IMPROVEMENT THROUGH INVESTIGATION

An investigation into the care and treatment of Patient B

A report for
NHS North West

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Authors:
Chris Brougham
Amber Sargent

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Verita is an independent consultancy which specialises in conducting and managing inquiries, investigations and reviews 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

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1. Introduction

1.1 Patient B killed his sister's boyfriend by beating him to death with a pool cue. The victim's body was later found by refuse men clearing rubbish from an alleyway.

1.2 A retired couple (both in their 60s) had befriended Patient B some years earlier. Patient B and his girlfriend arrived unexpectedly at their home after the murder. Patient B kidnapped them at knifepoint and forced them to drive him to London. On arriving in London the couple were left in their car and Patient B continued with his escape.

1.3 Patient B was arrested in Southampton the following week and charged with the murder of his sister's boyfriend.

1.4 Patient B was sentenced to life imprisonment at Liverpool Crown Court with a minimum tariff of 30 years for murder and kidnap.

1.5 Patient B had received mental health services from Cheshire and Wirral Partnership NHS Foundation Trust (the trust) on a number of occasions. He was first referred in May 2003.

1.6 The trust carried out an internal investigation to examine the circumstances surrounding the treatment and care of Patient B.

1.7 The internal investigation report was completed in July 2009. The report reviewed the care and treatment NHS services had provided to Patient B and an action plan was developed by the trust which made recommendations for improvements to the services.

1.8 NHS North West commissioned Verita, a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations, to undertake the independent investigation into the care and treatment of Patient B. It follows guidance published by the Department of Health (DH) in HSG 94(27), *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the

updated paragraphs 33-36 issued in June 2005. The TOR for this investigation are given in full in section two of this report.

1.9 The trust wrote to Patient B and asked for permission to access his clinical records. He gave his consent in July 2010 and our independent investigation started in September 2010.

1.10 We were given a full copy of Patient B's clinical records and a copy of the trust's internal investigation report and action plan.

1.11 The trust also supplied us with copies of the discussion notes from their interviews with staff as part of their internal investigation.

1.12 We received a list of contacts from Merseyside Probation Trust outlining the contacts that Patient B had while he was under supervision but not a full copy of the probation records.

1.13 Patient B was invited to meet with us as part of our investigation and we visited him in HMP Full Sutton on 16 September 2010. We explained the TOR and the investigation process to him but did not clinically assess him.

Overview of the trust

1.14 In July 2007 Cheshire and Wirral Partnership Mental Health Trust became the first mental health trust in the north of England to achieve foundation trust status.

1.15 The trust serves a million people across Cheshire and Wirral. Its principal activities are to provide services in primary and specialist mental health, learning disabilities, child and adolescent mental health, and drug and alcohol - as well as a range of specialist services connected with eating disorders services and occupational health.

1.16 Mental health services for adult and older people suffering from complex and serious mental health problems are based mostly in the community, though inpatient beds are available for service-users who need admission.

1.17 The trust has a criminal justice mental health liaison team (CJMHLT) whose purpose is to act as a key link between health, social services and all criminal justice agencies in their work with adult mentally disordered offenders.

2. Terms of reference

2.1 NHS North West commissioned this independent investigation with the cooperation of Cheshire and Wirral Partnership NHS Foundation Trust (the trust). It is commissioned in accordance with guidance published by the department of health in HSG 94(27) *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-6 issued in June 2005. It also takes into account the Good Practice Guidance issued by the National Patient Safety Agency in February 2008.

The investigation will examine:

1. The care and treatment provided to Patient B, from his first contact with services in 2003 to the time of the offence in April 2007 (including any from non-NHS providers e.g. voluntary/private sector, if appropriate);

   - the suitability of that care and treatment in the light of Patient B's history and assessed health and social care needs;

   - the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies;

   - the adequacy of any risk assessments and risk management plans, taking into account Patient B's history of violent behaviour;

   - whether the care programme approach was carried out in keeping with trust policy;

   - the extent to which the trust, the police and probation services worked together and communicated appropriately in providing Patient B with his mental health care;

   - the extent to which the various services engaged with Patient B's carers and the use made of carer's assessments;

- the quality of the internal investigation and review conducted by the trust, and the progress that the trust has made in implementing the action plan.

2. To write a report for NHS North West that includes:

- a chronology of events from Patient B's first contact with services leading up to the offence;

- an analysis highlighting any missed opportunities and findings based on the evidence received;

- any areas of notable good practice;

- any new developments in services since Patient B's engagement with mental health services and any action taken by services since the incident occurred;

- measurable, achievable recommendations for action to address the learning points to improve systems and services.

3. Executive summary and recommendations

Executive summary

3.1 Patient B killed his sister's boyfriend by beating him to death with a pool cue. A week later he kidnapped a retired couple (both in their 60s) - who were known to him - at knifepoint and forced them to drive him to London. He was arrested the following week and charged with the murder of his sister's boyfriend.

3.2 Patient B was jailed for 30 years for murder and kidnap at Liverpool Crown Court.

3.3 He has 27 convictions for a total of 148 offences. These include robbery and causing death by dangerous driving.

3.4 Patient B first came into contact with mental health services in 1978, at the age of 18 when he was serving a custodial sentence for a violent offence.

3.5 In 1997 Patient B was admitted to Allensford Hospital in Newcastle upon Tyne. He was diagnosed as having mental and behavioural disorders due to the use of alcohol and underwent a detoxification programme.

3.6 In December 2001 Patient B was seen by CP1, a consultant in general adult psychiatry - she was asked to write a psychiatric report for a court before he was sentenced for dangerous driving. Her report made a tentative diagnosis of bipolar disorder. CP1 was employed by Cheshire and Wirral Partnership NHS Trust but on this occasion she was operating in a private capacity and Patient B was not receiving services from the trust at this time.

3.7 CP1's report became the focus for Patient B's diagnosis later when he was accepted for treatment and care.

3.8 In February 2002 Patient B was sentenced to a 28-month custodial sentence for a dangerous driving offence.

3.9 In June 2003 Patient B was seen by CP1, the same consultant psychiatrist who had previously written the court report. At this point Patient B did not want to be prescribed medication and CP1 did not make any formal plans to see him again.

3.10 Patient B saw CP1 again in September and October 2003 at his request. She arranged a follow-up appointment for him in December 2003 with a locum consultant because she was leaving the post to work in another area of the trust. Patient B failed to attend the appointment in December 2003 and a further appointment in February 2004 and was subsequently discharged from trust services.

3.11 In March 2005 Patient B was sentenced to a community punishment order and a two-year community rehabilitation order. In April 2005 Patient B was remanded on bail from Wirral Magistrates Court on a charge of harassment.

3.12 On 6 May 2005 there was an incident at the community service work site where Patient B became aggressive and abusive. His offender manager was concerned this might be a sign of his bipolar disorder but there is no record that the community mental health team (CMHT) subsequently assessed him.

3.13 A locum GP sent an urgent referral to the CMHT in May 2005 but Patient B failed to attend his appointment. A senior house officer (SHO) undertook a psychiatric assessment in June 2005. This assessment did not include information about Patient B's risk history and the team do not appear to have liaised with the criminal justice team to try to glean further information.

3.14 Patient B's community punishment order was revoked because of his deteriorating mental health and he was resentenced to a community supervision order in October 2005.

3.15 Patient B told his offender manager in December 2005 that he had lost his job because his partner was in hospital and he had to take time off work to help with her children.

3.16 In January 2006 Patient B moved from Merseyside to West Mercia and his probation order was subsequently transferred.

3.17 Patient B failed to attend an outpatient appointment with the CMHT and a letter was sent by the trust to his GP saying he had been discharged.

3.18 Patient B was again referred by his GP to the CMHT in October that year (2006). The SHO who saw him made the decision to end the interview with Patient B as he had been drinking alcohol.

3.19 In December 2006 Patient B was charged with a public order offence relating to an incident on a train where he became verbally abusive towards a train official who had asked to see his ticket. He received a one-month community order and a one-month curfew.

3.20 Patient B failed to attend his outpatient psychiatry appointment in January 2007. A multi-disciplinary team (MDT) meeting discussed his case and decided to send another routine appointment letter because they did not perceive there were risk issues which warranted an urgent follow-up.

3.21 We found no evidence that Patient B was sent another appointment or discharged from trust services.

3.22 Patient B completed his community order in March 2007 and it was subsequently terminated and the probation service ended its involvement in his case.

3.23 A letter was sent in April 2007 offering Patient B an outpatient appointment with CP2 (consultant psychiatrist) on 10 May 2007. By this time Patient B had already been arrested for murder.

3.24 The trust set up an investigation team and carried out an internal investigation into the care and treatment of Patient B as outlined in their trust policy. The investigation started in September 2007 but was not completed until July 2009.

Conclusions

3.25 CP1's report of 2001, which was prepared privately for the court, recognises Patient B's alcohol intake as excessive, and mentions that personality traits might be significant in Patient B's offending behaviour. However, the report concludes that Patient B suffers from bipolar affective disorder (also known as manic depressive psychosis), a major mental illness. It is the view of the independent investigating team that the evidence upon which this diagnosis is made is insufficient and uncertain.

3.26 Whilst in CP1's letter to Patient B's GP dated 31 December 2001 there is mention of alcohol and antisocial personality traits, the proposed management plan focuses almost exclusively on the bipolar affective disorder. CP1 suggests that Patient B requires psychiatric intervention for a bipolar effective disorder and fails to refer to any proposed management of the alcohol issue and those underlying personality traits that might have been significant in shaping Patient B's behaviour.

3.27 Unlike the evidence for the diagnosis of bipolar affective disorder, the evidence for harmful use of alcohol was overwhelming. There is little doubt that Patient B was physically dependent on alcohol much of the time he was out of prison. He described himself as a "*drinker*" and he had tried to withdraw from alcohol by going 'cold turkey'. The court report had the unfortunate effect of drawing attention away from the alcohol dependence and appears to have become the basis for Patient B's subsequent management by clinicians. This led to a failure to question Patient B more about his alcohol use or to challenge him about it. Whether addressing the alcohol problem in itself would have had any significant impact on Patient B's behaviour or the course of events is another matter, as we were not able to identify the degree to which alcohol played a role.

3.28 Patient B was seen by a number of locum psychiatrists during his engagement with the trust and there did not appear to be any one person responsible for his overall care and treatment. Doctors who were subsequently involved in Patient B's care all appeared to have relied entirely on the court report by CP1, and made no attempt to either critically assess the report itself or to re-assess Patient B as time went on. Patient B chose when he engaged with mental health services - this made it difficult for staff to assess him. Due to his irregular attendance and the high number of locum staff - Patient B was never seen by the same clinician (other than CP1) on more than one or two occasions.

3.29 It is our view that CP1's report had an adverse effect on the way the psychiatric services (and, indeed, the criminal justice services) managed Patient B. Not only did the report, and CP1's subsequent management of Patient B, fail to take account of the possible role of alcohol in the offending behaviour, it also failed to follow-up on the personality traits referred to in the report. Such underlying personality issues could possibly have been addressed by various psychological means, including a cognitive behavioural approach or a more insight-oriented dynamic psychotherapeutic approach. CP1 told us that, during assessment, she would have been making a judgement as to his suitability for psychotherapy in terms of psychological mindedness. However, there is no written evidence that psychological approaches were considered.

3.30 Patient B had a long forensic history including robbery and death by dangerous driving. This information was available to CP1 and to those clinical staff within the trust who subsequently became involved in his care. The information was detailed in Patient B's records but it was not used to carry out a comprehensive risk assessment or to put clear risk management plans in place at any time during the three episodes of care when Patient B was in contact with the trust. This information was not made use of in CP1's original court report; nor does the report contain an attempt to assess the risk that Patient B posed to others.

3.31 Though CP1 makes a diagnosis of a major mental illness – bipolar affective disorder – no comprehensive management plan for this condition is pursued and there was no consideration of risk in the event of a relapse. CP1 discharged Patient B from the services upon her first assessment of him within NHS services and subsequently there was little attempt to pursue treatment of the condition.

3.32 Patient B rarely engaged meaningfully with the services, although he did appear to engage with CP1.

3.33 There is no doubt that Patient B's deteriorating behavior presented a risk to himself and others. A risk assessment and closer working with partnership agencies – such as the probation service may have helped to manage the risks posed by Patient B. It may have also provided the opportunity for Patient B to address his alcohol misuse. Though CP1 appears to have referred the patient to forensic services, it is not clear whether any of the forensic assessments were ever fed back to the team and to CP1. In other words, did the NHS team make use of any forensic findings in their management of the patient? It does not seem so.

3.34 However, this would have required Patient B's full engagement with the service and we do not know whether he would have been prepared to do this. Given his history of poor engagement it is quite possible that he would have been unwilling to do so.

Recommendations

Diagnosis

R1 Where a diagnosis is tentative or being developed, this should be clearly documented in the patient's notes to ensure that further assessments are conducted so as to formalise a diagnosis and develop a treatment plan.

Forensic service

R2 The trust should ensure that all staff, medical and otherwise, are aware of what forensic services are available, how to refer, and what the waiting time is. This should include knowledge of the referral process and criteria for referring service users to the forensic service for assessment.

Risk assessment and risk management

R3 The trust should assure itself that the current process for Care Programme Approach (including care planning, risk assessment, risk management planning) is robust. The clinical governance team should audit compliance at least every six months and report their findings to the board.

R4 The trust should ensure that all staff involved in the assessment and management of risk are appropriately trained.

Coordination of care

R5 The trust should assure itself that patients are treated and managed in a holistic way and are referred to appropriate services. We recommend that the trust conducts audits (annually at a minimum) to review patient pathways from referral to discharge.

R6 The trust should ensure that they have the appropriate number of consultant psychiatrists in post - in line with the Royal College of Psychiatrists' guidelines. If necessary, a review of locum staff use should be conducted.

Communicating, liaising and sharing information effectively with other agencies

R7 The trust should ensure – through regular audit - that their newly introduced information sharing protocol is adhered to. Regular meetings should be held with partnership agencies such as the probation service to ensure the importance of effective communication is understood and promoted throughout the services.

Management of failing to attend appointments and discharge from services

R8 The trust should ensure that all staff adhere to the trust's policy and procedure for managing informal service users' non-compliance with treatment and managing DNA (did not attend) or cancelled appointments.

Identification of potential safeguarding issues

R9 The trust should ensure there is a robust policy in place for safeguarding children and ensure through regular audit that all staff adhere to it.

R10 The trust and probation services should ensure that service-users with a history of violence who provide care or supervision for children receive an assessment of risk under child safeguarding procedures to assess whether they are able to provide safe and consistent care.

Trust incident investigations

R11 The trust should ensure that internal investigations into serious incidents are completed by the date their commissioners require so that improvements can be made as soon as possible.

4. Approach and structure

4.1 The investigation team (referred to from now on in this report as 'we') comprised of Chris Brougham and Amber Sargent, both senior investigators with Verita. Expert psychiatry advice was provided by Dr Mostafa Mohanna, the medical director and a consultant psychiatrist from Lincolnshire Partnership NHS Foundation Trust. Biographies are included in appendix A.

4.2 We examined documentary evidence including policies and procedures from the trust, Patient B's clinical records, the internal investigation report and the chronology of contacts with probation services. A list of documents reviewed is included at appendix B.

4.3 We read the discussion notes from the trust's interviews with the following professionals. These interviews formed part of the trust's internal investigation:

- CP1 - consultant psychiatrist
- CP2 - consultant psychiatrist
- GP1 - general practitioner
- GP2 - general practitioner
- CC1 - clinical care coordinator
- TM1 - team manager, criminal justice liaison team
- TM2 - team manager

4.4 Once we had reviewed all the documentary evidence we only sought to interview staff to clarify outstanding issues. This resulted in the investigation team interviewing two members of staff.

4.5 We interviewed a general manager from the trust who told us about the internal investigation and the progress made since the report was completed.

4.6 We also interviewed a consultant psychiatrist (CP1) who had written a psychiatric court report for Patient B and later had provided care and treatment for him.

4.7 We followed established good practice in conducting interviews. The interviewees

were given the opportunity of being accompanied by a representative or a friend at their interview. They were provided with the opportunity to comment on the factual accuracy of the interview transcript.

4.8 We have analysed all of the evidence received and made findings and recommendations to the best of our knowledge and belief based on our interviews and the information available to us.

4.9 We have included a chronology outlining the care and treatment of Patient B. We have written some of our comments throughout this chronology but the main analysis appears in section six, where we highlight particular issues and themes.

5. Care and treatment provided to Patient B

Narrative chronology

Forensic history

5.1 The probation records indicate that Patient B has 27 convictions for a total of 148 offences. He first came to the attention of the criminal justice service in 1973 at the age of 13 years when he was charged with two counts of assault and sentenced to a two-year supervision order.

5.2 Patient B served his first period in custody in 1974 for three counts of taking a conveyance without authority, theft, theft from a vehicle, driving while disqualified and driving with no insurance.

5.3 His longest custodial sentence was in 1989 when he was jailed for 14 years for two counts of robbery and causing death by dangerous driving.

5.4 He has served 15 custodial sentences for a variety of offences, usually featuring alcohol and violence. He has convictions for driving under the influence of alcohol, driving while disqualified, robbery and burglary.

Mental health history

5.5 Patient B told us he first had contact with mental health services in 1978, at the age of 18 when he was serving a custodial sentence for a violent offence. He said he was considered to have a 'conduct disorder'[1] and was subsequently 'forced' to take medication.

[1] Conduct disorder is a psychiatric category marked by a pattern of repetitive behavior wherein the rights of others or social norms are violated. Symptoms include verbal and physical aggression, cruel behavior toward people and pets, destructive behavior, lying, truancy, vandalism, and stealing.

5.6 His GP records show that on 3 July 1997 his GP identified him as a "*suicide risk*" with underlying depressive disorder and chronic alcohol symptoms. He was referred to the on-call psychiatrist at Newcastle County Hospital.

5.7 Patient B was admitted to Allensford Hospital, Newcastle upon Tyne on 4 July 1997 for an assessment of his dependence on alcohol and associated behavioural disturbance. Patient B told them he had experienced problems with chronic alcohol use for 17 years and it had worsened in the last six months. He said that before he was admitted to hospital he was having trouble controlling his temper and was sometimes aggressive towards his partner. He reported a self-harm episode at the age of 15. He also said he had experimented with illicit substances including amphetamines, LSD, heroin and methadone. He was diagnosed as having mental and behavioural disorders due to the use of alcohol. He undertook a detoxification programme while he was in hospital and was discharged on 18 July 1997.

5.8 A discharge summary dated 28 July 1997 noted that Patient B had experienced problems with chronic alcohol use for 17 years, that "*he began drinking in the early morning within one hour of waking*" and that he "*drank constantly throughout the day*". The summary stated that Patient B said he felt unwell when he was not drinking alcohol.

5.9 The following entries in a GP summary of treatment card in 1997 (no dates were given) noted, among others: "*alcoholism, drug addiction, anger management problems, bipolar affective disorder*".

Comment

The GP records indicate that concerns had been raised as early as 1997 about Patient B's alcohol use and anger management. There was also a diagnosis of bipolar affective disorder documented in the GP summary. We do not know where this diagnosis came from and we did not seek to interview the GP in relation to the comments made in 1997. We have relied on transcripts from the trust's internal investigation for all GP related matters. The important point is that these issues featured in Patient B's GP records as early as 1997.

December 2001 – April 2003

5.10 Patient B first came into contact with CP1, a consultant in general adult psychiatry, when she was asked to write a psychiatric report for the court before he was sentenced for dangerous driving. CP1 was employed by Cheshire and Wirral Partnership NHS Trust but on this occasion she was operating in a private capacity.

5.11 CP1 met with Patient B on 4 and 18 December 2001 in order to carry out her assessment. CP1's report noted that Patient B probably suffered from bipolar affective disorder that services had previously missed. She also recorded he had antisocial personality traits with a tendency to misuse alcohol. She thought he had been "*brutalised*" and "*institutionalised*" by the prison system, that he was a "*thoughtful*" individual who, at times, was plagued by feelings of remorse and guilt for his past behaviour. She thought that Patient B would benefit from a psychiatric follow-up appointment.

5.12 CP1 says in a letter of the same date as her psychiatric report, addressed to a GP of 'Treetops Surgery' in Wirral, that Patient B "*describes clear psychotic episodes, which are characterised by auditory hallucinations, passivity phenomena and running commentary*", though her report makes no mention of these findings.

5.13 Patient B was imprisoned for 28 months in February 2002 following a hearing at Mold Crown Court for the offence for which CP1 had provided a report.

5.14 The discussion notes from the trust's interview with the manager of the criminal justice liaison team record that a probation officer at the prison referred Patient B to the trust's criminal justice liaison team in January 2003. However, Patient B had not returned from prison leave so the assessment could not take place. He was apprehended and taken back to prison.

5.15 The probation officer made another referral on 9 March 2003. CP1 agreed to send a copy of her court report to the criminal justice liaison team.

5.16 The trust's internal investigation shows that Patient B was assessed on 27 March 2002 in prison by a consultant forensic psychiatrist from the criminal justice team. He was then referred to the CMHT. We found no record of this assessment in Patient B's notes.

Comment

Cheshire and Wirral Partnership Trust was not caring for or treating Patient B in December 2001. We mentioned the court report and CP1's tentative diagnosis because we conclude that the report did not fully lay out the necessary evidence to support a tentative diagnosis of bipolar disorder. This is important because the report became the focus of Patient B's diagnosis and management later when the trust accepted him for services. We discuss this point and our rationale for our comments in more detail in section six.

April 2003 – February 2004

5.17 Patient B was released from prison on licence[2] in April 2003. He was required to report regularly to an offender manager[3] at his local probation service. Patient B also registered with a GP at this time.

[2] If a person is sentenced to more than 12 months in prison, they can be released early on licence. Being on licence means that you are still serving a prison sentence but can live in the community instead of being in prison.

[3] An offender manager is responsible for the management of an offender from one end to the other of their contact with prison and/or probation. Their role is to ensure that the needs of offenders are properly assessed; that actions to meet those needs are delivered in a way that optimizes their chances of success; and that resources are used efficiently, engaging where necessary with external partners.

5.18 A mental health approved social work practitioner for the criminal justice mental health liaison team (CJMHLT) wrote to CP1 (in her capacity as a consultant in general adult psychiatry for Cheshire and Wirral Partnership NHS Trust) on 9 May 2003 asking her to offer Patient B an appointment. She also wrote that she considered it appropriate for Patient B to be referred to community mental health services for effective care coordination (ECC). The letter said Patient B had been prescribed Olanzapine 10mgs daily while in custody but this was stopped in late December 2002 with the agreement of prison staff. The letter stated that Patient B recognised his triggers for deterioration as alcohol and illicit substance misuse and said he would try to avoid them when he was released. The letter says: "*These have in the past been high risk indicators in both his deteriorating mental health and offending behaviour*".

Comment

Despite Patient B's recognition of triggers for deterioration (alcohol and illicit substance misuse) a risk management plan was not drawn up by the trust and little attention appears to have been paid to his admission that alcohol and illicit substance misuse were potential trigger factors for both deteriorating mental health and offending behaviour.

5.19 On 11 June 2003 Patient B attended an outpatient psychiatry appointment with CP1 at the Stein Centre[4]. After the appointment CP1 wrote to Patient B's GP, the letter stated that given his diagnosis of bipolar affective disorder and his desire not to take medication she was "*fearful that a relapse at some stage is perhaps inevitable*". The letter concludes:

> "*I have not made any formal plans to see* [Patient B] *at the present time. He has ways of accessing me should deterioration occur.*"

[4] The Stein Centre is located within St Catherine's Hospital, Birkenhead and is run by the trust.

Comment

We recognise that there are times when an assessment allows only a tentative diagnosis; CP1 herself in her court report of 2001 states that her diagnosis of bipolar disorder in the case of Patient B is only tentative. However, when CP1 wrote to the GP on the same date as that of the report, she conveyed the distinct impression of a certainty in the diagnosis. And in her letter of 13 June 2003 to Patient B's GP she refers to the diagnosis of 'bipolar affective disorder' as a conclusive diagnosis: there is nothing to suggest this is a 'working' or 'tentative' diagnosis.

5.20 Probation records show that Patient B told his offender manager (at Merseyside Probation service) on 1 September 2003 that he had been feeling depressed for a few weeks and had subsequently arranged to see CP1 the next day.

5.21 Patient B attended an outpatient psychiatry appointment with CP1 at the Stein Centre on 2 September 2003. The letter detailing the session states that Patient B asked that his appointment be brought forward. It says Patient B reported feeling 'low' for about six weeks. CP1 concludes that his presentation was consistent with the diagnosis of bipolar affective disorder and that he would benefit from an antidepressant. She said that on this occasion Patient B was happy to consider antidepressant medication despite his previous resistance to it. CP1 said she would like Patient B to start on a mood-stabilising drug such as Sodium Valproate. CP1 suggested that Patient B be started on the antidepressant Venlafaxine 37.5 mg at night. If he tolerated this, the plan was to increase this to 75 mg after two weeks. Her letter also stated that the "*risk of re-offending is high*" in Patient B's case and that she had arranged to see him in a month's time but would review him as a matter of urgency if the situation deteriorated.

5.22 After the appointment with CP1, Patient B told his offender manager he had found the session with CP1 useful and that he had been prescribed anti-depressant medication.

5.23 Patient B attended the Stein Centre for an outpatient psychiatry appointment with CP1 on 14 October 2003. CP1 noted that she was "*a little concerned about his frame of mind*" at this appointment. He smelt of stale alcohol and was talking in "*philosophical and expansive terms*". She recalled that he had stopped taking his medication (Sodium Valproate) because he had developed a skin rash. A follow-up appointment was arranged for 23 December 2003. CP1 also noted:

> "*He is aware of my imminent departure and I am mindful of the fact that he is very suspicious of new arrivals. Therefore I will ensure that we keep him under some sort of review when I leave.*"

Comment

Other than arranging a further outpatient appointment for Patient B to be seen in 10 weeks time there is no evidence in the notes to indicate what action CP1 took to ensure Patient B was **"kept under some sort of review"** ***as by this point she had left her role in this part of the trust.***

5.24 GP records indicate that Patient B was placed on the "*severe mental illness register*[5]" in November 2003.

5.25 The probation records indicate that Patient B's licence terminated on 26 November 2003 because his supervision period had expired.

Comment

It was good practice for the GP to place Patient B on the severe mental illness register to ensure that Patient B received regular physical health monitoring. However, the notes do not make clear whether Patient B received regular physical health checks in line with guidance.

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[5] It is recognised that people suffering from severe mental illness face a greater risk of developing some physical health problems. GPs are expected under contract to place someone suffering from severe mental illness on the severe mental illness register (with the persons permission) this means that the person will undergo regular physical health checks.

5.26 Patient B failed to attend his outpatient psychiatry appointment on 23 December 2003 with a different consultant psychiatrist at the trust - CP3. A follow-up appointment was arranged for 4 February 2004.

5.27 Patient B did not attend the follow-up appointment on 4 February 2004.

5.28 As Patient B had failed to attend two appointments he was discharged from the outpatient clinic (and therefore from the mental health services, as Patient B was not being seen by any other of the trust's services). CP3 wrote to Patient B's GP asking whether Patient B was in custody and advising that "*we are of course happy to have a further try at seeing him at your request*".

Comment

During the episode of care in 2003 Patient B was seen by a consultant psychiatrist and not any other members of the mental health team. The national policy of developing community mental health teams was being put in place in the trust between 2001 and 2003. Urgent referrals would go to the team but the consultant would pick up non-urgent referrals. Since then, the trust system has been further developed and under the current trust policy all referrals (urgent and non-urgent) go to the team for discussion and allocation. Service-users should receive a more holistic approach to treatment and care now that the trust has fully developed community mental health services.

The letter from CP3 to Patient B's GP contained no information about Patient B's diagnosis, forensic history, risk assessment or risk management plan. Given Patient B's history, this is an important omission. We comment in more detail in section six on the risk assessment and management of Patient B.

March 2005 – January 2006

5.29 Patient B was sentenced on 4 March 2005 to a Community Punishment Order[6] and a two-year Community Rehabilitation Order[7] for an excess alcohol offence, two counts of driving while disqualified and with no insurance, and obstructing a police constable.

5.30 Patient B attended a probation appointment with his offender manager and community service officer on 7 March 2005. It was recorded by the offender manager that Patient B was in good health but suffering from bipolar disorder that manifested itself in severe mood swings. CP1 is (inaccurately) identified as the consultant in charge of his care. It was noted that Patient B was not registered with a GP, not taking medication or using any illicit drugs but was noted to be consuming approximately eight pints of alcohol two or three times a week.

5.31 Probation records note that on 21 April 2005 Patient B was remanded on bail from Wirral Magistrates Court on a charge of harassment.

5.32 Probation records on 6 May 2005 indicate that following an apparent period of stability there was an incident at the community service work site. Patient B is said to have told the supervisor that he had to leave early to go to his GP (presumably having registered with a GP) because he was having problems with the medication he was taking for his mental health. The supervisor asked him for health and safety purposes to put his shirt on. Patient B is reported to have responded in an aggressive and abusive manner.

[6] An order made under s46 of the Powers of the Criminal Courts (Sentencing) Act 2000 that requires an offender (who must consent and be aged at least 16) to perform unpaid work for between 40 and 240 hours under the supervision of a probation officer.
[7] A court order, placing an offender under the supervision of an offender manager for a period of between six months and three years, imposed instead of a sentence of imprisonment. The order contains conditions for the supervision and behaviour of the offender during the rehabilitation period.

5.33 The records show that Patient B phoned his offender manager on the same day in a "*very overwrought state*" asking whether he was in breach of his community punishment order. The offender manager told him a meeting would be arranged with all parties to discuss appropriate action. Patient B then called the community service manager and was abusive towards him.

5.34 Patient B's offender manager noted "*this could be a manifestation of his bi-polar disorder*". He contacted the primary care trust to find out who Patient B's GP was and whether he needed an urgent referral for a psychiatric assessment. Having established the details of Patient B's GP it is not known whether any action was taken in relation to making contact with the mental health team or Patient B's GP.

5.35 Patient B's probation records show that he phoned his offender manager on 9 May 2005 to apologise. He said his conduct was a result of problems with his medication and that he would see his GP and a community psychiatric nurse (CPN) to review his condition.

5.36 Patient B attended a meeting on 10 May 2005 to discuss his suspension from the community punishment work place and his impending breach of his community order. He said he had been medication-free for 18 months and that he had started self-medication over the weekend with leftover medication. It was agreed that Patient B would need to provide evidence that he was in contact with a CPN and that he was taking his medication before he could return to his community punishment placement.

5.37 On 11 May 2005 a locum GP at Patient B's GP surgery dictated an urgent referral to be sent to the trust's psychiatry department requesting that Patient B be offered an "*urgent appointment*". At this GP appointment Patient B was prescribed Olanzapine, 5mg daily. The notes show that the practice secretary could not type the referral letter that the locum GP had dictated because she had a problem with the dictaphone. Instead she printed the consultation notes from the electronic GP system and faxed them with an explanatory letter.

Comment

While this resulted in less-detailed information being included in the referral it meant that the referral could still be made. This was good practice given the urgent nature of the referral.

5.38 The community mental health CPN received the referral on 12 May 2005 and contacted the GP surgery asking for information the referral lacked. No further information was provided and it was agreed that Patient B would be discussed at the MDT meeting the following Tuesday.

5.39 The same CPN from the CMHT wrote on 19 May 2005 to Patient B's GP saying that Patient B was discussed at the MDT meeting after the GP referral and it was felt that there was "*little reason*" to offer Patient B an appointment. They said there did not appear to be any 'significant risks or urgency' because the referral did not indicate an expression of self-harm or of depression.

5.40 The CPN spoke to the locum GP on 24 May 2005. The GP said Patient B had presented as 'paranoid', believing that people were 'watching him'. He was 'slightly high'. Reception staff said he had been reorganising the waiting area. Patient B was discussed in the MDT meeting again, and it was agreed that an appointment would be made for Patient B with the SHO in clinic. The locum GP put her concerns about Patient B in writing on 26 May 2005 and shared them with the psychiatric service.

5.41 The CMHT wrote to Patient B on 27 May 2005 to tell him that they had received a referral letter from his GP and that he needed to phone to arrange an appointment at the outpatient clinic.

5.42 On 21 June 2005 Patient B failed to attend an outpatient psychiatry appointment with the SHO to CP4 (the third consultant psychiatrist to be allocated to Patient B). Patient B's GP was informed. It was noted that Patient B would be offered another appointment in due course.

5.43 On the same day a meeting took place between the CJMHLT and probation to consider Patient B's behaviour. The probation service decided to suspend Patient B from community punishment. They noted he had been prescribed Olanzapine and Procyclidine. The probation service decided to get a medical certificate from Patient B's GP in order to revoke his community punishment order on medical grounds. Concerns were recorded about Patient B's previous engagement with mental health services and it was noted that his risk would increase if he failed to engage again.

5.44 Patient B attended the Stein Centre for an outpatient psychiatry appointment with CP4's SHO on 28 June 2005. A psychiatric assessment was undertaken and Patient B told the SHO that he had been taking Olanzapine (initially self-medicating with left-over medication, then prescribed by his GP) for about two months because he had been feeling anxious and agitated. He reported 'feeling better' since taking Olanzapine. The diagnosis was given as a bipolar affective disorder relapse that settled after he started on Olanzapine. Patient B did not want to take mood stabilisers and preferred to take Olanzapine if his condition deteriorated. He had been taking Olanzapine for nearly eight weeks and appeared settled, so the SHO advised him to decrease the Olanzapine to 2.5mg daily, to stop in five days. Patient B was also advised to stop taking Procyclidine.

5.45 The letter to Patient B's GP says Patient B "*told me that he had been drinking around 4 to 5 cans of lager a day*" and the SHO noted that Patient B "*smelled of alcohol and on being questioned he said that he had had a can of lager before coming to the appointment*". The SHO also carried out a mental state examination and recorded "*bipolar affective disorder relapse*". The SHO spoke to Patient B's girlfriend, who lived with him. She said he had been restless. The trust made arrangements for Patient B to see CP4 when he was next available in clinic.

Comment

There was no assessment of risk documented in the clinical notes although there was evidence in the clinical notes that alcohol was a clear and major risk factor. We discuss this in more detail in section six.

5.46 CP4 (from the Stein Centre psychiatry department) received a phone call from a support worker for the CJMHLT on 30 June 2005. The support worker said she had seen Patient B in court (where he was answering a plea on a new matter) and wanted to discuss his presentation. The conversation was confirmed in writing on 7 July 2005.

5.47 The letter said Patient B was due to stand trial over another matter and had been suspended from his community punishment order because he had been verbally aggressive and threatening during a work session. The support worker questioned whether Patient B's disinhibited presentation in court was a "*sign of hypomania*". The support worker expected that CP4 would be asked to provide the court with a medical report in relation either to the new matters or to the breach of the community punishment order.

5.48 Probation records from 7 July 2005 show that Patient B met with his offender manager on a home visit at his mother's address. He confirmed that he had stopped taking his medication as agreed with his GP.

5.49 The probation service received a letter from Patient B's GP on 18 July 2005, having requested information to inform their decision whether to revoke Patient B's community punishment order. The letter said Patient B had bipolar affective disorder and that he was on the severe mental illness register. Patient B was described as "*prone to flare ups if he is not compliant with medication*".

5.50 Patient B's community punishment order was revoked on medical grounds and he was resentenced to a community rehabilitation order on 22 September 2005.

5.51 Patient B cancelled his appointment with CP4 on 5 October 2005. On that date Patient B was at Wirral Magistrates Court where the harassment case against him was dismissed. A mental health practitioner for the CJMHLT spoke to Patient B at court. He recalled in a letter to CP4 that it was evident that Patient B had been drinking alcohol before his court appearance that morning.

5.52 A support worker for the CJMHLT wrote to CP4 on 25 October 2005 to tell him that all outstanding criminal justice matters in relation to Patient B had been concluded. Patient B's community punishment order had been revoked and he had been resentenced to a community supervision order.

5.53 Patient B failed to attend an outpatient psychiatry appointment with CP4 on 5 December 2005. A letter to his GP said a further outpatient appointment would be sent to him in due course.

5.54 Patient B attended an appointment with his offender manager on 6 December and said he was attending the Stein Centre for an outpatient psychiatry appointment the next day to get more medication for his bipolar disorder. The records state that Patient B felt that he was in need of medication and that it was perceived as a positive step that he was self-monitoring and taking action before he "*becomes critical*".

5.55 Patient B attended an appointment with his offender manager on 13 December 2005. He said he had lost his job because he had to take time off work to help look after the children of his partner, who was in hospital.

5.56 Patient B's probation order was transferred from Merseyside probation to West Mercia probation in January 2006 because he had moved to a new area.

5.57 Patient B failed to attend an outpatient psychiatry appointment on 24 January 2006. This was the third consecutive appointment he had missed so a letter was sent to his GP to say that Patient B had been discharged from mental health services.

Comment and Analysis

Between March 2005 and January 2006 Patient B was offered a total of five appointments with mental health services, of which he attended just one. Having failed to attend three consecutive appointments, Patient B was discharged from services on 24 January 2006. We found no indication that the decision to discharge Patient B was made by a multi-disciplinary team or that a risk assessment was undertaken on his discharge.

The phone conversation on 30 June 2005 and subsequent letter on 7 July 2005 from the CJMHLT support worker to CP4 dealt with the charges of 'harassment' Patient B was facing, with no reference to his forensic history. Nothing in the letter conveys any concerns of particular risks he posed. And, again, like the SHO, the support worker appears to view Patient B's behaviour in terms of mental illness, querying whether Patient B's behaviour at court might be 'a sign of hypomania'.

The signs of alcohol problems were repeatedly present over the years and documented in the notes and letters. On several occasions those who interviewed Patient B noted the 'smell of alcohol' on his breath or the 'stale smell of alcohol'. It was established more than once in the notes that Patient B was drinking throughout the day. Much of the symptomatology ('expansiveness...grandiosity...uninhibited behaviour...etc) attributed to bipolar affective disorder by CP1 could just as easily, and with better evidence, have been due to the excessive and chronic consumption of alcohol.

The notes of Patient B's appointment with CP4's SHO on 28 June 2005 contain no reference to any forensic history, nor to any assessment of risk. The SHO considered the case purely as one of bipolar disorder, assuming that there had been a relapse that improved when he took Olanzapine.

October 2006 – April 2007

5.58 Patient B attended an appointment with his offender manager on 3 October 2006. The offender manager noted that Patient B was displaying a demeanour that may indicate a "*return to a manic phase of his bi-polar condition*". Patient B said he was not registered with a GP and regarded himself to be a 'banned patient'.

5.59 Patient B's GP made a referral to the trust on 17 October 2006. The referral letter said that Patient B had been experiencing feelings of "*lack of control*" over the last few days; he felt uninhibited and had been experiencing some *"spontaneous and uncontrolled behaviour"*. His GP said he put Patient B back on 2.5mg Olanzapine and that he would appreciate psychiatrist input into his further management as "*clearly, he is beginning to relapse*".

5.60 Patient B turned up unexpectedly at his probation office on 24 October 2006. He told his offender manager that he had had a major argument with his partner and she had thrown him out. He said also that he had lost his job after 'an incident' with a colleague. This had given him cause to question his mental state and he had gone back to his GP and had been prescribed further medication for his bipolar disorder. His offender manager felt that Patient B's behaviour over the last two appointments indicated deterioration in his mental condition.

Comment

By the end of October 2006 both Patient B's GP and his offender manager had recognised that Patient B's mental health was starting to deteriorate. His GP referred him to the trust's services.

We spoke to Merseyside Police who confirmed that Patient B was not subject to multi-agency public protection arrangements (MAPPA)[8]. Patient B's treatment needs and risk factors might have been discussed and managed in a more holistic way if he had been subject to MAPPA. However, given Patient B had not committed a 'serious offence' since 2001 he was unlikely to have qualified for management under MAPPA.

5.61 Patient B contacted the trust on 22 November 2006 having received an appointment letter. He arranged to attend an outpatient psychiatry appointment with CP2 on 5 December 2006 but the notes indicate that he was next seen on 13 December 2006. We found no explanation as to why the appointment on 5 December 2006 did not go ahead.

5.62 Patient B attended the trust for an outpatient psychiatry appointment with CP2's SHO on 13 December 2006. The SHO did not have access to the referral letter but said Patient B had drunk four cans of strong lager that morning. The SHO and CP2 agreed that he had drunk too much alcohol for them to formally assess his mental state. He was therefore offered a further appointment.

[8] MAPPA was introduced by the Criminal Justice and Courts Services Act 2000 and was strengthened under the Criminal Justice Act 2003. It tasks the 'responsible authorities' (including the local probation and mental health services) with the management of high-risk offenders in the community.

5.63 The SHO contacted Patient B's GP on 15 December 2006 to discuss Patient B's presentation at the outpatient clinic appointment on 13 December. The GP informed the SHO that Patient B had attended the surgery shortly after his outpatient appointment and that she did not have any particular concerns about Patient B, nor did she notice any slurring in speech or the smell of alcohol.

Comment

Patient B's GP re-referred him to the trust's services on 17 October 2006. The referral highlighted concerns that Patient B was starting to relapse. Patient B was clearly under the influence of alcohol at the outpatient psychiatry appointment on 13 December 2006. The notes indicate that the SHO did not have access to the GP referral at the time of the appointment - it is not clear why it was not in Patient B's records. Nothing in the notes shows that Patient B's increased alcohol use was recognised as potentially indicative of a relapse. No risk implications were noted or risk assessment forms completed. However, a follow-up conversation between the SHO and Patient B's GP took place. The GP had no particular concerns about Patient B at that time despite having concerns at the time of the referral.

5.64 Patient B attended an appointment with his offender manager on 20 December 2006. He said he had been charged with a public order offence relating to an incident on a train when he was accused of not having a ticket and a 'shouting match' had developed between him and the train official.

5.65 Patient B failed to attend his outpatient psychiatry appointment with CP2 on 19 January 2007. CP2 told the internal investigation that Patient B was subsequently discussed at a MDT meeting - no risks for urgent follow-up were identified and they decided to send him another routine appointment letter. We found no evidence to suggest that a follow-up appointment letter was sent at this time.

Comment

Patient B was not offered a further appointment until 19 January 2007 despite his presentation on 13 December 2006, it does not appear that he was considered as in need of an urgent follow-up. Patient B failed to attend his follow-up appointment on 19 January 2007 and he was not sent a further appointment at that time, nor was he discharged from the service.

5.66 Manchester Magistrates Court sentenced Patient B to a one-month community order and a one-month curfew (between 7pm – 7am) on 28 February 2007 arising from the public order offence on a train in December 2006.

5.67 Patient B's community order was terminated and all probation intervention was concluded on 22 March 2007.

5.68 A letter was sent by the outpatient psychiatry department on 18 April 2007 offering Patient B an appointment on 10 May 2007 with CP2. However, Patient B had already been arrested for murder by this point.

Comment

Patient B was offered two outpatient appointments between 13 December 2006 and the offence. He attended just one of these. When Patient B failed to attend an appointment on 19 January 2007 he was not offered a further appointment until 10 May 2007, by which time he had already murdered his sister's boyfriend. We found no evidence to explain why Patient B was not offered a follow-up appointment for almost four months.

Immediately after the offence

5.69 The Merseyside Police notes registering the arrival of Patient B in their custody on 22 April 2007 state that Patient B was "*withdrawing from alcohol*" and that Chlordiazepoxide was administered several times that day.

5.70 A letter dated 11 May 2007 to CP2 from the team manager of CJMHLT said that Patient B completed a Librium detoxification regime[9] while in prison on remand sometime between late April 2007 and early May 2007.

[9] The drug of choice for control of withdrawal from alcohol.

6. Issues arising, comment and analysis

6.1 In this section we provide further comment and analysis on the issues we have identified as part of our investigation.

The themes are:

- the court report
- diagnosis, treatment and case management
- risk assessment and risk management
- communicating, liaising and sharing information effectively with other agencies involved with Patient B
- coordination of Patient B's care
- management of failing to attend appointments and discharge from services
- identification of potential safeguarding issues.

The court report

6.2 CP1's private psychiatric court report found its way into Patient B's NHS clinical records. The discussion notes of the interview with the team manager of the criminal justice team for the trust internal investigation say that CP1 agreed to send a copy of the report to the receiving consultant in April 2003 when Patient B was assessed. When we interviewed CP1 she could not remember how the court report had come to be in the file. However the trust internal investigation report indicated that CP1 provided probation services with a copy of the report when he was referred there and that it is likely that they shared the report with the trust. Whatever happened, it was placed in Patient B's clinical notes and would have been available to the various doctors who saw Patient B, such as SHOs and locum consultants in the trust who had access to Patient B's clinical records. The report proved to be critical to Patient B's care from December 2001 onwards. The report made a "*tentative*" diagnosis of bipolar affective disorder. The evidence put forward in the report to support this diagnosis consisted of the points below.

6.3 In relation to the observation that on occasions Patient B:

> "*has become extremely violent and aggressive towards prison staff*", the report states, "*in retrospect, he described these incidents as psychotic as his feelings of aggression were accompanied by a sense of his own superiority, a feeling of being able to communicate with his dead father and loss of reality*."

6.4 Under the heading 'mental state examination', the report states that Patient B:

> "*talked insistently and at times it was difficult to stop his narrative*"... and "*he displayed pressure of speech and pressure of thought. He had a tendency to make expansive gestures and much of the content of his speech was grandiose in nature*" (no examples of grandiosity are given).

6.5 The report goes on to state that Patient B "*did not display any signs of psychosis and was cognitively unimpaired*." It was noted that he was well presented and coherent. However, later in the report, under opinion, it is stated that Patient B describes clear and well-demarcated episodes of what appear to be psychosis.

6.6 As for Patient B's mental state at the time of the alleged dangerous driving incident, the report states that Patient B claims that he was psychotic at the time but adds "*However, it should also be noted that the defendant himself admits that he was likely to be intoxicated at the same time*".

Comment

It is our view that the report failed to put forward sufficient evidence to support even a tentative diagnosis of bipolar disorder.

6.7 In relation to the role of alcohol in the symptomatology, under the heading 'drug and alcohol history' in the report, CP1 states:

> "*He admitted that he was inclined to drink alcohol excessively on a regular basis and had done since a young man ... He would regularly become drunk ...*"

6.8 There is nothing in the CP1's report to indicate that she was aware of Patient B's inpatient episode in 1997 dealing with his alcohol misuse. But Patient B had told CP1 that he could not remember the events surrounding the dangerous driving offence and that the first thing he remembered was "*the sound of the hydraulic equipment, which was used to free him from the vehicle*". He also told CP1 that he had been drinking alcohol that day. The combined intake of alcohol and inability to remember events would suggest the blackouts often experienced by chronic drinkers. However there is no follow up of such hints in the report.

Comment

CP1 should have considered more carefully the role of alcohol in Patient B's behaviour given his history of excessive alcohol use.

The court report did not develop further the 'anti-social personality traits' to consider how far they played a role in the behaviour that brought Patient B before the courts.

The report also failed to properly consider the behaviour of Patient B and to what extent he posed a risk to others. CP1 saw Patient B in the context of dangerous driving, which led to the severe injury of an individual. When the report refers to risk and offending behavior, it focuses on car crime rather than the risk posed to others. CP1 did not go further to consider whether there was more direct violent behaviour to others in spite of noting in the report, under 'psychiatric history':

> **"*[Patient B]* admitted that on occasions he has become extremely violent and aggressive towards prison staff".**

There is little information in the court report about Patient B's personal and social life that might shed light on his behaviour or help in understanding the underlying antisocial traits. More of an attempt should have been made to elicit relevant information which could be linked to personality traits and the behavior displayed.

6.9 We interviewed CP1 on 31 January 2011. She told us:

> *"I do not have the terms of engagement from the solicitor that asked me for the* [court] *report –, I guess I would have answered the questions that were posed to me. The Legal Aid Board I think often have a set of questions that they ask experts to comment upon. I suspect that is probably what I was asked to do. I think the other issue here is it was quite clear to me that Patient B was going to face a custodial sentence."*

Comment

We accept that the report was written for court purposes and that CP1 was responding to specific questions posed. However, the report does address the diagnosis in some detail and goes on to suggest what treatment is available. At the same time CP1 writes to the GP with the categorical diagnosis of bipolar affective disorder. Furthermore, when CP1 subsequently assesses Patient B within the NHS services, she relies on her own court report when making a diagnosis and drawing up treatment: there is no documentary evidence that a re-assessment was conducted. The report was less emphatic about the diagnosis than the letter to the GP.

Finding

F1 The report was filed in Patient B's NHS medical notes and it became the platform for all further care and treatment from 2003 onwards. Those who subsequently assessed or reviewed Patient B relied almost entirely on the contents of this report and no-one questioned or challenged the diagnosis or management plan. There is no indication why this did not happen – but as Patient B chose when he engaged with mental health services - it was difficult for staff to assess him. Due to his irregular attendance and the high number of locum staff - Patient B was never seen by the same clinician (other than CP1) on more than one or two occasions.

Diagnosis, treatment and case management

6.10 Documentary evidence demonstrates that alcohol was a clear and major risk factor. This was not considered carefully or seriously by any medical professional dealing with Patient B's offending behaviour.

6.11 We did not carry out a direct clinical examination of Patient B and have relied on Patient B's clinical records to see whether there was evidence for a diagnosis of antisocial personality disorder. CP1 does not appear to have thought so, though she does not deal directly with this diagnostic possibility. She refers to "*antisocial personality traits*" and to Patient B being "*institutionalised*" and "*brutalised*" by the prison system, but then she abstains from further consideration of this issue, which would have raised the related question of personality disorder. However, from the information available (and it is not clear if any fundamentally different information was available to CP1), it is not possible to state with certainty whether the traits amounted to a disorder. For example, there is little information about Patient B's relationships with family members or with those of the opposite sex. It is not clear if he was capable of enduring relationships or if he was ever in stable employment, though the impression is that he was not. Nor is it clear whether Patient B was capable of genuine remorse for his actions and whether he learnt from his experiences or if he was capable of learning, whether on his own or with professional help.

Comment

The documentary information provides little convincing evidence for bipolar illness or indeed for any other formal mental illness. What information is available points to harmful use of alcohol at the very least and to underlying antisocial personality traits.

At the very least, there was interplay between personality factors of an antisocial kind and alcohol. Patient B's antisocial behaviour appears at an early age: he was expelled from school and sent to borstal at the age of 14. Adding a major mental illness to these two factors greatly increased the complexity. A more detailed analysis was needed around the interplay of these three factors (personality, alcohol and bipolar illness). To better understand the personality, more information would have been needed about Patient B's social and interpersonal life around the time he was being seen, rather than just about his upbringing. For example, Patient B's clinical records, whether the secondary mental health ones or the criminal justice ones, contain little about his relationships with women or about his relationship with his mother or his sister. We found no evidence that Patient B disclosed difficulties with his relationship with his sister, or his sister's boyfriend (who Patient B later murdered).

The fact that Patient B spent a considerable part of his life in borstals and prisons adds to the difficulties in understanding his behaviour. In 1989 he was given a 14-year prison sentence, of which he served nine years. This was his longest continuous stretch in prison. It is difficult to estimate how long he spent in prison apart from this, but it appears to have been substantial.

It can be assumed that Patient B did not drink alcohol, at least not excessive amounts or in any continuous fashion while he was in prison. It would have been critical to ascertain what his behaviour was like while he was presumably sober: was he still violent to others? It appears from some hints in the notes that Patient B sometimes accessed psychiatric care while he was in prison. It would have been helpful to know what the circumstances were, what psychological or psychiatric assessments might have been carried out, and by whom. CP1 unsuccessfully tried to access these notes.

6.12 The electronic printout of GP notes, undated but clearly leading up to and including the events of April 2007, indicate two *"active"* problems: *"bipolar affective disorder"* and "*alcohol addiction*". The entry about the latter condition says: "*8.1.2007: alcohol consump: 70 units/week*". This recognition by the GP(s) of the role of alcohol in Patient B's case is almost absent in the secondary mental health services notes.

6.13 In a GP summary of treatment card, and under the year 1997 (no month or dates), are entries stating: "*alcoholism, drug addiction, anger management problems, bipolar affective disorder*".

Comment and analysis

The information in the GP summary is important as it is recognition, at a relatively early stage (1997), of alcoholism, and bipolar disorder.

This is the only occasion in Patient B's clinical records that anger and anger management are mentioned.

Patient B spent a lot of time in prison so his prison medical notes would have been crucial in ascertaining the nature of his condition and in understanding his behaviour. We have not had access to Patient B's prison notes, and it is clear that they would not have been available to trust medics or indeed to CP1 when she prepared her report.

When the team manager from the CJMHLT wrote to CP1 on 9 May 2003 her letter stated that Patient B **"indicated his intention to avoid use of alcohol and illicit substances"** ***having recognised these as*** **"triggers to deterioration".** ***We found no indication in Patient B's clinical records that this information was used to inform any assessments of his risk or alcohol misuse.***

CP1 saw Patient B three times in the outpatient psychiatry clinic, the first time was on 11 June 2003. The outpatient letter of 13 June 2003 to the GP re-asserts that Patient B **"suffers from bipolar affective disorder",** ***adding that this*** **"has always been missed by the services".** ***The tentative diagnosis of bipolar affective disorder appears to have been finalised without evidence to support it, such as a further mental health assessment.***

Recommendation

R1 Where a diagnosis is tentative or being developed, this should be clearly documented in the patient's notes to ensure that further assessments are conducted so as to formalise a diagnosis and develop a treatment plan.

6.14 The letter from CP1 of 13 June 2003 to Patient B's GP refers to Patient B having had a tendency to misuse alcohol in addition to the diagnosis of bipolar affective disorder. In spite of this potentially explosive combination of major mental illness and alcohol misuse (added to the offending behaviour and the reference earlier to antisocial personality traits) there is no overall outline of a management plan. Rather, Patient B is discharged from the services:

> "*I have not made any formal arrangements to see…* [Patient B] *at the present time*."

6.15 The second outpatient psychiatry appointment was on 2 September 2003. In the letter of the same date CP1 states her understanding of the link between bipolar disorder and the offending behaviour:

> "*The concern is that when* [Patient B] *is high he becomes irresponsible and starts taking unnecessary risks. This has led to offending behaviour in the past. Indeed I would have to admit that the risk of re-offending is high ...*"

Comment

The view put forward is that Patient B's risk of offending escalates during the manic phases of the bipolar illness. This correlation should have been identified and the risk identified should have been a key component of any management plan.

6.16 The third outpatient contact with CP1 was on 14 October 2003. The outpatient letter dated 17 October 2003 notes that Patient B "*smelt of stale alcohol*" and that he "*was talking in philosophical and expansive terms*". The letter goes on to say that Patient B "*denies abusing alcohol*" and no further comments are made regarding this. The letter also states that Patient B "*did agree that he was perhaps on the elated side of things*", but this suggestion is not elaborated on in the letter.

6.17 We found no evidence of a formulation, management plan, or assessment of risk. No medication was prescribed in spite of the suggestion that Patient B was *"elated",* explaining that Patient B *"is very reluctant to take any form of medication".* A follow-up appointment was made for 23 December 2003, by which time there was a locum consultant (CP1 had left to work in a different part of the trust) and Patient B did not attend. He failed to attend a second time for an appointment arranged for 4 February 2004.

6.18 The outpatient letters CP1 wrote suggested that her understanding of Patient B was almost exclusively in mental illness terms. She considered him to be suffering from bipolar affective disorder and she viewed any presentation and any reported incident or experience through this prism. Neither alcohol nor antisocial traits appear to have been incorporated in the overall view.

6.19 CP1 discussed medication with Patient B and encouraged him to take mood stabilisers (Sodium Valproate caused a rash so Patient B refused to take it). She considered Olanzapine a suitable treatment because he was deemed to be 'high' at times. It appears she considered Patient B to have been 'high' when he committed the dangerous driving offence in 2001.

Comment

CP1's rationale for the management of Patient B's case, as evidenced in her outpatient letters, is not developed or stated in clear terms. On the one hand, she appears to have attributed Patient B's 'dangerous' behaviour to his being hypomanic, but when he refused to take prophylactic medication, she offered him no further outpatient appointments (though she did tell him he could always contact her when needed). Given the seriousness of the behaviour Patient B displayed over the years and the fact that CP1 had information about this in her notes, a more active and assertive approach should have been pursued.

Given that CP1 believed that Patient B became aggressive and dangerous as a result of being mentally ill, and suffering from hypomania, she would have spelt this out, alerting others to this danger. In a scenario like this there would ordinarily be a resort to the Mental Health Act, as the patient, in addition to suffering from a mental illness and as a direct result of this he poses a danger to others. There is no mention of any of this in the letter.

Forensic consideration

6.20 We asked CP1 whether she considered referring Patient B to the forensic community service. She said the trust did not have forensic community services and that she did not have experience of how such a team would operate.

6.21 We spoke with a service manager who told us that mental health staff have always worked closely with the CJLMHT who look into a service user's forensic history if any concerns are raised. She also told us that staff are able to escalate concerns to their manager who will arrange for an HCR20[10] formal forensic assessment to take place.

[10] The HCR20 is a structured clinical judgement tool. It consists of 20 items, dividing risk assessment into three components: historical factors, clinical factors and risk management factors. These are seen as informing the clinician of relevant issues in a service user's past history, evaluating the presence of current dynamic issues in risk, and informing the practitioner of future risk management requirements. Each item is coded on a three point scale ('absent', 'possibly present' or 'definitely present'). Timescales for conducting the assessment are quite flexible and allow considerable leeway for individual judgement.

Comment

We feel that Patient B's past behaviour warranted a forensic referral. While the trust do not have a forensic service the service manager told us that a number of staff are trained to undertake HCR20s – as such staff should be aware of the criteria for forensic referral and assessment and should know how to escalate concerns. However, CP1 reported that she was unaware of how the forensic service operated.

Recommendation

R2 The trust should ensure that all staff are aware of the referral process and criteria for referring service users to the forensic service for assessment.

Risk assessment and risk management

6.22 Patient B was known to trust services between May 2003 and April 2007. During his engagement with services a care policy was introduced – in February 2006. The policy states that a number of assessments should be completed within four weeks of contact with a service-user. The assessments include:

- risk assessment
- care coordinator assessment
- care coordinator mental state examination
- age appropriate HoNOS.

6.23 The policy states that risk assessments are intended to alert professionals and subsequently carers to identified risks and factors associated with an increased level of risk and how such risks should be managed. It also states:

- *"Risk must be considered during every actual or failed contact with service users and the outcome of such recorded factually. As a minimum, risk assessments must include the following;*

- *Risk to self*
- *Suicide*
- *Violence to others*
- *Other types of risk to others*
- *Self neglect*
- *Exploitation by others/vulnerability to abuse*"

6.24 In relation to the involvement of 'carers' in Patient B's care and treatment, the notes indicate that the SHO spoke with Patient B's girlfriend (with whom he lived) after an appointment with him on 28 June 2005. She told the SHO that Patient B had been 'restless'. There appears to have been no further communication with Patient B's family or potential carers. A carer's assessment was not undertaken nor did the trust seek to gather information or insight in order to build a full picture of Patient B and his treatment needs.

6.25 The trust policy states that all treatment plans should be formulated with the involvement of the service-user and, where appropriate, family, carer and the MDT, and information provided about any treatments and the likely consequence of non-compliance.

6.26 In this case, Patient B's clinical records contained substantial information about his past offending behaviour but we found no evidence that this was used as an indication of risk. A more determined assessment of what risk Patient B posed to others might have led to more probing of Patient B's personal life and to perhaps the interviewing of significant others in his life. More information might have been gained about his past offending and, in particular, about the nature of the 'violent' behaviour. Without such information, it would have been difficult to ascertain the role excessive alcohol played in his behaviour.

6.27 Patient B was discharged from the trust's psychiatry services in February 2004 due to non-attendance. CP3 wrote to Patient B's GP asking whether Patient B was in custody again and telling the GP that Patient B could be seen again at the GP's request. The letter did not contain information about Patient B's diagnosis, forensic history, risk assessment or risk management plan.

6.28 The trust's internal investigation report made two recommendations about risk assessment. These are discussed in detail in section seven.

Current practice

6.29 These aspects of the Care Co-ordination Policy, February 2006, are now encompassed in the Care Programme Approach (CPA) Policy, implemented in January 2009. The policy clearly defines risk and how it should be assessed and reviewed. It also differentiates between the levels of care provided to the service-user based on their needs (CPA or standard care). National guidelines are also used to define the role and the expectations of the care coordinator.

6.30 We spoke with the general manager of adults' and old people's mental health services in East Cheshire (at the time Patient B was known to the services she was the general manager for the services in Wirral). She told us that in 2007:

> *"There was a trust-wide assessment tool in place, but there was nothing that said who did it and when they did it, so it was very much if a consultant saw a person they would do the risk assessment that they were trained in. They would not necessarily go on to a computer and do the CARSO assessment."*

6.31 She told us that it is now standard procedure for a CARSO screening to be undertaken and the appropriate risk based assessments to be completed.

Recommendations

R3 The trust should assure itself that the current process for CPA (including care planning, risk assessment, risk management planning) is robust. The clinical governance team should audit compliance at least every six months and report their findings to the board.

R4 The trust should ensure that all staff involved in the assessment and management of risk are appropriately trained.

Coordination of care

6.32 Patient B's care lacked a holistic approach during the three episodes of care (April 2003 - February 2004, March 2005 – January 2006 and October 2006 – April 2007). After the three separate referrals by Patient B's GP to the mental health service, he was offered only appointments with the consultant psychiatrist and with no other members of the mental health team. Given the absence of a coherent management plan, it is difficult to see what the various agencies could have done had they been involved. This case was reduced to one of major mental illness with the patient being left not taking the necessary medication and no plan as to how to address this.

6.33 Furthermore, the approach to Patient B's care and treatment was not consistent. Seven consultants and SHOs were involved in Patient B's care. Four of them saw him: CP1, CP4's SHO (under his instruction), CP2 and his SHO. Patient B failed to attend a number of appointments with CP3 and CP5 (consultant psychiatrist). No one individual appears to have taken overall responsibility for Patient B's care and treatment.

Comment

The trust was putting in place the national policy of developing community mental health teams when Patient B was first referred to its services in 2003. Urgent referrals would go to the team but the consultant would pick up non-urgent referrals. The trust system has since developed and the current system is for all referrals to go to the team for discussion and allocation.

The internal investigation found that in addition to the trust's use of locums, a number of staff were on sick leave and there were vacancies that had an impact not only on consistency of care but also on the ability to follow-up patients in a timely manner.

Recommendations

R5 The trust should assure itself that patients are treated and managed in a holistic way and are referred to appropriate services. We recommend that the trust conducts audits (annually at a minimum) to review patient pathways from referral to discharge.

R6 The trust should ensure that they have the appropriate number of consultant psychiatrists in post - in line with the Royal College of Psychiatrists' guidelines. If necessary, a review of locum staff use should be conducted.

Communicating, liaising and sharing information effectively with other agencies involved with Patient B

6.34 The trust introduced a policy in December 2003 to outline the process for sharing information about individuals receiving services. Its aim was to assist staff in the trust, social services for Cheshire and Wirral and GPs caring for and treating these individuals. The main focus of the policy was in relation to confidentiality and appropriate disclosure of information. It outlines the process for sharing information and when it should be withheld and the exceptional circumstances in which confidential information should be shared.

6.35 The policy does not provide guidance on communicating with the probation service or other criminal justice agencies.

Comment

In Patient B's case trust staff communicated effectively with Patient B's GP on a number of occasions. For example, on 15 December 2006 the SHO contacted Patient B's GP to discuss Patient B's presentation at the outpatient clinic appointment on 13 December 2006.

Improved communication with other agencies might have helped trust staff to identify risk factors or recognise deterioration in Patient B's presentation.

Recommendation

R7 The trust should ensure – through regular audit - that their newly introduced information sharing protocol is adhered to. Regular meetings should be held with partnership agencies such as the probation service to ensure the importance of effective communication is understood and promoted throughout the services.

6.36 Patient B's GP held significant knowledge from both the probation service and mental health services about his presentation and behaviour. However, we found no evidence that this information was shared in order to help form a holistic opinion of Patient B and his care needs.

6.37 Patient B moved away from Merseyside in January 2006 and his probation order was subsequently transferred to West Mercia. He returned to Merseyside in June 2006 and resumed appointments at Merseyside probation office in early July 2006. We found no evidence that Patient B told mental health services about his move. On his return to the Merseyside area Patient B re-engaged with mental health services in October 2006. The referral from his GP dated 17 October 2006 said he had put Patient B on 2.5mg Olanzapine and that he would appreciate psychiatrist input into his further management as "*clearly, he is beginning to relapse*".

Comment

If information had been routinely shared between the services involved with Patient B there might have been an opportunity to continue Patient B's mental health input when he moved out of area.

Management of failing to attend appointments and discharge from services

6.38 At the time that Patient B was known to trust services they were operating under the "*Policy and procedure for managing informal service users' non compliance with treatment and managing DNA or cancelled appointments, February 2006*".

6.39 The 2006 policy says that when a 'follow-up' DNA occurs, the staff member should:

> *"Make an assessment of risk if any posed by the DNA and should decide and document the course of action if any to be taken. In all cases the staff member must document their judgment and plan. If assessment is that urgent action is required this should be taken without waiting for the weekly MDT meeting. The DNA should be discussed in the weekly MDT meeting; the team should assess the case. Depending on the outcome of the MDT assessment the next course of action can be determined."*

Comment

Patient B attended the trust for an outpatient psychiatry appointment with CP2's SHO on 13 December 2006, having been re-referred by his GP. The SHO did not have access to the referral letter but said Patient B attended having consumed four cans of strong lager that morning. The SHO and CP2 agreed that they could not properly assess his mental state because he had had too much to drink, so he was offered another appointment.

Patient B failed to attend his outpatient clinic appointment with CP2 on 19 January and a follow-up appointment letter was not sent, as trust procedures required it to be. CP2 told the internal investigation team that Patient B was discussed at a MDT meeting and the opinion was that there were no risks for urgent follow up.

There is evidence that Patient B's case was discussed at a multidisciplinary team meeting, but rationale, details and decisions for discharging Patient B were not recorded in the minutes or in Patient B's case notes. We found no written evidence that any other agency - such as the probation service - were notified of his discharge from trust services.

6.40 In relation to record keeping, the 2006 policy states:

> *"All information about the DNA/cancellation should be recorded in the case notes and/or patient information system as appropriate."*

Comment

As mentioned previously, the decision to discharge Patient B from the trust's services was not recorded in Patient B's notes as trust policy required it to be.

Current trust practice

6.41 The trust operates under the CPA Policy, January 2009 (the policy was due to be reviewed in January 2011 but we have not seen evidence that this has yet taken place). The policy is thorough and robust and clearly outlines what staff should do when informal patients fail to attend appointments. The policy is supported by flowcharts that outline what should happen if a service-user fails to attend an appointment.

Recommendation

R8 The trust should ensure that all staff adhere to the trust's policy and procedure for managing informal service users' non-compliance with treatment and managing DNA or cancelled appointments.

Identification of potential safeguarding issues

6.42 The trust's Child Protection Policy, February 2006, was in place at the time trust services were providing care for Patient B. It states that details of any dependent children must be recorded, particularly any associated risks and the involvement of other professionals. The policy contains clear instructions to the trust's child protection officer if there are concerns regarding the welfare of a child. This is not limited to the children of service-users but can also apply to children a service-user may care for.

Comment

We are aware from probation records that Patient B told his offender manager on 13 December 2005 that he had lost his job as a result of taking time off work to help with his partner's children while she was in hospital. We do not know if Patient B shared this information with trust staff. Knowledge of such circumstances might have had an impact on Patient B's perceived risk both of harm and of relapse. Or it might at least have triggered an assessment of his needs, care and risk.

Recommendations

R9 The trust should ensure there is a robust policy in place for safeguarding children and ensure through regular audit that all staff adhere to it.

R10 The trust and probation services should ensure that service-users with a history of violence who provide care or supervision for children receive an assessment of risk under child safeguarding procedures to assess whether they are able to provide safe and consistent care.

7. The trust's internal investigation and progress made against the recommendations

7.1 The terms of reference (TOR) for this independent investigation include assessing the quality of the internal investigation and reviewing the progress made by the trust in implementing the action plan.

7.2 In this section we examine the trust's incident policy and whether its investigation into the care and treatment of Patient B met the requirements of trust policy.

Reporting of serious incidents

7.3 The trust's incident reporting policy (April 2007) says:

> *"Every incident, including Serious Untoward Incidents and near misses must be reported using the Trust's accident and incident book"*.

7.4 In this case, a clinical services manager from the trust was made aware on 17 April 2007 that Patient B had previously received care and treatment from the trust, and had been arrested on suspicion of murder. There is evidence that a mental health serious untoward incident form was completed on the same day providing a summary of the incident.

Conclusion

The clinical services manager worked in line with trust procedure by completing a serious untoward incident form.

The trust's internal investigation

7.5 The trust's incident reporting policy (April 2007) also states:

"Following some incidents, for example a homicide, it may be necessary to hold an internal inquiry. These will have an inquiry team, appointed by the Executive team and will include an executive director. No members of the inquiry team should be directly involved with the service in which the incident occurred. The Terms of Reference need to be agreed with the Director of Nursing, Therapies and Patient Partnership and the Strategic Health Authority. The Inquiry Report will be approved by the Trust Board."

7.6 Documents provided by the trust show that an investigation into the treatment and care of Patient B was commissioned and the TOR were signed by the director of nursing.

7.7 The purpose of the trust investigation was to:

- examine all the circumstances surrounding the care and treatment provided by the trust to Patient B from January 2004. Particular consideration was to be given to his contacts with the trust between October 2006 and the date of his arrest
- consider the adequacy of the clinical assessment including risk assessment, treatment interventions, risk management plans and follow-up processes
- consider the trust's response and engagement with the referring GP
- consider any issues that the respective family or carers might want to raise
- to examine how far the care provided to Patient B complied with statutory requirements, national guidance and local policies
- consider any other relevant issues that might emerge as part of the investigation

- prepare a report and make necessary recommendations stemming from any learning that might emerge which would reduce the risk or likelihood of similar events recurring
- identify any areas of good practice
- write a report and make any necessary recommendations.

7.8 The TOR for the trust's investigation also outlined the methodology to be used. The trust acknowledged that the police were investigating and that it must liaise with the police before talking to witnesses or to Patient B.

7.9 The TOR included ensuring that:

- transcripts of interviews were made and interviewees had the opportunity to amend them
- evidence was used only for the investigation and the report
- any information obtained and processed was considered after obtaining consent for disclosure of confidential information.

7.10 An executive lead was identified to ensure that input was independent and to make sure that the investigation team received administration support as needed.

7.11 The investigation team consisted of:

- chief operating officer (executive lead)
- general manager (internal)
- consultant psychiatrist (internal)
- consultant psychiatrist (external)
- clinical services manager (nurse)
- acting clinical services manager (social worker)
- non-executive director.

Conclusion

The trust commissioned an internal investigation into the care and treatment of Patient B. Terms of reference were clear and an executive lead was appointed. These actions met the requirements of the trust's incident reporting policy.

7.12 In this section we look at the trust's progress in implementing the action plan resulting from the internal investigation report.

Recommendations from the trust investigation

7.13 The report identified several areas that needed improvement and made eight recommendations, as listed below.

- Review the trust's expected standard of documentation for all professionals in relation to assessment of risks to patients.

- Review the training available to all services regarding risk assessment and management.

- Teams should provide the service-user with a diagnosis as soon as possible after assessment. If this is not possible, the reason should be documented with a clear management plan until a diagnosis can be made.

- Teams should be provided with clear guidance about what should be documented at the MDT meetings with the standard documents.

- When consultants see service-users in outpatient settings, they should be aware of the next available outpatient clinic slot. A consistent system should be in place.

- The Wirral (sub division) should explore a system for referral to teams where the service-user is not registered with a GP.

- A review should be undertaken to ensure that teams work with various public bodies regarding sharing of information protocols for the protection of users and the public.

- When team managers and clinical staff are off work for more than four weeks, a review should take place and an identified person should be allocated to take on this important role until the staff member comes back.

Comment

Many of the recommendations from the trust's internal investigation are not result-focused but they identify the main problems identified by the internal investigation.

Action plan

7.14 The trust developed an action plan to take forward the recommendations. In addition to examining the action, we interviewed the general manager responsible for leading the internal investigation and we examined trust policy and procedure to see how the recommendations had been taken forward. The general manager told us:

> *"Each locality* [within the trust] *has a local incidents and complaints meeting where any action plans are taken back to those meetings. They are shared with the clinicians and the managers there, and then those actions are taken out into the workplace. The Audit team are at that meeting, so they will decide then how they will audit those actions in practice."*

7.15 The table below shows what progress the trust has made against the recommendations that were made from the internal investigation report.

Recommendation	**Progress**
Review the trust's expected standard of documentation for all professionals in relation to the risk assessment of risks to patients.	The trust has devised and implemented a trust-wide care coordination policy and procedure that outlines the need to carry out risk assessments. The policy states that assessments should be documented in CareNotes, an electronic system that meets requirements set by the Department of Health to improve the patient pathway.
Review the training made available to all services regarding risk assessment and management.	A clinical risk management mandatory training programme has been developed and implemented.
Teams should provide the service-user with a diagnosis as soon as possible after assessment. If this cannot be provided, the reason should be documented with a clear management plan until a diagnosis can be made.	The trust action plan says a directive has been sent to teams and consultants.
Teams should be provided with clear guidance about what should be documented at the multidisciplinary team meetings with the standard documents.	A records policy is now in place in the trust, outlining the expected standard of documentation.
When consultants see service-users in outpatient settings, they should be aware of the next available outpatient clinic slot. A consistent system should be in place.	The trust told us that their electronic patient record system 'Carenotes' can search for available appointments in actual time so that staff – including consultants - can identify the next appropriate slot and book it at that time.
The Wirral (sub division) should explore a system for referral to teams where the	A policy is in place to allow patients to be referred to the CMHT without being

service user is not registered with a GP.	registered with a GP.
A review should be undertaken to ensure that teams work with various public bodies to share information protocols for the protection of users and the public.	The trust has developed an information-sharing protocol for specific public bodies, including probation, and social services.
When team managers and clinical staff are off work for more than four weeks, a review should take place and an identified person should be allocated to take on this important role until the staff member comes back.	The trust has in place a managing attendance policy (May 2009) which outlines the process to be followed in such instances. The trust told us that when a manager is absent their line manager is responsible for ensuring that reallocation of caseload and management responsibilities are completed. If a person is absent for 15 days, Human Resources trigger the long-term sickness process, which includes review of caseload and any management responsibilities.

Comment

Overall, we found evidence that the trust has put into place the recommendations of its internal investigation.

We build on recommendations 1 and 2 about risk assessment and management by making a recommendation about the need to ensure that CPA is complied with. This will ensure that all service-users receive regular risk assessment and that management plans are in place.

We also make a further recommendation about partnership working to ensure effective communication and information sharing for the safety of patients and the general public.

Timescale for the trust investigation

7.16 The trust investigation started in September 2007 and was expected to be completed by the end of October 2007 and considered at the trust board in November 2007. It was not completed until July 2009. The lead investigator told us that once the report was submitted it took a while before feedback was given and that the report needed to be amended. We were also told that the lead investigator had moved to a new post and this slowed down the investigation.

Comment

The delay in completing the trust investigation report meant that any recommended changes to practice would not have been implemented in a timely way. This is of particular importance given that Patient B did not receive a comprehensive risk assessment while he was receiving services from the trust. These recommendations should have been put in place as a matter of urgency.

Recommendation

R11 The trust should ensure that internal investigations into serious incidents are undertaken within the time their commissioners require so that improvements can be made as soon as possible.

8. Overall conclusions and recommendations

8.1 Patient B chose when he wanted to engage with mental health services which therefore limited the significance of any impact that they could subsequently have on his behaviour. He appeared to engage with CP1, but possibly because she had given him a reason outside himself for his unacceptable behaviour: she never challenged him about his drinking and never probed into the "*antisocial personality traits*". Her view of him was that he had been "*brutalised*" and "*institutionalised*" by the prison system, that he was a "*thoughtful*" individual at times plagued by feelings of remorse and guilt for his past behaviour.

8.2 It is our view that the clinicians providing treatment and care for Patient B should have identified alcohol as an issue and challenged him about it. He agreed to be admitted to an alcohol unit in 1997 for detoxification, and on another occasion he tried to stop drinking by going cold turkey. He admitted to drinking too much alcohol at the start of the day and to having experienced withdrawal symptoms. Whether addressing the alcohol problem in itself would have had any significant impact on his behaviour or the course of events is another matter, as it is not clear what role alcohol played as opposed to the underlying personality and his inclinations and urges. Nor is it possible to speculate whether Patient B was prepared to address his alcohol use or whether he would have engaged with the services had support been offered.

8.3 Clinicians did not look carefully enough at those *"antisocial behavioural traits"* identified by CP1 in her court report. Psychological approaches to address such traits were not considered.

8.4 We think CP1's report had an adverse effect on the way the psychiatric services (and, indeed, the criminal justice services) managed Patient B. It focused almost exclusively on the diagnosis of bipolar disorder (for which there was insufficient evidence) and drew attention away from another serious problem for which there was undeniable evidence: alcohol dependence. It also drew away attention from underlying personality issues.

8.5 Furthermore, having made the diagnosis of bipolar illness, CP1 did not pursue a comprehensive management plan for this condition and there was no consideration of risk in the event of a relapse. And there is evidence in the clinical notes that other staff involved in the care of Patient B did not take the diagnosis seriously, which in one instance was described as *"vague"*.

8.6 There is no doubt that Patient B's deteriorating behavior presented a risk to himself and others. A full risk assessment, a forensic referral and closer working with partnership agencies – such as the probation service may have helped to manage the risks posed by Patient B. It may have also provided him with the opportunity to address his alcohol misuse.

8.7 However, this would have required Patient B's full engagement with the service and we do not know if he would have been prepared to do this. And given his history of poor engagement up to that point, it is quite possible that he would have been unwilling to do so.

Recommendations

Diagnosis

R1 Where a diagnosis is tentative or being developed, this should be clearly documented in the patient's notes to ensure that further assessments are conducted so as to formalise a diagnosis and develop a treatment plan.

Forensic service

R2 The trust should ensure that all staff are aware of the referral process and criteria for referring service users to the forensic service for assessment.

Risk assessment and risk management

R3 The trust should assure itself that the current process for CPA (including care planning, risk assessment, risk management planning) is robust. The clinical governance team should audit compliance at least every six months and report their findings to the board.

R4 The trust should ensure that all staff involved in the assessment and management of risk are appropriately trained.

Coordination of care

R5 The trust should assure itself that patients are treated and managed in a holistic way and are referred to appropriate services. We recommend that the trust conducts audits (annually at a minimum) to review patient pathways from referral to discharge.

R6 The trust should ensure that they have the appropriate number of consultant psychiatrists in post - in line with the Royal College of Psychiatrists' guidelines. If necessary, a review of locum staff use should be conducted.

Communicating, liaising and sharing information effectively with other agencies

R7 The trust should ensure – through regular audit - that their newly introduced information sharing protocol is adhered to. Regular meetings should be held with partnership agencies such as the probation service to ensure the importance of effective communication is understood and promoted throughout the services.

Management of failing to attend appointments and discharge from services

R8 The trust should ensure that all staff adhere to the trust's policy and procedure for managing informal service users' non-compliance with treatment and managing DNA (did not attend) or cancelled appointments.

Identification of potential safeguarding issues

R9 The trust should ensure there is a robust policy in place for safeguarding children and ensure through regular audit that all staff adhere to it.

R10 The trust and probation services should ensure that service-users with a history of violence who provide care or supervision for children receive an assessment of risk under child safeguarding procedures to assess whether they are able to provide safe and consistent care.

Trust incident investigations

R11 The trust should ensure that internal investigations into serious incidents are completed by the date their commissioners require so that improvements can be made as soon as possible.

Appendix A

Biographies

Chris Brougham

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

Amber Sargent

Amber joined Verita as a senior investigator in 2009. Amber previously worked at the Care Quality Commission (CQC) as an investigation officer where she led interventions into trusts where patient safety concerns were identified. She also worked on several major investigations that CQC were undertaking at the time. During her time at CQC Amber worked with many mental health and acute NHS trusts as well as strategic health authorities to identify patient safety concerns, governance issues and concerns around performance and to provide recommendations for improvement. Before this, Amber worked for London Probation as a probation officer for three years where she routinely worked with domestic violence perpetrators.

Dr Mostafa Mohanna

After graduating from medical school with an MB, BCh, Mostafa went on to get his basic training in psychiatry at Leicester and subsequently, after gaining membership of the Royal College of Psychiatrists (MRCPsych), became a lecturer with the Leicester Medical School. From there he went on to become a senior registrar in the Cambridge rotation. Mostafa then took up a consultant post in Lincoln in 1990 and has been in that position since. Mostafa, during his consultant tenure, became the clinical tutor organising the junior doctor rotation and from there went on to become the clinical director for the mental health services. He then became the medical director for the newly formed Lincolnshire Partnership Trust in 2001 and has been in that post since. The post involves, amongst other things, investigating untoward incidents and complaints and liaising with external bodies coming into the trust to investigate incidents. As medical director, Mostafa is joint lead, with the director of nursing, on clinical governance and quality, and has the lead on research and clinical effectiveness. Mostafa was recently made a Fellow of the Royal College of Psychiatrists (FRCPsych).

Appendix B

List of documents reviewed

- Patient B's clinical notes
- A chronology of probation intervention provided by the probation service
- CP1's court report, December 2001

Policies, procedures and guidelines

- Care Coordination - Issue1, February 2006
- CMHT Operational Policy - Issue 1, Feb 2010
- CPA Policy - Issue 1, December 2008
- CPA Policy - Issue 1, January 2009
- Guidelines for the use of Valproate Semisodium Issue 2, September 2003
- Incident Reporting - Issue 2, February 2004
- Incident Reporting - Issue 3, April2007
- Incident Reporting - Issue 5, June 2009
- Information Sharing Policy - Issue 2, December 2003
- Management on Internal and External Recommendations - Issue 2, June 2009
- MAPPA Guidance - Issue 2a, February 2008
- MAPPP - Issue 1, 2003
- Non- compliance with treatment -Issue1, Feb 2006
- Police Liaison -Issue1, January 2006
- Post Incident Review, 2003
- Records Policy, May 2009
- Risk Management Policy - Issue 2, August 2006
- Risk Management Policy - Issue 4, May 2009
- Service Specification - Adult - Criminal Justice Mental Health Liaison Service (CJMHL), December 2010
- Trust Records Policy - Issue 3, July 2005