VERITA

IMPROVEMENT THROUGH INVESTIGATION

# An independent investigation into the care and treatment of Mr M

A report for
NHS East of England

August 2012

Author:
Tariq Hussain
Chris Brougham

Peer reviewer:
Derek Mechen



Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for public sector and statutory organisations.

**Verita**
**53 Frith St**
**London W1D 4SN**

Telephone **020 7494 5670**
Fax **020 7734 9325**

E-mail enquiries@verita.net
Website www.verita.net

# Contents

# 1. Introduction

**1.1** On 26 April 2009 Mr M was arrested and charged with the murder of his mother's partner Mr N, in Essex. Mr M had been drinking heavily, had returned to the family home, and used a knife to stab his mother's partner, who subsequently died from injuries sustained. He was jailed for five years for manslaughter on the grounds of diminished responsibility.

**1.2** Mr M had been in contact with South Essex Partnership NHS Foundation Trust (the trust) since April 2003, when he was referred by his GP because of a social phobia and agoraphobia. His care was mainly managed through outpatient appointments. Mr M was assessed by two consultant psychiatrists during his six years of contact with the trust; he attended outpatient appointments; he was treated by a psychologist; and he was assessed by Basildon community mental health team (CMHT) who did not accept him as a patient. The CMHT referred him to the resource therapy team for anxiety management and confidence building but he did not attend despite numerous attempts to follow up.

**1.3** He had a history of illicit drug use taking cannabis and occasionally LSD. He would also engage in binge drinking.

**1.4** The trust carried out an internal investigation after the incident. The trust did not interview Mr M, his family or the victim's family because the legal process was underway. They did not interview Mr M's GP. We have carried out these interviews.

**Approach and Structure**

**1.5** As a result of Mr M's limited contact with trust services and as a result of our assessment that the trust internal investigation appeared comprehensive and robust, we agreed with NHS East of England that this investigation should be proportionate and focus on how the trust had implemented the recommendations of its own investigation. The trust had not been able to interview family members because of pending court proceedings, so we recommended a limited number of individual interviews to supplement those the trust had undertaken. These interviews were with Mr M, his family, his GP and Mr N's family.

**1.6** Our meeting with Mr N's family was to explain why the investigation had been commissioned and that its purpose was to review Mr M's mental health care up to the point of the incident but not the incident itself.

**1.7** We also held a group meeting with Basildon CMHT to discuss how the trust recommendations had been implemented and to evaluate the quality of team working and whether this had impacted on the care M received.

**1.8** We also examined whether any important matters were overlooked in the trust investigation. This approach provided the trust with an external audit of the progress of their investigation recommendations and assurance to the SHA that necessary changes had been made.

**1.9** The investigation was undertaken by Tariq Hussain, senior consultant, supported by Chris Brougham, senior consultant. Derek Mechen, partner, peer reviewed it. Biographies are attached at appendix E. We agreed with the commissioners that expert medical advice was not likely to be necessary.

# 2. Terms of reference

**Commissioner**

**2.1** This independent investigation is commissioned by NHS East of England in accordance with guidance published by the Department of Health in circular HSG (94) 27, *The discharge of mentally disordered people and their continuing care in the community,* and the updated paragraphs 33-6 issued in June 2005.

**Terms of reference**

**2.2** To provide an independent report into the care and treatment provided to Mr M from his first contact with mental health services up to the time of the offence.

**2.3** Following the review of clinical notes and other documentary evidence:

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of his offence.
- Compile a comprehensive chronology of events leading up to the homicide and establish the circumstances of the incident itself.
- Review the appropriateness of the treatment, care and supervision of the mental health service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themself or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.

- Consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence.

Provide a written report to the SHA that includes measurable and sustainable recommendations relevant to the present day clinical environment.

# 3. Executive summary and recommendations

**Executive summary**

*Personal background*

**3.1** Mr M was 31 at the time of the offence and lived at home with his mother in privately rented accommodation. He has one sister, one half-sister and one half-brother. He has never been in employment, having left school with no qualifications.

*The incident*

**3.2** On 26 April 2009 Mr M had been drinking heavily. He heard his mother and partner as they argued outside his house. He separated them and then stabbed his mother's partner, inflicting fatal injuries. He was jailed for five years for manslaughter on the grounds of diminished responsibility.

*Referral*

**3.3** Mr M first came into contact with the trust's services in March 2003 when he was referred by his GP, who described him as suffering from agoraphobia[1], social phobia[2], anxiety and depression for years. She said he could never go into a workplace and hold a job and that he lived with his mother. He had no qualifications and had had paranoid feelings over many years. Mr M had seen a counsellor from the GP practice in the previous few months but had not found it helpful. He had used cannabis and other hallucinogenic drugs in the past but was not currently using them regularly or in large amounts neither was he drinking to excess. The GP prescribed paroxetine (an antidepressant) 20mg OD (once a day).

[1] Agoraphobia is an intense fear about being in public places where you feel escape might be difficult.
[2] Social phobia is the fear of social situations that involve interaction with other people.

*Outpatient assessment*

**3.4** Mr M was assessed in outpatients on 9 June 2003 by consultant psychiatrist 1. This appointment was more than two months after the referral. Consultant psychiatrist 1 agreed with Mr M's GP's assessment and referred him on the same day to the trust's psychology services for *"…some form of psychological behavioural psychotherapy for his phobias"*.

*First contact with psychology*

**3.5** The referral to the psychology service was sent on 13 June 2003 but the letter from a secretary to Mr M was not sent until 21 October 2003, almost four-and-a-half months after the initial referral. Mr M was asked to return a form outlining how he saw his difficulties. When he did not do so, he was not accepted for treatment and consultant psychiatrist 1 was notified.

*Second contact with psychology*

**3.6** Mr M told consultant psychiatrist 1 at his next outpatient appointment on 29 March 2004 that he had not received the psychology appointment. Consultant psychiatrist 1 asked him to contact the service and said he would also do so. It appears that neither did so. Consultant psychiatrist 1's senior house officer (SHO) 1 saw Mr M in outpatients on 7 December 2004. Mr M repeated that he had not received a psychology appointment and the SHO 1 referred him again. Psychology told the SHO 1 that all referrals were discussed in their bi-monthly referrals meeting.

**3.7** The psychology service wrote to Mr M on 23 December 2004 asking him to complete a referral form and return it within two weeks. He was also told the waiting list was up to 12 weeks.

Comment

***Combining the time it took for psychology services to write to a client, receive the client's assessment form, discuss the referral at the referral meeting and the possible length of a waiting list, could mean the client waited over 20 weeks for treatment.***

***The potential delay in receiving treatment is now less as referral meetings occur on a weekly basis rather than bi-monthly and a letter informing the client that they have been placed on the waiting list is sent out the next day.***

*Mr M's description of his difficulties*

**3.8** The psychology department's letter to Mr M asked him to complete a form describing his difficulties and what he hoped to achieve as a result of treatment. He returned this on 6 January 2005. The form provides a useful insight into how Mr M viewed his problems at that time. It is set out in full later in this report but can be summarised as:

- wanting to get on with his life and not feel paranoid
- get a job
- not to be *"having a go at people all the time"*.

Mr M's response identifies that his social phobia was partly caused by his paranoia and was not only a result of social anxiety.

*Psychology assessment*

**3.9** Mr M was offered an appointment for 14 February 2005 and was seen by a trainee counselling psychologist. He left after 20 minutes saying that the counsellor could not help him.

**3.10** The counsellor wrote to consultant psychiatrist 1 to tell him what had happened and that Mr M had told him *"…he had had a history of drug use (LSD and Cannabis) and still occasionally uses the latter, he believes that his feelings of paranoia arise as a result of this drug use"*.

*Discharge from psychology*

**3.11** The psychology service subsequently sent Mr M appointments for February, March and April 2005 which he failed to keep. He was discharged as a result.

*Discharge from outpatients*

**3.12** Mr M was sent an outpatient appointment for 6 October that he did not keep, and his GP was advised of this by consultant psychiatrist 1. He was then sent an appointment for 4 July 2006, which he did not attend either. Consultant psychiatrist 1 told his GP that he would not be offered a third appointment but could be re-referred. No record of this discharge appears on the trust central booking system.

Comment

***This discharge from trust services was made after Mr M was assessed principally as needing psychological help to overcome agoraphobia and social phobia. The consultant and his team had been in consistent contact with his GP and he was referred back to her care with an offer to accept a re-referral if needed. Mr M's discharge was appropriate on the basis of his presenting symptoms and the prerequisite for him to be willing to engage in psychological therapy.***

*New consultant*

**3.13** Consultant psychiatrist 1 left the trust (date uncertain) and a new consultant was appointed. Mr M's name was still on the trust's central booking system so the new

consultant believed he was still registered as an outpatient and arranged an appointment for him.

**3.14** The appointment took place on 20 February 2008, just over three years after the previous one. Mr M attended with his sister. In the period between outpatient appointments he was under the care of his GP. She made no new referrals to the trust for him.

**3.15** Consultant psychiatrist 2's assessment was that Mr M's agoraphobia had worsened. He was now quite paranoid that people were staring at him and had taken to staying in his room and stacking boxes against the window. Mr M said he had reduced his use of street drugs and was drinking less.

**3.16** This degree of agoraphobia and paranoia was higher than both Mr M's previous consultant and the psychologist three years earlier had found. Consultant psychiatrist 2 suggested to Mr M that he receive support from the crisis resolution and home treatment team. Mr M refused, so consultant psychiatrist 2 offered him an early outpatient appointment in six weeks' time.

**3.17** Consultant psychiatrist 2 said he had the impression that Mr M was showing signs of a psychotic illness that may have been drug induced as a result of his use of cannabis in the past. He continued Mr M on his paroxetine and also started him on Olanzapine.

**3.18** Mr M was offered a follow up appointment for 2 April 2008, which he did not attend. He was offered another appointment for 9 June 2008, which he attended alone. He was not as intensely paranoid as at his previous appointment but was continuing to stay indoors most of the time. Mr M told consultant psychiatrist 2 that his feelings were not as bad as they used to be. He was drinking alcohol occasionally, but when he did it was in substantial amounts. He had reduced his cannabis intake to about once a month but was not consistent in taking his prescription medicine as he could not see any benefit from it.

*Referral to Basildon community mental health team (CMHT)*

**3.19** Consultant psychiatrist 2 referred Mr M to the Basildon CMHT. They invited him to a screening assessment on 26 June but he did not attend. The team wrote to him and

arranged to undertake the screening assessment at his home on 16 July 2008. Two staff members visited Mr M's home but it seemed empty. The team contacted his sister and arranged another appointment for Mr M for 13 August, which he attended.

**3.20** A community mental health nurse from the CMHT conducted the assessment. The nurse noted in the summary of needs section of the assessment that Mr M needed *"to get some confidence in life"* and *"refer to Resource Therapy"*.

*Referral to resource therapy*

**3.21** The resource therapy team is largely staffed by occupational therapists who offer group work, anxiety and anger management and coping skills. Mr M was offered an appointment with the resource therapy team in January and two in April, none of which he attended. The team made no further contact with Mr M after these abortive appointments. We found no record that Mr M was referred back to the CMHT or that the resource therapy team sought advice on what alternative approaches should be taken.

Comment

***If the resource therapy team had formally referred Mr M back to the CMHT this would have provided an opportunity to reconsider what further action, if any, the CMHT or the resource therapy team could take. He was not discharged from the service because the consultant in outpatients was still seeing him.***

*Outpatients*

**3.22** The day Mr M attended for his screening appointment with the CMHT consultant psychiatrist 2 also saw him as an outpatient. He found him much better in himself with more insight into his illness. He noted that Mr M joked and laughed appropriately.

**3.23** This appointment was the last time that Mr M engaged with the services. He subsequently failed to attend resource therapy (as outlined above) and further outpatient appointments.

**3.24** Mr M was sent an outpatient appointment for 15 April 2009 but he did not attend and his GP was informed by consultant psychiatrist 2. She was told that Mr M would be offered another appointment and was asked to encourage him to attend and to provide an update of any recent changes in his condition.

**3.25** The incident that led to the death of Mr N occurred on 26 April 2009.

*Overall conclusion*

**3.26** We set out below a number of findings and recommendations we believe will help the trust to improve its services. What is clear from our investigation is that even though we have identified some suggested improvements to organisational arrangements the service that Mr M received from the trust staff and his GP were of a high standard. In particular the communication between GP, consultants, psychology, CMHT and resource therapy was in the main timely and ensured that all those involved were kept informed of relevant information.

**3.27** Assessments were generally comprehensive and led to consistent care planning decisions. The trust said in its internal investigation that:

> *"There were a number of positive attempts to engage the service user that included liaison and communication with the GP and home visit following non attendance at outpatients. However, this was not consistent and more assertive attempts could have been made to engage the service user with the services."*

**3.28** We support this view because when Mr M failed to attend outpatient appointments the CMHT could have been asked to reassess him and his home circumstances. Though it is clear that at his last outpatients appointment his mental health had improved and therefore continuing to offer him outpatient's appointments was an acceptable alternative approach.

**3.29** Mr M frequently disengaged from the service and was often ambiguous about the help he wanted. One of the recommendations arising from the trust investigation is a review of the trust disengagement/did not attend policy. This is a necessary and helpful recommendation and supported by the members of Basildon CMHT that we met.

**3.30** Our interview with Mr M's GP showed that overall partnership working with this GP practice was working well but that the trust needed to consider how to improve communication/consultation.

**3.31** We discussed supervision with Basildon CMHT. They told us that supervision was working effectively except in the case of one group of professionals. The consultant at our meeting said no clinical supervision took place of his work in outpatients, neither was this work integrated into the overall remit of the CMHT. The lack of supervision of consultant's outpatient work creates a clinical blind spot. As a consequence the lack of supervision leaves open the possibility that some clients continue to have outpatient appointments when they should be discharged or referred to other services.

**3.32** The other significant matter arising from our meeting with the CMHT was the availability of a single electronic patient record system. At a time when many trusts have moved to a single electronic CPA and notes system the trust's system of electronic notes does not allow all professionals to enter clinical information on a single system. Because of the particular system operated by the trust staff it makes it more difficult for multi professional teams in different locations to ensure that they are fully aware of the most recent action being taken by other professionals. This is a serious disadvantage.

**3.33** We found some ways that CMHT team working could be improved but overall the team was working well and we are not aware of any aspect of its practice that significantly impacted on the care of Mr M.

**3.34** The trust undertook its own investigation after the incident. It produced three recommendations of which two have been actioned. It is important that when recommendations are made by an internal investigation that there is an audit trail showing how they have been dealt with. If they are not to be specifically actioned then this should be explained. The investigation also identified two lessons to be learnt.

*Predictable or preventable*

**3.35** Mr M received care from his GP, two consultant psychiatrists, one psychologist and the CMHT. None of these assessments by different professionals suggested he was likely to be a risk to others. His mother and sister confirmed this. Therefore we conclude that the incident was not predictable.

**3.36** Mr M was clear in his interview with us that the actual incident did not happen as a result of his mental health problems but because he wanted to protect his mother from her partner with whom she was arguing. The circumstances of this incident are such that it appears to be solely related to a domestic argument and not to a worsening of Mr M's mental health. Consequently there were no indicators which the mental health staff could or should have been alerted to prior to the incident. We therefore conclude that the incident was not preventable by the mental health services.

**Findings**

**F1** The psychology service was persistent in responding to Mr M and referrals made by consultant psychiatrist 1 and his SHO 1. Following Mr M's request for counselling and then his failure to attend appointments the psychology service kept Mr M and the referrers informed at all times.

**F2** We conclude that discharging Mr M in July 2006 after his second non-attendance at outpatients was a reasonable clinical judgement in light of his presenting symptoms, problems and assessed risks.

**Recommendations**

**R1** The commissioners should satisfy themselves that the period from referral to assessment and then treatment for psychology services is within acceptable time parameters.

**R2** We recommend that Basildon CMHT review with their referring GPs what improvements to partnership working may be needed and how they might be implemented.

**R3** The trust should review with its consultant body how outpatient clinical work can be brought within the framework of the trust supervision policy and how outpatient work can be more integrated into the overall work of the CMHT.

**R4** The trust commissioners should review with the trust its progress in moving to a single electronic record system that allows all professionals to input entries and view the notes of other professionals working with a client.

**R5** The trust should provide for the commissioners a report on any actions they have taken or intend to take in relation to the internal investigation recommendation 12.2.

# 4. Chronology

**4.1** Mr M had no contact with the trust mental health services before 2003 but was under the care of his GP. We reviewed the GP notes but we do not include a review of Mr M's earlier medical history because it has no relevance to the care he received from the trust.

**4.2** One of the key themes arsing from this chronology is Mr M's non-attendance at various appointments. We set out here a table that provides an overview of the missed appointments.

| Appointment Date | Service | Attendance |
|---|---|---|
| **2003** | | |
| 21 October | Referred to psychology and asked to complete screening form | Did not attend (DNA) and no notification |
| **2005** | | |
| 7 February | psychology | DNA but sent apologies |
| 14 February | psychology | Attended but left after 20 minutes |
| 28 February | psychology | DNA but sent apologies |
| 14 March | psychology | DNA-no notification |
| 11 April | psychology | DNA- no notification |
| 6 October | outpatients | DNA-no notification |
| **2006** | | |
| 4 July | outpatients | DNA-no notification |
| **2008** | | |
| 4 February | outpatients | DNA-no notification |
| 2 April | outpatients | DNA-no notification |
| 26 June | CMHT | DNA-no notification |
| 17 July | CMHT-home visit | No one at home |
| **2009** | | |
| 20 January | resource therapy team | DNA-no notification |
| 30 April | resource therapy team | DNA-no notification |
| 15 April | outpatients | DNA-no notification |

**2003 - referral to mental health services**

**4.3** Mr M's GP, referred him on 31 March 2003 to consultant psychiatrist 1 from the trust. She described Mr M as suffering from agoraphobia, social phobia, anxiety and depression for years. She said he could never go into a work place and hold a job and that he lived with his mother. He had no qualifications and had had paranoid feelings for many years. Mr M had seen a counsellor from the GP practice in the previous few months but had not found it helpful. He had used cannabis and other hallucinogenic drugs in the past but was not currently using them regularly or in large amounts neither was he drinking to excess. The GP prescribed him paroxetine (an antidepressant) 20mg OD (once a day).

**4.4** Consultant psychiatrist 1 saw Mr M as an outpatient on 9 June. He wrote to Mr M's GP with a summary of his assessment and his review of Mr M's mental health problems, which was consistent with Mr M's GP's information. Consultant psychiatrist 1 described Mr M as feeling depressed with poor sleep and appetite but denying feeling suicidal. He detected no evidence of any thought disorder and said Mr M's cognition was intact and his judgement was reasonably good.

**4.5** Consultant psychiatrist 1 assessed him as a young man with a social phobia. Consultant psychiatrist 1 told Mr M's GP that he would refer him to the trust psychology department for counselling and would review him again in due course.

*Comment*

***Consultant psychiatrist 1 saw Mr M just over two months after the referral, which appears to be a long wait for a psychiatric assessment. Based on consultant psychiatrist 1's assessment, his referral to psychology was appropriate.***

*Referral to psychology*

**4.6** Consultant psychiatrist 1 referred Mr M to psychology on 13 June 2003, the day he assessed him in outpatients. The letter of referral requested *"…some form of psychological behavioural psychotherapy for his phobias"*. The referral letter to psychology included a copy of the letter that he had sent to Mr M's GP.

**4.7** A secretary in the psychology service wrote to Mr M on 21 October 2003. The letter was accompanied with an information booklet and a referral form for Mr M to complete confirming that he wanted the appointment and to tell the psychology service *"…a little bit about how you see your difficulties"*. The letter told him there was an 18-month waiting list, but if he felt the need to be seen earlier, he should say why in the letter. It also told him that if on reflection he did not want to continue with the referral he could always go back to his GP at a later date and request a re-referral. He was given three weeks to respond.

Comment

***The referral to the psychology service was sent on 9 June 2003 but the letter from a secretary to Mr M was not sent until the 21 October 2003, four and half months after receipt of the request for an appointment. We recognise that there can be long waits for psychology treatment but it is difficult to explain such a long wait for the first contact from a secretary. We did not investigate this gap because a later referral was dealt with much sooner.***

**4.8** The psychology service did not hear from Mr M within three weeks so an administrator wrote to consultant psychiatrist 1 on 26 November to tell him that Mr M's name had been removed from their records but that he could be re-referred or that consultant psychiatrist 1 should tell them if he knew of any extenuating circumstances.

**2004**

**4.9** Consultant psychiatrist 1 saw Mr M in his outpatient clinic on 29 March 2004. Mr M told him he had not received an appointment from the psychology department. Consultant psychiatrist 1 advised Mr M to contact them and said he would write to them. Consultant psychiatrist 1 kept Mr M on his paroxetine medication.

**4.10** We found no evidence in the file that consultant psychiatrist 1 sent a letter of referral or that Mr M contacted the psychology service himself. There is no further

contact by consultant psychiatrist 1 or his team with Mr M until 7 December 2004 (nine months later) when the SHO 1 to consultant psychiatrist 1, saw him as an outpatient. The SHO 1 to consultant psychiatrist 1 wrote to Mr M's GP after the appointment saying again that Mr M claimed not to have received the initial psychology appointment and wanted to be re-referred. The SHO 1 to consultant psychiatrist 1 notes in the letter that he believed consultant psychiatrist 1 had referred Mr M to psychology on 29 March.

**4.11** On the same day (7 December) the SHO 1 to consultant psychiatrist 1 referred Mr M to the psychology service for *'psychological behavioural therapy for his phobias'*. He enclosed a copy of the clinic letter he had sent to Mr M's GP.

**4.12** Mr M told the SHO 1 to consultant psychiatrist 1 that his current medication was not helping much. The SHO 1 to consultant psychiatrist 1 spoke with consultant psychiatrist 1 and advised Mr M's GP on a process for reducing his current medication and replacing it with Cipralex 10mg, also an anti-depressant.

**4.13** The psychology service wrote to the SHO 1 to consultant psychiatrist 1 on 20 December to say the referral would be discussed at the next bi-monthly referral meeting. They also wrote to Mr M on 23 December asking him to complete a referral form, telling him to return it in two weeks and explaining that there was a waiting list of about 12 weeks.

*Comment*

***This response to Mr M was considerably more prompt than the previous referral taking into account the time taken to initially make contact and receive a referral response form from the client.***

*Recommendation*

**R1** The commissioners should satisfy themselves that the period from referral to assessment and then treatment for psychology services is within acceptable time parameters.

**2005**

**4.14** Mr M completed a questionnaire sent out with a letter from the psychology service on 6 January 2005. He wrote in the form how he saw his difficulties and what he hoped as a result of treatment. We quote below in full the questions asked and his response. We have left the questions and Mr M's response as recorded in the clinical file:

> ***"What do you feel is the main difficulty that you would like help with?***
> *Being able to get on with my life and getting on with people around me to stop getting paranoid and think everyone's plotting something against me."*
>
> ***"How far do you think this interferes with your life at the moment?***
> *A lot. I can only get on with people like my friends the one's I've got anyway plus one day I would like to get a job and keep it without getting paranoid about people all the time and being able to get out and about again."*
>
> ***"How do you think other people are involved in this?***
> *Every time I go out into open spaces I get paranoid when there's lots of people around me that's why when I do go out sometimes I go out at weird hours so there's no one about and I'm getting cheesed of with having a go at people all the time and the next day think that's nothing happened."*

*Comment*

***It is clear from Mr M's response that his agoraphobia was based not just on a high level of social anxiety brought about by crowds, but also on his paranoia.***

**4.15** The psychology service wrote to Mr M thanking him for returning his questionnaire and saying that they had a waiting list and hoped to see him at the earliest opportunity and within three months.

**4.16** The actual response time from the service was much shorter. Mr M was sent a letter on 1 February 2005 offering him an appointment for an initial assessment a week later on 7 February with a trainee counselling psychologist. Mr M contacted the service to

say that he could not attend on this day because he had to go to a funeral. He was offered another appointment for 14 February.

**4.17** Mr M kept his appointment with the trainee counselling psychologist on 14 February but left after 20 minutes saying he could not help him. The trainee counselling psychologist wrote next day to consultant psychiatrist 1 to tell him about the appointment and its outcome. He told consultant psychiatrist 1 that Mr M had told him among other things that *"…he had had a history of drug use (LSD and Cannabis) and still occasionally uses the later, he believes that his feelings of paranoia arise as a result of this drug use"*.

**4.18** The trainee counselling psychologist told consultant psychiatrist 1 that it was possible that Mr M would not attend his next appointment and that he would be discharged if so. He also suggested that Mr M could be referred to the drug and alcohol service if he did not engage further with psychology.

*Comment*

***We found no record that Mr M was referred to the drug and alcohol service. It is clear from the records and confirmed in our interview with Mr M that he was not motivated to stop his use of illicit drugs or to moderate his binge drinking. A referral to drug and alcohol services was therefore unlikely to be effective. It must have been clear to consultant psychiatrist 1 that Mr M's likelihood of engaging with the service was low.***

**4.19** The trainee counselling psychologist wrote to Mr M on 15 February saying *"realise that you found today's session very difficult and appreciate your difficulty"*. He offered Mr M another appointment for 28 February 2005. The trainee counselling psychologist also wrote to consultant psychiatrist 1 and told him among other things that *"During the assessment, he* [Mr M] *said that he had had a history of drug use [LSD and Cannabis] and still occasionally uses the latter, he believes that his feelings of paranoia arise as a result of this drug use"*.

**4.20** Mr M could not attend the appointment on 28 February but made contact in advance to say so. On 1 March he was sent another appointment for 14 March, copied to consultant psychiatrist 1. Mr M did not keep the appointment.

**4.21** The trainee counselling psychologist wrote to consultant psychiatrist 1 on 15 March to say he had written to Mr M telling him that *"…this may not be the most appropriate time for him to engage in counselling and therefore will be discharging him"*.

**4.22** Mr M contacted the psychology service to say he would like counselling. He was therefore offered another appointment on 11 April. Mr M did not attend the appointment or contact the service and was discharged.

*Finding*

**F1** The psychology service was persistent in responding to Mr M and referrals made by consultant psychiatrist 1 and his SHO 1. Following Mr M's request for counselling and then his failure to attend appointments the psychology service kept Mr M and the referrers informed at all times.

**4.23** Mr M was sent an outpatient appointment for 6 October which he did not keep. The SHO 2 to consultant psychiatrist 1 wrote to Mr M's GP letting her know and saying he would be sent a follow-up appointment in due course.

**2006**

**4.24** Consultant psychiatrist 1 wrote on 4 July 2006 to Mr M's GP telling her that Mr M had failed to attend a second outpatient appointment and would therefore not be offered a third appointment but could be re-referred. We found no record of this discharge from outpatients on the trust central booking system.

*Comment*

***We do not know why the discharge from outpatients was not registered but as this was in 2006 and as the trust has picked this matter up within their internal***

***investigation and features as part of their recommendations and action plan we have not sought to examine it further.***

***Mr M's last contact with consultant psychiatrist 1's team was an appointment with the SHO 1 to consultant psychiatrist 1 on 7 December 2004 when his medication was changed and he was re-referred to psychology. He was seen by the psychology service on 14 February 2005. He then failed to attend further psychology appointments and consultant outpatient team appointments.***

***The trust remarked on this matter in its investigation and said in its report:***

> **"…more assertive attempts could have been made to engage the service user with the services."**

***We accept that with hindsight a more assertive approach might have helped Mr M to engage with services. At this point he had been assessed as principally needing psychological help to overcome his agoraphobia and social phobia. The consultant team was in regular contact with his GP and he was referred back to her care with an offer to accept a re-referral if needed.***

*Finding*

**F2** We conclude that discharging Mr M in July 2006 after his second non-attendance at outpatients was a reasonable clinical judgement in light of his presenting symptoms, problems and assessed risks.

**2008**

**4.25** There was no further contact by the trust staff with Mr M until a new consultant, consultant psychiatrist 2, sent him an appointment for 4 February 2008. Consultant psychiatrist 2 had taken over from consultant psychiatrist 1 as team consultant.

*Comment*

***This appointment was just over three years since Mr M had been seen in outpatients and by psychology.***

**4.26** Consultant psychiatrist 2 wrote to Mr M's GP that Mr M did not attend his appointment on 4 February and that another appointment will be sent to him in due course. He advised that Mr M rang in advance to cancel.

**4.27** Consultant psychiatrist 2 wrote to Mr M's GP, on 26 February stating that he had seen Mr M in his clinic on 20 February, accompanied by his sister. He said the gap since his last outpatient appointment was because illness prevented him from leaving the house and because he did not receive the outpatient appointments.

**4.28** The following quote from consultant psychiatrist 2's letter shows how Mr M's agoraphobia had worsened:

> *"Presently things are quite difficult for* [Mr M]. *He is living with his mother in Basildon, however, he hardly goes out of the house and mostly locks himself in his room.* [Mr M] *has been given a diagnosis of social phobia and has been treated mainly with antidepressants and was referred for psychological input as well. In the past he has quite a strong history of polysubstance misuse, including LSD and cannabis. Presently he is taking Paroxetine 20mg daily, however, does not find any benefit from it. His substance abuse has decreased considerably and, according to* [Mr M] *and his sister, he is not taking any street drugs. He very occasionally drinks alcohol and occasionally smokes cigarettes, managing to smoke about 10 a week. However, the main problem seems to be the fact that* [Mr M] *is very afraid to come out of the house. This is because he feels that people are plotting against him and want to harm him. When* [Mr M] *does go out of the house he feels that people are staring at him and also laughing behind his back. Due to this he locks himself in the bedroom and stacks boxes against the window so that no one can see him. He does use music to distract himself."*

**4.29** Consultant psychiatrist 2 refers to risk:

*"In his mental state* [Mr M] *appeared as a young Caucasian gentleman who was looking anxious and suspicious. He was wearing a large cap so that people would not look at him. He does appear to be frustrated and low in his mood because of the feeling that he has got. And says that every day he feels* "what is the point of him living as he is not doing anything and just staying in his room". *However, thoughts of his family and especially his niece prevent him from doing anything to harm himself. He did say that he wants to get better and to do things that he likes to do."*

**4.30** On diagnosis he says:

*"Except for the paranoid symptoms that I have mentioned above I could not elicit any perceptual abnormalities in terms of hallucinations or delusions. However, there is a possibility and suggestion that he may be having some ideas or even delusions of reference when he watches movies and thinks that they may be referring to him but they were not very clear cut and not any delusional intensity at the moment. Because of these symptoms* [Mr M] *finds it very difficult to go to bed and only manages to sleep about two or three hours in the early hours of the morning. His appetite is not great as well. He does say that when he was smoking a lot of cannabis at that time he was having quite strange thoughts and beliefs that are not there at the moment.*

*My impression is that* [Mr M] *is showing signs of a psychotic illness rather than simple or social phobia. The intensity of these paranoid thoughts is quite strong and history suggests that in the past he may have had a drug induced psychosis when he was using a lot of cannabis. Quite often residual symptoms do remain even after stopping the precipitating drug and it is quite possible that the symptoms of social phobia are one of the symptoms of this paranoia leading* [Mr M] *not to come out of the house and meet people."*

**4.31** His advice about treatment and management was:

*"In view of the fact that he does have low mood I have advised him to continue on Paroxetine 20mg daily. However, I have started him on Olanzapine 10mg nocte. I*

*have explained to him the side effects of the medication. I did also suggest to* [Mr M] *that I would like a referral to the Crisis Resolution and Home Treatment Team to see him in the community. However, he was reluctant for this and said that he would rather take the medication and report back to me in my clinic and decide from there on what he wants to do. Therefore, I did not make a referral to the Crisis Team. I have, however, made arrangements to review* [Mr M] *in my clinic in approximately six weeks time to monitor his mental health.*

*Meanwhile if he needs a prescription of Olanzapine 10mg daily or indeed if the need be it can be increased to 15mg daily I shall be grateful if you could do so. Once I see* [Mr M] *in my clinic in six weeks I shall let you know of the progress."*

*Comment*

***This assessment shows that Mr M's agoraphobia had become worse at this time. Consultant psychiatrist 2 said Mr M's agoraphobia was caused by his paranoia. This agrees with Mr M's own assessment when he attended the psychology appointment and said he did not go out much because of his paranoia.***

***Mr M told consultant psychiatrist 2 he believed that people were plotting against him, wanting to harm him and talking about him. We saw nothing in the records from his previous appointments with his GP, consultant psychiatrist 1 or his team (in December 2004) or the trainee counselling psychologist (in February 2005) to suggest that his paranoia was as severe as consultant psychiatrist 2 had assessed it.***

***Consultant psychiatrist 2 considered that the CRHT may be of assistance he did not assertively pursue this with Mr M but did fix an appointment for six weeks hence which indicates that he assessed closer supervision of Mr M as warranted.***

**4.32** Mr M's next outpatient appointment with consultant psychiatrist 2 was arranged for 2 April but he did not attend. Consultant psychiatrist 2 told Mr M's GP this and said a follow-up appointment would be sent out.

**4.33** Mr M attended consultant psychiatrist 2's clinic alone on 9 June 2006. Consultant psychiatrist 2's letter to Mr M's GP after the outpatient's appointment says Mr M was not as intensely paranoid as previously assessed:

> "[Mr M] *continues to stay indoors most of the time. He is mostly in his room which he has darkened and informed me that he has put three layers of blankets on top of the window to darken the light. When I asked him why that is the case he says that this is how he likes it. He also says that now and then he feels people are talking about him, however, went on to say that these feelings are not as bad as they used to be in the past.* [Mr M] *spends most of his time watching television. He stays up very late in the night and goes to sleep only in the early hours of the morning. However, he says that his appetite is not too bad. He does say that his mood is up and down and he occasionally gets thoughts of self harm or suicide, however, he went on to say that the thoughts of his family stop him from doing anything to harm himself."*

**4.34** He also told consultant psychiatrist 2:

> *"…he very occasionally drinks alcohol; however, when he does drink he drinks a substantial amount. According to him he has reduced his cannabis intake to about once a month."*

He also said he was not consistent in taking his prescribed medication because he could see no benefit from it. He also told us he did not like taking prescription medication and preferred small regular amounts of cannabis.

*Referral to Basildon CMHT*

**4.35** Consultant psychiatrist 2 says in his letter to Mr M's GP *"I shall also be referring* [Mr M] *to the Community Mental Health Team for an assessment to see if they can provide some support to him. We shall review him again in our clinic in due course".*

**4.36** Consultant psychiatrist 2 referred Mr M to the Basildon CMHT on 9 June 2008 and the duty officer wrote to Mr M inviting him to attend a screening assessment on 26 June. Mr M did not attend this appointment and the CMHT wrote again inviting him to be

assessed at home on 16 July 2008. Two CMHT staff visited his home that day but Mr M was not present and the house seemed empty. A neighbour suggested that they had moved.

*Screening assessment*

**4.37** Following contact by the CMHT with Mr M's sister a new appointment was sent to him to attend an assessment on 13 August 2008. He did attend.

**4.38** A community mental health nurse from the CMHT assessed Mr M. The community nurse completed a trust core assessment form. The core assessment covers 25 areas related to assessing life and mental health history and risks. The assessor completed this and wrote in the summary of needs section that Mr M needed *"to get some confidence in life"* and *"refer to Resource Therapy"*.

*Referral to resource therapy team*

**4.39** The form given to Mr M following the assessment said he would be referred to Resource Therapy for anxiety management and that he was not to be allocated to the CMHT. Mr M was informed that the resource therapy team would contact him.

*Outpatient appointment*

**4.40** Mr M attended an outpatient appointment with consultant psychiatrist 2 on the day of his screening assessment. Consultant psychiatrist 2 then wrote to Mr M's GP. We quote here a large part of the letter because it provides a helpful update of the improvement in Mr M's mental health.

Mental health assessment

> *"*[Mr M] *informed me that on the same day i.e.13 August he had been seen by Basildon CMHT following my referral and after an assessment they had suggested a referral to a Confidence Building Course with the CMHT. They also said that following this course they may look at some kind of voluntary work for* [Mr M] *as a way to get back into work. He seems to be very pleased with this outcome. In general I found* [Mr M] *to be much better in himself. He was euthymic in his mood and appeared to be having more insight into his illness. Besides this he was able to joke and laugh appropriately during the interview."*

Medication

> *"He says that although I had advised him to continue on Olanzapine he has not been taking that regularly as he should. This is in view of the fact that* [Mr M] *feels that medication is not a good thing and one should not rely on them for one's whole life. I did counsel him about this and say that he may only need this for a short period and we already have seen the evidence that he is better.* [Mr M] *did agree to take it again on a regular basis."*

Referral to CMHT

> *"I feel that* [Mr M's] *engagement with Basildon CMHT will be very beneficial for him as at the moment he spends most of his time at home sitting on his own and not doing much. However, he denies any active thoughts of deliberate self harm, suicide or harm to others and says that if he had to do something he would have had done so by now."*

Action

> *"I have advised* [Mr M] *to continue on Olanzapine 10mg daily and to attend the Resource Therapy Centre as suggested. We shall review him again in our clinic in due course and inform you of the progress."*

Comment

***Mr M had improved since his appointment with consultant psychiatrist 2 and he was hopeful about the future. This appointment was the last time Mr M engaged with the services. He subsequently failed to attend screening services with the resource therapy team and further outpatient appointments.***

**4.41** The CMHT screening assessor wrote to consultant psychiatrist 2 on 17 September:

> *"…we came to a conclusion that he should be referred to the Resource Therapy Team and that he is not for allocation to the CMHT at the moment. I spoke to...(OT) at Aston Court who said the referral is appropriate for Anxiety Management and she agreed to take the referral. Please find enclosed assessment papers for your information."*

The assessor wrote to the resource therapy team the same day, referring Mr M for anxiety management. The referral included copies of the assessment and correspondence.

Comment

***The two letters the CMHT assessor sent to the referring consultant and the other to the resource therapy team were sent a month after the screening assessment. This is too long.***

**4.42** The resource therapy team wrote to Mr M on 6 October asking him to confirm that he wanted an appointment. He was subsequently sent an appointment for 20 January 2009.

**2009**

**4.43** We found no records indicating that Mr M attended his appointment with the resource therapy team in January and on 14 April he was sent another appointment for 30 April 2009. Again, we found nothing in the records to suggest that he attended this appointment. Mr M had no further contact with the resource therapy team.

*Comment*

***Mr M was first referred to the resource therapy team in September 2008. He was offered appointments in January and April 2009 - seven months from the initial referral. We found no record in this period of a referral back to the CMHT by the resource therapy team and no record of any discussion at a resource therapy team meeting to decide what to do about M's non engagement.***

***Our meeting with the Basildon CMHT identified a need to improve the disengagement/did not attend policy. A review should always take place before an individual is discharged.***

***The trust has now ratified its non-concordance and disengagement policy and procedure as an action arising from the trust investigation and it has been in use since May 2012.***

**4.44** Mr M did not attend the appointment he was sent for 15 April. The SHO to consultant psychiatrist 2 wrote to Mr M's GP to tell her this and that he had not been seen in outpatients since 15 August 2008, the day CMHT assessed him. She was told that another appointment was to be sent and the letter asked Mr M's GP to encourage Mr M to attend appointments and update him of any recent changes to Mr M's condition.

*Comment*

***No one from trust services saw Mr M for eight months. He had contacted the services in the past when he wanted to be seen, so asking Mr M's GP to encourage him to attend future outpatient appointments was an acceptable clinical decision.***

***Instead of or as well as asking the GP to encourage Mr M to attend the next offered outpatients appointment, consultant psychiatrist 2 could have asked the CMHT to re-engage with Mr M to reassess him. The trust report deals with this:***

> **"There were a number of positive attempts to engage the service user that included liaison and communication with the GP and home visit following non attendance at outpatients. However, this was not consistent and more assertive attempts could have been made to engage the service user with the services."**

***We support this view but we say again that consultant psychiatrist 2's decision was acceptable.***

**4.45** The incident that led to the death of Mr N occurred on 26 April 2009. Mr M was convicted in August 2010 of manslaughter, due to diminished responsibility.

## 5. Meetings with Mr M, Mr M's family and victim's family

**Interview with Mr M**

**5.1** We interviewed Mr M in prison and he provided a clear account of his mental health problems and life history. Most of this section is taken from the interview but some supplementary information is included.

*Summary history*

**5.2** Mr M told us he never liked taking prescription medication and he had smoked cannabis regularly since he was 15 and also occasionally hash.

**5.3** His GP notes for 11 September 2000 state:

> *"...smokes too much cannabis. If doesn't smoke it says feels paranoid & moody & has a go at his mum. Wants to stop it but can't do it on his own. Says can't sleep without it."*

**5.4** He used to take lysergic acid diethylamide **(**LSD) between the ages of 16-20 and started again a few months before the incident.

**5.5** He said he had never worked. He would spend most of his time in his room on his computer with the window covered up. He would go out and binge drink about once a month.

**5.6** He said his mother had abusive partners and that he had witnessed the abuse, that Mr N did not like him because he was not working and when Mr N was in the house he would not mix with the rest of the family. He would have his meals in his room and would go to the kitchen when no one else was around. At times he would feel down and would cry for no reason. He admitted that he kept a knife in his room. He told us he was not hearing voices or persecutory delusions. He just preferred to stay in his room.

**5.7** Mr M said he was badly beaten up by a gang of youths while out on his bike when he was 26 or 27. He told us he was seriously injured, left for dead and as a result

hospitalised. This attack, he said, made him anxious about going out. He told us that he felt paranoia before the attack but it was not so strong. But this attack increased his paranoia and when he did go out he thought people were looking at him.

*Treatment*

**5.8** Mr M told us he was not consistent in taking his medication because he did not like pharmaceutical drugs. He would sometimes stop taking them and at other times reduce his dosage.

**5.9** He went to see the psychologist once but did not think he was going to help him so did not go again.

**5.10** He missed his appointments because he did not like going out. He went with his sister for one assessment with the CMHT team, but the services did not offer to go to his home.

*The incident*

**5.11** Mr M told us he would cycle to see his sister, sometimes cycling about 40-50 miles a day. On the day of the incident he went by bike and train to see his sister in Southend but she was out. He came home and went to the pub where his mother and her partner Mr N were drinking. He stayed in the pub until almost closing time and cycled home. His mother had been arguing with her partner in the pub and they had left a few minutes earlier. After a few minutes at home there was banging at the door: it was Mr N. He left him outside for about 30 minutes. He then heard his mother and Mr N arguing so he opened the door, pulled her in and left Mr N outside. He went to his room picked up his knife, went outside and stabbed Mr N, who left. Later the police arrived and arrested him.

*Summary of interview*

**5.12** Mr M gave the impression of a young man who at the time of these events had become reclusive as a result of a combination of his low-level social phobia brought about by his mild paranoia, a serious assault and as a result of family dynamics such as his mother's abusive partners. Mr M told us he did not stab Mr N because of any delusions or other mental health symptoms but because he was protecting his mother.

**Meeting with Mr M's mother and sister**

**5.13** We met Mr M's mother and sister, who were open with us about Mr M's history and family issues that may have had an impact on his mental health.

**5.14** They told us that Mr M did not like to sit in the sitting room at home. He would stay in his bedroom with a blanket over the window. The room would be in darkness. He had a TV, Xbox and phone and he would eat his dinner in his room.

**5.15** His sister said he went off the rails when his mother left his father when he was about fifteen. She went abroad for a year. Mr M stayed with his father. When his mother returned he stayed with his mother and stepfather. He went to college and gained some National Vocational Qualifications.

**5.16** He started to stay in his room when he was about 20. It grew worse as he grew older. He had about two friends. He would rarely go to their house and would socialise at home. He would eat his meals in his room, even on Christmas day. He sometimes tried to go to a nightclub. He would also visit his sister by bike and train. His mother had to tell him to shower and change his clothes. If he was out she would clean his room, which would annoy him.

**5.17** His nieces would go to his room and talk with him. He had never been violent and there were no problems with his nieces going to his room. They described him as a hermit. His mother said that she could sometimes hear him talking in his room when he was on his own.

**5.18** As a result of the assault against him by a gang he suffered head injuries and needed plastic surgery. His paranoia increased and his reclusiveness grew worse.

*Treatment*

**5.19** Mr M's mother and sister told us they kept telling him he needed to see someone and as a result, he was referred to the mental health services after an appointment with his GP. He would not let them go with him to appointments with mental health staff, (except once when his sister accompanied him). He would miss appointments because he would often not open letters.

**5.20** He had no relationship with Mr N. Mr N and Mr M's mother were heavy drinkers and had a volatile relationship, arguing a lot. He was getting more reclusive in August 2008. He thought his mother and Mr N were poisoning him.

**5.21** On the day of the incident he had gone on his bike to see his sister but she was out. He returned home and then went to the pub where Mr N and his mother were drinking. He had one or two pints and then went home.

**5.22** His sister said that he was not properly diagnosed. He was not taking his medication regularly. He could have had a home visit. He did not have a criminal history. They were shocked as this was out of character.

**Meeting with Mr N's family**

**5.23** Our meeting with Mr N's family was principally to explain about the process of the investigation but the family told us that they could not understand why Mr M had not been better treated by the mental health services. His son told us that he had met Mr M a number of times and thought *"he wasn't right"*.

## 6. Meeting with the GP

**6.1** We reviewed the GP notes about Mr M and all the letters sent to her. The purpose of the interview was principally to focus on the trust's partnership working with Mr M's GP. Our chronology sets out the contacts between trust staff and Mr M's GP. It shows that Mr M's GP was kept fully informed of plans and was maintained as an active partner in Mr M's care.

**CPA**

**6.2** Mr M's GP told us it was rare for her to be invited to CPA meetings, though because of time constraints the ability of GPs to attend would be limited. She told us they might have been invited in one or two instances, but it was rare.

**6.3** She said that her and her GP colleagues always received a detailed in depth written report about CPA meetings which set out the mental health issues and the plans that were in place.

*Comment*

***The trust told us that they routinely invite GP's to CPA meetings but due to their other clinical commitments they are rarely able to attend. The fact that CPA reports are always sent by the trust to GPs is good practice and obviously helpful to the GPs.***

**Assessments**

**6.4** Mr M's GP commented on assessments:

> *"…on the whole when they are seen they are given a very thorough assessment. I am reasonably confident with the assessments they have. Yes, it would be great if they were seen sooner, and it would be great if they were always seen by the same psychiatrist. I was just looking on this patient's notes, and I referred him, he was given one of these CPA things, and then the conclusion of that was he was*

*just referred to the CMHT. He wasn't actually seen by a psychiatrist, which I suppose is fair enough, but they have obviously decided that his symptoms didn't warrant him seeing a psychiatrist."*

*Comment*

***When Mr M's GP referred to Mr M not seeing a psychiatrist this was in relation to his referral to the CMHT. Mr M was being seen by a psychiatrist in outpatients.***

**Referrals**

**6.5** We asked about the response she received after a referral to the health service. She told us:

*"What happened for a while is that certain cases were just bounced back to us saying 'More suitable for primary care counselling', but I have to say that is happening less now, partly because we are aware of which ones they won't treat, and our primary care counselling now is probably a bit more in-depth than it used to be. We have something called* "Therapy For You Now"*, which is quite comprehensive in what it can treat. They have brought more skills in, and they can deal with anxiety and depression and various other things more than just straightforward counselling."*

*"We are having hardly any referrals rejected now. Usually straightforward anxiety and depression, if it was just an anxiety thing, yes, that should be amenable to primary care."*

**Non-concordance disengagement policy**

**6.6** We asked whether any consultation on the draft non-concordance disengagement policy had taken place. Mr M's GP was not aware of any.

**Partnership working**

**6.7** Mr M's GP thought that communication with the mental health services could be improved by having some meetings with local consultants. She told us:

> *"We probably need a better system for keeping an eye on anyone on an antipsychotic drug, for example. Whether just some meetings with the local consultants would be helpful? We are a big health centre here, we occasionally have consultants come and meet us to talk to all the doctors about local policies and changes to services, but we haven't had a meeting with the psychiatrists for a very, very long time – not that I can remember, and I have been here a long time, and a case like this might flag up 'What else can we do to improve communications?'."*

**6.8** She said a CPN would usually hold a depot injection clinic at the surgery but she was not sure if that still happened. Contact with the team via the switchboard was more difficult since the CMHT moved from Aston Court. She felt that a named individual from the CMHT for liaison purposes would be helpful.

**Recommendation**

**R2** We recommend that the Basildon CMHT review with their referring GPs what improvements to partnership working may be needed and how they might be implemented.

# 7. Meeting with Basildon CMHT

**7.1** We met the Basildon CMHT to review how the recommendations of the trust investigation had been implemented and to discuss general team working as it related to our terms of reference. We met the lead occupational therapist; interim team manager; consultant psychiatrist; deputy director, community west; speciality doctor; CMHT clinical lead; representative from the clinical assessment service.

**Team structure and working**

**7.2** The CMHT consists of a manager; CPNs; social workers (some are also approved mental health practitioners); an employment specialist; a carer link worker; health and social care support workers; part-time (two days a week) psychology input. The Basildon CMHT service also contains a clinical assessment service, an assertive outreach team and a resource therapy team.

**7.3** Resource therapy consists of four OTs who work with the team but are not managed by the team manager. Care co-ordinators and GPs refer clients to resource therapy. It is largely staffed by occupational therapists who offer group work, anxiety and anger management, coping skills etc.

**7.4** Medical input to the CMHT is via the speciality doctor[1] who can be available immediately. Consultants are available for back-up but usually see individuals throughout patient appointments. South Essex has four consultants covering four geographic areas. Two of the consultants in rotation attend the multi disciplinary team (MDT) meeting that discusses referrals.

**7.5** The clinical assessment service (CAS) within the CMHT deals with referrals. Clinical assessors now automatically ask about carers. Home visits for assessment are done with back up from the duty officer. Clients who do not respond to invitation for appointment are either referred back to a GP, police, welfare or back to the duty officer. The trigger

[1] A specialty doctor post is not a training grade; it is a grade where a doctor has at least four years of postgraduate training, two in a relevant specialty. Their roles are usually focused on meeting NHS service requirements, compared to consultant roles. For example, specialty doctors often have considerably fewer administrative functions than consultants.

for a home visit is if a client does not turn up for an appointment. Staff are now following Disengagement and Non-Concordance policy issued in May 2012.

**7.6** A home visit was carried out to Mr M when he failed to attend for his booked screening assessment.

**7.7** Care co-ordinators ensure all clients are risk assessed. 'Imminent risk' is acted on immediately. When someone is referred their records will show if there has been previous contact with mental health services. The case is then allocated to a care co-ordinator and a 'buddy' oversees the case if the care co-ordinator is away.

**7.8** A referrals meeting attended by the team manager, Band 7 CPN and social worker, took place at the time of Mr M's involvement. Then and now consultants see individuals as outpatients and refer clients to the team if necessary. The Friday MDT decides whether to accept or refer onto another service. Complex or difficult cases can go to consultants for preliminary discussion before MDT. Referrals that are an easy 'no' do not go to MDT. The cases are assessed against 'shared care guidelines'.

**7.9** The CMHT had 519 cases at the time of our meeting. At the moment it has no 'cases for concern' or Red Amber Green (RAG) zoning means of identifying those needing close attention. The trust is piloting a RAG rating scheme in another CMHT which may be adopted in the future.

*Comment*

***A method of highlighting individual cases that need to be notified to the rest of the team is now a common approach in many community teams. It helps to ensure that the whole team can support clients who may be at risk or a risk to others.***

**Supervision and case reviews**

**7.10** The trust supervision policy states that:

> *"4.1 Supervision is recognised by the South Essex Partnership NHS Trust as a requirement for all staff. Staff will be afforded supervision, during their working hours.*
>
> *4.2 Clinical staff are regarded as, all grades of doctors, nurses. Allied health professional, pharmacists, psychologists and all other persons involved in any aspect of direct clinical care of the patient/service user."*

**7.11** We were told that individual members of the CMHT had regular supervision and case reviews.

**7.12** Consultant outpatient's work is not part of the CMHT caseload and this means that consultants need to refer a case to the CMHT. Whilst consultants supervise junior medical staff their outpatient work is not supervised. Consequently the lack of consultant supervision means that whether individuals should continue to be seen in outpatients is not reviewed.

*Comment*

***The lack of supervision of consultant outpatient clinical work is a feature of many trusts. The lack of supervision of consultant outpatient work creates a clinical blind spot and leaves open the possibility that some clients may be retained on outpatient appointments when they should be discharged or that they should be referred to other services when they are being seen solely through outpatients.***

***Despite our comments about possible improvements to the supervision of consultant outpatient work, we have no criticism of the care Mr M received in outpatients. He was assessed and referred to other teams and professionals appropriately and liaison with the GP and other professionals was of a high standard.***

*Recommendations*

**R3** The trust should review with its consultant body how outpatient clinical work can be brought within the framework of the trust supervision policy and how outpatient work can be more integrated into the overall work of the CMHT.

**IT systems**

**7.13** The team said the trust operated several case management systems that could not talk to each other. For example, occupational therapists in the resource team could not see CMHT records. Staff in A&E Liaison services could not access CMHT electronic files. The trust has a 'life cycle' electronic system that allows staff to know which other professionals are involved with a client but it gives no access to the records from that professional group. It provides a chronology but is really only a signposting service.

**7.14** Medical staff who want access to the files of clients who have had previous contact must ask the medical records office during normal business hours. The system relies on the availability of staff.

**7.15** The trust investigation recommendation five stated:

> *"A review must be undertaken of existing policy, procedures or protocols in relation to sharing key information between professionals so that there is an accurate understanding of previous assessment and work undertaken."*

This recommendation is a review of policy, procedures and protocols but one of the most effective means of achieving this is through a single electronic patient record system.

*Comment*

***At a time when many trusts have moved to single electronic CPA and notes system the trust's system of electronic notes does not allow all professionals to enter clinical information on a single system. Because of the particular system operated by the trust staff it makes it more difficult for multi professional teams in different***

***locations to ensure that they are fully aware of the most recent action being taken by other professionals. This is a serious disadvantage.***

*Recommendation*

**R4** The trust commissioners should review with the trust its progress in moving to a single electronic record system that allows all professionals to input entries and view the notes of other professionals working with a client.

*Comment*

***In response to our draft report the trust has provided a comprehensive explanation of their current progress in moving to a single electronic patient record system. This is attached at appendix B.***

**Drug & alcohol services**

**7.16** Drug & alcohol (D&A) services is a separate service dealing mainly with Tier 3, which usually means chronic illness resulting in liver damage. It does not deal with anything less serious. D&A will do a joint assessment with the CMHT or it can be consulted.

**Discharge**

**7.17** The CMHT told us that the trust recognised the need for a more robust disengagement/did not attend policy. A face-to-face meeting should take place with the client before the case was closed. Standard practice should be to review the case before discharge - including risk assessment.

**Serious untoward incident dissemination**

**7.18** Serious untoward incident (SI) reports go to the senior management team meeting. Lessons from an SI are usually disseminated to the CMHT at the multidisciplinary team meeting (MDT) each Friday. Individuals directly involved in a SI receive personal feedback.

**7.19** Whilst lessons learned from SIs are a standing item on CMHT meeting agendas, if a SI relates to their own team the CMHT does not hold a separate learning lessons meeting to review the care they provided. Such a meeting would allow the team to take responsibility for examining how they can embed learning and consider other action they could take.

*Comment*

***The process for disseminating investigation findings and recommendations appears robust.***

**Summary**

**7.20** Our meeting with the CMHT found a robust team that was working well. We identified a number of areas that could help to improve team working but no aspect of the team practice had a significant impact on the care of M.

## 8. The trust's internal investigation

**8.1** The trust undertook a number of internal investigations into the care of Mr M. They carried out a 72-hour serious untoward incident management report and a seven-day serious untoward incident report update.

**8.2** Two trust staff - an assistant director for social care and a ward manager - then carried out a panel investigation. The internal report was reviewed and amended by a nurse consultant. The report authors interviewed three staff:

- a consultant psychiatrist
- an integrated team manager
- a social worker and approved mental health practitioner.

**8.3** The trust submitted an investigation report to the primary care trust for comment in October 2009. After receiving comments from the primary care trust and revising the report, the trust agreed the final report on 21 September 2010.

**8.4** The report contains terms of reference; evidence of a review of relevant documents and provides a satisfactory chronology. The chronology identifies the key care issues and there are three recommendations arising from them.

**8.5** The report's commendations are:

> *"12.1 Basildon CMHT to conduct and record regular quality reviews of mental health assessments carried out within the team to ensure that they meet the standards identified in Trust Policies CLP 30 & CLPG 29. Individual practice must be monitored by supervising managers and include case files review as outlined in the Policy for Supervision for staff (CP 26).*
>
> *12.2 Basildon CMHT to review their processes for working with people who are difficult to engage and present with complex needs. This must include family involvement as per CPA policy (CLP 30).*

*12.3 The Medical Director and Clinical Directors to review the patient booking system to ensure it is sufficiently robust. It is noted that work has already been undertaken which has included out of hours, evenings and weekend appointments."*

**8.6** The report includes two lessons learnt:

*"13.1 There must be regular reviews and audit of assessment quality against policy standards to provide assurance that there is accurate assessment and formulation of care and treatment. There should also be clear risk assessments that are regularly audited.*

*13.2 There must be clear protocols for sharing information between professionals involved in the care of a client so that there is an accurate understanding of previous assessment and work undertaken with that person."*

**8.7** The trust produced an action plan to take forward the recommendations and lessons learnt. It is included in this report at appendix B. The lessons learnt paragraph 13.1 (above) does not feature explicitly in the action plan it is similar to paragraph 12.1 (above) and has been covered by the action 1 of the plan.

**8.8** Recommendation 12.2 (above) deals with difficult-to-engage clients with complex needs. It does not feature in the plan. The plan also includes an action (2) that relates to supervision. Problems with supervision do not feature as a major element in the findings of the trust report.

**8.9** All the actions in the plan are identified as green - that is completed – as of January 2012 except Action 4. It relates to producing a revised disengagement policy and procedure. It is shown as amber because the new policy was awaiting ratification by the trust.

**8.10** We found no evidence that recommendation 12.2 had been dealt with.

*Comment*

***It is important that when recommendations are made by an internal investigation that there is an audit trail showing how they have been dealt with. If they are not to be specifically actioned then this should be explained as part of the action plan.***

***Following submission of our draft report the trust acknowledges this as an oversight. The recommendation has now been added to the trust action plan and progress on its implementation will be monitored through the trust's governance arrangements.***

*Recommendation*

**R5** The trust should provide for the commissioners a report on any actions they have taken or intend to take in relation to the internal investigation recommendation 12.2.

## Appendix A

**Mr M action plan updated May 2012**

South Essex Partnership University NHS
NHS Foundation Trust

| No | Recommendation | Identified Lead | Target Date | Progress/RAG status |
|---|---|---|---|---|
| 1 | In order to provide assurance that qualitative mental health assessments are being undertaken as part of the clinical assessment process, the Basildon CMHT Manager must complete two spot audits within six months of completion of the final report. | Deputy Director – Community West | 30 June 2011 | Two spot audits completed by Acting Team Manager.<br><br>Two further qualitative audits completed. |
| 2 | The CMHT Manager must provide assurance and evidence to the Deputy Director that supervision processes within the team are sufficiently robust and follow Trust policy and procedure. | Basildon CMHT Manager<br><br>Deputy Director – Community West | 31 March 2011 | All Basildon CMHT staff are using 'supervision passports' in accordance with Trust Supervision Policy.<br><br>Assurance received from the Deputy Director that regular clinical and managerial supervision is maintained as per policy. |
| 3 | The Executive Medical Director and the Clinical Director must review the patient booking system to ensure it meets the needs of service users. | Executive Medical Director – Essex<br><br>Clinical Director | 30 September 2011 | Work undertaken which included introduction of out of hours, evenings and weekend appointments.<br><br>Outpatient redesign project completed. Consultation on proposals for implementation of recommendations completed. |
| 4 | Consideration should be given about strengthening existing policies and practice in relation to disengagement | Deputy Director – Community West | Date amended to March 2012 to enable review, consultation and ratification of trust wide policy | Full review of former BLPT non-concordance and disengagement policy and procedure undertaken as part of the work to integrate policies trust wide.<br>Policy and Procedure was ratified in May 2012 and is now in use trust wide. |
| 5 | A review must be undertaken of existing policy, procedures or protocols in relation to sharing key information between professionals so that there is an accurate understanding of previous assessment and work undertaken. | Director of Operations | 30 May 2011 | The Admission, Transfer and Handover Policy and the CPA Policy and Procedure provide specific guidance for staff around the information sharing protocols and good practice in relation to sharing and discussing key clinical information to inform risk assessment processes. |

# Appendix B

**Unified electronic patient records**

The Trust has recognised that maintaining patient safety and improving service quality would be enhanced significantly by the development and implementation of a fully unified electronic patient record (EPR). Although EPRs are becoming more common in single-site acute Trusts, mental health and other community-based Trusts face specific challenges in that patients access our services in many different ways and at many different levels (eg: drop-in self-referral to therapies, teams or services, booked out-patients appointments with Consultants via GP referral, direct access to services via other health or social care professional referrals, direct access to acute services via sections of the Mental Health Act, access to assessment via A&E depts. and so on). Additionally, our services have been provided across many sites for many years (SEPT has 200 sites spread across two counties) and the paper records are currently held securely at several of these sites. Finally, we are required by law to keep mental health records for 30 years, so we have a significant archive to factor into our plans to implement a fully accessible unified electronic patient record system.

Currently, all clinical staff and some authorised administrative staff can access electronically each patient's summary care record. This would, for example, allow a MH assessment nurse in A&E see whether the patient had a care coordinator and, if so, how to contact them; which other MH services have been involved with the patient previously; where each part of the patient's paper record is held securely and allow them to request the relevant paper records to be delivered to them quickly.

Clinicians can already access patients' CPA and up to date risk assessments electronically. This system has been rolled out Trust-wide in the past two months.

SEPT is likely to be the first mental health Trust to implement a fully unified EPR system. As part of the Trust-wide roll out programme for this, since January 2012, we have been running the new system in in-patient and community-based pilot areas in Bedfordshire and Essex to learn any implementation lessons and to assist the smooth roll out of the programme Trust-wide from September 2012. This is a huge project, which includes scanning many thousands of large paper records accurately into the new system on demand, as well as working closely with clinicians to develop "smart forms" for use with the new system and a Trust-wide staff training programme on using the new system effectively and safely. SEPT currently has around 7000 staff.

# Appendix C

**Document list**

*Clinical records*

- GP notes
- CPA notes

*Additional documents*

- Mr M internal investigation report, June 2010
- Mr M action plan updates, January and May 2012
- Disengagement or non-concordance policy, May 2012
- CLP28 - Clinical Risk Assessment Management Policy , November 2007
- CLP30 - CPA Policy, September 2006
- CLPG28 - Clinical Risk Procedure, November 2007
- CLPG29 - Suicide Procedure, August 2010
- CP26 - Supervision for Staff, October 2010
- General correspondence between agencies

# Appendix D

**List of interviewees**

- Representatives from Basildon CMHT
- Mr N's family
- Mr M
- Mr M's family
- Mr M's GP

# Appendix E

**Biographies**

*Tariq Hussain*

Tariq is a senior consultant at Verita. He is a former nurse director who brings to Verita his considerable experience in the fields of learning disability and mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations.

Before joining Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting. He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

*Chris Brougham*

Chris is an experienced investigator with considerable experience of carrying out mental health homicide investigations. She has worked with several SHAs on their 'legacy' mental health cases to determine the scale of independent investigation each case requires using an assessment tool she helped develop. Chris is also head of training for Verita where she has created and delivered courses on systematic incident investigation. In her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people.