr SUA had been assessed under the Mental Health Act and detained in hospital prior to 9 June. However, there simply is insufficient information available retrospectively to say that there were sufficient grounds to have followed such a course of action. Consequently, on the balance of probabilities it is unlikely that, had the early intervention service done what it should, the incident would not have occurred. The family of the deceased told the Independent Team that although they understood why the Independent Team had reached this conclusion, it remained their perspective that the lapse in care removed any prospect for the prevention of Mr D's death.

5.0 ACTIONS TAKEN BY THE THEN EAST LONDON AND THE CITY AND THE NOW EAST LONDON FOUNDATION NHS TRUST FOLLOWING ITS OWN RECOMMENDATIONS MADE IN FEBRUARY 2008

Following the incident involving Mr SUA, East London and the City Mental Health Trust undertook its own internal investigation to identify what lessons it could learn and to make recommendations for improving its internal systems and processes.

The following recommendations were made as a consequence of the internal investigation:

1. Supervision: The supervision structure in the team needs clarification. Accountability for case work, auditing of files and day-to-day management issues should rest with the team manager. If professional supervision is sought outside the team, this should be primarily to discuss professional development.

Current position: The current manager for Mr SUA's early intervention service has implemented a much more rigorous system of supervision, for which he takes personal responsibility, supported by two identified senior practitioners in the team. Case management supervision is provided to all staff. Furthermore, the length of time dedicated to the weekly clinical team meeting has been extended, so that this is now a three-hour meeting, allowing time for cases that must be discussed and for cases that team members want to bring forward for team discussion and exploration. The Tower Hamlets early intervention team is also now housed in a large open-plan office which facilitates easy communication within the team and optimal opportunities for team members to seek support from and to give support to each other.

2. Traffic light system: Team members should be reminded of the need to adhere to the 'traffic light' system in use in the team, even when service users are perceived to present low risk. A failure to attend for appointments should always be reviewed and other members of the service user's network should normally be contacted for information.

Current position: The Independent Team did not identify a lack of understanding in the staff it spoke with about the traffic light system. However, it was noted that the current Tower Hamlets early intervention team leader allocates new staff a mentor, whose job it is to take them through policies and procedures, including the traffic light system. However, the reliability of the traffic system has not been audited and this is therefore a recommendation of this investigation.

3. Documentation: Team members should be reminded of the need to record discussions about a service user with a doctor when such discussions have occurred outside the CPA meeting framework. Brief notes would suffice, but should certainly refer to any decisions arising from 'informal' discussion.

Current position: Documentation is an issue that is afforded significantly more attention than it did in 2006 and 2007. The increased attention is not

confined to a service user's own clinical record, but also to how minutes of clinical team meetings are recorded and the history of a service user's placement on the traffic light board.

The current team manager considers that they are much more sophisticated than they were, using electronic record-keeping tools effectively and also digital photography for archiving the 'traffic light' board and who was on it.

4. Safeguarding children: All team members must attend the Level 2 Safeguarding Children training. If a service user discloses a pregnancy or the birth of a child, a perinatal planning CPA must always be held, whether or not the service user resides with the child. The Named Professional for Safeguarding Children should be approached for advice where necessary.

Current position: This recommendation has been fully addressed.

5. Medication: Team members need to ensure that medication regimes are adhered to as far as possible. The collection and filling of prescriptions should be checked with the GP, where there is doubt, and if symptoms persist.

Current position: The principle of this recommendation is enshrined in the role and responsibility of a care co-ordinator. The Independent Team is satisfied from its discussions with the Tower Hamlets Early Intervention Service that staff deliver their responsibilities in respect of medication management.

6. Care co-ordination: Special consideration should be given to any team member who has not had experience of care co-ordination prior to joining the team. They may need training in this role, particularly in the area of risk management.

Current position: Action taken soon after this incident, when staff vacancies allowed, was to employ into Mr SUA's early intervention service only staff experienced in care co-ordination. Although this reduced the psychological therapy element of the service in the short term, it was considered necessary to stabilise and enhance its care co-ordination function. Now, in 2011, the team again employs a clinical psychologist to provide the necessary psychological input to the team. This individual is employed as a specialist and not as a care co-ordinator. The Independent Team also noted that the team continue with their rolling education programme and that the Trust itself has a dedicated education programme for care co-ordinators.

7. Trainees/students: If trainees/students are allocated cases by team members who are supervising them, an agreement should be in place as to how regularly the service user is seen by the care co-ordinator alongside the trainee.

Current position: With regards to nursing students the Nursing and Midwifery Council (NMC) have set out clear rules with regards to the mentorship of students. The Independent Team are advised as follows: Students, "*must be*

supervised in practice by a 'Mentor' who is registered on the part of the register the student is hoping to register on.

The 'Mentor' is a Mental Health Nurse who has been qualified for at least one year and who has completed and passed a mentor training course at University level. This course was known as the ENB 997/998. Then was called 'Prep for Mentorship' and is currently called 'Standards to support learning & Assessment in practice'

Prior to 2009, the University would advise the NMC at the end of their course a student was 'fit for practice' and fit for award' and this would allow the student to apply for their PIN number and be entered onto the relevant part of the NMC register.

Since 2009, it has become the responsibility of the Trust (Placement provider) to state the student is 'fit for practice' . To accommodate this all final year students are supervised by a 'sign off mentor' - In addition to the mentor training, experienced mentors receive additional training which denotes their 'sign off mentor' status. If the student is signed as 'fit for practice' by their sign off mentor, the University send a joint declaration advising the NMC the student should be allowed to apply for their PIN number.

Furthermore all students must work alongside their mentor for 40% of a 37.5 hour week (average) - This works out to two shifts of 7.5 hour duration- If the clinical area is working on a long day model of say 12 hours over a period of three days this roughly calculates to supervised contact of 14 hours".

In addition to the above actions, the care co-ordinator for Mr SUA undertook an extensive professional development programme, addressing all aspects of the care co-ordinator's role. Although this professional has elected to work as a specialist and not as a care co-ordinator, he informed the Independent Team that he considers that the development programme has enabled him to have insights, especially in relation to risk management, that he would not otherwise have achieved. As a consequence of this incident, the Independent Team found the individual's self-reflections and commitment to his professional development impressive.

Mr SUA's early intervention team also undertook a raft of work aimed at strengthening their internal systems and processes. This included implementing a rolling internal education programme that operated on a fortnightly basis. The topics for presentation and discussion were published in advance and team members were nominated to take the lead for specific sessions. An example of the programme initiated in July 2007 is as follows:

1. *Early Warning Signs and using a 'Timeline' for Recovery Planning*
2. Engagement Techniques for an EIS.
3. *Risk Assessments and Management (self, others and vulnerability). 2 sessions.*
4. *Cultural Awareness (anthropological issues, local issues). 2 sessions.*

5. *CBT utility and techniques for Psychosis and Anxiety. 2 sessions.*
6. *Using a Phased Stage-Specific Intervention Model for Schizophrenia.*
7. *Confidentiality and record keeping.*
8. *Care Co-ordination.*
9. *Evaluating a group programme.*
10. *Family Intervention Work and techniques for an EIS.*
11. *THEIS Assessments.*
12. *Discharge Planning.*
13. *Relapse and crisis planning within a recovery-focused service.*
14. *Vocational and employment support for Patients.*
15. *Physical and side-effect monitoring for the MDT.*
16. *Compliance/adherence/concordance therapy.*
17. *Skills for presentations (IT skills, facilitation, feedback, etc).*
18. *Dual Diagnosis."*

The Tower Hamlets Early Intervention Service were able to demonstrate the continuation of this programme.

Finally, the Independent Team asked the current consultant psychiatrist if he was confident that the lapse in usage of the traffic light system that occurred with Mr SUA would not occur today. He responded verbally and in writing to this question. His written response said:
"I am confident that the risk of such an error occurring in THEIS now is negligible. The reasons for my confidence include:

- *My experience of all the Care Co-ordinators having a good understanding of the Traffic Light Protocol and its application in practice – specifically the absolute solidity and universally known principle that a patient can only move from Red to Amber after a medical review agrees that this is appropriate.*
- *My personal attendance at the vast majority of daily Traffic Light Meetings (ditto for the Operational Lead) enables me to monitor the Care Co-ordinators' understanding and application of the Traffic Light system, as well as maintaining a day-to-day knowledge of who is 'in Red'.*
- *The daily Traffic Light Meetings are minuted, made available electronically to the team (in case anyone is not able to attend) and a printed copy brought to each daily meeting by the team administrator and the duty worker – an accurate record of who is 'in Red' is thus available at every daily meeting to ensure nobody is inadvertently missed off.*
- *The Traffic Light Board is saved as an Excel Spreadsheet on a daily basis on the team's shared hard drive so it can be checked/consulted at any time. This is only amended by the team administrators if the team specifically tell them to do so at the end of the Traffic Lights Meeting.*
- *Thus, once a patient goes 'into Red' it takes a combination of a medical review taking place, the doctor agreeing that 'Amber' is appropriate, discussion with the team in the next Traffic Lights*

Meeting, physical moving of their magnetic name badge on the physical Traffic Light Board on the wall and then electronically recording the change both on the minutes of the meeting and the electronic Excel version of the Traffic Lights Board on the shared hard drive. I would argue that a patient is more likely to accidentally remain 'in Red' than accidentally move 'to Amber'."

This consultant did, however, concede that:

"thus far no formal audit has been conducted of the Traffic Lights Protocol in THEIS." He could also reassure the investigation team *"that one will be conducted, in liaison with the Trust's Assurance Department, in the near future – the draft audit protocol we have drawn up will aim to identify a) whether the expected clinical contacts for patients in Red actually do happen; and b) whether, on a random snapshot of the caseload, patients are felt to be allocated to the correct Zone".*

The Independent Team is itself satisfied that the risk of a recurrence of those lapses of practice identified by the internal investigation, and its own findings, would be an unlikely event.

6.0 CONCLUSIONS

The incident in which Mr SUA was involved was tragic, and its impact has been enormous for all concerned. The Independent Team's conclusions are based on an objective and detailed analysis of Mr SUA's care and treatment in the then East London and the City Mental Health NHS Trust in the 10 months preceding the incident.

With regard to the question "Was it predictable that Mr SUA would act in the way that he did?", the Independent Team does not believe that the incident of violence that occurred on 9 June 2007 was predictable.

With regards to the question "Was the death of Mr D preventable by virtue of different mental health care and treatment?", it is the perspective of the Independent Team that, although there was a clear lapse in care standards in the month preceding the death of Mr D, it cannot be said with any degree of certainty that the incident would have been prevented had the service delivered to Mr SUA been of the standard expected between 8 May and 9 June 2007. However, the family of the deceased told the Independent Team that although they understood why the Independent Team had reached this conclusion, it remained their perspective that the lapse in care removed any prospect for the prevention of Mr D's death.

With regards to the specific terms of reference, these have been addressed throughout the findings section of this report (section 4). To summarise:

- The Trust's internal investigation report did not fulfil the calibre of investigation expected following an incident of such seriousness.
- The clinical records do show that the mother of Mr SUA was appropriately involved in the care management of her son up to 20 February 2007, and was provided with appropriate support after the incident.
- The information provided by the family of the deceased does not show that the Trust handled the sharing of the Trust's investigation findings with them well.
- In the 10 months Mr SUA was a patient of the early intervention service, the care he received did meet the expectations of local and national policy as it related to the Care Programme Approach (CPA). However, compliance with the local Traffic Light system was not as good as it should have been in November 2006 and May 2007. Furthermore, although the face-to-face meetings with Mr SUA were well documented when this was undertaken by assistant psychologist [1] and the trainee psychologist, this robustness was lacking from 2 April 2007, and there was no record made of any discussions held in the clinical team meetings about Mr SUA after 4 October, even though these discussions are reported to have occurred.

- The care plan for Mr SUA was appropriate, and he received a good level of input from the assistant psychologist [1], trainee psychologist and his care co-ordinator up until 8 May 2006. Furthermore, as one would expect, Mr SUA's care co-ordinator attended at all home visits conducted by the assistant psychologist, an unqualified team member.
- With regards to the effectiveness of inter-agency working in this case, up until May 2006 this appeared to be of a reasonable standard. In the month preceding the incident, although calls to the supported living/housing provider were reported at interview, only one such contact was recorded, on 8 June. There should have been more careful communications with the supported living/housing provider over this period. Optimum communication would have been achieved via a face-to-face meeting where the quality of contact the housing provider was having could have been better explored.

7.0 RECOMMENDATIONS

Since the incident occurred, the systems in the Tower Hamlets early intervention service have been tightened up. Under the new team leadership, systems for documentation have improved, the wording in the traffic light system is more explicit, and therefore less vulnerable to mis-interpretation, and management supervision is robustly carried out.

As a consequence of the above, recommendations addressing these issues are no longer required. However, there are four recommendations for East London Foundation NHS Trust to consider and implement.

Recommendation 1: East London Foundation NHS Trust must ensure that all mental health teams using a Traffic Light System for clinical management purposes, rather than resource management, audit the system on an agreed periodic basis to provide assurance that it is working as intended and to the expected standard of reliability.

With regards to priorities, it is essential that the Tower Hamlets early intervention service conduct such an audit as soon as possible, as to date there has been no audit of system reliability since its implementation in 2006. This is not good governance.

In formulating an appropriate audit process, the Independent Team recommends that at least the following factors are incorporated:

- The appropriateness of the traffic light level/zone.
- The quality of documentation when a decision is made to manage a service user outside of the protocol guidelines.
- The quality of documentation when a decision is made to move a service user to a lower-risk tier of the traffic light system.
- Whether the documented frequency of medical review shows protocol compliance, and where the frequency does not meet this, do the notes provide a reasonable explanation as to why? (e.g. a decision has been made for less frequent reviews and is a documented component of the management plan, or the service user has DNA'd for appointments).
- Appropriateness and frequency of medication review.
- Appropriateness of actions planned, following consecutive periods of non-attendance for planned contacts, that the traffic light system says requires action.

Target audience: The Medical Director, the Clinical Leads and Team Managers for all Early Intervention Services, The Clinical Lead for adult services.

Timescale: The need for the above was highlighted to East London Foundation NHS Trust in May 2011. Consequently, within twelve weeks of the

publication of this report it should be in a position to report the findings of its audit across all of its early intervention services to NHS London.

Recommendation 2: When a considerable change is made to a service, and the role expectations of the staff working in that service, East London Foundation NHS Trust must ensure that it has appropriate processes in place to ensure the following issues are considered and addressed where appropriate. In this case, the early intervention service responsible for Mr SUA's care and treatment had, almost immediately prior to him becoming a patient, been the Early Psychosis Service, operating on a psycho-social model and not a care co-ordination model. There was no effective transition period for staff and neither were the role changes and staff development needs given sufficient attention in the way the transition was managed. For at least one member of staff, there was little to no resemblance between the job he had been doing and his newly expected role.

In designing a system to ensure that appropriate consideration is given to staff development and supervision when there are notable changes made to the functionality, and purpose, of a clinical team, the following components are recommended for inclusion:

- Clarity about the critical success factors for the 'new' or 'revised' service.
- A map of existing systems and processes within 'the existing' team and the degree to which they meet the new expectation.
- A knowledge and skills map of what is required to reliably deliver achievement of the new/revised service's critical success factors.
- For safety-critical activities, a Failure Modes and Effects map (control map) and/or Task Analysis should be conducted in the planning phases for significant service change.
- Where a significant alteration to an individual practitioner's job description is required, the individual should be advised of this and its implications.
- A training needs analysis and/or self-assessment against an appropriate knowledge and skills map.

The Independent Team is aware that, although East London Foundation Trust has more robust processes in place for managing service change and re-design than it did in 2007, these systems and processes do not meet the specific requirements set out above.

Target audience: Deputy Chief Executive and Director of Performance and Business Development, Director of Nursing and Quality, Director of Operations.

Timescale: East London Foundation NHS Trust should be able to advise NHS London on how it plans to address this recommendation within four weeks of the publication of this report.

Recommendation 3: The Clinical Lead and Team Manager for Tower Hamlets early intervention service must assure themselves that, where there is a detailed clinical review prior to a planned CPA meeting, the content of this is comprehensively documented in the relevant service user's records. In this case, although both involved medical staff reported such a review occurring, both also reported no knowledge of the extent to which Mr SUA had not been present for planned assessments in November 2006 and January 2007.

The Independent Team suggests that determining the extent to which pre-CPA meetings are being recorded could sensibly be incorporated into the traffic light system audit.

Timescale: On the basis that the records assessment is incorporated into the traffic light system audit, completion should be possible within 12 weeks of publication of this report.

Recommendation 4: Following the death of Mr D, an executive director of the then East London and the City Mental Health Trust met with the relatives of Mr D to share with them the findings and recommendations of the internal investigation. The family of Mr D found the Trust's representative to be insufficiently informed about Mr D, the circumstances of the care and treatment of Mr SUA, and over protective of the Trust's investigation report. Consequently it is essential that East London Foundation NHS Trust ensures that when serious untoward incidents occur and there is a decision to meet with the family of a service user and/or the family of 'the victim' the person tasked with meeting with the family:

- **Knows the name of the service user.**
- **Knows the name of the victim.**
- **Is fully conversant with the care the service user received and in particular the antecedent period to the incident.**
- **Has given careful consideration as to his/her response if the family ask to read the report, and/or to be provided with a copy of it at the time of the meeting.**
- **Considers seeking a legal opinion on the content of the Trust's internal investigation report before a meeting with the family is arranged so that any issues in how the information is presented can be appropriately addressed.**
- **Is accompanied by a senior member of the clinical team responsible for the patient where it is possible and reasonable to achieve this.**

The Independent Team is mindful that East London Foundation NHS Trust currently appoints named investigators and/or Panel Chairs for all of its serious untoward incident investigations and that a component of their role is to be fully conversant with the incident, its antecedents and the identity of affected family members/victims. Because it now has this system in place the Independent Team recommends that the Trust assure its commissioners that :

- the lead investigator/panel chair leads the feedback process to families in all cases; and
- the lead investigator/panel chair is accompanied by a senior member of the clinical team when meeting with families.

In addition the Trust must:

- Finalise its policy and practice guidance on the process on sharing of reports and activities that must be completed in advance of this.

This policy guidance must meet the standards of 'Being Open' as espoused by the National Patient Safety Agency and the principles listed above.

Target audience: Deputy Chief Executive and Director of Performance and Business Development, Director of Nursing and Quality, Director of Operations, Medical Director.

Timescale: The principle of 'Being Open' is an established concept within the NHS regarding communications with patients and families adversely affected by an untoward incident. Because East London Foundation NHS Trust already has in place a process it believes meets the above listed principles it should be in a position to provide assurance with regards to the reliability of its practice and its completed policy document along with an audit and monitoring framework within two to three months of the publication of this report.

APPENDIX 1: INVESTIGATION METHODOLOGY

The methodology employed for this investigation was structured and embraced the key phases detailed in the National Patient Safety Agency's root cause analysis e-learning toolkit. Key activities were:

- Critical appraisal of Mr SUA's clinical records and the creation of a structured (tabular) timeline.
- The identification of areas that the Independent Team needed to understand better.
- Critical appraisal for the Trust's own internal investigation report and the original internal investigation interview records to determine the extent to which the information already gathered answered the Independent Team's questions.
- Face-to-face and telephone interviews and discussions with staff working in the early intervention service.
- Liaison with the Metropolitan Police.
- Liaison with the solicitors for Mr SUA.

The investigation tools utilised were:

- Structured timelining.[13]
- Triangulation and validation map.
- Investigative interviewing.
- Affinity mapping.
- Qualitative content analysis.

Documentary information:

- Mr SUA's home treatment and early intervention service records.
- Internal Investigation Interview records (x7).
- Pre-interview information provided by:
  - early intervention consultant psychiatrist;
  - early intervention clinical psychologist;
  - early intervention service manager (2006 to date);
  - early intervention team manager (May 2007 to date).
- Independent Team interview records:
  - early intervention consultant psychiatrist and staff-grade;
  - early intervention clinical psychologist and Mr SUA's care co-ordinator;
  - early intervention assistant psychologist [1];
  - early intervention team manager (May 2007 to date);

[13] M. Dineen (2004). *Six Steps To RCA,* 2nd Edition.

        - early intervention service manager (2006 to date);
        - Round table meeting 3x early intervention staff (2006 to date).
    - “Wednesday MDT Meeting Minute Book”, 2006-2007.
    - One-page Traffic Light Protocol (post-May 2007).

Missing Information

The Independent Team wrote to the then team manager (no longer working at East London Foundation NHS Trust) on 21 March 2011. No response was received to this. Further efforts were made to locate him in July 2011 with the support of East London Foundation NHS Trust. At the time of writing (August 2011), the previous team leader had not responded to any requests to make contact with East London Foundation Trust or the Independent Team and had not provided any information to the independent Team.

The Independent Team is confident that the non-involvement of this individual has not compromised the completeness of the investigation.

APPENDIX 2: GLOSSARY

The Role of the Care Co-ordinator – East London and the City Mental Health Trust, 2006

12.1 In line with DH Guidance and to alleviate any confusion, the term of 'Care Co-ordinator' has replaced the term 'Key Worker'. The person who is best placed to oversee care planning and resource allocation should take on the role of care co-ordinator. (Specific roles and responsibilities in preparation for discharge back into the community from in-patient care are detailed in section 12.3 below.)

The care co-ordinator should build up a professional relationship with the service user and maintain close contact with him/her, liaising with other members of the Multi-Disciplinary Team (MDT) involved, and informing them of changes in the service user's circumstances which may influence the need for review of changes to the plan of care under CPA.

12.2 Where a service user is on **Standard Level** of the CPA and may only have contact with one mental health professional, that person should take on the care co-ordinator role. The care co-ordinator will be responsible for updating the plan of care and crisis interventions where appropriate.

12.3 Where a service user is on **Enhanced Level** of the CPA, the care co-ordinator role should be taken on by a professional who is part of the Multi-Disciplinary Team (MDT), e.g. Community Mental Health Nurse, Social Worker, Medical Staff, Occupational Therapist, Psychologist, etc. A mental health professional from a community team often takes on this role, as they are better placed to maintain contact with the client and oversee the package of care given.

12.4 Allocation of a care co-ordinator should reflect the assessed health and social care needs of the service user and take into consideration which professional would be best placed to take on the role of care co-ordinator.

It is crucial that the care co-ordinator can understand and respond to the specific needs of the service user that may relate to their cultural or ethnic background and communication needs.

12.5 Both health and social care managers should ensure that the care co-ordinator is able to combine the roles of CPA care co-ordinator and care manager by having:

- Competence in delivering mental health care (including an understanding of mental illness);
- Knowledge of service user/family (including awareness of race, culture and gender issues);
- Knowledge of community services and the role of other agencies; and
- Co-ordination skills and access to resources.

12.6 The care co-ordinator is responsible for co-ordinating the development and review of an agreed plan of care; this should include a contingency plan in case the service user relapses or fails to engage with services.

Other members of the MDT have the responsibility to communicate and liaise with the care co-ordinator regarding the delivery of the agreed plan of care.

The care co-ordinator can only fulfil the role if all members of the MDT communicate effectively.

12.7 The key essentials of the care co-ordinator role include:

- Ensuring that the focus of the CPA process remains firmly on the individual's strengths and identified goals and promoting recovery.
- Optimising, in collaboration with the service user, opportunities for choice, self-determination and independence and facilitating preparation of advance directives.
- Maintaining regular contact with the service user and developing a therapeutic relationship.
- Providing a link with services for the service user and carers and providing support in the community.
- Continuing assessment of need and risk.
- Monitoring mental state and responding appropriately to signs of deterioration.
- Involving Social Services Children and Families when appropriate,
- Monitoring the implementation of the CPA care plan and liaising with others as appropriate.
- Ensuring that regular reviews of the CPA care plan are taking place and appropriate documentation is completed and up-to-date and that the service user has signed and received a copy of the care plan. (When a service user is in hospital, the named nurse will take on the responsibility of ensuring reviews are arranged.)
- Remaining in contact with the service user and named nurse, if the service user is admitted to hospital.
- Working with the service user towards promoting well-being and preventing admission and re-admission.
- Being able to access both health and social care resources whilst also being accessible to other members of the MDT.
- Recognising that any member of the MDT can call an emergency review where circumstances arise. The care co-ordinator should always be informed.
- Liaising with others to ensure that immediate action is taken when the CPA care plan no longer meets the service user's needs in a crisis.
- Plan for their own absence by ensuring that cover arrangements are in place and that the service user is informed.

The Care Programme Approach (CPA)[14]
CPA is the framework for good practice in the delivery of mental health services. In early 2008, the *"Refocusing the Care Programme Approach: policy and positive practice"* document was published.[15] This made changes to the existing Care Programme Approach.

One of the key changes is that CPA no longer applies to everyone who is referred to and accepted by specialist mental health and social care services. However, the principles and values do apply. CPA still aims to ensure that services will work closely together to meet your identified needs and support you in your recovery. If you have a number of needs, and input or support from a range of people or agencies is necessary, then the formal CPA framework will apply. When your needs have been identified and agreed, a plan for how to meet them will be drawn up and a care co-ordinator will be appointed. You and your views will be central throughout the care and recovery process.

There are four elements to the Care Programme Approach:

- Assessment – this is how your health and social care needs are identified.
- Care co-ordinator – someone is appointed to oversee the production and delivery of your care plan, keep in contact with you, and ensure good communication between all those involved in your care.
- Care plan – a plan will be drawn up which clearly identifies the needs and expected outcomes, what to do should a crisis arise and who will be responsible for each aspect of your care and support.
- Evaluation and review – your care plan will be regularly reviewed with you to ensure that the intended outcomes are being achieved and, if not, that any necessary changes are made.

The (new) CPA will function at one level and what is provided is not significantly different to what has been known previously as "enhanced CPA".

Risk Assessment
Risk assessment and risk management should be part of the routine care provided to a mental health service user. At present there is great local variability in the practice of risk assessment and in the documentation tools used. However, the general principles of risk assessment and risk management rely on undertaking an assessment and identifying aspects of an individual's behaviour and lifestyle that might pose a risk to self, or to others, and to the qualification of that risk where possible. Once risks are identified, it is the role of the assessing professional to judge the magnitude of the risk and to devise a plan aimed at reducing or removing the risk.

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[14] http://www.mentalhealthleeds.info/infobank/mental-health-guide/care-programme-approach.php
[15] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf

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