An independent investigation into the care and treatment of a person using the services of Nottinghamshire Healthcare NHS Trust

Undertaken by Consequence UK Ltd

Ref 2009/6978

October 2011

This is the report of an independent investigation commissioned by East Midlands SHA 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 (MHSUs) involved in adverse events, defined as including the commission of homicide, where there has been contact with specialist mental health services[1] in the six months prior to the event.

The CUK Investigation Team members were:

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Acknowledgements

The Investigation Team wishes to thank:

- the family of the service user;
- the mental health service user (MHSU);
- staff employed by Nottinghamshire Healthcare NHS Trust;
- individuals no longer employed by Nottinghamshire Healthcare NHS Trust, but who met with CUK anyway,

all of whom assisted in the investigation conducted.

[1] Specialist mental health services are those mental health services that are provided by mental health trusts rather than GP and other primary care services. Usually persons in receipt of specialist mental health services will have complex mental health needs.

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ACRONYMS USED IN THIS REPORT

Acronym	Full Title
A&E	Accident and emergency
AO	Assertive Outreach
AOCC1	Assertive Outreach Care Co-ordinator 1
GP	General practitioner
CMHT	Community mental health team
Cons P1	Consultant psychiatrist 1
Cons P2	Consultant psychiatrist 2
CPA	Care Programme Approach
CPN	Community psychiatric nurse
EMSHA	East Midlands Strategic Health Authority
LASSL	Local Authority Social Services Letter
MCA	Mental Capacity Act
MDT	Multi-disciplinary team
MHA[1]	Mental Health Act (1983)
MHA[2]	Mental Health Act (2007)
MHP	Mental health professional
MHSU	The mental health service user whose care and treatment is the focus of the report
NHS	National Health Service
NPSA	National Patient Safety Agency
RMO	Responsible medical officer
SHA	Strategic health authority
SW	Social worker

EXECUTIVE SUMMARY

Incident overview and intention

On 24 July 2009, a mental health service user, subsequently referred to in this report as 'the MHSU', attacked his grandfather and grandmother. As a consequence of this, the MHSU's grandfather died. Although the MHSU's grandmother survived, her life has been irrevocably changed by what happened, as have the lives of the MHSU's mother and all other near family members.

At the time of the incident the MHSU was a patient of Nottinghamshire Healthcare NHS Trust. Consequently, in keeping with statutory requirements, his care and treatment in the antecedent period to the incident has been independently assessed to determine i) whether the MHSU's care and treatment was reasonable; and ii) whether or not the attack on his grandparents was predictable and/or preventable at the time in which it occurred.

Purpose of the investigation

The initial terms of reference for this investigation did not include a re-investigation of the care and treatment of the MHSU. The requirement was for a review of Nottinghamshire Healthcare NHS Trust's own investigation and to determine following this whether a more thorough investigation was required. This process, and involvement of the families of the MHSU and the deceased, resulted in a more searching investigation which set out to provide answers to the following questions:

- Did the Assertive Outreach (AO) Team responsible for the MHSU have a sufficient understanding of his diagnosis, presentation and relapse indicators?
- The AO Team relied on a number of information givers between 2007 and 2009 to enable them to be informed about the MHSU, who refused to engage with them. Was this strategy reasonable, and was it effective?
- Was the medication prescribed appropriate and was it administered as prescribed?
- Was it reasonable that the AO Team did not re-attempt an assessment of the MHSU under the Mental Health Act after its unsuccessful attempt on 9 April 2009?
- The AO Team considered the threshold for an assessment of the MHSU under the MHA had been reached on 15 July 2009. Was it reasonable that they decided to conduct this assessment during the week of 27 July 2009?
- On 24 July evidence of further deterioration in the MHSU was identified. Was it reasonable not to pursue an urgent Mental Health Act Assessment on this day?
- Was there any information available to the AO Team between 16 April 2009 and 19 July 2009 that should have prompted earlier consideration of the need for an assessment of the MSHU under the Mental Health Act?
- Was sufficient consideration given to the MHSU's mother and grandparents as carers?

Conclusions

The incident in which this MHSU was involved was tragic, and its impact has been enormous on the MHSU's family. CUK's conclusions are based on an objective and detailed analysis of the MHSU's care and treatment in Nottinghamshire Healthcare NHS Trust in the 20 months preceding the incident and are also cognisant of his mental health history since 2002 and the precipitators to his previous relapse episode in 2007.

With regard to the question "Was it predictable that the MHSU would attack his grandparents in the way that he did?", CUK does not believe that it was predictable. The MHSU did not have a history of violence or aggression to the extent that one would reasonably have considered him of any significant risk of harm to others. His family agrees with this.

The risks in relation to this MHSU were risks of harm to self through self-neglect, manifested by poor diet and poor hygiene. Any risk of harm to others was considered in terms of environmental health issues, manifested through his lack of care with his home, and the storage of 'various fluids' in bottles, some of which during his relapse in 2007 had been identified as urine.

With regard to the question "Could different management by mental health services have averted the incident?", this is a far more complex question. Clearly, had the MHSU been assessed under the Mental Health Act (MHA) prior to 24 July and admitted to hospital on a compulsory basis, then the incident that occurred would have been avoided. However, there are three components here:

- Assessment under the Mental Health Act;
- The purpose of the assessment; and
- The outcome of such an assessment.

From the interviews conducted with the AO staff it seems that they were waiting for a sufficient deterioration in the MHSU for the threshold for compulsory detention into hospital to have been assured. It is the opinion of CUK that there were sufficient indicators emerging between April and mid-June 2009, to have justified an assessment of the MHSU under the Act before this threshold was reached. CUK considers that the optimal time for an assessment of the MHSU was between 15 and 24 June 2009. However, CUK cannot say that, had a Mental Health Act assessment been achieved, it would have resulted in the compulsory treatment of the MHSU. It simply is not possible to determine this retrospectively. However, what an assessment would have provided was a clear and detailed analysis of the MHSU's mental state and opportunity to have re-engaged him in a treatment plan, or to have made clear to him the consequences, to him, of not re-engaging in treatment.

It is the lack of assessment of the MHSU, and the loss of opportunity to have assessed his mental state in advance of the incident, that continues to generate anger and distress for his family.

After 24 June 2009, the next clear opportunity for pushing forward with a MHA assessment was from 15 July 2009. The MHSU's care co-ordinator did, at this time, consider that the threshold the AO Team had been waiting for had been reached. The AO Team planned to conduct such an assessment on Monday 27 July. It considered that, in the context of the MHSU's slow deterioration, a planned assessment at a time where the MHSU was most likely to be at home was the

optimal approach. In view of the lack of risk history associated with the MHSU, and the fact that his care co-ordinator had laid out clearly for a range of colleagues the optimal time to find the MHSU at home, so that an assessment could be conducted, it is difficult to criticise the rationale.

However, the clearly laid out strategy by the care co-ordinator (on 19 July) was not progressed as it should have been. Although all AO staff interviewed by CUK agreed that a MHA was necessary and believed that it was going to happen on 27 July, at the time of the incident the actual arrangements had not been made for the conduct of a MHA on the morning of 27 July. This was and remains an unacceptable lapse in process.

With regards to the events of 24 July (the day of the incident), a visiting AO CPN observed concerning features on the door of the MHSU's flat. This individual contacted the MHSU's grandfather and was advised that there had been further deterioration in his grandson. As a consequence of this, the CPN did contact the duty Approved Mental Health Practitioner to discuss the situation and to explore whether an urgent Mental Health Act assessment was required. CUK is satisfied that this CPN undertook an appropriately detailed discussion with the Approved Mental Health Professional on duty. It is also satisfied that the decision both of these professionals came to that there was insufficient information to justify a section 135 warrant allowing forcible entry into the MHSU's home that evening/night was reasonable.

Other conclusions of CUK are:

- The management and care of the MHSU in the community between 2002 and March 2007 was of a good standard.
- The management and care of the MHSU between October 2007 and April 2009 was reasonable.
- There is sufficient evidence available to evidence that the MHSU's care co-ordinator had a reasonable relationship with the MHSU's grandfather and that they did make reasonable effort to communicate with the mother of the MHSU on the occasions this was necessary.
- The interface between the Dual Diagnosis Service and the AO Team was ineffective and the level of proactive communications between the teams was unacceptably low.
- After 9 April 2009 it is the contention of the CUK team that the care and treatment of the MHSU was misguided because of:
    - an over-reliance on negative reporting;
    - the lack of a complete picture within the AO Team of the MHSU's past risk behaviours;
    - the non-progression of the AO Team's own plan of action agreed on 23 April 2009 that the situation in relation to the MHSU would be reviewed in six weeks' time; and
    - the lack of assertive response to the early warning signs in evidence for the MHSU, i.e. reports of verbal aggression to the extent that cleaners would not go back to the corridor outside his flat unaccompanied, allegations (unsubstantiated) of assault.

The systems issues that CUK considers as contributory to the missed opportunities for further MHA assessments of the MHSU after 9 April 2009 were a lack of:

- robustness in the multi-disciplinary weekly clinical meeting;
- robustness in the zoning system used;
- effective team leadership; and
- an insufficient number of funded medical sessions for the MHSU's AO Team.

These issues were compounded by:

- The size of the AO Team caseload, which was and remains notably large compared to other teams in and out of Nottinghamshire.
- The frequency with which the MHSU's care co-ordinator was on sick or carer's leave.
- The dispersed and enlarged geographical area for the AO Team that resulted as a consequence of aligning the service with the relevant local authority and funding Primary Care Trust.
- The rapid rise in caseload size following the previously mentioned alignment of service boundaries and the subsequent impact on the time available for conducting assessments of service users.

Recommendations

The IIT has five recommendations for Nottinghamshire Healthcare NHS Trust.

Recommendation 1: As a corporately delivered service, all AO Teams in Nottinghamshire Healthcare NHS Trust should have a consistency in approach across all of its core systems and processes, including the zoning system.

Nottinghamshire Healthcare NHS Trust must ensure that all of its AO teams work to a common operational policy, with the individual requirements of these reflected accordingly. The County North Operational Policy provides a useful framework for achieving consistency for the whole service.

In addition to the operational policy, issues such as the method for minutes taking at 'same type' meetings could be standardised so that across-team audits are easier to accomplish.

Finally, a key issue that was identified as significant in the care and treatment of the MHSU subject to this investigation observation was the lack of formalised criteria for moving service users up and down the traffic light ratings, and a lack of clearly defined clinical expectation/intervention associated with each level of the traffic light or zone.

Although there is variability in how AO, and other specialist teams, approach the usage of traffic light and other zoning systems, these systems are central to service user management. Consequently, having a robust framework, including features that dictate the focused discussion of a service user and the documentation of clinical decisions subsequently made, is sensible.

It is therefore recommended that the AO service managers, team leaders and clinical leads explore:

- the range of approaches currently in use across the AO teams;
- approaches in other mental health trusts and other teams such as early intervention services;
- the range of criteria that might constitute a robust framework for dictating the necessity for clinical discussion of a service user at the weekly clinical team meeting, and/or the service user's escalation up the zoning system;
- the process by which the service user, once escalated up the zoning system, can be 'de-escalated'.

In conjunction with the above, it is recommended that:

- clear guidelines are developed for the zoning system agreed;
- documentation standards around clinical decision making are agreed;
- the way the zoning system is to be audited, including audit criteria and the frequency of audit, is agreed and planned for.

Target audience: It is imperative that all of the team leaders/managers and lead clinicians and consultant psychiatrists for AO across Nottinghamshire are involved in considering and taking this recommendation forward.

Timescale: The CUK team highlighted the necessity for a single approach to the zoning system in January 2011. The draft report was delivered to the Trust in May 2011. Consequently, it is suggested that the above is achievable by 31 December 2011.

Recommendation 2: If the current model of AO is to continue in Nottinghamshire, it is essential that there is an increase in the provision for dedicated medical sessions to the County South AO Team.

This investigation, and the Trust's own investigation, identified insufficient medical sessions provided to this AO Team. This means that the provision of necessary and meaningful medical input is challenging. It is the contention of CUK that, had there been more appropriate levels of medical input provided by the Trust, then it may have made an impact on the assessment and management of the MHSU involved in this incident.

If an increase in medical sessions were to be achieved, CUK considers that this should result in:

- a more robust approach to the gathering of historical information about a service user;
- greater medical involvement in the initial assessment of service users referred to the AO service.

Target audience: The Service Manager for County South AO, the Medical Director for Nottinghamshire Healthcare NHS Trust, the commissioners for the County South AO Service.

Timescale: As soon as possible.
CUK considers that the lack of medical resource to the County South AO Team is not tenable, even in light of the prevailing changes that may be implemented in

relation to AO services. The lack of medical provision does not equate to a safe and effective service.
However, it appreciates the complexity of achieving increased funding and does not see it as appropriate to impose a fixed timescale for this recommendation.

Recommendation 3: That the County South AO Team undertakes a randomised audit of a 20% sample of its current caseload to determine to what extent all relevant historical risk factors are detailed within the contemporary risk assessment and effective care co-ordination documents.

Note: If such an audit reveals findings that show:

- significant gaps in the contemporary risk assessment and/or effective care co-ordination documents,
- a lack of rigour in the information provided to AO by feeder teams such as community mental health teams,

then a more far-reaching audit of risk assessment will be required across all adult service teams (general and specialist), exploring:

- the methods by which staff access historical information for a new client with a pre-existing history;
- how historical information is recorded and whether the current process facilitates ease of retrieval;
- the transfer of information between documents, e.g. sequential risk assessments; and
- the transfer of information between services, e.g. CMHT to AO.

Note 2: This recommendation should be implemented across all AO teams in Nottinghamshire.

Rationale
During this investigation it came to the attention of CUK that there was information of relevance to the assessment of the MHSU's risk that was not known by his care co-ordinator or other team members. Staff in this case relied on fragmented historical knowledge of a service user in order to make informed judgements on clinical risk management decisions. They need to rely on as complete information as is possible.

Progression of the recommendation
In making the above recommendation, the CUK team are aware that it is a sizeable piece of work. However, accurate historical as well as contemporary risk information is important to the delivery of a safe and effective mental health service.

Suggestions for how the recommendation could be achieved are:

- Via CPA Review as a rolling programme
- As a rolling programme via a separate weekly case review meeting
- A one-off structured audit.

CUK suggests that the AO managers put an option appraisal together alongside the costs for delivering each option and present this to the senior managers who will need to provide the necessary support for achieving this recommendation.

It is expected that the outputs of the audit process will trigger any additional patient safety project work required in relation to the above.

Target audience: The Executive Director responsible for patient safety and governance; the AO Team Managers and their Service Managers.

Timescale: It is not possible to provide a timescale for the conclusion of this work, as the size of AO team will have a significant impact on this. However, CUK expects that the Trust will have agreed with the relevant service managers a project management plan for delivering the above by September 2011.

Recommendation 4: There needs to be an AO Managers' Forum across Nottinghamshire Healthcare NHS Trust.

During this investigation it came to the attention of CUK that there is no forum where the AO managers can share and reflect on the practice of their individual teams. This has meant that, although there are some shared values, there has been inconsistency in what should be core elements of practice. The formulation of an AO managers' forum should help to alleviate this.

Target audience: The AO Managers and their Service Managers.

Timescale: This is a non-complex recommendation and CUK suggests that such a forum could be arranged with a launch date of September 2011.

Recommendation 5: Nottinghamshire Healthcare NHS Trust needs to consider developing more practice-based training for its qualified community staff around the requesting of and organisation of a Mental Health Act Assessment.

This and the Trust's own investigation highlighted a lack of clarity amongst staff about the mechanics of organising a Mental Health Act Assessment. Discussion with a number of approved mental health practitioners about this suggested that a more practically focused training opportunity would be of benefit. However, this case may not be representative of the general level of understanding across mental health professionals.

In the first instance the Trust may wish to conduct a fit-for-purpose survey of staff to determine the overall level of understanding about the requesting of, organisation of and conduct of a MHA assessment. This would enable it to determine i) whether there is a clear need to modify and/or expand the current MHA training provided within the Trust's non-AMHP staff; ii) what needs to be provided.

The persons best placed to design such a survey instrument would be the Mental Health Act Manager and a selection of Approved Mental Health Practitioners.

Target audience: The Executive Director responsible for Governance, the Trust's Mental Health Act Manager, the senior AMHP manager.

Timescale: CUK recognises that this is a recommendation that may not be a priority for the Trust at this time. However, it would expect the Trust to be able to advise East Midlands SHA of the outcome of a scoping survey, the results of which should determine the progression, or not, of the above by December 2011.

1.0 INTRODUCTION

This investigation was commissioned by East Midlands Strategic Health Authority to determine:

- whether the quality of care and treatment afforded the MHSU was reasonable and in keeping with local and national standards; and
- whether, or not, the incident on 24 July 2009 could have been prevented by different management and/or actions by the specialist mental health services in Nottinghamshire Healthcare NHS Trust.

On 24 July, the MHSU went to his grandparents' home, where he attacked them. The attack was focused primarily on the MHSU's grandfather, who died as a result of his injuries. His grandmother, whom he also attacked, survived. The incident has had a profound impact on all family members.
The MHSU was subsequently sentenced in Nottingham Crown Court and was ordered to be detained indefinitely in a high-security hospital.

1.1 Overview of the MHSU's contacts with specialist mental health services in Nottinghamshire Healthcare NHS Trust

21 May 2002: The MHSU was first referred to specialist mental health services at the age of 22 years. He had been noted as depressed for a year or two prior to this date and had been treated in the community by his GP with Lofepramine 70mg three times a day.

Subsequent assessment of him by a Consultant Psychiatrist (Cons P1) identified a range of presenting symptoms. These focused on:

- a range of beliefs about others,
- a trance-like state in which he would experience visual and auditory hallucinations,
- that a friend might try to kill him,
- that he had no control over his thoughts,
- that his father was "winding him up" and might try to kill him with a knife.

The correspondence to the GP after this said: "Consequently, he has been sleeping with an axe by his bed. He said, however, that he didn't think he would really attack anyone."

9 January 2003: By this time, Cons P1 noted that, "although I feel that any risk of harm to others has subsided, he remains with only partial response to our treatment with Olanzapine and Sertraline. I think it would be reasonable now to increase the Olanzapine further to 20mg at night." This remained a consideration in May 2003 when Risperidone was commenced at 2mg, rising to 4mg after two days. This was subsequently increased to 6mg in August 2003.

In August 2003 it was also noted that, although the MHSU had ceased taking illicit drugs, he continued to drink more than he should.

August 2003: The MHSU was reviewed at outpatients. He is noted to have stopped using illicit drugs but continued to drink excessively. His Risperidone was increased to 6mg a day.

October 2003: By this time the MHSU was noted to be 50% back to his normal self. However, he remained troubled by pseudo-hallucinations, but partial insight to these now.

August 2004: Contact between the MHSU and Cons P1 has reduced considerably and Cons P1 noted that there had been a considerable delay in achieving a mutually convenient appointment with the MHSU. However, between August 2004 and April 2005 the MHSU continued to attend at outpatients.

May 2005: At a meeting with his CPN (CPN2) it was noted how impressed the CPN was with the MHSU's progress. The MHSU's progress was linked to the cessation of his use of Amphetamines.

October 2005: It is in this month that the MHSU decided that "he will not accept any further input from the community mental health team at the present time". The MHSU was subsequently discharged from the CPN's caseload, although it was made clear that he could re-engage at any time. The MHSU continued to engage with his Tenancy Support Worker at this time.

October 2005 – February 2006: The MHSU remained out of touch with mental health services.

February 2006: The MHSU attended an outpatient appointment with his tenancy support worker. At this appointment it was noted that the MHSU continued to intermittently misuse illicit drugs. It was noted that he had resolved not to use amphetamines or crack cocaine, but that he had "run into difficulties with heroin". The MHSU was noted to remain troubled by hallucinations and a range of delusions and he appeared to be actively psychotic at the time of the appointment. Cons P1 noted that he considered that "Clozapine is definitely the right option now, though this would require a high level of commitment from the MHSU". A plan was made to see the MHSU again in five weeks' time.

March 2006: The MHSU had his first referral to the Dual Diagnosis Service, following which he received a full assessment and acceptance by the service.

May – September 2006: The MHSU disengaged from the Dual Diagnosis team, his mental health team and Cons P1. He also withdrew from his tenancy support worker. A referral was therefore made for his case management to be transferred to the AO Team.

October 2006: There was concern raised by Cons P1 that the MHSU had returned to street heroin and a recommencement of amphetamine use. To all intents and purposes, Cons P1 also believed that the MHSU had also stopped all of his anti-psychotic medication.
Cons P1 noted in his correspondence to the MHSU's GP that "it is difficult to evaluate the risks in this situation. However, following discussion with various people who have had contact with him, including yourselves, it does not seem as though we have reached the threshold for compulsory admission under the Mental Health Act."

November 2006 – March 2007: The MHSU continued to remain disengaged from mental health services and his mental health deteriorated to the extent that in March 2007 he was admitted to hospital on a compulsory basis under section 2 of the

Mental Health Act (1983). The MHSU's detention under section two of the Mental Health Act was subsequently changed to section three.

March 2007 – September 2007: The MHSU remained under the care of in-patient services.

September 2007: The MHSU commenced a rolling programme of leave. This was supported by his mother.

25 October 2007: The MHSU was discharged from in-patient services.
The seven-day post-discharge visit was achieved on 2 November 2007, as the MHSU was not in when the AO Team called at his home on 31 October.

November 2007 – March 2008: The AO Team's contact with the MHSU was punctuated with a mix of successful home visits and unsuccessful home visits. Although the MHSU was reluctant to engage with the AO Team, it had some success in maintaining him on depot medication.

March 2008: The MHSU's grandfather made contact with the Dual Diagnosis Service, a consequence of which was the re-assessment of the MHSU by the Dual Diagnosis Service and recommencement of prescribed methadone 50ml as of 22 April 2008.

April – October 2008: The AO Team continued to provide support to the MHSU and to administer his depot medication. The visits remained slightly chaotic, with the MHSU not always being available. The MHSU's grandparents remained closely involved with him and other professionals such as the community pharmacist, who provided valuable information regarding the MHSU's reliability in collecting his methadone prescription as well as his general appearance.

October – November 2008: The MHSU started to deteriorate and in November stated he no longer required treatment and was unwilling to engage. The only service he is willing to engage with is the Dual Diagnosis Service.

December 2008: This month was punctuated by repeated unsuccessful attempts to make contact with the MHSU.

January 2009: The MHSU decided that he no longer wanted to take his depot medication.

January 2009 – April 2009: The MHSU fully disengaged from the AO Team. By April there was sufficient concern about him that Mental Health Act assessment was organised for 9 April. This, however, was not achieved as the MHSU was not at home when the relevant professionals attended there.

April 2009 – July 2009: Following the unsuccessful attempt to assess the MHSU, a decision was made to gather further information about the MHSU before attempting another Mental Health Act assessment. It was considered in April, May and June that there were insufficient indicators to warrant this.

19 July 2009: The MHSU's care co-ordinator sent an email to a range of colleagues advising that he considered that a Mental Health Act assessment was required. This was subsequently discussed at a clinical team meeting on 20 July and a decision was to conduct a Mental Health Act assessment on a planned basis on 27 July.

24 July 2009: A CPN from the AO Team attempted to visit the MHSU at home. Concerning features were observed on the MHSU's front door, and the community pharmacist confirmed that the MHSU's self-care had further deteriorated, and that he looked thin. The MHSU's grandfather provided further corroborating information that the MHSU's mental state had deteriorated, including information suggesting that he was now psychotic. The CPN discussed the situation with the duty Approved Mental Health Professional. The outcome of this discussion was that neither professional believed that there was sufficient information to justify an application for a warrant under section 135 of the Mental Health Act to enable forced entry into the MHSU's home to conduct an assessment.

25 July 2009: The AO Team were informed of the arrest of the MHSU and the death of his grandfather.

More detailed chronology of the MHSU's contacts with the mental health service in Nottinghamshire is included in each relevant section of this report.

2.0 TERMS OF REFERENCE

The terms of reference for this independent investigation, set by East Midlands Strategic Health Authority, were as follows:

- To establish whether the timeline is accurate and all-encompassing, ensuring that the Trust has considered all the relevant evidence; for example, Trust documentation, key witness statements and interviews.
- To undertake a scoping exercise to identify whether all necessary agencies have been considered and included in the internal investigation. Where this has not been the case, assess whether the inclusion of the information into the timeline could affect the findings.
- To assess whether the analysis undertaken is reasonable and proportionate and accurately reflects the issues identified with the quality of health and social care provided to the MHSU.
- To review the Trust's policies and procedures to validate their compliance and that this was accurately reflected in the internal investigation report, paying particular attention to:
  - the Care Programme Approach (CPA);
  - the risk assessments process;
  - care plans; and
  - the Mental Health Act assessment process (if appropriate).
- To establish whether the recommendations identified in the Trust's internal investigation report are appropriate, paying particular attention to Recommendation 5, and determine whether the implementation of any recommendations from the AO review would mitigate against the issues identified.
- To identify any additional learning from this investigation through applying Root Cause Analysis (RCA) tools and techniques as applicable.
- To report the findings of this investigation to East Midlands Strategic Health Authority.

Following CUK's analysis of the Trust's internal investigation and the original interview transcripts of the Trust's internal investigation, the CUK team did not consider that it had a sufficient understanding of how or why the MHSU's care and treatment had not met with local expectations. Furthermore, the CUK team found the Trust's report to be highly critical of the MHSU's care and treatment, without setting out a clear evidence base for this. Consequently, CUK advised the SHA that, because of the incident that had occurred, it considered that some re-investigation of the care and treatment of the MHSU was required and therefore re-interview of some, but not all, staff was necessary. This approach was supported by the SHA.

The rationale for this decision was further endorsed following a meeting with the family of the deceased, where it became clear that, for the family to trust the findings of the independent investigation process, they expected at least the core staff involved in the care and treatment of the MHSU to be re-interviewed. Under the circumstances, the SHA and CUK considered this to be reasonable and underlined the necessity for the decision already made.

3.0 CONTACT WITH THE FAMILIES OF THE DECEASED, THE FAMILY OF THE MHSU AND THE MHSU HIMSELF

CUK and East Midlands SHA held an initial meeting with the family of the MHSU, and the deceased, in mid-November 2010. CUK subsequently met with the family in June 2011. In between times, CUK and the MHSU's family exchanged a number of emails in relation to the investigation, as was the preferred method of update and communication for the MHSU's family. A final meeting was conducted between the MHSU's family, East Midlands SHA, CUK and the family's solicitor on 24 August 2011.

With regards to the MHSU, a meeting was initially planned with the MHSU and his mother in January 2011, but this was not possible owing to adverse weather conditions. A decision was subsequently made to meet with him towards the end of the investigation processes. This was considered as preferable for him and his family.

Issues of concern

The following questions were posed by the family of the service user to the Trust's own investigation team and subsequently to CUK:

1. "We understand that our nephew's last medication was administered in Nov/Dec of 2008, so why was it left until Feb 2009 before our father and our sister were contacted by the AO Team informing them that our nephew had just missed his monthly injection, when clearly he had in fact missed at least 3 months' medication.
2. Under normal circumstances, how often would our nephew be visited by his carers and did this actually happen? [Carer's refers to AO staff]
3. If a condition of his 'release' [i.e. discharge from hospital in October 2007] was that he must accept his monthly injections, why was he allowed to miss them?
4. Knowing that he was not receiving his medication, why was a more pro-active direction towards his care and greater monitoring of his mental state not conducted?
5. From February 2009 our father repeatedly made contact with the AO Team; not, we must stress, to enquire about our nephew's condition, but to inform them of the steady decline in his condition. Phone records held by the police will verify that our father made numerous calls right up to the day he died, trying to convince the AO Team that he was extremely concerned about our nephew's condition and that something needed to be done to help him. Why were these calls not heeded?
6. In May 2009 both our sister and our father were telephoned separately by the AO Team and informed that any day now our nephew would be sectioned again. So at last some action was recognised as being necessary; so why did this not happen?
7. If it was recognised in April that action needed to be taken, how often was our nephew's condition being monitored by his team and who was making the decisions**?**

8. In June and July our father made further phone calls about our nephew's now extremely poor condition. With all these alarm bells ringing, lack of medication, worsening physical appearance and mental condition, surely someone on his team must have wanted to check out and evaluate these concerns; after all, 3 months earlier they thought that sectioning was the answer.
9. Again from the time that it was decided to section him again at the end of April 2009 no contact was made with him until after his arrest for my father's murder; this was in spite of contact from our father about his deteriorating condition.
10. [MHSU's] behaviour was mirroring the same behaviour prior to his earlier sectioning, so again why were his carers not looking at the bigger picture and joining up the dots?"

All of these issues were addressed during the investigation process.

The meetings between the MHSU's family and CUK clarified that the issue of greatest importance to them was to understand why the AO Team did not re-attempt to conduct an assessment of the MHSU after 9 April 2009 and before 24 July 2009.

To the family it was clear that the MHSU was deteriorating. The wife of the deceased told CUK that her husband was hoping that his information to the MHSU's care co-ordinator, and the fact that his grandson was not on any of his anti-psychotic medication, would prompt such an assessment.

The MHSU's family accept the fact that, had he been assessed during this time period, he may not have met the criteria for compulsory treatment. They understand this. However, they feel strongly that no-one was in a position to make any 'at a distance' judgement about the MHSU's mental state, because no-one from the AO Team or Dual Diagnosis Service had been able to

- speak with him; or
- observe the state of his flat.

The family do not accept that the information provided to the AO Team was sufficient to give any reassurance about the MHSU's mental state.

The MHSU's family were unaware that they could have requested a Mental Health Act assessment of the MSHU themselves. Had they been so aware, they would have requested this.

4.0 FINDINGS OF THE INVESTIGATION

This section of the report is divided into two main sections:

- An overview of CUK's findings in relation to the Trust's Internal Investigation Report
- The presentation of CUK's findings based on its analysis of the care and treatment of the MHSU between October 2007 and July 2009.

4.1 Overview of CUK's assessment of the Trust's Internal Investigation

On reading the Trust's internal investigation report, it was evident to CUK that the internal investigation team appointed by Northamptonshire Healthcare NHS Trust undertook its investigation with vigour and integrity.

Overall, the report evidences that the internal investigation team were 'fearless and searching' in their approach and did identify a range of issues it considered to be unsatisfactory about the care and treatment of the MHSU. Although CUK considered that a number of the issues were accurately reported, it also found that some of the issues appeared to be too strongly stated without the necessary evidence base to support the Trust's opinion being set out in its report.

The Trust's investigation team did endeavour to set out the range of contributory factors it considered to have contributed to the lapses in care and treatment it reported; however, the approach taken to this did not achieve what they had hoped for. This left a lack of clarity for the reader of the report.

CUK understands that a range of factors conspired against the Trust's investigation team conducting a robust evidence analysis and delivering a report that fully represented the effort and diligence expended on the investigation. These factors were:

- The terms of reference for the investigation changed after the investigation was commissioned.
- Not all members of the investigation team were familiar with how to analyse evidence collected or how to present such volume of data within an investigation report.
- The investigation team were given insufficient time to construct an investigation report that properly reflected the investigation team's understanding and analysis.
- The investigation team were all maintaining their regular clinical and managerial posts during the course of the investigation, which did (and always will) curtail the cohesiveness of the investigation process.

The Recommendations Made

The Trust's investigation team made six recommendations, mostly targeting the practice and policies and procedures in the MHSU's assertive outreach team. Recommendation Five highlighted the need for more medical sessions to be provided to this assertive outreach team. CUK's findings support this recommendation and have reiterated it in section 7.0 of this report.

4.2 CUK's findings in relation to its analysis of the MHSU's care and treatment between October 2007 and July 2009

As previously stated in section 2 of this report, it was agreed with East Midlands SHA that, in order to deliver a proportional assessment of the MHSU's care and treatment, and to meet the needs of the family of the MHSU and the deceased, the following questions were agreed as appropriate:

4.2.1 Did the AO Team responsible for the MHSU have a sufficient understanding of his diagnosis, presentation and relapse indicators:

- Prior to his compulsory admission to hospital in March 2007;
- When he was discharged from inpatient services in December 2007?

4.2.2 The AO Team relied on a number of information givers between 2007 and the time of the incident in 2009 to enable them to be informed about the MHSU, who refused to engage with them. Was this strategy reasonable, and was it effective?

4.2.3 How effective was the medicines management for the MHSU between October 2007 and July 2009?

4.2.4 Was it reasonable that the AO Team did not re-attempt an assessment of the MHSU under the Mental Health Act after its unsuccessful attempt on 9 April 2009?

4.2.5 The threshold was considered to have been met for an assessment and compulsory treatment of the MHSU from 15 July 2009. Was it reasonable that the AO Team decided to conduct this assessment during the week of 27 July 2009?

4.2.6 On 24 July evidence of further deterioration in the MHSU was identified. Was it reasonable not to pursue a Mental Health Act Assessment on this day?

4.2.7 Was there any information available to the AO team between 16 April 2009 and the 19 July 2009 that should have prompted earlier consideration of the need for an assessment of the MSHU under the Mental Health Act?

4.2.8 Was sufficient consideration given to the MHSU's mother and grandparents as carers?

The focus of the questions above is on the period of care and treatment following the MHSU's discharge from inpatient services in October 2007. It is this 20-month time-frame that constitutes the most significant antecedent period to the incident.

In setting out its findings, CUK is mindful of the tragic outcome of the incident that occurred on 24 July and the irrevocable impact it has had on the MHSU's grandmother, his mother and other family members, as well as for himself.

CUK has also been mindful of its responsibility to avoid hindsight bias[2] and to analyse the appropriateness of decisions made on the basis of the information

[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,

available to clinicians at the time the care and treatment was provided, and the circumstances in which they acted.

Other considerations
Before setting out its findings in relation to the above questions, CUK believes that it is important that appropriate acknowledgement is given to the care and treatment the MHSU received before being transferred to the AO Team in 2006.

Between 2002 and 2006 the MHSU was under the care of a general adult psychiatrist, Cons P1, and a community mental health team.

During this period the care and treatment afforded the MHSU was appropriate and Cons P1 particularly was successful in achieving substantial periods of contact with the MHSU.

The clinical records evidence:

- appropriate consideration of the MHSU's existing physical health needs;
- appropriate consideration of risk for the MHSU;
- appropriate adherence to NICE guidelines in the consideration of Clozapine when the MHSU appeared not to be responding to other anti-psychotic medications;
- appropriate referral to the Dual Diagnosis Service;
- appropriate referral to an employment support agency;
- appropriate referral to a housing association providing support in sustaining tenancy;
- appropriate liaison with the Department for Work and Pensions regarding the MHSU's benefits;
- appropriate consideration of the need for a more AO service for the MHSU, and the subsequent referral for this.

Following the MHSU's referral to the AO Team, the clinical records evidence:

- persistent attempts by his appointed care co-ordinator to make contact with him and to inform himself and the AO Team about the MHSU;
- appropriate communications with the family of the service user as an information resource;
- appropriate communications with Cons P1 and the previous CMHT in order to achieve a good baseline of information about the MHSU;
- positive action to assess the MHSU under the Mental Health Act in 2007;
- appropriate advice and input sought from a psychologist during a period when the MHSU was experiencing debilitating panic attacks; and

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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".

- reliability in the contacts between the MHSU and the AO Team following his discharge from hospital in October 2007 through to the MHSU's decision to disengage from the AO service from January 2009.

The following sections specifically address in detail the questions posed above.

4.2.1 Did the AO Team responsible for the MHSU have a sufficient understanding of his diagnosis, presentation and relapse indicators?

It is clear that the mental health professionals working in the AO Team understood that:

- the MHSU had a diagnosis of paranoid schizophrenia;
- the MHSU had a methadone addiction;
- the MHSU displayed increasing signs of self-neglect, suspiciousness and withdrawal from his family when relapsing;
- medication non-compliance was a precursor to relapse.

The following information sets out the evidence base upon which this premise is made.

The clinical records show that the MHSU had been in contact with the specialist adult mental health services in Nottinghamshire since May 2002. Over this period of time he had refused to accept the support of the Community Mental Health Team and only engaged with his consultant psychiatrist (Cons P1). However, even this engagement could be sporadic and between 2006 and 2007 tailed off completely. He did, however, meet with a member of the dual diagnosis team in March 2006 with reference to his heroin, crack cocaine, amphetamine and methadone use. The purpose of this meeting was to assess the MHSU's suitability for support with methadone and to come off all other illicit drugs. He also initially engaged well with his 'Framework' key worker. However, in August 2006 he was reluctant to do so. The clinical records note that at this time the MHSU was becoming "increasingly suspicious and paranoid" and that he "felt that the Framework Key Worker was involved". The records noted that the MHSU felt "watched in the flat, therefore was not spending much time there and was walking around his home area". By September 2006 the MHSU had "cut all contact" from his Framework key worker.

Following this, the MHSU had no contact with any of the mental health services, including the Dual Diagnosis Service, and did not respond to any of the appointments he was offered.

Consequently, on 1 September 2006, the Community Mental Health Team (CMHT) referred the MHSU to the AO Team (AO). This referral was confirmed in a subsequent telephone call between the MHSU's GP and Cons P1 on 8 September 2006. The plan at this time was also for Cons P1 to remain as the MHSU's consultant psychiatrist as he had at least engaged with him in the previous four years. Appointments were offered to the MHSU in October and November 2006 (x2). He did not attend any of these.
On 27 November his AO care co-ordinator spoke with Cons P1 about the MHSU and he was provided with the contact details of the MHSU's sister and the MHSU's GP.

An email between the AO care co-ordinator and the secretary for Cons P1, dated 29 December 2006, evidences that the care co-ordinator had made contact with the MHSU's family and 'acquired a lot of information from them'.

The email noted:

- That the MHSU had been seen a few times by family members;
- That the MHSU was refusing to speak with family members;
- That local shops had reported seeing the MHSU out and about at 6am when they open and at other times of the day;
- That his grandparents are concerned about 'drug' use;
- That the MHSU has not been accessing family members for money;
- That the MHSU's grandparents had been involved in addressing the MHSU's finances most recently and had previously been "subject to badgering for money but not in past 2 months, which is the time he had been most disengaged";
- That all family members are concerned about his physical appearance, which has been getting progressively worse by sight.
- That the AO care co-ordinator had contacted the MHSU's housing provider.
- That the AO care co-ordinator suggested to Cons P1 that he send the MHSU several outpatient appointments, not on a Monday, to see if he will again engage. If not, the AO care co-ordinator noted, "I do wonder if we are looking at a more direct route [assessing], especially if he continues to appear unwell".

The email also noted that the AO care co-ordinator had spoken with the MHSU's mother in Australia.

Following this email, the clinical records evidence that the AO care co-ordinator maintained contact with:

- Cons P1;
- The MHSU's grandparents; and
- The MSHU's sister.

He was not, however, able to meet and assess the MHSU himself.

Furthermore, on 1 January 2007 the AO records noted that:

- they were aware that the MHSU's physical health was poor; and
- the MHSU had been off his medications for some months.

The next significant entry in the AO records was on 5 March 2007, following a telephone call from the MHSU's sister to the AO Team at 19.00hrs. The records noted that this individual had driven past her brother's home three days earlier. Noting the curtains to be open, which was unusual, she stopped and looked in. The record made notes that she was shocked by what she saw:

- carpets ripped up,
- no furniture except for a sofa,
- Plasticine over the electrical sockets, and
- approximately 50 bottles on the floor with foil over the top of them.

The CPN who took the call advised the MHSU's sister that he would speak with Cons P1 and that a Mental Health Act assessment seemed like it was required. This individual also contacted and spoke with the MHSU's mother, who had seen him the

week previously. She confirmed that her son would not speak to her, crossed the street if he saw her and would not open the door to her.

On 8 January 2007 a contingency/crisis care plan is documented by the MHSU's AO care co-ordinator. This document summarises:

- the social situation for the MHSU and his avoidance of family members; and
- details of the range of known issues for the MHSU at the time.

This list of issues included reference to the lack of clarity about the MHSU's known risk to self or others.

A clear plan was documented which included, "if no contact by the end of March to look at carrying out a MHA (1983) assessment, due to Cons P1's awareness of his history. AO to not be a part of this assessment but may need to be around if not sectioned so can be introduced as part of an ongoing care package."

The rationale here was that Cons P1 was due to retire at the end of March 2007, and that AO did not want to alienate the MHSU from them further by participating in a MHA assessment.

The plan also included regular contact with family members and the MHSU's housing provider.

On 13 March 2007 there was an attempt by another AO CPN to visit the MHSU with Cons P1. However, no access was achieved. This CPN noted that: "The MHSU does have a history of sleeping with a baseball bat in his bed as he believed that his father was going to attack him, but no history of actual assaults".

On 14 March at 16.35hrs a further attempt was made to gain access with two AO CPNs in attendance. They did see "a man sitting motionless in a chair", but raised no response. A neighbour told them that the MHSU was withdrawn and never spoke. There was no aggressive or threatening behaviour.

On 15 March 2007 a further attempt at contact was made. The MHSU was outside his flat on this occasion, but went inside when mental health professionals tried to approach him. He did not respond to their knocking on the door.

As a consequence of the AO Team's attempts to make contact with and assess the MHSU, and their observations, coupled with the information received from the MHSU's family, a decision was made to proceed to a Mental Health Act assessment on 19 March 2007. The outcome of this was the compulsory admission of the MHSU under section 3 of the Mental Health Act.

CUK Opinion

The above information shows that the MHSU's care co-ordinator did make reasonable efforts to find out as much as they could about the MHSU, even though they were not able to conduct a formalised assessment of him themselves. It was helpful that a contingency/crisis care plan had been created in January 2007.

Although the 'plan' was appropriate for the situation at the time, what would have aided the overall understanding of the AO Team and the MHSU's future management was a composite record:

- summarising his early contacts with the mental health services;
- setting out known risk behaviours/early warning signs:
  - non-engagement with mental health services;
  - illicit drug use (heroin, amphetamines, street methadone, crack cocaine);
  - Self-report of keeping a weapon under his pillow;
  - suspiciousness and paranoia;
  - thoughts that others would harm him;
  - reports of him keeping a 'baseball bat' under his pillow (2007);
  - reports of him keeping an axe by his bed (2002);
  - self-neglect; and
  - avoidance of family members, including crossing the street, not acknowledging them, being out of contact.

Although most of this information was contained within the AO progress notes, the narrative style of these records does not make it easily accessible to other team members who may have contact with the MHSU. Furthermore, a composite summary of history and risk enables all staff to have a contextually correct overview of a service user and relevant information is less likely to be lost.

4.2.1.1 The understanding the AO Team had of the MHSU when he was discharged from inpatient services in October 2007

The above information establishes that there was sufficient information in the clinical records for the AO Team to have all been adequately informed about the MHSU and of his early warning signs pre-admission. Furthermore, when the MHSU was detained in March 2007 the in-patient staff completed a 'FACE' risk profile which noted:

- no known risk of violence to others;
- risk of suicide was rated as low (1);
- risk of self-harm was rated as low (1);
- risk of accidental harm to self – no risk;
- risk of severe self-neglect was rated as low (1);
- risk of abuse/exploitation by others was rated as low (1); and
- risk of relapse – high.

The detail on the form also noted the MHSU's non-compliance with medication and the social isolation being indicative of increasing risk of relapse.

The summary of risks stated:

- self-neglect;
- isolation;
- ?paranoia, although the MHSU denies hearing voices/visual hallucination; however, he has a history of visual/auditory hallucination; and
- being guarded and pre-occupied.

The author of the FACE risk profile noted that there was "very little information available at present".

On 26 June 2007 a report for the Mental Health Review Tribunal was prepared. This document clarified a range of detail that was important for the AO Team to be

knowledgeable of in any subsequent community management of the MHSU, including that:

- pre-admission he had destroyed his television;
- he was doing creative work at home and was using texture and colour to fill up bottles;
- on admission he was suspicious;
- he showed no insight to his illness;
- he suffers from an enzyme insufficiency (this had already been noted by the MHSU's AO care co-ordinator);
- he refused to eat or drink on admission to hospital.

The Mental Health Tribunal report also noted that a Mental Health Act assessment was performed on 12 April, following an unsuccessful appeal by the MHSU "against his Section 2". The Mental Health Review Tribunal report also noted that the MHSU "continued to refuse treatment, remained very thought disordered, was unkempt, continued to lack insight and re-affirmed his belief that medication was poison". At this time he was therefore detained under Section 3 of the Mental Health Act.

The report also noted that, prior to the assessment, the MHSU had "become angry about being on the ward and wished to leave. He had threatened to be physically violent to staff." And that subsequent to this he absconded during a period of escorted leave. The final conclusion in report prepared was "were he not to be detained in hospital he would not comply with medication and the main risks would be to himself in terms of neglect and vulnerability".

The above information validates what was known about the MHSU prior to his admission, but did not add substantially new information other than the MHSU's threat to physically harm the staff when he wanted to leave the in-patient ward. Although the MHSU did not act on this threat, it was something the AO Team needed to be aware of in the context of the MHSU's noted risk behaviours.

The combination of the existing pre-admission records and key records made during the MHSU's 7-month in-patient stay should have resulted in an AO Team that was well informed. However, interviews undertaken with a number of the AO staff who were involved in the care and treatment of the MHSU following his discharge from in-patient services but prior to the incident that occurred revealed that these staff did not feel well informed about the MHSU. In particular, they reported not feeling well informed about his early warning signs and risk factors. All, however, were able to recount fluidly issues associated with:

- medication non-compliance,
- paranoia,
- the MHSU's tendency to walk for hours at speed,
- his risk of self-neglect,
- his early warning signs of withdrawing from family members,
- poor self-hygiene and poor self-care generally.

The staff interviewed by CUK were also aware of the challenges associated with making the MHSU's flat habitable, which it was not at the time of his discharge from hospital to his mother's then address. They were therefore collectively knowledgeable about the MHSU.

Staff, however, were not aware that the MHSU had previously kept an axe by his bed (2002); had thoughts that he might harm someone (2002); or that he was noted to have kept a baseball bat by his bed (2007).

Why did the AO staff not feel as well informed about the MHSU as they could have been?

Firstly, although there was a CPA discharge meeting between ward staff and members of the AO Team, there was no comprehensive CPA documentation or risk assessment documentation completed at this time. The community psychiatric nurse who attended the discharge meeting was not the MHSU's care co-ordinator, but someone who was standing in for him until he returned to work after a number of weeks' leave. This individual did not know the MHSU and was not expected to complete the necessary CPA documentation. It was expected that the MHSU's regular care co-ordinator would do this on his return to work. This was expected to occur within a month of the MHSU's discharge.

Secondly, the prelude to the MHSU's discharge from hospital was an extended period of unescorted leave, where the plan seemed to be for AO staff to visit him at his mother's home. The clinical record evidences that difficulties were experienced with this, and with the in-patient ward being able to achieve successful contact with the AO Team. The MHSU's mother recalled that, when the MHSU's care co-ordinator was at work, communication and contact usually worked well. However, when he was not available, communications and contact with the AO Team was generally less reliable.

Thirdly, following the MHSU's discharge from in-patient services on 25 October 2007, there was no discharge summary sent to the GP or to the AO Team. No one has been able to identify, this length of time after the fact, how this omission occurred.

The factors that contributed to the above were:

Practice Issues

- It was not the usual practice of this AO Team to systematically review all existing volumes of a service user's clinical records and to set out the service user's history in an accessible easy-reference chronology.
- AO Team to systematically review all existing volumes of a service user's clinical records and to compile a list of historical and current risk issues.

Policy/Procedural Issues

- It was the policy within the Trust (CPA) that service users were 'fostered' if the regular care co-ordinator was absent from work for more than one month. However, if the time period was to be for less than a month, then team members would only undertake essential care contacts, including medication and 7-day discharge visits. Care co-ordination responsibility would not be adopted by those 'caretaking' the service user. The expectation was that the service user's care co-ordinator would address these on his/her return. In this case, towards the end of November 2007.

Working Environment Issues

- Insufficient consultant psychiatric hours provided to the AO Team, which meant that activities such as historical reviews and case presentations of anything other than the highest risk cases were not possible.

Organisational/Commissioning Issues

- Insufficient corporate consideration of the impact of allowing a situation to prevail where the consultant psychiatrist for the MHSU's AO Team was responsible for three other clinical services on six sessions per week, one of which was dedicated to trainee doctor supervision. This meant that there were only two sessions per week for the MHSU's AO Team.
- The MHSU's AO Team had the largest caseload of all the AO teams in Nottinghamshire and a sizeable geographical patch. It also had the lowest number of consultant psychiatric sessions comparatively. Not only were the number of medical sessions low comparatively across Nottinghamshire, but they were the lowest across the AO teams the consultant psychiatrist working with CUK contacted. Furthermore, her enquiries confirmed that the MHSU's AO Team caseload was also the largest. CUK understands that the size of caseload was as a consequence of the team's boundary becoming coterminous with local authority boundaries. Nottinghamshire Healthcare Trust, CUK understands, did resist this change, but was not able to influence this.

Patient Issues and Individual Practitioner Issues

- This MHSU's care co-ordinator had a disability that made keeping up to date with his clinical record-keeping challenging for him. Furthermore, he did require more time to read through records. Within a busy mental health team, although it is difficult to make specific provision for this type of disability, consideration should be given to disability. It is the impression of CUK that none was made.

Of the above factors, the most significant factor was the fact that it was not customary for the MHSU's AO Team to conduct a comprehensive review of all of the existing records for a service user when first accepting them on to the team's caseload and to generate a composite history as a consequence and that there was no requirement for the team to do so.

Of secondary influence was the lack of medical sessions provided to the AO Team. The retrospective review of a service user's history to ensure all salient information is gathered does not require the presence of a medical practitioner. However, greater medical sessions may have enabled stronger clinical leadership around these aspects of practice.

4.2.1.3 Overall opinion of the CUK team

In spite of what is set out above, it is the contention of the CUK team that the AO Team did have a reasonable level of understanding about the MHSU when he was discharged from the in-patient services in October 2007. All were aware:

- of his diagnosis;
- of his lack of insight;

- of his ambivalence about his medication;
- that he did not want to be in contact with mental health services; and
- of his early warning signs of disengagement, self-neglect and disengagement from his family, which included active avoidance.

In terms of his day-to-day management, CUK is not convinced that knowledge that the MHSU slept with an axe under his pillow in 2002 would have made a material difference to his day-to-day management when medication compliant and engaging with services. However, this information should have made a difference to the formulation of the contingency and crisis management planning for this MHSU and the length of time he could be allowed to disengage and deteriorate without an assessment under the Mental Health Act.

4.2.2 The AO Team relied on a number of information givers between 2007 and the time of the incident in 2009 to enable them to be informed about the MHSU, who refused to engage with them. Was this strategy reasonable and was it effective?

The AO Team utilised three sources of information to try and gather information about the MHSU when he was refusing and avoiding any face-to-face contact with them. These sources were:

- the family of the MHSU,
- the community pharmacist, and
- the Dual Diagnosis Service.

Before setting out CUK's findings and perspectives in relation to appropriateness and effectiveness, it is important to make clear that, in circumstances where a service user does not want a clinical team's involvement, and there is insufficient evidence to support an assessment of the service user under the Mental Health Act, then it is reasonable for a clinical team to rely on third-party information as a core component of the service user's care plan. Therefore, the AO Team's strategy of gathering third-party information to be informed about this MHSU was reasonable.

4.2.2.1 The reliance on family members for information about the MHSU
There is a clear history of involvement of the MHSU's family with the mental health teams and professionals caring for the MHSU from very early on in his contact with adult services. The MHSU's family were close-knit, and his grandparents featured strongly as a positive influence, and it was reported in the clinical records that their home was a place where the MHSU felt calm and safe.

In this case, the MHSU's family were proactive in raising concerns with the mental health services about the MHSU. In fact, it was information provided by his sister that provided the final impetus for the assessment of the MHSU's mental state under the Mental Health Act in March 2007. The MHSU's grandparents were also valuable informants for the MHSU's care co-ordinator when he was first allocated to the MHSU's case management in September 2006.

When the MHSU was discharged from hospital in October 2007, it was his mother who was the prominent family member providing him with a home while his flat was being made habitable. She also championed his needs with regards to his flat with the mental health professionals.

Family members also provided the AO Team with important information about the MHSU's behaviours in April 2009, prior to the attempt to assess him under the Mental Health Act, and again in July 2009, when consideration was again being given to the need for a Mental Health Act assessment (the detail of these communications is set out at section 4.2.4 (p 43 of this report) and 4.2.5 (p 55 of this report)).
The family's recollection is that there was frequent communication from the MHSU's grandfather to the AO Team.
The CUK team considers that, in this case, it was very reasonable for the AO Team to depend on the MHSU's family for reliable information. The MHSU's family were a very effective information source.

4.2.2.2 The reliance on the community pharmacist for information about the MHSU

The CUK team is in agreement with the findings of the Trust's own internal investigation report with regards to the pharmacist's input. There is no doubt what so ever that this individual did her best to provide the AO Team with reliable information about the MHSU in relation to the regularity with which he turned up for his methadone, his demeanour towards her and his general appearance. However, it is the contention of the CUK team that, once the MHSU had fully disengaged from the AO Team and the Dual Diagnosis team by April 2009, then there should not have been the continued reliance there was by the AO Team on the information provided by the pharmacist.

Members of the AO Team most involved in trying to engage with the MHSU told the CUK team that they did not consider that they did overly rely on the pharmacist. AO staff told CUK that "they used to turn up at the MHSU's flat at 08.30am in the morning" to try and intercept with him, and that with the benefit of hindsight their efforts may well have been bordering on "the intrusive for the MHSU". The professionals also told the CUK team that they also tried to meet with the MHSU at the chemist, but they did not want to do this every day because of the risk to the MHSU disengaging from his methadone. However, because of the MHSU's absolute avoidance of AO staff, the AO professionals told CUK they had to conduct some sort of "at a distance surveillance". This included information from the pharmacist. The information provided was validated by the MHSU's care co-ordinator, who used to try and intercept him when he was walking, and the community pharmacist, who reported her knowledge that AO staff did observe the pharmacy until it became clear the this was distressing the MHSU.

AO staff interviewed also told the CUK team that the pharmacist had initially passed written communication from them to the MHSU; however, she had to stop doing this as the MHSU raised an objection to this. To have continued may have been counter-productive in terms of the MHSU's regular attendance at the pharmacy. In spite of this set-back, the MHSU's care co-ordinator told the CUK team that the pharmacist "was good at advising how the MHSU looked and if he was chatty, quiet etc". The Dual Diagnosis professional also complimented the community pharmacist on her efforts to keep Dual Diagnosis and the AO Team informed about the MHSU. For the Dual Diagnosis Service there was a standing arrangement with community pharmacists that if a service user did not collect methadone over three consecutive

days, then the Dual Diagnosis Service would automatically be informed. In this case, such a situation never arose.

4.2.2.2.1 CUK Comment

Information from a pharmacy source is most valuable when it is part of a package of information, which initially it was. However, when (unbeknown to the AO Team) the MHSU was never at home when his Dual Diagnosis professional attended there to meet with him after March 2009 and then he gradually distanced himself from his family, the pharmacist became the sole source of information and therefore the usefulness of the information was reduced. This was because:

- the community pharmacist could only tell the AO Team that the MHSU was turning up for his methadone;
- the community pharmacist could only tell the AO Team how the MHSU looked, how he smelt, and how he acted on a superficial level; and
- the community pharmacist could not make any comment about the MHSU's mental state.

The information from the pharmacist, as the only consistent person seeing the MHSU, could provide assurance that the MHSU was 'alive and breathing' and flag up to the AO Team significant observable changes, including changes in habit as to when the MHSU collected his methadone. These are considered gross changes in presentation and demeanour. They do not provide reassurance that there is no psychosis, or give sufficient insight into an individual's mental state.

The analysis of the interviews conducted with the AO Team evidence that they did appreciate the limitations of the information the community pharmacist provided. However, the analysis of the information provided also revealed that the AO Team placed more value on it than they should because they were not aware of the lack of contact the Dual Diagnosis Service was having with the MHSU. The AO Team were always working on the assumption that the Dual Diagnosis professional was achieving contact with him.

4.2.2.3 The reliance on the Dual Diagnosis Service for information about the MHSU

Reliance by the AO Team on the Dual Diagnosis Service for information was reasonable. Dual Diagnosis is staffed by qualified and skilled individuals with the capability to assess mental state and to provide appropriate information to another specialist team. Also, all of the indicators in 2008 suggested that the MHSU was engaging with the Dual Diagnosis Service and the MHSU himself had said he would engage with the Dual Diagnosis Service. Initially, he did do this.

Unfortunately, the strategy of relying on the Dual Diagnosis Service for information was not at all effective from April 2009 onwards. This was mainly due to:

- the MHSU's disengagement from his Dual Diagnosis professional, and
- the lack of effective communication between the MHSU's care co-ordinator and his Dual Diagnosis professional.

Of these two issues, the lack of effective communications between the AO Team and the Dual Diagnosis Service was the most influential.

The contributory factors as to why there were ineffective communications between the Dual Diagnosis professional and the AO Team are not all that clear. The individuals most closely involved do not have a clear recall of the efforts made to achieve positive communications, or of why more effort was not made. However, from interviews conducted with:

- the team manager for the AO Team;

- the then acting team manager for the Dual Diagnosis Service;
- the MHSU's care co-ordinator;
- the Dual Diagnosis professional; and
- a range of other staff working in addictions, dual diagnosis and AO,

the following has been established:

Practice Issues

- The AO Team retained care co-ordination responsibility for the MHSU throughout and therefore responsibility for his case management. The service manager for the AO Team told CUK that it was a care co-ordinator's responsibility to chase up insufficient communications with colleagues in teams also engaged with a service user for whom AO held care co-ordination responsibility. The service manager for the Dual Diagnosis Service, however, told the CUK team that she believed that the responsibility was jointly held between the services. The MHSU's care co-ordinator told CUK that he "struggled to get clarity on how much the Dual Diagnosis professional was seeing the MHSU". It was not the cultural norm for him to escalate such issues through the line management chain.
- There should have been a joint management plan agreed between the Dual Diagnosis Service and AO Team for the MHSU. CUK considers that this was agreed in principle but it was not formalised in writing. The enhanced care plan for the MHSU documented on 23 November 2008 does mention the Dual Diagnosis involvement with the MHSU, but in general terms only. It did not contain the detail expected of an effective care plan.
- The MHSU's AO care co-ordinator told the CUK that he assumed that the Dual Diagnosis professional was maintaining contact with the MHSU, as he did not receive any communication to the contrary. However, he did recall that achieving positive communication between them after April 2009 was difficult. CUK asked the Dual Diagnosis professional, at interview, about this and she reported that "it was possible that the care co-ordinator thought I was seeing [the MHSU] more often than I was."
- The Dual Diagnosis professional did not follow the established processes in the Dual Diagnosis team for documenting care contacts, or for discussing service user with whom there was a persistent lack of contact.

Policy and Procedural Issues

- The contact between the Dual Diagnosis Service and the MHSU was initiated by his grandfather in March 2008. Consequently, she attended with the MHSU's care co-ordinator to meet with and assess the MHSU. This was in keeping with the Trust's policy guidance as stated in CL/CP30[3] (page 3, 3.3.2 and 3.3.3). Because this was not the usual route for a service user taking receipt of a service from

[3] CL/CP30 - Management of Risks with Clients who have Co-Occurring Mental Health & Substance Misuse.

Dual Diagnosis, there was no discussion of the case at the Dual Diagnosis allocations meeting, and consequently none of the usual paperwork was completed that should have been.

- The conduct of the AO Team meetings was not as structured as it could have been.
- Neither the Dual Diagnosis nor the AO Team leaders operated a system whereby the entire caseload of a practitioner was reviewed on a rolling basis.
- There was no effective follow-up at the AO Team meetings of actions agreed at previous meetings in relation to this case.
- At the time it was not an operational policy requirement for Dual Diagnosis staff to attend at the weekly clinical team meeting of the team with care co-ordination responsibility for a Dual Diagnosis client.
- At the time the AO Team 'Operational Policy' (undated) was not sufficiently explicit about the requirement for joint care planning between the care co-ordinating team and other specialist services involved. It did, however, say on page 4:

  "Assertive Outreach Service County will link with other services in a defined care pathways approach;
  Key pathways will include:

  Housing providers
  In-patients and Crisis Resolution Home Treatment
  PCL, R&R, EIP
  Specialist services
  Voluntary sector
  Well-being and social inclusion."
  The operational policy recognises and states clearly that the effectiveness of the Assertive Outreach team will be influenced by the effectiveness of its working with others.

Working Environment Issues

- Between April and June 2009 the Dual Diagnosis professional was working three rather than her usual four days per week because she was undertaking a CBT training course. Her caseload remained the same.

Cultural Issues

- It was assumed by the AO Team that no information was good information
- It was assumed within the Dual Diagnosis team that individual staff members would bring any matter of concern either to the weekly team meeting or to individual supervision
- It was not the routine, or expected practice, at the time that a Dual Diagnosis professional would attend at the AO weekly clinical team meeting.

Individual Practitioner Issues

- Towards the end of 2008 the Dual Diagnosis professional was unwell and was consequently working three not four days per week.
- It was not in the nature of the MHSU's care co-ordinator to have escalated the lack of communication from the Dual Diagnosis professional via local line management arrangements.
- The MHSU's care co-ordinator had a total of 24 unplanned days off work, 6 study days and one time-owing day in addition to his expected non-working days, between April and July. This was a total of 31 days.

In this case the factors of greatest significance to the ineffective communications between Dual Diagnosis and the AO Team were a combination of practitioner issues and systems issues. Specifically, the personal situations of the MHSU's care co-ordinator in terms of his health issues and also personal issues that caused deterioration in the personal practice standards of the Dual Diagnosis professional.

The systems issues of greatest significance were:

- The lack of effective review and follow-up of the case management of this MHSU within the AO weekly clinical meeting;
- The lack of clear direction in the operational policy for AO and Dual Diagnosis at that time that there must be a jointly agreed and monitored care management plan.
- The lack of effective supervision of the MHSU's care co-ordinator.

The Dual Diagnosis professional's own reflection about the interface between Dual Diagnosis and AO in relation to the MHSU was that perhaps "we should have had a better plan in place specifying responsibility, what was expected of each team and how this was to be communicated". CUK can only agree.

4.2.2.3.1 Factors impacting on the effectiveness of the contacts the Dual Diagnosis professional had with the MHSU

The contacts that the Dual Diagnosis professional had with the MHSU were not as effective as hoped for. This was not due to any practice lapses on the part of the Dual Diagnosis professional, but was as a consequence of the MHSU's unwillingness to divulge any information about his mental state and, from April 2009, the fact that he was never at home when his Dual Diagnosis professional attended to meet with him.

Prior to April 2009 the clinical records and interview with the professional concerned evidence that she did try and utilise her skills to try and formulate a perspective about his mental health; however, she was confined to using her observational skills for this as the MHSU would not discuss anything with her other than that relating to the provision of a urine sample for drugs screening. On the last occasion she met with the MHSU (24 March 2009) he asked her to leave his flat when he became aware that she was trying to look into his living area.

Following this, the Dual Diagnosis worker recalled that she "didn't send letters to the MHSU". But she "mentioned to him that [she] had to continue to see him to monitor

his prescription, but this was more to do with seeing if [she] could get to see him at all, in order to try and build some sort of therapeutic relationship. The MHSU's acceptance of the need to provide urine samples was a way for me to spend even a small amount of time with him and as I was his 'drug worker' and not a 'psychiatric nurse'; the hope was that this might be less threatening to him."

The Dual Diagnosis professional told the CUK team that, even prior to 24 March, the contacts the MHSU had with her were very short. She told CUK: "I think the longest time I met with the MHSU was on the first occasion with his care co-ordinator", in 2008. The reason that the meetings were short was that they were always curtailed by the MHSU. The MHSU was, she recalled, "anti-services", and she was keen not to antagonise him.

The Dual Diagnosis professional was very clear on one point. That was that the MHSU never said he would not engage her; it was simply that he was never in when she went to visit him. She told CUK that she recalled one occasion where she "sat waiting for him in the car park and then intercepted him for a urine screen". She also told CUK that she often sensed that he was in his flat but that he "wouldn't answer the door". However, she had "no proof of avoidance and as there was no letterbox for the flats it made it difficult to leave a note" for him.

With regards to the MHSU's mental state and any insight to this, the Dual Diagnosis professional was very aware that the MHSU's attendance to collect his methadone "only demonstrated a dependency on the medication and a willingness to collect and take it on a daily basis".

With regards to his self-care, she told the CUK team that "self-care was always of a poor standard, much worse than a lot of other people on my caseload. However, when I tried to raise the issue of self-care with him he refused to discuss it."

The Dual Diagnosis worker considered the MHSU to be the least engaged and least motivated client to make any changes not of his choosing on her caseload.

4.2.3 How effective was the medicines management for the MHSU between October 2007 and July 2009?

Medication compliance was a long-term problem for this MHSU, and for any team working with this MHSU it was going to be challenging. With regards to this investigation, it was not possible to explore the AO Team's medication management for the MHSU without also including the level of disengagement of the MHSU and the efforts the AO Team undertook to try and maintain a level of awareness of the MHSU's presentation in the community once he became medication non-compliant.

Medicines Management October 2007 – April 2009

Following the MHSU's compulsory admission to hospital in March 2007, he was discharged on flupenthixol deconate 100mg once a fortnight. In March 2008 this dosage was reduced to 50mg a fortnight. There was no deterioration in the MHSU's presentation following this. However, the medication was something the MHSU accepted reluctantly. Depot medication was the most appropriate form of medication for him. He could not be relied on to take oral medication.

For almost fourteen months following discharge from hospital the MHSU was provided with this medication, by the AO Team, on a reasonably reliable basis.

However, it was prescribed to be administered fortnightly and, other than in the immediate post-discharge period, administration at this time interval was rarely achievable. The MHSU did, however, receive his medication on 19 occasions in 2008, i.e. 73% of the doses he should have received. This evidences the efforts the AO Team undertook to ensure that he received this. This frequency of administration was sufficient to maintain some stability in the MHSU's mental state; however, he was never symptom-free.

On 11 January 2009 the clinical records note that the MHSU refused his medication and that he told the AO CPN that he did not want to take it. The clinical record identified that the MHSU lacked insight into his illness at this time and talked of odd and unusual ideas at this time in terms of esoteric experiments and denied having any concerns. The MHSU's care co-ordinator recalled him asking if he had to take his medication. The care co-ordinator provided an honest answer to the MHSU, the context of which was:

- He could not be compelled to take it; and
- He needed to take it for the maintenance of his mental well health.

The next medication entry in the clinical records was on 19 March, when the MHSU telephoned the AO Team complaining about one of the CPNs.
The clinical records noted that the MHSU complained that one of the CPNs (CPN2) had spoken to the pharmacist about his depot and he (the MHSU) needed to see them (AO). The clinical record noted that the MHSU stated that he did not want the AO to visit. It also noted that the MHSU admitted to having problems, but felt he could sort these out alone and without help. He told the AO professional that he did not feel unwell, and should never have been sectioned previously. He also told the AO professional that he did not want to see the 'John Storer Clinic' about his methadone. The AO professional tried to negotiate with the MHSU that he saw someone, but he (the MHSU) hung up.

There is a further reference to the MHSU's depot medication on 30 March, when his grandfather made contact with the AO Team. The clinical record noted that the MHSU's grandfather told AO that the "MHSU is angry that pharmacist is encouraging him to see AO for depot". The record also noted that AO fed back to the MHSU's grandfather that they had not been able to see his grandson, but that his case remained a priority and that his case would again be discussed in the AO clinical team meeting that day.

CUK comment

The CUK team empathises with the AO Team with regards to the medication management of the MHSU. Other than trying to persuade the MHSU to continue with medication because it helped keep him well, there was little else the AO Team could do at the time. The MHSU was not subject to a Compulsory Treatment Order (under the Mental Health Act) and there would have been no justification for him being subject to this at the time. He had only one in-patient admission, and presented with no significant risk factors of serious harm to self or of harm to others. He was, as we all are, self-determining. The AO Team needed to respect this until such time that the MHSU became sufficiently unwell to warrant an assessment of him under the Mental Health Act to determine whether or not he could be treated on a compulsory basis.

This being said, the CUK team is not satisfied that there was sufficient consideration at the MHSU's discharge from hospital, or subsequent to this, as to what the plan was to be should the MHSU decide not to take his medication. This was predictable and it was clear that all professionals involved knew that he would again relapse if unmedicated. What is entirely unclear was the extent to which the AO Team were going to allow the MHSU to be:

- unmedicated;
- unwell, i.e. displaying signs of relapse;
- un-assessed; and
- untreated.

The clinical records of 2007 (January to March) show that the MHSU was floridly psychotic when he was assessed and detained in hospital (March 2007) and required in-patient care for 7 months before he was discharged. CUK suggests that one would have wanted to have avoided, if possible, a situation where he became so unwell again before treatment was instituted.

Between September 2008 and April 2009 information was gathered by his care co-ordinator in order to complete his CPA assessment.
The CPA document completed identified one of the MHSU's presenting issues as 'medication', but did not expand on this.

The care plan which appears to have been dated on 23 November 2008, and then subsequently signed and updated on 7 April 2009, said:

Need: "Monitor mental state and deliver/monitor medication taken."
Service/Action: "Visit weekly and administer depot 2/52. Clarify if experiencing any side effects from medication. Review with medical team. Encourage and facilitate space for the MHSU to express/explore any issues."

Expected outcome: "Improved current mental state and the MHSU feeling more able to cope."

The Crisis Contingency Plan said: "The MHSU is currently starting to be actively engaging with services; however, this is at a distance. He tends to get on better with a smaller group of individuals, though he will see others. He is seeing more of the medical team and is more responsive of their advice and or guidance. He is also more willing to see the DD team."

The crisis plan did not set out what the plan of action was to be if the MHSU disengaged from his treatment plan, which included contact with AO and Dual Diagnosis.

A crisis intervention plan should set out clearly the actions and interventions required, and the persons with whom communication should take place and their contact details. The plan should contain sufficient detail that if a member of staff unfamiliar with a service user is involved in the crisis management then they know what the core elements of the action plan are.

The crisis intervention plan detailed for this MHSU did not constitute such a plan.

The above being said, it is clear from CUK's review of the AO progress notes and interviews with AO staff that staff did use their observational skills, as well as

information from the MHSU's family, the community pharmacist and the Dual Diagnosis professional to try and determine the extent of the MHSU's well or ill health in terms of his physical care as well as his mental health. It was the combination of these activities that prompted the arrangement of the Mental Health Act Assessment for 9 April 2009.

The CUK team believes that, on the basis of the information known to AO at the time, this was the correct course of action. Nevertheless, the contingency and crisis plan for the MHSU documented on 23 November 2008 and presumably updated on 7 April 2009, as it is dated and signed by the MHSU's care co-ordinator on this date, remained insufficient for this MHSU.

The CUK team would have expected a much more detailed plan, setting out:

- What features of the MHSU's presentation would require him to be escalated on the AO team's zoning/traffic light system at 'amber' and 'red'. Medication non-compliance and disengagement/avoidance of his family one would have expected to have featured here.
- How the AO Team planned to try and conduct 'at a distance' surveillance, if the MHSU was unmedicated and avoiding contact with the AO Team. One would have expected to see some indication of known haunts for the MHSU and methods known to be effective for surveying him.
- The strategies the AO Team would use to maximise its communications with the MSHU's family, Dual Diagnosis and the community pharmacist.
- What specific information, relapse indicators, should prompt consideration and/or usage of the Mental Health Act to achieve an assessment of the MHSU.

However, the AO Team did consider one strategy that might have been a component of a relapse prevention and/or crisis intervention plan. This was to use the MHSU's methadone script as a lever to achieve a medical assessment with one of the Addictions Consultants for the MHSU. However, on reflection it was considered that this strategy presented a risk to the potential for a therapeutic relationship between the Dual Diagnosis Service and the MHSU and also potentially with the AO Team. With the benefit of hindsight, CUK considers the above strategy had merit. There was no therapeutic relationship with the MHSU to preserve and methadone was something the MHSU was complying with. Furthermore, after March 2009 the MHSU did not maintain any contact with the Dual Diagnosis Service. The mooted strategy therefore offered an opportunity for assessment that could have been utilised. However, during her interview the MHSU's Dual Diagnosis professional revealed that she did not believe the MHSU would have engaged with such an initiative. On the basis of the information provided to CUK about him, the perspective of the Dual Diagnosis professional is on balance more than likely to be correct.

The CUK team explored the MHSU's medication management, and the risks associated with his disengagement and refusal of medication with a number of AO staff, including the MHSU's consultant psychiatrist. A range of opinion was revealed.

The following is reflective of the aggregated information provided to CUK about the MHSU and medication:

"At the time I was with AO I was not aware of a pathway/guideline over the length of time someone could be non-compliant. If a service user deteriorated and was very unwell, a Mental Health Act assessment or medical assessment would be undertaken."

"Question: How many service users would be completely medication non-compliant and also not making themselves available for assessment?
Response: There were a couple of clients that would often be non-compliant and avoidant of contact, but the team would get to assess them."

There were "frequent discussions about the MHSU not taking his medication in the AO Team. He came up for discussion regularly. The MHSU did not want to work with the AO Team."

The importance of medication was explained to the MHSU and "he was offered tablets, etc, but the MHSU did not consider himself to be mentally unwell, so he did not see why he needed medication."

The information provided to the CUK team resulted in CUK determining that the fact that the MHSU was both refusing any medication and avoidant of contact with and assessment by the AO Team did not factor highly enough in the AO Team's consideration of risk for him, or in the formulation of a clear management plan.

To the Consultant Psychiatrist and the Nurse Advisor working as part of the CUK Team, the situation was unusual, and would herald significant concern and the need for a clearly laid out management plan. It is the perspective of both professionals that such features would automatically place a service user in the 'red zone' of their respective traffic light systems.

To test out the experience of AO staff in Nottinghamshire of service users who are off medication and avoidant of assessment, a small survey across the Nottinghamshire Healthcare NHS Trust's AO teams revealed that the proportion of service users who were completely medication non-compliant and not at all available for the assessment of their mental state was very low.

Forty-one staff responded to the survey questionnaire. Of these:

- Four staff said that 'greater than 1, but less than five' service users were inconsistent in making themselves available for an assessment of their mental state.
- When asked 'how many service users are not making themselves at all available to AO for the assessment of their mental state?', only two respondents said '1' service user. All other respondents said '0' service users or 'not applicable'.
- When asked 'of the non-compliant depot clients, how many are not making themselves at all available to AO for the assessment of their mental state?', no respondent said they had any such service users at the time they completed the survey document.

These survey results highlight how uncommon it is for a service user to be both completely non-compliant with medication and completely avoidant of mental health assessment.

Although CUK accept that the AO Team responsible for the MHSU did their reasonable best to put strategies in place to maintain 'tabs' on the MHSU and his general physical presentation in the community, this did not tell them anything about the degree of deterioration in his mental state once he decided not to take his depot medication. The AO Team should have devised a much clearer plan of action about how they were going to address this situation, including the boundaries that once breached would have activated an assessment of the MHSU under the Mental Health Act. Greater clarity would not only have served the MHSU better, it would have avoided the feeling for some AO Team members that the MHSU was allowed to drift, with there being no clarity amongst the team as to what they were going to do with him.

4.2.3.1 Was the management of the MHSU's methadone reasonable?

Methadone was the only medication that the MHSU complied with, attending at his local community pharmacist on a daily basis for the dispensing and observed consumption of this.

However, from March 2009 the MHSU disengaged from the Dual Diagnosis Service and consequently was non-compliant with the methadone protocol which required him to provide regular urine samples, in his case on a monthly basis.

Although a letter was written to the MHSU highlighting the possible risk to his continuing to receive methadone, on prescription, a decision was made to not discontinue it. The reasons for this were:

- The MHSU's behaviour suggested that he was not mixing other illicit drugs with his methadone; all of his urine screens up to March 2009 had been clear except for methadone. Furthermore, the reliability with which he attended for methadone suggested that he was not using any other street drugs. It was the experience of the MHSU's Dual Diagnosis professional that most drug users on her caseload, at the time, were far more chaotic than this MHSU, and that he was the least problematic of them all from a drugs management perspective.
- Methadone does have some anti-psychotic properties. Consequently, as it was the only medication the MHSU was taking, no-one would have wanted to have withdrawn this from him and for him to go back to street methadone.

CUK agrees with the decision of the MHSU's Dual Diagnosis professional that maintaining his methadone prescription was the most appropriate approach under the presenting circumstances at the time. However, what is clear from the interviews undertaken is that the Dual Diagnosis professional should have discussed this situation with her colleagues, which she did not do. Had this occurred, there may have been the opportunity to have considered increasing the MHSU's methadone prescription, or suggesting the possibility of this to the MHSU to try and effect a face-to-face assessment of him by one of the consultant psychiatrists in addictions. Although CUK agrees with the perspective of the wider Dual Diagnosis team regarding the lapse in adherence to practice standards by the MHSU's Dual Diagnosis professional, the information provided to it suggests, as stated above, that

it seems unlikely that the MHSU would have attended for an assessment at the John Storer Clinic.

4.2.3.2 Overall opinion of CUK in relation to the MHSU's medicines management between October 2007 and July 2009

CUK considers that the situation with this MHSU was very difficult. The MHSU did not want to take his medication and the AO Team did not, until April 2009, consider there to be sufficient indicators to justify an assessment of him under the Mental Health Act. Furthermore, the MHSU was actively avoiding contact with the AO Team. Consequently, monitoring the impact of him not taking medication was challenging.

It is clear from the clinical records and also interviews conducted with the AO Team, including medical staff working with the team at the time, that there was a consistent and persistent concern about the MHSU and his non-engagement with the service, and his refusal of anti-psychotic medication. Furthermore, there was intelligence being provided from a range of sources that indicated that the MHSU was maintaining some level of functionality.

Consequently, CUK has no criticism of the AO Team's management or efforts to monitor the MHSU up to and including April 2009.

However, after April 2009 CUK considers that the AO Team did not consider in a sufficiently structured way the increasing risk profile for the MHSU in relation to his continuing medication non-compliance and his ongoing avoidance of contact with the AO Team.

It is acknowledged that the MHSU was discussed at AO Team meetings and that the team were operating under the belief that the Dual Diagnosis Service was having continuing contact with the MHSU. This belief dampened any concerns that the AO Team might otherwise have had. CUK also accepts that the MSHU's care co-ordinator did his reasonable best to maintain regular 'at a distance' surveillance of the MHSU, and that he reports attempting to engage with him when he came across him in the community, but to no avail.

Nevertheless, as previously stated in this report, as the team holding care co-ordination responsibility, it was the AO Team's duty:

- to make sure it was accurately informed by the Dual Diagnosis Service and not to rely on 'no communication' from this service as a positive indicator of ongoing contact between that service and the MHSU.
- To ensure that there was a clearly formulated plan for the MHSU that was understood by all.

The AO Team have reflected on their over-reliance on negative reporting and also their strategy of arm's-length surveillance for this MHSU. As a consequence, 'arms-length surveillance' over a prolonged period of time for disengaging service users who are also disengaged from their medication is no longer a plan of choice.

4.2.4 By April 2009 the AO Team were sufficiently concerned about the MHSU that an assessment under the Mental Health Act was planned and attempted on 9 April 2009. However, the MHSU was not at home, so the assessment could not be pursued. A decision was subsequently made not to make a further attempt to assess the MHSU under the Mental Health Act at this time. Was this decision reasonable?

Before setting out the findings of the CUK team in relation to the above, the chronology of events leading to the AO Team's decision to conduct an assessment of the MHSU under the Mental Health Act, and core information relevant to its decision making after the lack of success experienced with this, is detailed below.

Date (all in 2009)	Chronology
11 January	The MHSU refused to take his depot injection.
12 – 23 January	The AO Team tried to visit the MHSU at home on three occasions. On one of these occasions there were signs that the MHSU was at home, but he would not answer the door.
25 January	The AO Team contact the MHSU's grandfather, who told the AO Team that he has not seen his grandson for four weeks.
28 January	Unable to gain access in spite of having left notes on the door for the MHSU. On this occasion the MHSU had left a note saying 'AO - gone to the dentist, back soon'. There were no lights in flat.
31 January	Established that the MHSU is attending for his methadone. The MHSU's care co-ordinator was informed of unsuccessful AO visits.
6 February	The record notes that on basis of pharmacy intelligence the MHSU is no worse than he was. Hygiene may be better.
13 February	The records noted that an AO CPN had waited for the MHSU outside his home on 9 February. He saw the MHSU return with his shopping, but did not manage to catch him to assess him. The MHSU was noted as annoyed that the AO Team were there. He did not want to see AO. It was noted that the MHSU said he will see Dual Diagnosis only. Messages were left for the MHSU's mother, with no response elicited.
20 February	The clinical record noted that: The MHSU was leaving the flat and was surprised to see AO waiting. It was immediately noticeable that his self-care had deteriorated. He was "extremely unkempt, wearing slippers, where he would normally wear trainers". His face was "mucky and soiled". The MHSU was also noted to have a distant look in his eye - only words were: "I don't want to talk to you. I will only talk to my drugs worker."

Date (all in 2009)	Chronology
23 February	The issues above were discussed. The plan was to: ascertain levels of contact with family; the services he is having. An Indicator is reduced self-care as it has previously been identified as a relapse indicator. The plan is also for the MHSU to see the staff-grade doctor who will have a further assessment of MHSU's mental health. The plan is also to discuss the situation with the Dual Diagnosis professional.
16 March	The MHSU's care co-ordinator was walking in town and spoke with him. The MHSU was noted to be walking fast, sweating a lot, and that he said he was coping OK and didn't want to see anyone from the AO Team. The care co-ordinator noted that he tried to reference some form of contact, but the MHSU declined. It was noted, however, that the MHSU did ask for beta blockers. He was noted to say that he would be in on Sunday afternoon. It was agreed that the CPN would bring beta blockers out then (Propanalol).
18 March	AO makes a telephone call to pharmacy: The records note that the Pharmacist says the MHSU is unkempt. He is neglecting his self-care, and emits an odour and was muttering to himself. The Pharmacist is also noted to say that the MHSU is unpredictable and that she is uneasy. This new information is discussed at the AO Team meeting.
19 March	A home visit is attempted. No response was elicited, so the CPN went to write a note for the MHSU in his car. As he did so, the MHSU walked speedily by. The CPN got out of his car to speak with him and noted that his appearance was shabby and unkempt. The MHSU was not able to have a two-way conversation. He underlined to CPN that he did not require AO services and that AO comes too early and wakes him up. The MHSU was noted to have used unsavoury language to discuss his care co-ordinator, and stated that he had asked for him not to be coming round, but still he came.
19 March	The MHSU called the AO Team and complained about a CPN who had spoken to the pharmacist about his depot and that he needed to see them. The records note that the MHSU told AO that he did not want the team to visit. He is noted to have admitted to having problems, but feels he can sort these out alone without help. He is noted to not feel unwell, and that he believed that he should never have been sectioned previously. The MHSU was also noted to have said that he did not want to see the 'John Storer Clinic' about his methadone. The lead clinical practitioner for AO tried to negotiate that he see someone, but the MHSU hung up. The matter was discussed with the AO consultant psychiatrist and the following plan noted: - ?MHA assessment - ?achieve contact via Dual Diagnosis - Timescale for further action needed?

Date (all in 2009)	Chronology
23 March	The records note the MHSU to be disengaging with AO generally. There are numerous missed appointments, missed medical appointments, “deterioration continuing, but not necessarily at crisis point”. The records also noted that the AO need to be discussing with the Approved Mental Health Practitioner about a Mental Health Act assessment.
30 March	The records note that the MHSU’s grandfather called AO and reported that his grandson had not visited for a week, but has brought clothes around to be cleaned. The records noted that the MHSU’s grandfather was concerned that his grandson is not eating and would not accept food. It is also noted that the grandfather said his grandson was angry that the pharmacist was encouraging him to see AO for his medication. The records note that AO told the grandfather that they had not been able to see MHSU, but that his case remained a priority. There is a clear record showing that the MHSU’s case was discussed within the AO Team meeting. It was also noted that the Dual Diagnosis Service were not able to attend, but had left a message about their concerns for the MHSU’s care co-ordinator about these. The records also noted that the MHSU has changed his mind regarding his health centre appointment. The need for a Mental Health Act assessment to achieve an assessment of the MHSU is also discussed and that the dominant purpose for it is to conduct an assessment rather than to achieve an admission to hospital.
3 April	Telephone contact between the MHSU’s care co-ordinator and his (the MHSU’s) grandfather revealed that the grandfather had not seen his grandson for two weeks. At this time his grandson had been coming round, then moving off and bringing his washing. The MHSU’s grandfather told the care co-ordinator that the last time he saw his grandson he was quieter in presentation but communicated sufficiently to meet his needs. The care co-ordinator told the MHSU’s grandfather that he would contact the MHSU’s mother once they had the correct telephone number for her, which the MHSU’s grandfather is reported to have said he would obtain for the care co-ordinator. The clinical record noted that the care co-ordinator spoke with the MHSU’s grandfather about a possible Mental Health Act assessment and the MHSU’s grandfather was noted to have been supportive of this. On the same day a message was left for the MHSU’s mother, advising that her son’s care co-ordinator needed to speak with her and also the issue of a Mental Health Act assessment.

Date (all in 2009)	Chronology
6 April	AO tried to visit the MHSU at home, but obtained no response from his flat. The clinical record notes that there was no visual evidence of damage to his property. The AO nurse then went to the local pharmacy, where he learnt that the MHSU continued to attend for his methadone. It was noted that he was clean-shaven, however still muttering, dishevelled and emitting a body odour. The record also notes that the MHSU was less friendly than previously with the pharmacy staff when collecting his script. On the same day the AO Team conducted an enhanced CPA review and risk assessment of the MHSU. The following key points were noted in the clinical record: 1. s117 was not applicable. 2. The MHSU was noted not to see why he should have contact with services. It was also noted that the MHSU had said that he would see the Dual Diagnosis Service. 3. The MHSU's mother and grandfather are noted to be his carers. 4. It was noted that a Carer's Assessment was offered, but there is no notation regarding its acceptance or decline. The Summary of the MHSU's behaviours noted that MHSU was a long-term drug user, had many associates in the area and that he was not currently in contact with his family, "only occasionally responding to his grandfather's calls". It was also noted that he had previously been "collecting his urine for experiments and keeping it in bottles on the window sill", and, when relapsing, his hygiene neglect became a risk for himself and others. The summary also noted that the MHSU was irritated by AO and that he was leaving notes on his door that he will prosecute if the team or other authorities knock the door. With respect to the following risks, the records recorded: Deliberate self-harm: Not ever stated to services; however, family members have expressed concerns. Drug/alcohol usage: Noted to be a long-term user, but has engaged well with Dual Diagnosis Service. Problems commenced with steroid usage. The record also notes that in April 2009 the MHSU refused to supply a urine sample, and there was ongoing concern that his usage of illicit drugs may be increasing significantly. The record emphasised that the MHSU was more willing to see the Dual Diagnosis Service than the AO Team. It was also noted that he was requesting more money from his grandfather. Cognitive problems involving memory, orientation and understanding: The problems caused to the MHSU by dyslexia were highlighted and

that the MHSU did not want to address this as he did not perceive that to be possible. It was also noted that his mother had been very supportive of him during his school years.

Physical illness:
None were noted; however, physical neglect of his living environment has raised concerns for his physical health.

Positive symptoms of mental disorder:
The MHSU was noted to not openly discuss his positive beliefs. He was noted to have only referenced these twice in the last six months. It was also noted that he was persistent in saying that he was "not mentally unwell and services [were] invading his space". He is reported to have stated, "I had a bad reaction to drugs I took. [It is] not an issue now."

The record also noted that the MHSU did display paranoia – "people spying on him, chain around his neck. ... Voices argue between themselves ... sees spiritual people with his mind, the voices only come when he has panic attacks."

Other family/social relationships:
The record noted that the MHSU's grandfather was the primary family member with whom the MHSU had contact. The record noted that it was clear that the MHSU's grandfather was a source of consistent support.

7 April

The MHSU's care co-ordinator had a substantial telephone conversation with the MHSU's mother. The records of this noted that: She had not seen him since Christmas when he came over for lunch, stayed a while and then left. That the MHSU's mother had not been able to offer as much support to her son as she had previously, owing to other family factors that also needed her time and attention. The record also noted that she was aware that the MHSU's state of health had declined as she had seen him in the locality. The record clearly noted that the MHSU's care co-ordinator discussed the ongoing concerns the AO Team had for the MHSU with his mother, including the plan to initiate a Mental Health Act assessment and the possible implications of this for her son.

The record also noted that the care co-ordinator also contacted the approved mental health practitioner at the relevant community mental health team, who is noted to have organised the Mental Health Act assessment for the morning of 9 April.

Date (all in 2009)	Chronology
9 April	The AO consultant psychiatrist, the MHSU's GP and an approved mental health practitioner attended at the MHSU's flat to conduct an assessment of his mental state under the auspices of the Mental Health Act. However, the MHSU appeared not to be at home. Consequently, no assessment was possible. On the same day the MHSU's care co-ordinator received a telephone call from the MHSU. The clinical record noted that the MHSU described his preference not to see AO. The record also noted that the MHSU told the care co-ordinator that AO had no legal framework to support ongoing AO visits. It was noted that the care co-ordinator told the MHSU that the AO consultant psychiatrist would be content to meet with the MHSU at his home; however, it was noted that this offer was declined. It was also noted that the MHSU preferred to speak on the phone, but only in order to complain about the intrusiveness of the AO Team. On this same day AO also received a telephone call from the community pharmacist, reporting that the MHSU had requested a couple of days' methadone, saying he was going away for a few days with his mother. It is noted that the pharmacist reported that the MHSU was clean-shaven and wore clean clothes which looked new. There was no continuing evidence of self-neglect.
15 April	A letter is sent to the MHSU advising him that his AO consultant psychiatrist tried to visit him on 9 April. The letter acknowledged that the MHSU had maintained his willingness to continue to meet with the Dual Diagnosis Service and to take his methadone. The letter also stated that the "problem is because of the way services in Nottingham are configured; you cannot continue to ONLY see the Dual Diagnosis team, as that is a responsibility they are not permitted to carry on their own". The letter also tried to resurrect the idea of the MHSU going to the pictures with a member of the AO Team as he had previously indicated he wanted. The letter also said that the consultant psychiatrist hoped AO and the MHSU could find some way of occasionally meeting, "perhaps only for every three-four weeks", for a few minutes, if that's all that can be achieved. But enough to fulfil their duty of care so that current arrangements (i.e. with the methadone) could continue. The letter asked the MHSU to get in touch with the AO Team. The letter made clear that, if a way forward could not be achieved, a more formal assessment of the situation would need to be conducted.

Date (all in 2009)	Chronology
15 April continued	On the same day the records note that the MHSU's care co-ordinator had a telephone conversation with the MHSU's mother. The record noted that: ▪ The MHSU's mother had no awareness of her son's stated plan to go away with her for a few days. ▪ The MHSU's mother did, however, clarify that her son had tried to contact her twice since yesterday (14th) morning. This was unusual. ▪ The MHSU's mother was concerned about her son's dietary intake, which she thought was only fruit. ▪ No positive symptoms of illness were described by the MHSU to his mother when she last had contact with him three days earlier. ▪ The MHSU's mother was noted to have identified no evidence of further deterioration in her son's self-care. The record says: "by all accounts the MHSU has recently made effort to improve his appearance ... liaised with DD team, who will not issue prescription". The record noted that the care co-ordinator emailed an update based on the contact with the MHSU's mother to the AO consultant psychiatrist.
16 April	On this day one of the AO CPN's who had been providing support to the MHSU while his care co-ordinator was off work contacted the duty approved mental health professional to discuss further the need for a further attempt to achieve an assessment of the MHSU's mental state. However, as the AO consultant psychiatrist was not available, the advice of the approved mental health professional was that the issue needed to be discussed in the next AO Team meeting with the consultant psychiatrist present. It was also noted by the approved mental health professional that the AO consultant did not think a Mental Health Act assessment was required and that in first instance a letter should be sent to the MHSU. The record noted that at the time of this conversation this had happened, but that there had been no response from the MHSU. At the time of this conversation it was noted that the Dual Diagnosis Service had last seen the MHSU two weeks ago.
20 April	The situation was discussed at the AO Team meeting. As a consequence of this, the plan was to: ▪ continue pursuing contact with MHSU; ▪ continue weekly liaison with family and pharmacy and Dual Diagnosis to monitor awareness of possible deterioration; and ▪ continue with this plan for six weeks before pursuing a further assessment under the Mental Health Act.

4.2.4.1 CUK commentary

The whole issue of the use and non-use of the Mental Health Act to achieve a meaningful assessment of the mental state of this MHSU is central to the determination of the potential for preventability of the tragic incident that occurred in July 2009. Consequently, the decisions made in April 2009 by the AO Team in relation to the conduct of a Mental Health Act assessment have been carefully considered by CUK.

The decision to attend at the MHSU's home on the morning of 9 April, prepared to progress to the conduct of an assessment of the MHSU under the Mental Health Act, was appropriate given the known behaviours of the MHSU at the time. In particular, his persistence in not meeting with the AO Team to enable them to assess him, his medication non-compliance and the reported deterioration in his self-care, particularly his personal hygiene.

What is in question is whether or not it was reasonable, following the lack of success with the above plan, to decide at the AO clinical team meeting on 20 April to observe the situation for the MHSU over the following six weeks, i.e. until the week of 1 June, and to then review whether concerns about the MHSU prevailed, and whether these were sufficient to justify a further attempt to assess him under the auspices of the Mental Health Act.

On the basis of the information the AO Team received between 9 April and 15 April, CUK understands why the AO Team decided not to repeat an attempt of an assessment under the Mental Health Act immediately after the unsuccessful attempt on 9 April.

- The pharmacist had provided information suggesting that the MHSU had presented better and was sufficiently together to try and obtain a number of days' worth of methadone.
- The MHSU's mother had recent contact with her son and reported that she had identified no obvious signs of further deterioration.
- The fact that the MHSU was managing to maintain regularity in collecting his methadone, and his walking around the community, suggested that he was maintaining some degree of functionality.

Under the circumstances, the CUK team considers that the immediate plan to 'watch and wait' was a reasonable one.

However, the AO plan to review the management plan for him "in six weeks" did not occur. CUK expected to find AO clinical meeting minutes of subsequent considerations of the MHSU's situation and then a team decision about what the plan was for the MHSU at the end of the six-week period (1 June or thereabouts).

There was no such documentation in the MHSU's clinical records.

The MHSU's consultant psychiatrist told CUK that he clearly recalled discussions "about new information coming in" and "conclusions about whether or not to proceed [yet] with a MHA assessment". It was his perspective that there was no formal review at the six-week period because team discussions were occurring more frequently than this. CUK does not consider this to be satisfactory, concluding similarly to the

internal investigation conducted. There should have been a revised and documented management plan for the MHSU.

In determining how other staff perceived the situation, CUK drew the following from the Trust's own investigation data collected six months after the incident:

- The Senior House Officer working in AO at that time (February 2009 – end July 2009) was not particularly aware of the MHSU. He knew of him, and recalled that he had been discussed 'once or twice', but that usually it was the service users of greatest concern who were discussed the most. To his recollection, the MHSU's problems were ongoing and there was no discussion about acute presentation.
- The Specialist Registrar working part-time with the second AO consultant psychiatrist recalled that the MHSU was frequently discussed with regards to his non-engagement. Although her last face-to-face contact with the MHSU was in December 2008, she recalled him as a "constant presence in the team".
- Another Senior House Officer working with the team who was present at team meetings after 20 April was asked:
  "Question: Can you remember any discussion regarding management [of the MHSU]? How much discussion included potential deterioration?
  Response: None. I found it interesting that it was more a sustainment issue."
- One of the AO CPNs was asked:
  "There was a plan to review in six weeks and between May/June there was no contact with the MHSU. Can you recollect what was happening?"

  This individual responded: "I was on holiday, but I can remember before I went away speaking to the care co-ordinator to remind him about the assessment. There were plans to monitor remotely, cold calling, liaison with grandfather and pharmacy. The care co-ordinator planned to visit when he knew the MHSU was about. I remember being involved in this plan. On my return I wasn't surprised that the assessment had not taken place and I remember asking why it hadn't happened and it was raised at the MDT and I remember the care co-ordinator making enquiries about it."

The clinical records evidence:

- Information from the MHSU's housing provider on 23 April indicating that the MHSU was neglecting the cleanliness of his flat, as other residents could not open their windows because of the smell, and that the MHSU had been abusive to the cleaners, to the extent that they would not go back unattended.
- A discussion at the AO weekly clinical team meeting of 27 April 2009 where a decision was made to wait for further information and that there was insufficient information to progress another MHA assessment.
- An unsuccessful home visit to the MHSU's flat on 8 May.

- No evidence of attempted contact with the MHSU, communications with the community pharmacist, or the MHSU's family between 9 May and 6 June, a period of four weeks. However, AO staff said they are confident that attempts were made to achieve face-to-face contact with the MHSU over this period. This conflicts with the recollections of the MHSU's grandmother, who recalls a reduction in communications around this time.
- On 10 June there is a record detailing a concern raised by the MHSU's grandfather because the MHSU's care co-ordinator was not contacting him as he said he would. The grandfather is noted to be frustrated that he was doing all of the contacting and chasing regarding his grandson's care.
- On 11 June there was an unsuccessful home visit to the MHSU's home.
- On 15 June, at the weekly clinical team meeting, it was noted that the MHSU's grandfather was seeing him weekly. It was also noted that the team discussed the smell coming from the MHSU's flat.

The clinical notes, the original information gathered by the Trust's internal investigation team, plus further information shared with CUK, evidences sufficiently that the MHSU was in the minds of the AO Team between 20 April and mid-June 2009. However, it does have reservations about the frequency of contact with the MHSU's family and also the community pharmacist during this observation period. On the balance of probabilities, CUK believes there was a lapse in contact with the MHSU's family during this period. The lack of documentation and the Community Pharmacist's recollection of 'sporadic' contact from the AO Team also raises doubt about the extent to which the AO Team communicated with her over the surveillance period. There should have been contemporaneous and complete documentation of all discussions about the MHSU, and all efforts made to try and find out information about him. It has already been stated clearly in this report that the AO Team should also have documented a clearly formulated management plan for the MHSU with clear consideration of the extent to which the AO Team were going to allow him to continue un-assessed, untreated and deteriorating. That he was discussed between 20 April and the first week in June did not replace the need for such a management plan.

In stating the above, CUK accepts that the information coming in to the AO Team over this period of time was at times conflicted. On the one hand there was information from housing highlighting early warning signs of neglect/hygiene issues, and there was also an allegation (unsubstantiated) of assault. On the other hand, that the MHSU's grandfather continued to see him weekly, which was a reassuring feature, and there were signs that he was taking better care of his appearance. However, this conflicting information further underlines the necessity of:

- accurate and contemporaneous documentation;
- a clearly formulated plan.

Issues that CUK considers impacted on the lack of documentation, the apparent lack of attempted home visits to the MHSU's flat, and the lack of contact with the MHSU's family between 8 May and 6 June in particular were:

Practice issues

- The relative lack of perceived risk for this service user compared to other service users on the AO Team caseload because of his lack of violence risk.
- The lack of appreciation of the infrequency with which AO patients are both completely non-concordant with medication and not being seen by the AO service.

Policy and procedural issues

- The lack of structure to the zoning system in use by the AO Team and that it was seen as a "nursing tool" rather than a tool integral to the clinical management of the AO caseload. There were no clear guidelines for staff as to how the zoning system was to operate or what the clinical expectation was once service users were placed in particular zones. Where it was being used, the AO teams in Nottinghamshire were using the zoning method differently.
- No minutes of clinical team meetings taken.

Working environment issues

- The fact that the MHSU lived approximately 12 miles from the AO Team base, thus making regular 'pass-bys' difficult. This was a recognised challenge when the geographical boundaries of this AO Team were redefined and the AO teams had to become coterminous with the local authority boundaries. The AO Team managers in post at the time and medical staff highlighted the risks associated with changing the "set up" for AO in Nottinghamshire, and the Trust had, CUK believes, resisted the change in structure for AO for some time. As a consequence of the change, the shape of the MHSU's patch changed from a wedge shape (covering city and county-based clients) to a "do-nut" ring patch as it went around the boundaries of the entire city-based AO teams. This factor affected the frequency with which the AO Team could conduct 'drive-bys' of the MHSU's flat.
- The overall size of the AO Team's caseload (106 service users) and the geographical patch for the MHSU's AO Team.

Organisational/management issues, corporate and local

- The lack of dedicated medical sessions to the AO Team, thus reducing the opportunity for the Consultant Psychiatrist to be updated on a real-time basis about service users of concern. Furthermore, the lack of dedicated sessions meant that, for the time he was present at the AO base, his time was more pressured.
- Lack of robustness of the weekly clinical team meetings.

Individual practitioner issues

- The sickness absence of the MHSU's care co-ordinator.

Of the above, the factors of most significance were:

- The lack of a corporate approach to the core operational systems and processes in AO across Nottinghamshire. Although each AO service was using a similar operational policy, there was no agreed core criteria that all AO teams in the Trust were expected to work to and against which their performance was monitored.
- No Trust-wide commitment across AO teams to using a common system of prioritisation for 'at risk' service users, such as a traffic light, or zoning system. There was therefore a lack of robustness of the zoning system in place in the MHSU's AO Team at the time. Had there been clear criteria that dictated what range of features were always associated with a 'red zone' service user, it is inconceivable that this MHSU would not have been in the 'red zone'. This would have resulted in formal discussion of his case management at each weekly clinical team meeting.
- The lack of effective leadership of the MHSU's AO Team, and thus a lack of robust local systems and processes to ensure that errors of omission, such as the non-review of a significant case management plan as that which occurred in the MHSU's case, did not occur.

In setting out the above points, CUK emphasises that it does not infer that the AO Team were not concerned about the MHSU; it is clear that they were.

Overall conclusion of the CUK team regarding the reasonableness of delaying any decision about a further MHA attempt for six weeks

Following consideration of all of the above, it is the overall conclusion of CUK that it was reasonable for the AO Team to undertake a six-week period of watchful waiting between 20 April and the first week in June, instead of progressing immediately with another attempted Mental Health Act assessment.

However, it was not acceptable that:

- There was a lack of documentation of the surveillance and information-gathering efforts between 20 April and the first week in June 2009;
- There was no clearly documented and articulated management plan for the MHSU at the end of the six-week period.

Section 4.2.7 (page 64 of this report) sets out CUK's consideration of whether there were missed opportunities to have initiated an assessment of the MHSU under the Mental Health Act between 20 April and 19 July 2009. (19 July is when the clinical records evidence that the physical and mental health of the MHSU had deteriorated to the extent that the MHSU's care co-ordinator considered that the threshold for conducting a further Mental Health Assessment, with a view to compulsory treatment, had been met.)

4.2.5 On 15 July the MHSU's care co-ordinator came in possession of information that led him to believe that the threshold for conducting a further assessment of the MHSU under the Mental Health Act had been reached. He communicated this to colleagues on 19 July 2009. The proposal was for an assessment on 27 July. Was this reasonable?

CUK's commentary on the above is based on the actions taken and decisions made by the AO Team at the time they were responsible for the care and treatment of the MHSU.

4.2.5.1 Why didn't the care co-ordinator plan the Mental Health Act assessment for 20 July 2009?

Before addressing this, it is worthwhile contextualising the presenting situation for the MHSU in the month leading up to the care co-ordinator's actions and recommendation.

On 19 June 2009 the MHSU's care co-ordinator had visited the MHSU at home. The care co-ordinator observed the MHSU walking down the road away from him. On this occasion the care co-ordinator noted that his "presentation was fair; he did not look too unkempt". The care co-ordinator tried again to make face-to-face contact with the MHSU between 3.15pm and 3.45pm; however, he could not elicit a response. The care co-ordinator noted that there was a note on the MHSU's door that said: "all authorities to stay away from his flat, if uninvited he would prosecute".

Following this, the MHSU's care co-ordinator tried to visit him on:

- 5 July at 11.51am;
- 8 July (no time available);
- 15 July at 2.30pm;
- 16 July at 19.15pm.

The care co-ordinator was not able to meet with the MHSU on any of these occasions, even though he had tried calling at differing times of the day.

On 19 July 2009 it was then noted that he (the care co-ordinator) had spoken with the MHSU's grandfather on 15 July. It was recorded that the MHSU's grandfather advised the care co-ordinator that he had not seen his grandson for some time. This was a marked change in behaviour. One month earlier (i.e. mid-June) the MHSU had been having weekly contact with his grandfather and the care co-ordinator had also been able to observe the MHSU walking about 'not looking too bad'. However, it was well understood by the AO Team that when the MHSU withdrew from his family it was a concrete sign of an escalation in his deterioration.

In evidence of this, the clinical records say that the MHSU's grandfather "had been to the post office to try and see him (when he gets his money)"; he did see his grandson, but he (the MHSU) walked across the street and ignored him, "deliberately blanked him". This mirrors the documented behaviour of the MHSU towards his mother prior to his detention under the Mental Health Act in March 2007.

The care co-ordinator also noted in his record that prior to this sighting the MHSU had stated to his grandfather that he had no electricity in his flat. The record noted that the MHSU's grandfather provided him with a pre-paid electricity card he could top up at the post office for rent and electricity. The care co-ordinator's record noted

that, as far as the MHSU's grandfather was aware, the MHSU was not having any contact with other family members. This information added to an accumulative picture for the MHSU.

Throughout the month of June, as previously stated in this report, there had also been:

- complaints of the smells coming from his flat;
- issues associated with his benefits; and
- an accusation that he had been involved in an assault (this was never verified).

As a consequence of the information gathered, the care co-ordinator left a message on the MHSU's mother's mobile phone for her to get in touch with him. The MHSU's care co-ordinator wanted to discuss the possibility of a Mental Health Act assessment with her, as she was the MHSU's next of kin.

4.2.5.1.1 CUK's comments

Knowing about the incident that subsequently occurred, it is tempting to suggest that the care co-ordinator should have acted on the information shared by the MHSU's grandfather on 15 July and organised a Mental Health Act assessment sooner than was planned. However, for the care co-ordinator there was nothing in the information shared with him that required an urgent response at this time. He believed that the right approach was to organise a Mental Health Act assessment at a time where there was a greater chance of finding the MHSU at home. From his study of the MHSU's movements over the preceding months, this was a Monday morning.

In mid-July 2009 the care co-ordinator interpreted the information he had gathered as adding to the overall picture of deterioration for the MHSU, rather than escalating the concerns to a level where an urgent MHA assessment was required. This perspective was shared by the MHSU's care co-ordinator's colleagues.

Looking back at the MHSU's deterioration between 2006 and 2007, CUK can appreciate why the MHSU's care co-ordinator and his AO colleagues had this perspective, especially as the MHSU was displaying similar behaviours to his last relapse experience.

Although CUK understands the rationale of the MHSU's care co-ordinator, it suggests, however, that the care co-ordinator could have been more assertive and pushed for an assessment on the morning of 20 July. At this stage, and with the benefit of hindsight, there seemed little reason to delay.
However, CUK can appreciate why, 'at the time', the rationale was a planned and measured approach. The deterioration in the MHSU had been over a prolonged period previously between 2006 and 2007, with no serious risks emerging to him or to others. This 2009 relapse appeared to be following a similar pattern. The planned and measured approach to the staff at the time seemed to be the right course of action. Regardless of whether one sees it as a correct or incorrect approach, it was understandable. In relation to this particular period, the MHSU's family are able to accept that there was a clear rationale for the decision made.

The perspective of the MHSU's consultant psychiatrist

CUK explored the timing of the Mental Health Act assessment with the AO consultant psychiatrist. He told CUK:

"You have a patient who is at risk of self-neglect, not psychotic, no self-starvation or not drinking water, but doing odd things to their flat and not attending to their self-care and hygiene; do you ask for a MHA immediately, with all the risks of a GP & AMHP who don't know the patient, not identifying all the changes, and perhaps just considering the patient to be choosing to let themselves go a bit, or allow everyone a few days to arrange things with the right professionals and get it right? It's a balance of risks. I still accept that, had my availability been greater, I might have planned to go out before the weekend [of the 25th], not on the Monday [the 27th], but the bottom line is that the timescale did not seem inappropriate given the risk picture as it was understood at the time."

CUK empathises with the position of this consultant psychiatrist. The number of funded consultant psychiatric sessions to the AO Team was insufficient for the caseload of the team. It did mean that there was limited time for a careful evaluation of a service user known to be unwell and untreated, but contextually of low risk. The team would have had on its caseload service users who posed a much more quantifiable risk than this MHSU. Therefore, it is these service users who would have dominated discussions and deliberations within the team. The only part of the above quote that the CUK team disagrees with is the assertion that the MHSU was not psychotic. The truth is that neither the AO consultant psychiatrist, nor any other AO Team member, had any knowledge of the MHSU's mental state in terms of psychosis. They could not see into his flat, and his mental state had not been assessed.

4.2.5.2 The follow-through of the content of the 19 July email

The deteriorating situation with the MHSU was discussed, as intended, at the AO Team's weekly meeting on Monday 20 July. The documented plan as a consequence of this was:

- the care co-ordinator to monitor the MHSU in the community;
- "? for review" by the AO consultant psychiatrist 'next Monday' (i.e. 27 July 2009).

The record is signed by the senior house officer to the AO at that time. This individual's retrospective record documented on 28 July says: "I understood from the team and MDT discussion that the MHSU's self-care would continue to deteriorate, and he has not been engaging with AO staff for some time. Following discussion over last week's MDT, review by the RMO (consultant psychiatrist) and MHA (Mental Health Act Assessment) was planned for Monday 27 July 2009." Because it was not the practice of the AO Team to document all team members present at the meeting, CUK did ask the consultant psychiatrist to the AO Team to check his diary for that day to determine whether he was or was not at the meeting.

His response to the CUK was as follows:

"From my own diary, I probably was, as there is no record of leave or special meetings, etc. - which would usually be recorded there.

However, I'll get my secretary to check the clinical diary too (if records still exist). Again, if I were elsewhere it would normally be recorded there."

Following this further check, the consultant psychiatrist established that his "secretary confirms no evidence I wasn't there - reviews booked in afterwards, etc."

The consultant was not able to say why it had not been documented that a firm decision had been made regarding the Mental Health Act assessment. He was clear in his information given to the CUK team that it was his and everyone else's understanding that they would conduct a Mental Health Act assessment the following week. The MHSU's care co-ordinator also confirmed that he and the Consultant Psychiatrist had discussed the need for the MHA and that it had been agreed between them and that the consultant had confirmed his availability for the Monday morning.

4.2.5.2.1 The lack of formalisation of the plan for a Mental Health Act on 27 July following the AO Team meeting on 20 July

It remains completely unclear why there was no activity occurring between 20 and 24 July to organise the Mental Health Act assessment for 27 July. The memory recall of the staff interviewed is patchy regarding the fine detail. All, however, recall that a commitment was made to conduct an assessment of the MHSU under the Mental Health Act the following week, with all believing that this was going to be on 27 July.

CUK explored what had happened with the MHSU's care co-ordinator and other AO Team members at interview. His recollection was that he had been told by the then team manager that he could not plan for such an assessment in advance, and it had to be planned on the day. He also recalled being discouraged from making absolute arrangements for 27 July by the MHSU's consultant psychiatrist. The care co-ordinator also recalled being told that he could not request a Mental Health Act by email, that this was not acceptable. Apparently, the manager for the Approved Mental Health Practitioners, attached to the relevant CMHT, had contacted the team manager for the AO Team and communicated this message to him.
As previously stated, CUK can find no evidence that the email sent on 19 July constituted a request for a Mental Health Act assessment. The Approved Mental Health Professional to whom it was primarily directed told CUK that he received it as an advanced notification and consequently he sent it to all of his colleagues so that everyone was aware. Neither he, nor any of these colleagues, interpreted the email as a request for a Mental Health Act assessment. The AO staff interviewed recalled "mutterings" about the email the care co-ordinator had sent. However, they also saw the email as a "heads up" alert email, not an email trying to book a Mental Health Act assessment. Two AO staff told CUK that the MHSU's care co-ordinator "was an experienced CPN and it just was not credible that he would have tried to organise a MHA via email".

The same two AO staff also told CUK that "there was no question that the Mental Health Act assessment had to happen".

The MHSU's consultant psychiatrist also told CUK that, as far as he was concerned, the plan was for a Mental Health Act assessment the week commencing 27 July.

CUK also explored the arrangements for the Mental Health Act assessment with the then AO manager, himself an Approved Mental Health Practitioner, and the then manager of the Approved Mental Health Practitioners in the involved CMHT. Both professionals told the CUK team that there was no impediment to booking a Mental Health Act assessment in advance and that it was a not uncommon occurrence. This information matched the understanding the CUK team already had of the flexibility in the way in which a Mental Health Act assessment could be arranged.

CUK suggests that it does not make any logical sense for the timing of such an assessment to not mesh with the known movements of the service user to be assessed. All of the Approved Mental Health Practitioners the CUK team met at interview validated this information.

However, the MHSU's care co-ordinator remains adamant about what he was told by his then team leader, and that he remembers feeling that the decision was not a fair one. It remains his firmly held recollection that he was told that he could not book the MHA in advance. Because of the length of time that has elapsed since this incident, it is not possible to accurately determine what happened in terms of communication and instruction. All of the professionals involved have fixed perspectives. Whatever the situation, one fact remains. Although all AO staff expected to be conducting a MHA for the MHSU on the morning of 27 July, it was not booked.

4.2.5.3 Overall CUK opinion

On balance, and based on the up-to-date information about the MHSU and his behaviours, to have decided to take a planned approach to the conduct of his Mental Health Act assessment was reasonable at the time the decision was made. Although, CUK considers that it is arguable that the MHSU's care co-ordinator should have acted more decisively and driven this forward to occur on 20 July instead of 27 July. However, there is a high probability that similarly qualified practitioners may have done exactly as this practitioner did under the circumstances. Furthermore, the following factors may have made a planned assessment on 20 July difficult to achieve:

- Securing a GP known to the MHSU within 48hrs notice (i.e. Thursday 16 and Friday 17 July);
- Convincing the Approved Mental Health Professionals that this degree of urgency was necessary. Generally speaking, before attempting an assessment of an individual under the Mental Health Act, one needs to show consistent and sustained attempts to assess an individual. It is the perspective of CUK that the AO Team could have done this. However, it knows from an email sent from the manager of the Approved Mental Health Practitioners to her colleagues on the evening of 24 July that, in her opinion, given that the MHSU had been out of contact with the services for such a long period of time, that there probably was no urgency for the assessment and it possibly could wait for a few days after the optimal day of 27 July. That this perspective was articulated after 'new' evidence of further deterioration identified on 24 July means that the AO Team in all probability would have had to have articulated their case strongly to have obtained a 'short notice' assessment of the MHSU.

4.2.6 On 24 July an AO CPN attempted to assess the MHSU at his home. However, he was not in. The CPN observed what looked to be blood on his door handle and subsequent to this learnt from the MHSU's grandfather that the MHSU had increased in his suspiciousness and paranoia. He was also reported to have included his grandfather in his delusional framework. Following discussion of the CPN's findings with the duty Approved Mental Health Practitioner, a decision was made not to instigate an urgent Mental Health Act assessment under a section 135 warrant, but to proceed with an assessment on 27 July. Was this decision acceptable?

24 July was the day of the incident. The AO nurse who tried to visit the MHSU did so late afternoon around 3.30-4pm, and spoke to the MHSU's grandfather after this. CUK must therefore emphasise that, even had the decision been made on this day to organise an urgent Mental Health Act assessment, it is unlikely that it would have been achieved in time. This is because an application would have had to have been made to the duty magistrate for a warrant under s135 of the Mental Health Act, and this would have taken time. It would also have taken time to have organised a section 12 approved GP to attend with the duty psychiatrist and the duty Approved Mental Health Practitioner. There would also have been the challenge of locating the MHSU. With what the AO staff learnt that afternoon, it would not have been reasonable to have involved the MHSU's grandparents in any 'sting' operation to assess the MHSU. Which is what this type of emergency planning amounts to. Assessments organised in this way are extremely stressful for the relatives of a service user, and can require a degree of subterfuge that family members can feel very uncomfortable with and that cause lasting damage to the relationship between a service user and his/her family.

4.2.6.1 The events of 24 July 2009

CUK understands that, after 20 July but prior to 24 July, an effort had been made to try and locate the MHSU at home and assess him. This, as consistently had been the case, was unsuccessful. Consequently, another member of the team went again to try and meet with the MHSU on 24 July. He was accompanied by the AO Senior House Officer.

These professionals managed to gain access to the inner hall serving the flats in the building. They noted what looked to be "dried blood on the handle of the door, and blood on the door also?". They also noted a scrawled note on the door saying "warning, AO and other services to keep away". There were other statements such as "the magic eye is watching".

The professionals then went from the MHSU's flat to the local pharmacy, where they were told that the MHSU did continue to attend for his methadone, but that there had been recent concerns over "very poor self-care, evidenced by strong body odour, dirty disorganised clothing and poor hygiene". The clinical record also noted that the MHSU "appeared to have lost weight recently". The AO nurse then made a telephone call to the MHSU's grandfather, who it was noted was "hesitant to discuss recent contact with [his grandson], as he [the grandson] had expressed distrust and resentment about his [the grandfather's] collusion with MH services". It is also noted that the MHSU's grandfather told the CPN that the MHSU had visited him three times that very week, most recently that very morning. His grandfather told the CPN that his grandson seemed preoccupied with persecutory ideas with religious themes. He also told the CPN that his grandson was very concerned about an organisation called "the wrong reasons", whose influence included "the police and mental health

(AO) services". The MHSU's grandfather told the CPN that his grandson "believes that this organisation was monitoring his property – evidenced by police sirens in the locality and MH professionals (AO and Dual Diagnosis) knocking on his door". The grandfather also told the AO nurse that his grandson was also suspicious that he was involved in this organisation. The clinical records note that, when the MHSU's grandfather asked him about this further, he described concerns about the "anti-christ" and "Jesus". The MHSU's grandfather told the CPN that he was struggling to understand it all. The MHSU's grandfather also told the AO nurse that he was very concerned for his grandson and that he felt it had reached the point where he needed admission to hospital, and that his grandson would blame him if he were detained.

The AO nurse told the grandfather that he would liaise with him next week and that the AO Team would pursue a Mental Health Act assessment for his grandson. The AO nurse told the CUK team that there was nothing in the content of the conversation that suggested to the AO nurse that the grandfather was at all concerned for his or his wife's safety. The AO nurse also told CUK that risk of harm to the grandfather did not occur to him because of the MHSU's relationship with his grandfather. He was, however, concerned not to undertake any action that would further fuel the MHSU's suspicion of his grandfather and thus damage to their relationship. This was his dominant concern at the time.

On return to the AO Team base, some 12 miles from where the MHSU lived, the AO nurse had a detailed conversation with the duty Approved Mental Health Practitioner, the outcome of which was that there was insufficient information to justify obtaining a warrant from the duty magistrate to enable a Mental Health Act assessment to occur that evening under section 135 of the Mental Health Act. The rationale for this decision was:

- There had been an extended period of lack of contact between the MHSU and the AO Team; and
- There were no serious known risk factors of harm to self or others for the MHSU.

The decision was to review the situation on Monday and to proceed with the planned Mental Health Act assessment then. The AO nurse felt at the time that this was the right thing to do. He told the CUK team that at the time he felt that he and the duty Approved Mental Health Practitioner had engaged in a full and frank discussion about the situation and that he believed that the advice given was reasonable. This discussion took place between 4pm and 4.30pm. The AO nurse does not believe that the decision not to progress to an 'emergency' Mental Health Act assessment was influenced by the time of day. It would have been in no-one's interests to have been influenced by this.

4.2.6.3.1 CUK comment

It is very easy to be wise after the fact, especially in circumstances where a tragedy such as the one that occurred for this family. However, the AO nurse took the correct action by talking to the duty Approved Mental Health Practitioner about his concerns. A Mental Health Act cannot be progressed without the support of an Approved Mental Health Professional. It is their responsibility to determine whether it can be justified and to uphold the law.
Furthermore, at the time of speaking to this individual the AO nurse did not have it in his mind that they needed to progress to a Mental Health Act assessment then and

there. He did, however, feel that the information meant that it was imperative that the Mental Health Act assessment took place on 27 July as planned.

The CUK team appreciates that the family of the MHSU, and also of the deceased, will find it hard to accept CUK's conclusions in this section. However, CUK does not believe that, even had an emergency Mental Health Act assessment been organised, they could have guaranteed an assessment of the MHSU before the incident occurred.

As stated previously in this report, as an independent investigation, CUK has a duty to avoid as far as is possible to do so with hindsight bias. CUK recognises that some AO staff, most notably the MHSU's care co-ordinator, feel that an urgent Mental Health Act assessment should have been conducted on 24 July. However, it is CUK's perspective that these feelings are coloured by hindsight bias. On the balance of probability, even had a decision been made to progress an earlier assessment, it is unlikely that this would have occurred before 25 July because of the length of time the MHSU had been disengaged from the AO service, and the lack of risk associated with him.

4.2.7 Was there any information available to the AO Team between 20 April 2009 and 19 July 2009 that should have prompted earlier consideration of the need for an assessment of the MHSU under the Mental Health Act?

Following the decision to not repeat an assessment of the MHSU after the unsuccessful attempt to assess him under the Mental Health Act on 9 April, the AO Team continued to monitor the MHSU 'at a distance' until 19 July, when his care co-ordinator communicated to colleagues that he again believed that the situation for the MHSU had deteriorated to a level that the threshold for conducting a Mental Health Act assessment had again been met. The question for CUK and for the MHSU's family is whether or not there was information available to the MHSU's AO Team at an earlier point that should have resulted in a decision to progress a reassessment of the MHSU under the Mental Health Act prior to this date.

In the case of this MHSU, it is the contention of the CUK team that there were a number of occasions where the AO Team should have more carefully set out its management plan for the MHSU. A component of which CUK believes should have been clear criteria of what would trigger an assessment under the Mental Health Act and also under what circumstances 'actively watching and waiting' was considered the right approach and why.

Looking retrospectively at the MHSU's clinical records, CUK considers that the events detailed provided sufficient justification for an assessment of the MHSU under the MHA, to achieve an assessment of his mental state prior to 19 July 2009.

Furthermore, had the three CPNs, who shared the effort of trying to engage with the MHSU, known of the information documented in 2002, that the MHSU:

- had at that time had thoughts that others might try to kill him;
- had had thoughts of using a knife; and
- had reported sleeping with an axe under his pillow during a period he thought his father would attack him,

then their threshold for action in the face of increasing relapse indicators may have been lower, even though he had no history of acting on his thoughts and there had been no articulation of subsequent thoughts following his discharge from hospital in October 2007.

The occasions where CUK suggests the AO Team should have considered using the MHA to achieve an assessment of the MHSU's mental state were:

- 23 April;
- 24 April;
- 8 May;
- 12 June;
- 15 June;
- 15 July (Wednesday).

The purpose of using the MHA at these junctures would have been to have established a more accurate assessment of the MHSU's well-being physically and mentally. Of the above listed dates, CUK suggests that the optimal time period for attempting a repeat Mental Health Act assessment was around 15 June 2009.

The evidence base for CUK's consideration is as follows:

23 and 24 April 2009
On 23 April the MHSU's care co-ordinator received a telephone call from the MHSU's new housing officer. This individual reported that the housing association had received a number of calls from residents complaining about the smell coming from the MHSU's flat, to the extent that it was preventing them from opening their windows.

The housing officer also told the care co-ordinator that the MHSU had been verbally aggressive to the cleaners, who left the communal area they were cleaning as they felt under threat, refusing to return unless someone else was there to support them.

The housing officer also reported that there was a note on the MHSU's door saying: "to all authorities, including AO, do not knock on my door; it's none of your business or you will be prosecuted".

The clinical record noted that the care co-ordinator did talk through strategies with the housing officer, including that the housing officers visit the MHSU in pairs due to the MHSU's unpredictable behaviour. It is noted that the care co-ordinator felt that the AO Team would be more of a hindrance than a help, given the MHSU's antipathy towards them.

It was also noted by the care co-ordinator in the MHSU's clinical record that previous risk assessment showed "no history of aggression". However, the notes used did not cover the time period prior to the MHSU's contact with the AO Team. Consequently, the care co-ordinator noted that, "due to current potential deterioration in mental state, to proceed with caution".

The care co-ordinator also noted that neighbours were not concerned about the MHSU *per se* as he had been "seen around". They were, however, noted to be more concerned about the smell and his behaviour towards the cleaners.

On 24 April another AO Team member visited the MHSU's flat and he could not gain access.

On 27 April 2009 the situation with the MHSU was discussed at the AO Team meeting. The record states: "not felt at present to be appropriate to go for another MHA assessment". The record does not say why not.

8 May 2009 and 11 June 2009
There was an attempted visit to the MHSU's flat, but no access was gained. All of the windows were blocked up, so there was no opportunity to look inside either.

12 June 2009
The housing association again advised the AO Team that in the past two weeks there have again been further reports of the smell coming from the MHSU's flat. The issue was again raised at the AO Team meeting (15 June) and it was noted that the MHSU's care co-ordinator reported that the MHSU's grandfather was seeing his grandson on a weekly basis. The plan at this time was for the care co-ordinator to make contact with the housing association and also the Dual Diagnosis professional, to clarify what recent contact there had been with the MHSU.

It was also noted on this day (15 June) that the care co-ordinator received a call from the community pharmacist advising that the local police had been in to watch CCTV footage because a local couple had stated they thought the MHSU had attacked the woman in the local park with a machete, and then they had seen him face-to-face in the pharmacy. No charges were brought against the MHSU and the matter was subsequently dropped. The uncertainty around the incident and the knowledge that the MHSU was relapsing could and should have been given greater consideration by the AO Team at this time.

The perspective of CUK

The CUK team find it difficult to reconcile the AO Team's decision after 20 April, but before 15 July, that the threshold for conducting an assessment of the MHSU under the Mental Health Act had not been met. The MHSU was displaying a number of his early relapse warning signs, and evidence of this had not abated since 9 April.

- The MHSU had been off his anti-psychotic medication since January 2009.
- He had no relationship with the AO Team to speak of.
- No-one had been able to assess his mental health state for a number of months.
- The housing association were raising concerns about smells coming from his flat.
- There were signs of self-neglect.
- The last face-to-face meeting between the AO Team and the MHSU was in January 2009.
- The last face-to-face meeting between the MHSU and his Dual Diagnosis professional was in March 2009. However, at this meeting the MHSU refused to divulge any information about his thoughts and mental health. He provided the required urine sample only and when he realised that the Dual Diagnosis professional was trying to gain an insight into his mental state by assessing the state of his flat, he asked her to leave.

In addition to these features:

- The MHSU had been verbally aggressive to the cleaners at his accommodation to the extent that they refused to re-attend unaccompanied.
- A couple had alleged that the MHSU had been involved in an assault. There was subsequently insufficient information for the police to investigate this further.

Looking back at the MHSU's management, it is not entirely clear to CUK what the AO Team were waiting for. This lack of clarity is shared by some of the AO staff involved with the MHSU at the time. However, the MHSU's AO consultant psychiatrist was clear to CUK that at the time he believed that they were "actively" watching and waiting for the "right time" to conduct a Mental Health Assessment. However, no-one has been able to articulate clearly what additional features to those detailed above needed to be present for it to be the 'right time'.

Following CUK's interview with the MHSU's care co-ordinator, it was clear that for him the "right time" was following his discussion with the MHSU's grandfather on Wednesday 15 July 2009. It was at this time that he considered sufficient features were present to justify a Mental Health Act assessment. Moreover, at this time the MHSU's care co-ordinator considered that an assessment of the MHSU now would most likely result in a compulsory hospital admission, if the MHSU did not agree to this. He did not see that anything less would be sufficiently beneficial to the MHSU.

Although CUK can understand this thinking, it considers that in view of the above a further attempt at a Mental Health Act assessment would have been prudent.

In asserting that the AO Team, in the opinion of CUK, should have re-attempted a Mental Health Act assessment soon after 15 June (i.e. eight weeks after its 'wait and see' decision of 20 April), CUK is mindful that the MHSU was seen from a distance by a member of the AO Team on 19 June "walking down the road" and was considered not to "look too unkempt". However, under the circumstances, CUK believes such an observation to have been an insufficient reason for a continued 'wait and see' strategy.

CUK is aware that its perspective may be challenging to the AO staff involved at the time. Therefore, a review of the progress of the MHSU's previous relapse between 2006 and 2007 was conducted. As a consequence of this, it is noted that:

- When the MHSU was initially referred to adult mental health services in May 2002 the GP noted in a fax that "things have changed in that he came to see [the GP] today complaining of hallucinations. Hearing voices and has some psychotic features. The voice of his father tells him to pick up an axe. He says if someone is around he may use it."

- When the MHSU was assessed by his Consultant Psychiatrist (Cons P1) in May 2002, ten main presenting symptoms were identified. These focused on a range of beliefs about others, a trance-like state in which he would experience visual and auditory hallucinations, that a friend might try to kill him, that he had no control over his thoughts, that his father was "winding him up" and might try to kill him with a knife. The correspondence to the GP says: "Consequently, he has been sleeping with an axe by his bed. He said, however, that he didn't think he would really attack anyone."

- In January 2003 Cons P1 noted that the MHSU continued to report moderate depressive symptoms together with persecutory ideation and what appeared to be through broadcasting. Cons P1 also noted that, "although I feel that any risk of harm to others has subsided, he remains with only partial response to our treatment with Olanzapine and Sertraline. I think it would be reasonable now to increase the Olanzapine further to 20mg at night."

- By October 2005 the MHSU's symptoms had improved considerably to the extent that a plan to commence him on a supervised trial of Clozapine was halted. However, because of his persistent non-engagement with the community mental health nurses, consideration

of a more AO approach was considered. The MHSU had been attending at outpatients on a reasonably reliable basis.

- After October 2005 the MHSU disengaged from the mental health services, re-emerging in February 2006, when he was referred to the Dual Diagnosis Service, having recommenced illicit drugs. He subsequently disengaged from this service in May 2006 and remained out of contact with all services.

- In October 2006 Cons P1 wrote a letter of concern to the MHSU's GP, but concluded that they had not yet reached the threshold for a Mental Health Act assessment.

- In December 2006 the MHSU's grandparents advised his care co-ordinator that their grandson had not been having contact with the family for approximately two months.
- On 5 March 2007 the MHSU's sister contacted the AO Team. She had stopped at his flat when she noticed the curtains to be open, which was unusual. She had been shocked by what she observed in terms of the lack of furniture and also the number of jars with foil over them. She also shared her concern about his lack of contact with his family. It was also noted that the MHSU would not speak with his mother. She reported that she felt her son was avoiding seeing people he knows. The MHSU's mother reported that this deterioration had been taking place over the course of a year.
- Following this information, and on the advice of the Approved Social Worker, attempts were made to assess the MHSU on 12 March, 13 March, 14 March, 15 March. The only time the MHSU was sighted was 15 March and was noted to be putting his home furnishings and his sleeping bag in the bin. He ignored the mental health professionals and went back in his flat, refusing to acknowledge them.

A Mental Health Act assessment was arranged following this. The MHSU was admitted to hospital and subsequently spent seven months as an in-patient before being discharged.

What is clear from the above is that the MHSU did not present dramatically. Even when very unwell in March 2007 his outward presentation was not 'wildly psychotic'; rather, there were an accumulative range of features that brought the mental health professionals and the MHSU's family to the point where an assessment of him under the Mental Health Act was required to determine the state of his mental health.

This pattern of deterioration was similar to that which presented to the AO professionals in 2009. There was some variability between the 2006 and 2009 presentation; reassuringly, in May/June 2009 the MHSU maintained weekly contact with his grandfather and there were no gross signs that the MHSU was dismantling his living accommodation in the way he did in 2007; less reassuringly, the already articulated aggression towards cleaners and allegation of assault, information elicited after the incident, that the level of openness of the MHSU with mental health professionals had changed significantly between 2005/2006 and 2009. This was a

feature noted by the Dual Diagnosis professional who had assessed him in 2006. However, it seems as though this information was not shared with the AO Team.

On the basis of what is known about the MHSU's relapse in 2007, and the prolonged period of time he required in hospital, coupled with the fact that he never accepted his mental health illness, CUK asserts that the prudent team would have wanted, if at all possible, to have intervened before the MHSU deteriorated to the extent he had in 2007.

The AO Consultant Psychiatrist responsible for the MHSU told CUK that the consistency in the MHSU's behaviour made it difficult to determine when the right time was for repeating a Mental Health Act assessment. CUK agrees with this consultant. The timing of a Mental Health Act assessment for this MHSU was going to be challenging to judge. Nevertheless, it remains the contention of CUK that had the AO Team:

- had a more rounded picture of the MHSU's history of contacts with mental health services;
- been aware that the MHSU's level of openness about his mental health had changed since 2006;
- considered in a more structured way the reported verbal aggression and the allegation of assault; and
- considered the above in light of the other early warning features they already knew about, i.e. variable self-care, the smell emanating from his flat, no medication, complete avoidance of AO Team,

it is difficult to sustain a cogent argument supporting a delay in the conduct of a repeat Mental Health Assessment after 15 June 2009.

4.2.8 Was sufficient consideration given to the MHSU's family and in particular his grandfather as a carer?

The MHSU was on enhanced CPA, and he had a very supportive family who were supportive of him throughout his contact with mental health services. It is also clear from the clinical records and also information provided by the MHSU's family that the AO Team did communicate with them and that information from them was instrumental in initiating his Mental Health Assessment in 2007 and the plan for a Mental Health Assessment during the week commencing 27 July 2009.
Interviews conducted with the AO Team confirmed to CUK that the MHSU's family, and in 2008 and 2009 his grandfather in particular, were valued informants to the AO Team about the MHSU.

Examples of his family's involvement and support of him includes:

- It was his sister who initiated the increased level of concern about him, leading to his initial assessment and detention under the Mental Health Act.
- His mother was instrumental in providing support to the MHSU on his discharge from hospital in October 2007 and also in highlighting her concern over her son's ability to manage independently in his own flat, rather than supported accommodation.
- The MHSU's family undertook the initial cleaning and clearing of the MHSU's flat before he moved back into it in November 2007, and before an external cleaning company were commissioned to undertake a deep clean of this.
- The family's assistance was sought to achieve the re-connection of electricity to the MHSU's flat. The MHSU was not there when the electricity board attended to address this on 21 November.
- The MHSU resided at his mother's home after having initially moved out on 19 November while the issues with his electricity were addressed. He was often at her home until 20 January. This facilitated contact with the MHSU and the timely administration of his depot injections.
- His grandfather in 2008 re-approached the Dual Diagnosis Service to effect the re-engagement of his grandson with this, so that the risks associated with his methadone use could be minimised.
- The grandfather intervening with the energy supplier to the MHSU's home and also ensured that he had sufficient resource to pay his bills.

Between 2008 and 2009 the prominent family member for the AO Team and the family member with whom the AO staff reported regular contact was the MHSU's grandfather. However, both the MHSU's mother and his grandfather were identified as carers. This document noted that a 'Carer's Resource Pack' was provided, but not to whom.

The first notation of the offer of a Carer's Assessment was on 30 January 2008, presumably for the MHSU's mother, as at this particular time she was having most contact with the AO Team. However, it remains unclear whether an assessment was subsequently carried out.

The next reference to a Carer's Assessment was on 10 June 2009 in relation to the MHSU's grandfather. It appears that he had a conversation with one of the CPNs working in the AO Team, a consequence of which was that "it was entirely reasonable to expect carer's support, in the form of a courtesy call from AO/CCO" and "or a formal carer's assessment". The involved CPN documented that he assured the MHSU's grandfather that he would raise the issue with the MHSU's care co-ordinator.

The MHSU's care co-ordinator told CUK that he did discuss a Carer's Assessment with the MHSU's grandfather. However, in the event he decided that it would not be of value to him. The care co-ordinator recalls the grandfather telling him that what was of value to him was regular contact with the AO Team about his grandson. An agreement was made between the MHSU's care co-ordinator and his grandfather that the care co-ordinator would contact him on a fortnightly basis. The care co-ordinator reported to CUK that he did do this.

There is documentary evidence of these contacts with the MHSU's grandfather on:

- 15 June 2009, where it was noted that the care co-ordinator committed to contacting the MHSU's grandfather every other week.
- 19 July 2009, where it was noted that the MHSU's grandfather had not seen the MHSU for a while (refers to the contact on 15 July).
- 19 July 2009, when a message was also left on the mobile answering service of the MHSU's mother.
- 24 July 2009, when the visiting CPN contacts and speaks with the MHSU's grandfather, where it is made clear that the MHSU's mental state has deteriorated further. It is at this contact that the MHSU's grandfather suggests that he feels that MHA is required for his grandson.

Standard Six, page 69, of the National Service Framework standards for mental health says:
"All individuals who provide regular and substantial care for a person on CPA should:

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

In this case there is evidence in the clinical records that the subject of a Carer's Assessment was raised on two occasions, once in 2008 and once in 2009. Unfortunately, there is no documentation pertaining to the outcome of the discussions staff had with the MHSU's family about the Carer's Assessment. The outcome of the assessments offered to the MHSU's family should have been documented. It is also good practice to record any specific advice or contact numbers provided. In the case of this MHSU, it is known that his family did have the relevant contact numbers of the AO Team, as the family contacted the team regularly.

Good practice

On 23 July 2008, there was a letter from the MHSU's care co-ordinator to the MHSU's grandfather about a CPA review for his grandson. The letter informs that the MHSU said "he does not wish to be involved and ideally not to be discussed in this manner". The letter informed the MHSU's grandfather that his grandson had,

however, “agreed to meet with” his consultant psychiatrist on 7 August 2008 at his flat. The care co-ordinator continued with: “I feel it is important to respect his wishes; however, I am very much aware that yourself and the whole family provide a lot of support for [the MHSU] and that you also need to have the opportunity to give feedback into this process. I therefore enclose a copy of the form we usually send direct to the client, but I would very much appreciate your comments in these areas and ask for your feedback.” An addressed envelope was enclosed for the return of the form. A similar letter was sent to the MHSU’s mother.

The family’s concern

An issue for the MHSU’s family is that they did not feel that their concerns were listened to about the MHSU. It remains a source of anger for the MHSU’s mother that both she and her father felt that at times they were advocating strongly for the MHSU and not feeling that there was any tangible proactive response from the AO Team.

A particular occasion that caused stress and irritation to the MHSU’s mother was in relation to the inadequate cleaning and furnishing of the MHSU’s flat following his discharge from hospital in the autumn of 2007, and the lack of preparedness for his discharge in terms of her son’s accommodation. CUK could find no information relating to effective discharge planning in the MHSU’s clinical records prior to his discharge; however, the information in the AO records show that the MHSU was subsequently supported in being provided with financial help for the refurnishing and cleaning of his flat. It is also recorded that the MHSU was supported with the completion of appropriate forms so that he could apply for a loan from the social fund (July 2008). The clinical records contain evidence of the following:

- On 8 October 2007 a domestic and commercial cleaning service invoiced the AO Team for £129.50 for the cleaning of the MHSU’s flat;
- On 29 January 2008 £162.00 was requested from the “AOT Flexi-budget”; and
- In July 2008 the MHSU was supported in completing the application forms for a loan from the social fund to purchase carpets and kitchen flooring, bed linen, and an electric cooker. The sum of money asked for was £600.00.

The MHSU moved into his own accommodation initially in November 2007, and then he returned to his mother’s while his flat was made habitable, with the support of his family. His mother feels that the applications for funds to assist her son should have been achieved at an earlier time, given her son’s discharge from hospital was in October 2007. In relation to the content and purpose of this investigation, CUK considered that the passage of time involved was such that meaningful retrospective analysis of what happened around the time of the MHSU’s discharge from hospital was not going to be possible. This decision was communicated to the MHSU’s family at its meeting with CUK on 17 June 2011.

Reflecting further on the family’s feeling that it felt its anxiety about the MHSU was not heard as clearly as it should have been, the findings in Safer Services[4] from a range of local inquiries and research “showed that extreme crimes of violence,

[4] Appleby, L. *Safer Services: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (Department of Health, London, 1999).

manslaughter and murder are much more likely to be committed against family members or carers than against a stranger. Carers need to know what to do in a crisis, and to be assured that prompt action will be taken."

In this case, the MHSU's family knew that they could contact the AO Team if at all concerned about the MHSU. However, their experience was a variability in response, depending upon the availability of the MHSU's care co-ordinator. They reported a reasonable level of contact and response from this individual. However, they also reported to CUK that, when this individual was not on duty, the response from the AO Team was not as consistent.

The MHSU's family also told CUK that they did not know what they could do if they were not satisfied with the response of the AO Team. They did not know how to escalate any concern they might have had and they were completely unaware that they could have requested an assessment of the MHSU under the Mental Health Act.

Rethink[5] provides the following information on its website:
"[6]Rights of the nearest relative
The nearest relative has important rights which can be used very effectively. For example, the Act enables this person in certain circumstances to

- require an Approved Social Worker (AMHP) to assess someone who might need to be admitted to hospital;
- apply to the hospital managers for a compulsory admission;
- prevent compulsory admission from taking place;
- be given information;
- express their point of view when the hospital managers review the patient's detention;
- take part in the Tribunal; and
- order discharge of the patient."

The MHSU's family are adamant that had they known this then they would have utilised this in July 2009.

Issues raised by the Trust's own investigation

In addition to the above, the Trust's internal investigation report highlighted that "there was no evidence that consideration was given to the possibility that the grandparents might have been vulnerable adults in their own right and thus could have been subject to safeguarding procedures", 'Safeguarding Vulnerable Adults' Policy (CL/SG/04).

CUK does not consider that the AO Team should have considered the MHSU's grandparents as vulnerable adults in the general sense. They were independently living, self-sufficient and perceived as very capable. The Law Commission, 'Making Decisions', Lord Chancellor's Dept, 1999, defined a 'Vulnerable Adult' "as someone over 16 who is or may be in need of community care services by reason of mental or

[5] See Glossary.
[6] http://www.rethink.org/living_with_mental_illness/caring/practical_information_for_carers/rights_to_be_involve.html

other disability, age or illness and who is or may be unable to take care of him/herself or unable to protect him/herself against significant harm or exploitation."[7]

There is no evidence that the MHSU's grandparents met any of the above components; quite to the contrary. The MHSU's grandfather came across as assertive and capable and at no time expressed any concern about himself or his wife in relation to his grandson. The MHSU's care co-ordinator did ask him about whether he had any concerns and it is reported that the grandfather told the care co-ordinator that he did not.

With regards to the assessment of risk and the MHSU's grandfather, the AO Team did not see that the MHSU's grandfather was at any risk from his grandson at all. CUK can appreciate why the team did not see the MHSU's grandparents 'at risk' of harm. The MHSU had no previous history of assault on others. Furthermore, the clinical records show that the MHSU's grandfather was a capable man, who assertively addressed a number of issues that were problematic to his grandson. In addition to the professional perspective, the MHSU's family did not perceive him to pose a risk to other family members.

However, the MHSU may have posed a financial abuse risk to his grandparents. It is noted in the clinical record, prior to his detention into hospital in March 2007, that he "badgered" his grandparents for money.

The Trust's own policy (2008), section 3.3.1.4, on the protection of vulnerable adults, says:
"Financial/Material Abuse: Including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions or the misuse or misappropriation of property, possessions or benefits."

CUK is not convinced from all the information provided to it that the MHSU's grandparents were at risk of financial abuse from their grandson. Not only was the MHSU's grandfather strong minded and assertive, there's was a close nuclear family who would not have allowed this to happen.

With regards to the area the AO Team were most concerned about, this was in relation to the relationship the grandfather had with his grandson. AO staff were mindful that if/when the MHSU relapsed significantly he might perceive his grandfather as having colluded with them. This was also a concern of the MHSU's grandparents. Because of the concern, the AO Team had the MHSU's care co-ordinator elected not to meet the MHSU at his grandfather's; he felt it posed too great a risk to their relationship. He was satisfied with the quality of information shared with him by the MHSU's grandfather.

This same concern was reported by the CPN, who spoke with the MSHU's grandfather on 24 July. This individual reported that one of the grandfather's greatest concerns was the loss of the 'trust relationship' with his grandson if he continued to communicate with the AO Team, especially in view of the increasing suspicion being displayed by the MHSU. The CPN who communicated with the grandfather on this

[7] http://www.volunteering.org.uk/NR/rdonlyres/9EB3619B-2EBC-4618-B3EB-A1CE1CB872A5/0/SVSAdultProtectionPolicy.pdf

occasion told CUK that he “never thought to ask the grandfather if he felt at risk from his grandson. Harm to others and the MHSU just was not on their radar – there was no precedent for it.” On the basis of the information contained in the MHSU’s records and also the picture painted of him by his family, it is understandable that the AO Team did not have consideration of risk of harm to others at the forefront of their minds. The dominant consideration was the threat to the relationship between grandfather and grandson.

Overall conclusion with regard to the AO Team’s communications with the MHSU’s family and their attention to them as carers

It is the opinion of CUK that the MHSU’s care co-ordinator had a good relationship with the MHSU’s grandparents. It seems as though this was also extended to the MHSU’s mother in 2007 and early 2008, when she was the dominant carer.

As with aspects of practice previously commented on, lapses in documentation standards undermine the strength of evidence base for the effort the MHSU’s care co-ordinator reports putting into his relationship with the MHSU’s family. It is therefore somewhat re-assuring that the family remember the MHSU’s care co-ordinator well and speak warmly of him.

With regards to the offering of a carer’s assessment, recognition of the need for this was clearly documented in 2008 and 2009. CUK accepts the information provided that the MHSU’s grandfather decided not to have such an assessment. Again, the lapse here seems to be one of documentation standards rather than a lack of adherence to policy and practice guidance.

Finally, in spite of the genuinely expressed warmth about the MHSU’s care co-ordinator, the family do not feel that as a team AO communicated and engaged with them as it should have done. The MHSU’s family were and are mindful that the care co-ordinator was experiencing difficult circumstances in 2009; however, they do not feel that the role he filled, from their perspective, was effectively covered. As a family they still cannot understand why the AO Team did not act sooner on the information they provided.

5.0 Actions taken by Nottinghamshire Healthcare NHS Trust following the recommendations of its own investigation

Since the death of the MHSU's grandfather, and the completion of the Trust's own internal investigation report in 2010, there has been a range of activities undertaken within Nottinghamshire Healthcare NHS Trust with the purpose of ensuring optimal service provision across its AO teams. Some, but not all, of the initiatives were as a consequence of the incident that occurred.

Of particular note was the commissioning in 2010 of a practice development consultant, who has a national reputation in leading and developing mental health practice, to work with the MHSU's AO Team to facilitate optimisation of its team working, efficiency and clinical effectiveness. The main focus of this initiative was working with risk, building confidence in this area and positive risk-taking strategies with a recovery focus.

As a result of the development and exploratory work undertaken, the following practice priorities were identified:

- Achieving clarity about the aims and objectives of AO locally and corporately. A component of this was also to achieve efficient use of the limited resource and develop realistic expectation corporately about what an AO service could achieve.
- Achieving a higher level of commitment to team working and collaborative risk decision making across all team members. The AO Team needed to explore how it could maximise on the 'team-based approach' within its current resource allocation, recognising that a 'full-team approach' was not possible within this.
- The AO Team needed to determine how it could 'work smarter' and embrace 'LEAN' thinking.

A series of six workshops were delivered for the MHSU's AO Team through Autumn 2010 to further explore the above and develop a locally owned development plan.

Since this time there have been two further development days: one in 2010, focusing on record keeping, CPA and on developing a recovery group and recovery practices in AO, led by the psychologist. The other was held in February 2011, which focused on the recommendations from the above work and produced actions that are evaluated at a new monthly development meeting. The new team leader for the MHSU's AO Team oversees this work. This manager and the medical staff also meet monthly to evaluate progress at a senior level. As a consequence of these activities, the staff are reported to be well engaged and seem more confident and motivated to address issues. There is an action plan in place across all AO teams in the Trust, which CUK has had sight of, that was developed from the external review of AO in 2010. This is now monitored by the AO team leaders at their monthly meeting and has oversight from the service managers.

The Trust has also committed to implementing a zoning system across all AO teams in Nottinghamshire and to meet in full the recommendation about this made in this report.

With regards to the MHSU's care co-ordinator, he has received specific support in attaining the expected documentation standards, so that his records accurately reflect that care and service he delivers to service users on his caseload.

In addition to the above, a psychologist is reviewing AO practices across the county to feed into ongoing debates about the development of the team, and two further training events have been organised for October this year for all AO/DD staff, focusing on Mental Health Act, Mental Capacity Act, Community Treatment Orders, case studies and problem-solving scenarios.

With regards to the developments in the delivery of the Dual Diagnosis Service, these have been far reaching for the service. Examples of the changes implemented are:

A member of the Dual Diagnosis team attends at an AO clinical team meeting on at least a monthly basis. Dual Diagnosis clinicians also now notate their contacts and observations of a service user in the primary multi-disciplinary record, enabling the principle of 'one patient/one set of records' to be achieved. Should an occasion arise where meeting this principle is not possible, a standard has been agreed, and implemented, that ensures that contemporaneous information is provided to the service user's principal care team by:

- fax;
- email; or
- The Dual Diagnosis professional attending at the AO Team base to write in the service user's records and have a face-to-face discussion with the service user's care co-ordinator.

The above standard is audited on a six-monthly basis within the Dual Diagnosis Service. This represents good governance.

A component of the more rigorous approach to the sharing of information has been the inclusion of the Dual Diagnosis risk assessment in information that is shared across team boundaries. Furthermore, information generated as a consequence of the Dual Diagnosis medical review process is also communicated to the team holding care co-ordination responsibility for a service user. It is also now usual practice for a service user's care co-ordinator to be invited to attend the Dual Diagnosis medical reviews.

In addition to the above practice changes, there is now a bi-monthly meeting between Managers and Team Leaders of AO and Dual Diagnosis, looking to evaluate the joint working protocol and maintain the momentum and importance of continuing this.

A component of the Trust's commitment to achieving effective joint working between Dual Diagnosis and AO is the delivery of a two-day joint training venture between AO and Dual Diagnosis arranged for November 2011. The purpose of the training is to allow the services to continue to improve integrated working and further enhance professional working relationships.

In terms of supervision, this is now more robust than the good system in place previously, with a professional's entire caseload being reviewed on a rolling basis. The employment of a nurse consultant has also enabled a greater level of support and expertise to be available to all team members.

With regards to the particular Dual Diagnosis professional involved in the MHSU's case management, a professional and practice development programme was developed. This was a comprehensive programme that took some twelve months to complete. The Dual Diagnosis Service and the practitioner herself have fully embraced the need to address individual practice issues as well as systems issues.

Finally, there has been an increase in the medical cover provided to the Dual Diagnosis Service, which has been welcomed by the team.

6.0 Conclusions

The incident in which this MHSU was involved was tragic, and its impact has been enormous on the MHSU's family. CUK's conclusions are based on an objective and detailed analysis of the MHSU's care and treatment in Nottinghamshire Healthcare NHS Trust in the 20 months preceding the incident and are also cognisant of his mental health history since 2002 and the precipitators to his previous relapse episode in 2007.

With regard to the question "Was it predictable that the MHSU would attack his grandparents in the way that he did?", CUK does not believe that it was predictable. The MHSU did not have a history of violence or aggression to the extent that one would reasonably have considered him of any significant risk of harm to others. His family agrees with this.

The risks in relation to this MHSU were risks of harm to self through self-neglect, manifested by poor diet and poor hygiene. Any risk of harm to others was considered in terms of environmental health issues manifested through his lack of care with his home, and the storage of 'various fluids' in bottles, some of which during his relapse in 2007 had been identified as urine.

With regard to the question "Could different management by mental health services have averted the incident?", this is a far more complex question. Clearly, had the MHSU been assessed under the Mental Health Act (MHA) prior to 24 July and admitted to hospital on a compulsory basis, then the incident that occurred would have been avoided. However, there are three components here:

- Assessment under the Mental Health Act;
- The purpose of the assessment; and
- The outcome of such an assessment.

From the interviews conducted with the AO staff, it seems that they were waiting for a sufficient deterioration in the MHSU for the threshold for compulsory detention into hospital to have been assured. It is the opinion of CUK that there were sufficient indicators emerging between April and mid-June 2009 to have justified an assessment of the MHSU under the Act before this threshold was reached. CUK considers that the optimal time for an assessment of the MHSU was between 15 and 24 June 2009. However, CUK cannot say that, had a Mental Health Act assessment been achieved, it would have resulted in the compulsory treatment of the MHSU. It simply is not possible to determine this retrospectively. However, what an assessment would have provided was a clear and detailed analysis of the MHSU's mental state and opportunity to have re-engaged him in a treatment plan, or to have made clear to him the consequences, to him, of not re-engaging in treatment.

It is the lack of assessment of the MHSU, and the loss of opportunity to have assessed his mental state in advance of the incident, that continues to generate anger and distress for his family.

After 24 June 2009, the next clear opportunity for pushing forward with a MHA assessment was from 15 July 2009. The MHSU's care co-ordinator did, at this time, consider that the threshold the AO Team had been waiting for had been reached. The AO Team planned to conduct such an assessment on Monday 27 July. It considered that, in the context of the MHSU's slow deterioration, a planned assessment at a time where the MHSU was most likely to be at home was the

optimal approach. In view of the lack of risk history associated with the MHSU, and the fact that his care co-ordinator had laid out clearly for a range of colleagues the optimal time to find the MHSU at home, so that an assessment could be conducted, it is difficult to criticise the rationale.

However, the clearly laid out strategy by the care co-ordinator (on 19 July) was not progressed as it should have been. Although all AO staff interviewed by CUK agreed that a MHA was necessary and believed that it was going to happen on 27 July, at the time of the incident the actual arrangements had not been made for the conduct of a MHA on the morning of 27 July. This was and remains an unacceptable lapse in process.

With regards to the events of 24 July (the day of the incident), a visiting AO CPN observed concerning features on the door of the MHSU's flat. This individual contacted the MHSU's grandfather and was advised that there had been further deterioration in his grandson. As a consequence of this, the CPN did contact the duty Approved Mental Health Practitioner to discuss the situation and to explore whether an urgent Mental Health Act assessment was required. CUK is satisfied that this CPN undertook an appropriately detailed discussion with the Approved Mental Health Professional on duty. It is also satisfied that the decision both of these professionals came to that there was insufficient information to justify a section 135 warrant allowing forcible entry into the MHSU's home that evening/night was reasonable.

Other conclusions of CUK are:

- The management and care of the MHSU in the community between 2002 and March 2007 was of a good standard.
- The management and care of the MHSU between October 2007 and April 2009 was reasonable.
- There is sufficient evidence available to evidence that the MHSU's care co-ordinator had a reasonable relationship with the MHSU's grandfather and that they did make reasonable effort to communicate with the mother of the MHSU on the occasions this was necessary.
- The interface between the Dual Diagnosis Service and the AO Team was ineffective and the level of proactive communications between the teams was unacceptably low.
- After 9 April 2009, it is the contention of the CUK team that the care and treatment of the MHSU was misguided because of:
    - an over-reliance on negative reporting;
    - the lack of a complete picture within the AO Team of the MHSU's past risk behaviours;
    - the non-progression of the AO Team's own plan of action agreed on 23 April 2009 that the situation in relation to the MHSU would be reviewed in six weeks' time; and
    - the lack of assertive response to the early warning signs in evidence for the MHSU, i.e. reports of verbal aggression to the extent that cleaners would not go back to the corridor outside his flat unaccompanied, allegations (unsubstantiated) of assault.

The systems issues that CUK considers as contributory to the missed opportunities for further MHA assessments of the MHSU after 9 April 2009 were a lack of:

- robustness in the multi-disciplinary weekly clinical meeting;
- robustness in the zoning system used;
- effective team leadership; and
- a sufficient number of funded medical sessions for the MHSU's AO Team.

These issues were compounded by:

- The size of the AO Team caseload, which was and remains notably large compared to other teams in and out of Nottinghamshire.
- The frequency with which the MHSU's care co-ordinator was on sick or carer's leave.
- The dispersed and enlarged geographical area for the AO Team that resulted as a consequence of aligning the service with the relevant local authority and funding Primary Care Trust.
- The rapid rise in caseload size following the previously mentioned alignment of service boundaries and the subsequent impact on the time available for conducting assessments of service users.

7.0 RECOMMENDATIONS

CUK has five recommendations for Nottinghamshire Healthcare NHS Trust. These recommendations target the organisational commitment to a common strategy and common standards of practice across all AO teams in the Trust and also elements of 'hands-on' practice with AO teams in Nottinghamshire Healthcare NHS Trust.

Each and every one of the recommendations made is meant to be considered collectively by the service managers responsible for the AO services and collectively by the AO managers. It is essential that Nottinghamshire Healthcare NHS Trust achieves a corporate approach to the delivery of AO practice in relation to the operational systems and processes and also the tools and techniques designed to deliver an efficient and safe service.

This is not to say that there is no scope for each service to attend to the uniqueness of its geography or of any specific needs of its clients. But it does mean that things like the style of minute taking of clinical team meetings is uniform, and the way the zoning or traffic light system is used is uniform, as should the criteria governing the escalation and de-escalation of service users within it.

In making the recommendations it has, CUK is mindful that AO teams are in decline in England and that the validity of the model has been questioned through research outcomes and its relative importance in relation to national targets and policy has shifted. However, AO as a model continues to retain good support from clinicians and patients who are involved in the service. At the time of writing this report, Nottinghamshire Healthcare NHS Trust remains committed to providing an AO service. However, should this position change, the principles embodied in these recommendations should be transferred to whichever service or services take on the care and treatment of service users who require more intensive outreach and support.

Recommendation 1: As a corporately delivered service, all AO teams in Nottinghamshire Healthcare NHS Trust should have a consistency in approach across all of its core systems and processes, including the zoning system.

Nottinghamshire Healthcare NHS Trust must ensure that all of its AO teams work to a common operational policy, with the individual requirements of these reflected accordingly. The County North Operational Policy provides a useful framework for achieving consistency for the whole service.

In addition to the operational policy, issues such as the method for minute taking at 'same-type' meetings could be standardised so that across-team audits are easier to accomplish.

Finally, a key issue that was identified as significant in the care and treatment of the MHSU subject to this investigation observation was the lack of formalised criteria for moving service users up and down the traffic light ratings, and a lack of clearly defined clinical expectation/intervention associated with each level of the traffic light or zone.

Although there is variability in how AO, and other specialist teams, approach the usage of traffic light and other zoning systems, these systems are central to service user management. Consequently, having a robust framework, including features that dictate the focused discussion of a service user and the documentation of clinical decisions subsequently made, is sensible.

It is therefore recommended that the AO service managers, team leaders and clinical leads explore:

- the range of approaches currently in use across the AO teams;
- approaches in other mental health trusts and other teams, such as early intervention services;
- the range of criteria that might constitute a robust framework for dictating the necessity for clinical discussion of a service user at the weekly clinical team meeting, and/or the service users' escalation up the zoning system;
- the process by which service users once escalated up the zoning system can be 'de-escalated'.

In conjunction with the above, it is recommended that:

- clear guidelines are developed for the zoning system agreed;
- documentation standards around clinical decision making are agreed;
- the way the zoning system is to be audited, including audit criteria and the frequency of audit, is agreed and planned for.

Target audience: It is imperative that all of the team leaders/managers and lead clinicians and consultant psychiatrists for AO across Nottinghamshire are involved in considering and taking this recommendation forward.

Timescale: The CUK team highlighted the necessity for a single approach to the zoning system in January 2011. The draft report was delivered to the Trust in May 2011. Consequently, it is suggested that the above is achievable by 31 December 2011.

Recommendation 2: If the current model of AO is to continue in Nottinghamshire, it is essential that there is an increase in the provision for dedicated medical sessions to the County South AO Team.

This investigation, and the Trust's own investigation, identified the lack of medical sessions provided to this AO Team. This means that the provision of necessary and meaningful medical input is challenging. It is the contention of CUK that, had there been more appropriate levels of medical input provided by the Trust, then it may have made an impact on the assessment and management of the MHSU involved in this incident.

If an increase in medical sessions were to be achieved, CUK considers that this should result in:

- a more robust approach to the gathering of historical information about a service user;
- greater medical involvement in the initial assessment of service users referred to the AO service.

Target audience: The Service Manager for County South AO, the Medical Director for Nottinghamshire Healthcare NHS Trust, the commissioners for the County South AO Service.

Timescale: As soon as possible.
CUK considers that the lack of medical resource to the County South AO Team is not tenable, even in light of the prevailing changes that may be implemented in relation to AO services. The lack of medical provision does not equate to a safe and effective service.
However, it appreciates the complexity of achieving increased funding and does not see it as appropriate to impose a fixed timescale for this recommendation.

Recommendation 3: That the County South AO Team undertakes a randomised audit of a 20% sample of its current caseload to determine to what extent all relevant historical risk factors are detailed within the contemporary risk assessment documents.
If such an audit reveals findings that show:

- **significant gaps in the contemporary risk assessment documents;**
- **a lack of rigour in the information provided to AOT by feeder teams such as community mental health teams,**

then a more far-reaching audit of risk assessment, including the way in which staff access and are enabled to access historical information, will be required across all adult service teams (general and specialist). Ideally, this recommendation will be implemented across all AO teams in Nottinghamshire.

During this investigation it came to the attention of CUK that there was information of relevance to the assessment of the MHSU's risk that was not known by his care co-ordinator or other team members. Staff in this case relied on fragmented historical knowledge of a service user in order to make informed judgements on clinical risk management decisions. They need to rely on as complete information as is possible.

In making the above recommendation, CUK are aware that it is a sizeable piece of work. However, accurate historical as well as contemporary risk information is important to the delivery of a safe and effective mental health service.

Suggestions for how the recommendation could be achieved are:

- Via CPA Review as a rolling programme
- As a rolling programme via a separate weekly case review meeting
- A one-off structured audit.

CUK suggests that the AO managers put an option appraisal together alongside the costs for delivering each option and present this to the senior managers, who will need to provide the necessary support for achieving this recommendation.

It is expected that the outputs of the audit process will trigger any additional patient safety project work required in relation to the above.

Target audience: The AO Managers and their Service Managers.

Timescale: It is not possible to provide a timescale for the conclusion of this work as the size of AO team will have a significant impact on this. However, CUK expects that the Trust will have agreed with the AO team managers and the service managers the process by which the recommendation is to be addressed by October 2011 and should therefore be able to provide East Midlands SHA with a project management plan for this.

Recommendation 4: There needs to be an AO Managers' Forum across Nottinghamshire Healthcare NSH Trust.

During this investigation it came to the attention of CUK that there is no forum where the AO managers can share and reflect on the practice of their individual teams. This has meant that, although there are some shared values, there has been inconsistency in what should be core elements of practice. The formulation of an AO managers' forum will help to alleviate this.

Target audience: The AO Managers and their Service Managers.

Timescale: This is a non-complex recommendation and CUK suggests that such a forum could be arranged with a launch date of September 2011.

Recommendation 5: Nottinghamshire Healthcare NHS Trust needs to develop more practice-based training for its qualified community staff around the requesting of and organisation of a Mental Health Act Assessment.

This and the Trust's own investigation highlighted a lack of clarity amongst staff about the mechanics of organising a Mental Health Act Assessment. Discussion with a number of approved mental health practitioners about this suggested that a more practically focused training opportunity would be of benefit.

Target audience: The Trust's Mental Health Act Manager.

Timescale: CUK recognises that this is a recommendation that may not be a priority for the Trust at this time. However, it would expect the Trust to be able to advise East Midlands SHA of the outcome of any discussions it has about it by September 2011.

APPENDIX 1: INVESTIGATION METHODOLOGY and INFORMATION SOURCES

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

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

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

Face-to-face interviews with staff:

- The Consultant Psychiatrist for the MHSU's AO Team
- The MHSU's care co-ordinator
- Two AO mental health nurses
- The then team leader for the MHSU's AO Team
- The service manager for the MHSU's AO Team
- A previous team leader for the MHSU's AO Team
- All current AO managers employed by Nottinghamshire Healthcare NHS Trust
- The Dual Diagnosis professional for the MHSU
- The Nurse Consultant for Dual Diagnosis
- A Consultant Psychiatrist in Addictions
- The then Acting Team Manager for Dual Diagnosis
- The current Service Manager for Dual Diagnosis
- Two face-to-face meetings with the MHSU's family.

Other documentary information used:

- The MHSU's mental health records
- The original internal investigation report commissioned by Nottinghamshire Healthcare NHS Trust
- All interview records arising from the Trust's investigation
- Nottinghamshire Healthcare's Vulnerable Adults Policy 2008
- The MHSU's AO Team's operational policy pre-2008
- CL/CP 30 Management of Risks with Clients who have Co-Occurring Mental Health & Substance Misuse
- National Service Framework for Mental Health (DH, 1999)

- Appleby, L. *Safer Services: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (Department of Health, London, 1999)
- Best Practice in Managing Risk (DH, June 2007).

The investigation tools utilised were:

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

APPENDIX 2: GLOSSARY

Community Treatment Order (CTO)

A CTO is an option for Section 3 and unrestricted criminal and civil patients (hospital order, transfer direction, or hospital direction).

Longer-term leave of absence may not be granted to a patient unless the responsible clinician first considers whether the patient should be discharged on a CTO. Longer-term leave is defined as more than seven consecutive days, or an extension which would make the total period more than seven consecutive days.

The criteria of which the responsible clinician must be satisfied are found in s17A(5) of the Mental Health Act:

(a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
(b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;
(c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;
(d) it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) to recall the patient to hospital; and
(e) appropriate medical treatment is available for him.

An AMHP must certify in writing that he agrees the criteria are met and that it is appropriate to make the CTO.

The time periods for a CTO are the same as for detention under section 3 of the Mental Health Act. It lasts initially for a maximum of six months, but can be renewed for a further six months and thereafter can be renewed for 12-month periods.

The Care Programme Approach (CPA)[8]

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.[9] 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[10] and social care services. However, the

[8] http://www.mentalhealthleeds.info/infobank/mental-health-guide/care-programme-approach.php
[9] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf
[10] Specialist mental health services are those mental health services that are provided by mental health trusts rather than GP and other primary care services. Usually, persons in receipt of specialist mental health services will have complex mental health needs.

principles and values do. 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”.

Rethink
Rethink was founded over 30 years ago to give a voice to people affected by severe mental illnesses like schizophrenia. Rethink helps many people every year through its services, support groups and by providing information on mental health problems.

Its aim is to make a practical and positive difference by providing hope and empowerment through effective services, information and support to all those experiencing mental illness.

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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