Niche
PATIENT SAFETY

An Independent Investigation into the Care and Treatment of Mr A

Report FINAL
12 Oct 2012

CONTENTS

1.0 INTRODUCTION

1.1 Niche Health & Social Care Consulting was commissioned by NHS South West (now part of NHS South of England), the Strategic Health Authority (SHA) that covers the South West of England, to conduct an Independent Investigation to examine the care and treatment of Mr A. Under Department of Health guidance[1] SHA's are required to undertake an Independent Investigation:

1.2 "*When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.*

1.3 *When it is necessary to comply with the State's obligation under Article 2 of the European Convention on Human Rights. Whenever a state agent is or may be responsible for a death, there is an obligation for the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.*

1.4 *Where the SHA determines that an adverse event warrants independent investigation. For example, if there is concern that an event may represent significant systematic failure, such as a cluster of suicides."*

2.0 PURPOSE AND SCOPE OF INVESTIGATION

2.1 Independent Investigations should increase public confidence in statutory mental health service providers. The purpose of this investigation is not only to investigate the care and treatment of Mr A, but to put into context the care and treatment that he received up to the murder of his partner, Ms B, to establish whether or not that could have been prevented and to establish whether any lessons can be learned for the future.

3.0 SUMMARY OF INCIDENT

3.1 On 9th June 2008 Mr A was taken into custody after his partner, Ms B, was found dead at his home. After his arrest he was assessed under the Mental Health Act 1983 and deemed not to be detainable under the Act. He was deemed fit for interview. Police told the clinicians that Mr A had gone to his neighbour's house whilst drunk at 5pm the previous day and asked him to come and identify the body of his girlfriend. The police were immediately called by the neighbour. The Consultant Psychiatrist who saw Mr A following his arrest states that Mr A gave a coherent account and said that MS B had come to his house despite the fact he was on bail related to some charges of a recent assault on her. Mr A stated he and Ms B drank together before the homicide occurred. Mr A said he had been drinking heavily in previous weeks. There were no features of biological depression or symptoms of psychosis evident on interview.

[1] Department of Health (1994) *HSG (94) 27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community* amended by Department of Health (2005) *Independent Investigation of Adverse Events in Mental Health Services*

4.0 CONDOLENCES TO THE FAMILY OF MS B

4.1 The Independent Investigation Team would like to offer their deepest sympathies to the family and friends of MS B. It is our sincere wish that this report provides no further pain and distress but addresses any outstanding issues and questions raised by her relatives regarding the care and treatment of Mr A up to the offence.

5.0 ACKNOWLEDGEMENT OF PARTICIPANTS

5.1 This investigation involved staff from 2gether NHS Foundation Trust and Gloucestershire Police and we would like to acknowledge the helpful contributions of staff members.

5.2 In particular we would like to especially thank the Assistant Director of Clinical Governance and administration staff at 2gether NHS Foundation Trust for their valuable and efficient assistance.

6.0 TERMS OF REFERENCE

6.1 NHS South West has commissioned this independent investigation with the full co-operation of 2gether NHS Foundation Trust ('the Trust') and Gloucestershire PCT.

6.2 Background

6.3 Mr A, who has a history of mental health problems and alcohol abuse, was given a life sentence with a minimum term of 18 years at Crown Court on the 21st December 2009, after being found guilty of the murder of his partner at his home address on June 8th 2008. Mr A had been in frequent contact with mental health services since 1992, latterly this was provided by 2gether NHS Foundation Trust. Following the incident on June 8th 2008, the Trust completed a preliminary incident review on the 10th June 2008.

6.4 The Trust, along with the Care Services Improvement Partnership, then commissioned a Consultant Psychiatrist and Honorary Senior Lecturer to undertake an independent review concerning the care of Mr A. This was completed on 27th August 2008 and subsequently led to the development of an action plan from 2gether NHS Foundation Trust which would set in place a number of actions to address points raised.

6.5 Under Department of Health guidance, HSG (94) 27 (amended in 2005), SHAs are required to undertake an independent investigation 'when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event'.

6.6 The NHS South West SHA consequently commissioned an independent investigation of the above case as required by HSG (94) 27, and appointed Niche Health & Social Care Consulting to complete this independent investigation.

6.7 Terms of Reference

6.8 The aim of the independent investigation is to evaluate the mental health care and treatment of Mr A and to identify any contributory factors to the homicide and learn appropriate lessons. The investigation will be undertaken by a team of people with the relevant expertise, approved by NHS South West. If more specialist advice is required this will be negotiated separately with NHS South West. The investigation will include a review of key issues identified and focus on learning lessons. Where appropriate, recommendations based on best practice in mental health care will be made.

6.9 The investigation team will:

- *Review the assessment, treatment and care that Mr A received from 2gether NHS Foundation Trust*
- *Review the care planning and risk assessment policy and procedures*
- *Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment*
- *Review documentation and recording of key information*
- *Review communication, case management and care delivery*
- *Review Trust internal investigation of the incident to include timeliness and methodology to identify whether all key issues and lessons learned have been identified, recommendations are appropriate and comprehensive and flow from the lessons learned*
- *Review progress against any action plan*
- *Review processes in place to embed any lessons learned*
- *Review any communication and work with families of victim and perpetrator*
- *Establish appropriate contacts and communications with families/carers to ensure their appropriate engagement in the Independent Investigation process*

6.10 Approach

6.11 The investigation team will provide the necessary services to ensure the effective co-ordination and delivery of the independent investigation.

6.12 The investigation team will conduct its work in private and will take as its starting point the Trust internal investigation, supplemented as necessary by access to source documents and interviews with key staff as determined by the team.

6.13 As well as key staff, the investigation team is encouraged to engage actively with the relatives of the victim and Mr A so as to help ensure that, as far as possible, the investigation is informed by a thorough understanding of the incident from the perspective of those directly affected, and will provide appropriate support to relatives throughout the investigation process.

6.14 The investigation team will follow established good practice in the conduct of interviews, for example offering the opportunity for interviewees to be accompanied and be able to comment on the factual accuracy of their transcript of evidence.

6.15 If the investigation team identifies a serious cause for concern, this will immediately be notified to NHS South West.

6.16 Publication

6.17 The outcome of the investigation will be made public. NHS South West will determine the nature and form of publication. The decision on publication will take into account the views of the chair of the investigation team, those directly involved in the incident and other interested parties.

7.0 THE INDEPENDENT INVESTIGATION TEAM

7.1 This investigation was undertaken by the following team of healthcare professionals who are independent of the healthcare services provided.

1. Nicola Cooper - Investigation Manager and Report Author, Senior Patient Safety Lead of Niche Health & Social Care Consulting Ltd

2. Dr Ian Cumming - Consultant Forensic Psychiatrist

8.0 INVESTIGATION METHODOLOGY

8.1 This investigation follows national guidance[2]. The investigation commenced in July 2010.

8.2 Communication with Victim's Family

8.3 Telephone, written and face-to-face contact was made with Ms B's eldest child. The terms of reference and the methodology for the investigation were discussed with her and she was given the opportunity to discuss issues that were pertinent to her.

8.4 Consent

8.5 Consent to access Mr A's medical records was provided by Mr A to NHS South West prior to the commencement of the investigation. The Independent Investigation Team is grateful for Mr A's co-operation.

8.6 Communication with the Perpetrator and the Perpetrator's Family

8.7 Mr A was seen in prison by the Independent Investigation Team and the Team also met with his parents.

[2] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*

8.8 Witnesses called by the Investigation Team

8.9 The Team interviewed the staff involved in Mr A's care and treatment making reference to the National Patient Safety Agency *investigation interview guidance.*[3] The list of staff titles of those interviewed is detailed in the appendices. Niche Health & Social Care Consulting adheres to the Salmon Principles[4] in all investigations. The Independent Investigation Team had access to some police records regarding contact with Mr A and MS B via the Gloucestershire Police. The Independent Investigation Team considered this information and other information supplied by the police in so far as it was relevant to the care and treatment of Mr A and this investigation.

8.10 Twelve staff were invited for interview in this investigation. They are listed in Appendix B.

8.11 Investigation Team Communication

8.12 Throughout the investigation, the members of the Independent Investigation Team were in regular communication with each other and worked on specific areas of the investigation relevant to their areas of expertise.

8.13 Root Cause Analysis

8.14 This report was written with reference to the National Patient Safety Agency (NPSA) guidance[5]. The methodology used to analyse the information gathered was by the use of Root Cause Analysis (RCA). Root Cause Analysis is a retrospective multidisciplinary approach designed to identify the sequence of events that led to an incident. It is a systematic way of conducting an investigation that looks beyond individuals and seeks to understand the underlying system features and the environmental context in which the incident happened[6]. The NPSA's Fish Bone analysis was used to assist in identifying the influencing factors, which led to the incident. This is represented diagrammatically in Section 20.

8.15 The Trust's Serious Untoward Incident report was benchmarked against the National Patient Safety Agency's '*investigation credibility & thoroughness criteria*'[7] and the results analysed.

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[3] National Patient Safety Agency (2008) *Root Cause Analysis Investigation Tools: Investigation interview guidance*

[4] The '*Salmon Process'* is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere.

[5] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*

[6] id p38

[7] National Patient Safety Agency (2008) *RCA Investigation Evaluation Checklist, Tracking and Learning Log* http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60183&type=full&servicetype=Attachment

9.0 SOURCES OF INFORMATION

9.1 The Independent Investigation Team considered a vast and diverse range of information during the course of the investigation. This included (but is not limited to) the clinical records for Mr A held by 2gether NHS Foundation Trust and the primary care records held by Mr A's GP practice, which is governed by Gloucestershire Primary Care Trust, the Trust's Serious Untoward Incident report[8], police records, current and past 2gether NHS Foundation Trust policies and procedures and internal performance management information.

9.2 The Independent Investigation Team consulted local and national policies and strategy documents. A complete bibliography is provided in the appendices.

10.0 EXECUTIVE SUMMARY

10.1 In March 1992 Mr A was admitted to a psychiatric inpatient facility in Gloucestershire after taking an overdose. He had just split up with his long-term partner and gave this as a reason for his distress. He was discharged after two weeks.

10.2 In December 1992 Mr A took another overdose. He stated at the time that he felt under pressure from an ex-partner, to resume their relationship. On this occasion Mr A was not admitted to hospital as a result of the overdose as the assessing Consultant Psychiatrist deemed Mr A to be under considerable stress rather than objectively depressed.

10.3 In 1999 Mr A came to the attention of mental health services again as he was experiencing depressive symptoms, feeling paranoid, hearing voices, occasionally cutting himself, drinking alcohol to excess and using cannabis. During 1999 Mr A was admitted to psychiatric inpatient care on two occasions and was cared for in the community by the local Assertive Community Treatment (ACT) Team, he was treated with antipsychotic and antidepressant medication and psychological and occupational therapies.

10.4 Mr A continued to receive mental health care from the ACT Team and had occasional inpatient stays between 1999 and 2007 when he was discharged to the care of his General Practitioner (GP). During this time Mr A's medication compliance was erratic and his alcohol consumption increased, characterised by long periods of excessive drinking followed by periods of abstinence. He did, however, cease using cannabis. The ACT Team found that access to Mr A for home visits was on occasion problematic as he sometimes refused to answer the door when he was drunk or feeling particularly unwell or anxious.

10.5 In 2004 Mr A commenced a relationship with Ms B and she moved into his flat to live with him in the subsequent months. Ms B also used alcohol to excess on occasions and the couple used to drink together. Although the relationship was supportive and loving at times, there was some violence between the couple, usually whilst they were under the influence of alcohol. The first recorded incident of the police being called to the home was in summer 2004 when MS B was arrested for slapping Mr A.

[8] Report on the investigation into the Absconding of a Schedule 1 offender on 15 February 2008

10.6 Police were also called to the home in March 2005 when Mr A allegedly assaulted Ms B. Mr A was arrested on this occasion. He stated after the incident that he had no memory of assaulting Ms B. Ms A was charged with common assault and causing criminal damage but Ms B dropped the charges and told the police that she would consider suicide if they proceeded.

10.7 On 27th May 2005 police and ambulance services were called to the home after Mr A allegedly kicked Ms B. They later took Mr A to hospital as he stated he was experiencing palpitations but he discharged himself shortly after arriving at the hospital. He told clinicians that he had not been taking his psychiatric medication for three months.

10.8 On 22nd June 2005 Ms B went to the police station with facial injuries stating that Mr A had hit her. However, when this was investigated by the police Ms B withdrew her allegation.

10.9 On 22nd July 2005 Mr A was arrested and held in police cells after reports that Ms B had split her lip. He claimed he had not assaulted her, that he had been sober and that she had been drunk. No charges were pursued on this occasion.

10.10 On 22nd August 2005 Mr A was informally admitted to hospital after increasing his drinking and stopping his medication which led to an increase in psychotic symptoms. He underwent an alcohol detoxification programme whilst in hospital but discharged himself before this was completed.

10.11 Mr A was taken to hospital on Section 136 Mental Health Act[9] (transfer by the police to a place of safety) on 30th September 2005 after damaging his own property. This incident was precipitated by an argument with a family member.

10.12 On arrival at hospital Mr A was taken to a Psychiatric Intensive Care Unit and was admitted under Section 2 of the Mental Health Act (admission for assessment for up to 28 days). During this admission Mr A was observed to be experiencing psychotic symptoms and was physically aggressive. Ms B told clinicians on the ward that Mr A had been drunk prior to admission and showed bruising on her limbs, which she said he had caused. However clinicians admitting Mr A recorded that he did not appear to be drunk on admission.

10.13 On 20th November 2005, whilst on leave from hospital, Mr A was arrested and cautioned for assaulting Ms B.

10.14 In December 2005 Mr A evicted Ms B from the flat but she returned in January 2006.

10.15 In July 2006 Mr A ran out of his psychiatric medication for a few days. He said he had had a bad weekend as his son's car had broken down and he had pushed it whilst drunk and bumped a couple of cars on the way. He was arrested and charged with drunk driving and spent the night in police cells. Mr A stated that his hearing of voices had increased prior to drinking and was requesting a medication review.

[9] *Mental Health Act 1983.* (c.20)

10.16 At a Care Programme Approach (CPA) review, which took place in November 2006 it was agreed that Mr A should be regraded to standard CPA status and that discharge from the ACT Team, back to the care of his GP be arranged. A handover meeting with the GP took place on 18th January 2007.

10.17 On 27th February 2007 Mr A was arrested and charged with actual bodily harm after an assault on Ms B. He was bailed on the condition that he did not see her but she, according to Mr A, called at his home whilst bail conditions were in place.

10.18 On 13th September 2007 Mr A was informally admitted to hospital. He had been taking his medication sporadically and was drinking two litres of vodka and beer daily. He said he was hearing voices telling him to throw himself out of the window and solve mathematical problems. Ms B said that he had not eaten for two weeks. Mr A was prescribed an alcohol detoxification regime and to recommence on antipsychotic medication. On discharge he was referred to the 2gether NHS Trust Recovery Team.

10.19 In February 2008 Mr A started to experience alcohol related seizures.

10.20 In April 2008 Mr A was seen by his Recovery Team Worker and a Social Worker from the Substance Misuse Team. Mr A said he had not been drinking for some weeks due to stomach problems. The possibility of residential rehabilitation to help him overcome his alcohol issues was discussed, which Mr A refused stating that he had resumed contact with his family and that he would not want to leave Ms B. He was advised to engage with local alcohol services.

10.21 At the end of April 2008 Mr A was seen at home by a Recovery Team Worker. He said that in the previous few days he had been charged with common assault on Ms B. He said they had argued about his son who had been present at the time. Ms B had told police that Mr A had knocked out her dental plate. Both he and Ms B were drinking at the time. He said he was due in court regarding this offence.

10.22 On 25th May 2008 the Team Manager of the Recovery Team received an email from the worker who was supporting one of Mr A's close associates saying that Mr A had physically assaulted his partner badly to the extent that his knuckles were bleeding. The email stated that Mr A's son had left the house after receiving violence and that Mr A's father had been threatened with a knife on his last visit. As a result of this information the Recovery Team Manager issued a directive to the Team stating that workers should not attend Mr A's home unaccompanied due to risk of violence if Mr A had been drinking.

10.23 On 6th June 2008 the Recovery Worker contacted the police to ascertain the details of the alleged recent assault and threats to Mr A's father but they refused to share information with her under the Data Protection Act. She recorded that she would try again to make contact with the Court Liaison Officer.

10.24 On 9th June 2008 Mr A was taken into custody after Ms B was found dead. After his arrest he was assessed under the Mental Health Act and was deemed not to be detainable under

the Act. He was deemed fit for interview. Police told the clinicians that he had gone to his neighbour's house whilst drunk at 5pm the previous day and asked him to come and identify the body of his girlfriend. The police were immediately called by the neighbour. The Consultant Psychiatrist who saw Mr A following his arrest states that Mr A gave a coherent account and said that Ms B had come to his house despite the fact he was on bail related to some charges of a recent assault on her. They drank together before the homicide occurred. Mr A said he had been drinking heavily in previous weeks. There were no features of biological depression or symptoms of psychosis evident on interview.

10.25 From the outset of this investigation the Independent Investigation Team adopted a systems approach to analysing what happened and have been guarded against hindsight bias given that this has been a retrospective review of the care and treatment that Mr A received.

10.26 The Independent Investigation Team considered a diverse range of information during the course of the investigation including clinical records pertaining to the care provided to Mr A by the Acute Community Treatment Team (ACT), the Recovery Team, inpatient psychiatric services and police records.

10.27 The Independent Investigation Team have used a recognised framework and considered the following factors: patient factors, task factors, team and individual factors, work environment, organisational and strategic factors[10]. It is recognised that patient factors have a direct influence on practice and outcome. The availability and utility of protocols and guidance influence the care process. This framework provides the conceptual basis for analysing the care and treatment of Mr A and includes both the patient clinical factors as well as the high level organisational and strategic factors that may contribute to the final outcome.

10.28 Using this approach, the Independent Investigation Team have concluded that there were some care and service delivery problems and opportunities to learn lessons and that some aspects of Mr A's care fell short of expected standards. This includes issues with regard to clinical risk assessment, safeguarding procedures and communications between mental health services and the police.

10.29 It is the conclusion of the Independent Investigation Team that the tragic murder of Ms B was not predictable, as Mr A had never displayed the level of violence towards Ms B that he exhibited during the offence. However, the risk of ongoing, and potentially escalating violence towards her was an ongoing issue and therefore entirely predictable.

10.30 Mr A and Ms B were not supposed to be in contact at the time of the offence due to Mr A's bail restrictions so it is understood that the Recovery Team perceived that this restriction would eliminate risk to Ms B. However, given that they were in receipt of information in May 2008 that suggested that there had been further contact, a possible further assault on Ms B and threats to Mr A's father and son, it is the view of the Independent Investigation Team that the accuracy of this information, the nature of the contact between Mr A and Ms

B and the potential risks should have been explored and investigated further by the Recovery Team and communicated to the police in clear terms. It cannot be known if this would have prevented the tragic outcome in this case, but there is the possibility that this could have led to Mr A's arrest for breach of his bail conditions, and consequently prevented tragic outcome at that point in time.

10.31 After careful consideration the Independent Investigation Team makes twenty-four recommendations in eight key areas. These are relating to:

- Clinical risk assessment
- Substance misuse
- Safeguarding
- Medication
- Carers
- Clinical supervision
- Joint working with the police and
- Governance and management issues.

10.32 Details of are below in the recommendations table.

1a	Assessment and clinical risk assessment
1)	The Trust should ensure that a thorough assessment takes place for all service users newly admitted to the service, even if they have had historic involvement with the Trust.
2)	The Trust should carry out an audit of the quality and relevance of clinical risk assessments and management plans that are in place for current service users within three months of publication of this report.
3)	The Trust should ensure that staff are aware of their responsibility to communicate potential risk information and the conditions in which confidentiality restrictions should be overridden.
4)	The Trust should carry out qualitative audit to establish the quality of clinical risk assessments in relation to current risks outlined in clinical records and CPA review notes and the responsiveness and relevance of the subsequent risk management plans.
5)	The Trust should carry out qualitative audit to establish the quality, comprehensiveness and relevance of the content of core assessments with specific reference to personal and family histories.
6)	The Trust should develop a process for ensuring that diagnostic reviews take place for patients with long standing histories, multiple diagnoses and who have been taking a variety of medications, who are not responding to treatment, and establish processes for monitoring compliance with this.

2b	**Substance misuse**
1)	Commissioners of local substance misuse services should review the communication protocols between statutory and non-statutory commissioned substance misuse services and agree a minimum standard of communication and liaison with regard to shared service users.
2)	The Trust should review services offered to services users with dual diagnosis to ensure that they are receiving treatment consistent with national guidance and that the organisation has a training programme in place to ensure this can be consistently delivered.
3)	The Trust should carry out quantitative and qualitative audit to establish performance against the standards outlined within the Dual Diagnosis Strategy.
3c	**Medication**
1)	The Trust should ensure that there is guidance and training available to staff detailing a consistent approach to manage service users who are not concordant with their prescribed medication and monitor the efficacy of its use by a process of clinical audit.
4d	**Safeguarding**
1)	The Trust should ensure that the welfare of any children living with, or regularly visiting, a service user is considered as part of the risk assessment process and audit compliance with this on an annual basis.
2)	The body responsible for adult safeguarding in the area, and the agencies who are involved with it, should consider this case in detail, to ascertain if there is any learning or implications for future practice, particularly in cases where it is not clear which procedure best applies.
3)	The Trust should ensure that staff are aware of the appropriate referral pathways to utilize for service users who are experiencing, or are the perpetrators of, domestic violence.
5e	**Carers**
1)	The Trust should ensure that workers are aware of their responsibility to offer family intervention, to all service users with schizophrenia, and their significant others, and compliance with this should be subject to regular audit.
2)	The Trust should ensure that all eligible carers receive a carer's assessment.
3)	The Trust should ensure that a process is in place to ensure families and carers are appropriately involved in care planning and risk assessment.
6f	**Clinical supervision**
1)	The Trust should ensure that all Care Co-ordinators receive regular caseload supervision that includes documented formal review of care plans, clinical risk assessments and clinical risk management plans.
7g	**Joint working with the police**
1)	The Trust should work with the police to agree a robust process for ensuring that the police are able to identify Care Co-ordinators who need to attend Multi Agency Risk Assessment Conference (MARAC) meetings swiftly and monitor the effectiveness of this by a process of annual audit.
2)	A high level discussion between the Trust and local police needs to take place to agree to

	implement the components outlined within the Memorandum of Understanding; *Investigating patient safety incidents involving unexpected death or serious untoward harm* published by Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006)
3)	The Trust should ensure that senior managers and Trust directors are aware of their responsibilities outlined within the Memorandum of Understanding and these should be made explicit within Trust policy.
4)	The Trust should ensure that one of the functions of the incident co-ordination group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way.
8h	**Management and governance processes**
1)	The Trust should ensure that Team Managers are all aware of their responsibilities under the Trust's incident reporting procedure and the criteria for the escalation of concerns through the management structure.
2)	The Trust Board should confirm and challenge the outputs from the reports and the actions arising.
3)	The Trust should undertake a review to examine the efficacy of the processes in place for the learning and sharing of lessons learned to establish their efficacy.
4)	Commissioners of Trust services should ensure that clear standards are set and quality measures are agreed and that service outcomes are routinely appraised and monitored.

11.0 CHRONOLOGY

11.1 Background and early life

11.2 The following information has been gleaned from clinical notes, assessments and reports within Mr A's clinical records.

11.3 Mr A was born in December 1969. He lived with his parents and sibling throughout his childhood and adolescence. He is reported not to have enjoyed school and left at the age of 16. After leaving school Mr A went to work in a double-glazing firm. He was in a relationship for nine years and had two children prior to his first contact with psychiatric services in 1992. Mr A is reported in the clinical records to have a shy and introverted personality.

11.4 Criminal History

11.5 The Independent Investigation Team found no evidence to suggest Mr A had a criminal history prior to his involvement with Ms B, which commenced in July 2004.

13th August 2004

11.6 Mr A telephoned police saying Ms B was drunk and would not leave his home. Ms B was arrested for slapping Mr A across the face.

9th March 2005

11.7 Ms B alleged assault by Mr A which had caused bruising to her face and mouth. Mr A was arrested by the police.

7th April 2005

11.8 Mr A charged with common assault on Ms B and criminal damage. Mr A was due to attend court on 18th May 2005.

27th May 2005

11.9 An ambulance was called to Mr A's home. They requested police assistance as back up as it was reported that Mr A had kicked Ms B. Police officers accompanied paramedics to hospital after Mr A had a ''medical episode''. No further action was taken by the police following this incident.

22nd June 2005

11.10 Ms B turned up at the police station with facial injuries, claiming Mr A had assaulted her. When followed up by the police she said that nothing had happened and that she did not want to speak to the police.

22nd June 2005

11.11 A mental health professional arrived at Mr A's for a home visit at 10am as Mr A was returning from the shops with a bottle of vodka. He said he was drinking up to four bottles each week since he was arrested following an alleged assault on Ms B. He said that Ms B had fallen over whilst drunk and split her lip and that he had not assaulted her. He said that he had been sober. He was kept in custody for five hours before the charges were dropped.

Mr A reported being traumatised by this and a subsequent increase in auditory hallucinations and that he had punched the wall a few days earlier in response to this.

30th September 2005

11.12 Mr A arrested after damaging his own property. He was taken to hospital by police under Section 136 of the Mental Health Act[11]. Police were alerted to this situation when Ms B called police after Mr A 'trashed his room'. Ms B said he had been drinking. Mr A said he was upset as his son had told him that he did not want to see him. He was admitted to the Psychiatric Intensive Care Unit under Section 2 of the Mental Health Act[12].

20th October 2005

11.13 Police records show that they were called to a domestic argument at Mr A's home which was over before police arrived.

21st November 2005

11.14 A fax was received by the ACT Team from the Emergency Duty Team (EDT) saying Mr A had been arrested the night before after an allegation of assault from Ms B. Mr A stated he had slapped her in self defence but denied the bruising that police photographed. Mr A rang the service on his release saying that Ms B now had joint tenancy on his flat and that she was not allowing him back in to the flat as she had his keys. He said he had gone to stay with his parents. Mr A was seen at his parents' home and stated that he and Ms B had been drinking and he went to bed. He said while he was in bed MS B came up and scratched him. Mr A showed staff the scratches. He was released from police custody with a caution. He continued to deny harming Ms B other than slapping her when she was scratching him and said he thought that the bruises to her face were probably caused by her falling. He said that she often tripped on the steps into the living room when drunk. Mr A stated he remembered everything about the incident. Mr A said he had not been drinking to excess in the days up to the incident as Ms B claimed and said he had only missed a couple of doses of medication. He said he wanted to end the relationship with Ms B but was concerned as she had joint tenancy of the flat. He was advised to talk to the landlord about possibly evicting her.

11.15 Mr A's Consultant Psychiatrist noted in a letter to the ACT Team that the police told him Mr A had drank six pints of strong lager prior to this incident. Ms B apparently acted as 'appropriate adult' for Mr A at the police station.

25th December 2005

11.16 Police records show that Ms B was evicted from the flat by Mr A. The police agreed to find a refuge in Wales for her. Police gained entry to the flat to get Ms B's clothing as Mr A would not open the door. A refuge place was found due to her alcohol dependency and threats to self harm.

[11] *Mental Health Act 1983.* (c.20)
[12] *Mental Health Act 1983.* (c.20)

27th July 2006

11.17 Police records show that Ms B was found to be drunk in a newsagent's shop saying Mr A had locked her out and that she was scared of him. Police returned her to Mr A's address. Mr A was calm having taken medication.

4th August 2006

11.18 Mr A appeared in court for a driving offence, which resulted in a 28 month driving ban and a £295 fine.

12th September 2006

11.19 Police records show that they were called as Ms B was smashing windows at Mr A's home and threatened him with a knife. As a result of this Ms B was arrested for breach of the peace. Mr A went to stay with his sister as a result of this incident.

27th February 2007

11.20 Police records show that Mr A was arrested and charged with actual bodily harm against Ms B. They suggested that she go to a refuge. She declined this. She had been drinking.

17th October 2007

11.21 Police records show that they were called to an argument between Mr A and Ms B when she refused to leave his premises. He head-butted the window and smashed it in frustration. Ms B was found to be distressed outside the premises. She had no injuries following this incident.

30th October 2007

11.22 A carer's assessment was arranged for Ms B by the Recovery Team worker. Mr A said he had started drinking again after receiving a letter from a debt collection agency. This led to him threatening Ms B who left. The police were called by neighbours. On discussion about the incident Mr A blamed his aggression on Ms B for not leaving when he was angry. She said she stayed to help.

18th – 20th April 2008

11.23 Police records show that they were called to Mr A's flat. Mr A had drunk two bottles of vodka. Ms B had facial injuries and was drunk. Police advised Ms B not to have contact with Mr A. Mr A was arrested for assault and later charged with common assault following Crown Prosecution Service advice, despite Ms B not supporting the action.

29th May 2008

11.24 Email in clinical records saying that Mr A had badly physically assaulted his partner to the extent that his knuckles were bleeding. It states that Mr A's son had left the house after receiving violence and that Mr A's father had been threatened with a knife on his last visit. The email suggests that workers should not attend Mr A's home unaccompanied due to risk of violence if Mr A had been drinking. The email also stated that Mr A was due in court on 9th June 2008 due to a previous assault charge.

9th June 2008

11.25 Mr A in custody after Ms B found dead. After his arrest Mr A was assessed under the Mental Health Act and was deemed not to be detainable under the Act. He was deemed fit for interview. Police told the clinicians that he had gone to his neighbour's house whilst drunk at 5pm the previous day and asked him to come and identify the body of his girlfriend. The police were immediately called by the neighbour.

11.26 The Consultant Psychiatrist states in the clinical records that Mr A gave a coherent account of the incident and said that Ms B had come to his house despite the fact he was on bail related to some charges of a recent assault on her. They drank together before the homicide occurred. Mr A said he had been drinking heavily in previous weeks. The Consultant Psychiatrist stated in the clinical records that there were no features of biological depression or symptoms of psychosis evident when interviewing Mr A.

11.27 Medical and Psychiatric History

March 1992

11.28 Mr A had a brief informal admission to hospital for a reactive depression, when he took an overdose of various drugs, in March 1992 after splitting up with his partner of nine years. He was discharged from hospital after a short stay with no follow up care as he felt well at the time.

December 1992

11.29 Mr A took another overdose. His stated at the time that he felt under pressure from an ex-partner, to resume their relationship. On this occasion Mr A was not admitted to hospital as a result of the overdose as the assessing Consultant Psychiatrist deemed Mr A to be under considerable stress rather than objectively depressed.

March 1999

11.30 Mr A presented as experiencing depressive symptoms, feeling paranoid and hearing voices. This resulted in him feeling reluctant to go out due to social anxiety. He told clinicians that he used alcohol and cannabis to help him deal with his feelings and symptoms. Mr A reported occasionally harming himself by cutting his upper arms and was assessed as being at risk of suicide and self-neglect.

11.31 During 1999 Mr A was admitted to hospital on one occasion in March for approximately one month and was treated in the community as an outpatient. At this time Mr A reported drinking 30-40 pints of beer each week.

11.32 Two weeks after discharge from hospital Mr A was readmitted after feeling low in mood, increasing his alcohol and cannabis use and taking a small overdose of his psychiatric medication. His clinical records show that Mr A had very regular contact with a Community Psychiatric Nurse (CPN). He was offered involvement in anxiety management and relaxation therapies but his engagement with these was sporadic.

11.33 Mr A was employed for some of 1999 but lost this job due to him taking regular time off.

11.34 Mr A was prescribed a depot injection of Depixol (an antipsychotic medication), 40mgs every two weeks. This appeared to be very beneficial in terms of the management of Mr A's psychotic symptoms but caused extra pyramidal side effects. These diminished somewhat when the dose was halved in November 1999 but this did result in a return of Mr A's psychotic symptoms, paranoia and social anxiety.

2000

11.35 In early 2000 Mr A's Depixol injection was increased to 30mgs as the previous reduction in dose had led to Mr A drinking more to help him cope with the re-emerging symptoms.

11.36 His CPN was also helping Mr A to use psycho-social approaches to help him manage his symptoms including the use of headphones to help him reduce the intrusion of his voices. Both of these interventions appeared to help Mr A.

11.37 In March 2000 Mr A was also prescribed Olanzapine (an antipsychotic medication), 10mgs at night, which appeared to bring additional improvement to Mr A's mental state and functioning. In May 2000 Mr A reported an alcohol free week which was unusual and indicated significant progress.

11.38 An Associate Psychologist agreed to undertake family work with Mr A's family in May 2000 although MR A did not wish to take part in this.

11.39 Later in May 2000 Mr A reported that his psychotic symptoms were improved but that he was feeling low in mood and had been hiding this. He said that his alcohol intake and self harm was increasing. He was diagnosed as experiencing 'Depression in the Context of a Schizophrenic Illness' and was prescribed Fluoxetine (an antidepressant) 20mgs each day.

2001

11.40 In February 2001 Mr A reported a return of his psychotic symptoms and an inability to leave the house and on 12th February 2001 Mr A was seen at the request of his father who reported that MR A's paranoia had increased which had resulted in him running to his parents' house in the night as he thought he was being pursued by someone with a shotgun. He stated he had been taking extra Procyclidine (a medication which helps alleviate the side effects of antipsychotic medication) which may have exacerbated his psychotic symptoms. As a result he was prescribed Chlorpromazine (an antipsychotic medication), 100mgs at night and 25mgs three times a day.

11.41 Later in February 2001 Mr A reported feeling a little better and being able to go out more. He also reported that he was not drinking alcohol. The CPN was doing regular psychosocial work with MR A to assist him with the management of his symptoms. This appears to have been effective and helpful to Mr A.

11.42 In April 2001 a family session took place in which Mr A's family were encouraged to let Mr A have more control over his medication and finances as his parents were keeping these for him and giving them to him when they felt it appropriate.

11.43 In August 2001 Mr A reported feeling paranoid about people outside his flat. His CPN helped him to look at this using psychosocial techniques, his Olanzapine was increased and Chlorpromazine and Trazadone (an antidepressant medication) were prescribed, 150mgs per day.

11.44 In October 2001 Mr A reported that this had been helpful and that he was feeling a bit better.

11.45 Throughout 2001 Mr A was offered anxiety management sessions with an Occupational Therapist which he attended sporadically but appeared to engage well with the process and the group when he did attend. Mr A's attendance appears to have largely depended on his level of social confidence and psychotic symptoms at the time.

2002

11.46 In early 2002 Mr A stopped taking his medication, Olanzapine and Trazadone, for a month which resulted in him not feeling so well. He said that he had not picked up his medication from the GP as he did not like being questioned when he called them. After he commenced taking the medication Mr A appeared to have a stable few months. There were occasions in this time when he reported bad days and experiencing difficulty going out and hearing voices but generally appeared fairly well and engaged well with his CPN and an additional CPN from the Assertive Outreach Team who was undertaking an assessment following a referral in April 2002.

11.47 In June 2002 Mr A reported an increase in psychotic symptoms and self harming. It was agreed that he should be prescribed Quetiapine (an antipsychotic medication), initially in addition to his existing prescription. The plan was that this would be increased over time and other medications reduced if Mr A was able to tolerate it. This change seemed to have a good effect.

11.48 In August Mr A experienced 'a bad few days'. When the reasons for this were explored with him he acknowledged that his parents had booked a holiday and that he was concerned about not having enough support whilst they were away. However, he coped well during their absence.

11.49 A fire in the flat below Mr A's in September 2009 resulted in Mr A having to move in with his parents temporarily. Mr A applied for rehousing after this event as he was concerned about returning to the same address. At this time MR A stopped taking his Olanzapine for over a week as he stated he was having pain in his knees and was feeling wheezy. Apparently he experienced more unwanted thoughts due to this and agreed to recommence it at a lower dose.

11.50 Mr A also admitted to increasing his alcohol intake in October 2002. His father told clinicians that he found empty cans hidden in the house whilst Mr A was staying in the parental home.

11.51 Mr A moved to an alternative address in November 2002, which appears to have gone well.

11.52 In late 2002 Mr A complained of experiencing side effects of his medication.

11.53 In December 2002 Mr A was referred to the Specialist Substance Misuse Service due to his alcohol use and was assessed on 11th December 2002. The assessor stated that Mr A would benefit from counselling at Gloucestershire Drug and Alcohol Service (GDAS)[13] and asked Mr A to contact them.

2003

11.54 On 15th January 2003 Mr A was discharged from the Specialist Substance Misuse Service as he was controlling his drinking and attending GDAS.

Comment

11.55 GDAS are a charitable organisation in Gloucestershire who offer a range of services including needle exchange, assessment of asset and need, psychosocial interventions, group work and onward referrals. They work in partnership with other local services in order to provide a range of interventions to the client group they support. The majority of the funding for the services they offer comes from the Joint Commissioning Group in Gloucestershire and Service Level Agreements are in place.

11.56 The GDAS was contacted as part of our investigation and there is no record of them having contact with Mr A at this time. They state that they had two contacts with Mr A, once in July 2006 and then again in March 2007. On the first occasion Mr A was referred through the alcohol arrest referral scheme for an alcohol related driving offence and on the second occasion was referred by his GP. GDAS state Mr A was only seen for assessment on both occasions and did not engage with the service.

11.57 It is not specifically recorded in Mr A's clinical notes why clinicians were wrongly under the impression that he was engaging with the GDAS at this time.

2003 (continued)

11.58 On 21st January 2003 Mr A's father reported to the ACT Team that Mr A had been on a five day drinking binge in which he had consumed twelve litres of vodka and had been vomiting all night. His CPN advised him to contact Mr A's GP immediately, which resulted in Mr A's admission to a Medical Assessment Unit. When seen in hospital two days later by his CPN, Mr A had been diagnosed with aeoesophaegitis due to alcohol consumption but appeared mentally well and was expressing that he was glad to be alive and saw no future in drinking alcohol again.

11.59 A week later Mr A was seen again in hospital by his CPN. He had been diagnosed as having Type 2 diabetes and was experiencing derogatory command hallucinations. Communications were made with the hospital medical team to increase his Quetiapine.

11.60 On discharge Mr A reported feeling low in mood and uncomfortable due to constipation. He reported that his family had withdrawn their support although his mood seemed to brighten

[13] Local Gloucestershire charity working to minimise harm caused to people of all ages whose health and well being are at risk as a consequence of drug and alcohol or other dependency

over subsequent visits. Mr A's prescription at that time was Quetiapine 700mgs per day and Procyclidine 10mgs per day.

11.61 In mid March 2003 Mr A fell down some stairs and broke his ankle, which resulted in him needing to stay at his parents' home for a while. The investigation team found no evidence to suggest that Mr A was using alcohol at this time or experiencing any cravings. His parents were taking control of his finances during this period to help him regulate his drinking.

11.62 On 10th June 2003 Mr A reported a decrease in mood. He said this had resulted in an increase of stress, auditory hallucinations and self-harm.

11.63 On the next visit Mr A had visible grazes to his forehead after banging his head against a wall to harm himself but denied alcohol use.

11.64 At the end of August 2003 Mr A went on an alcohol binge session.

11.65 Two weeks later, in September 2003, Mr A's father reported that Mr A had been on another drinking binge, which had resulted in him attending the Accident and Emergency Department with multiple bruises and lacerations. He was referred to GDAS to deal with his alcohol problems as a result of this.

Comment

11.66 It is unclear from the clinical records who made this referral but GDAS have no record of receiving it.

2003 (continued)

11.67 When seen by his CPN the following week , Mr A stated that his mood had been affected by increased voices and stressors. Strategies for coping with this without using alcohol were discussed with Mr A.

11.68 At the end of September 2003, Mr A cancelled his appointment with his CPN stating he was going out with his family. Subsequent visits found Mr A not at home or not answering the door and when his parents were contacted on 1st October 2003 they had also not been able to contact Mr A for some days.

11.69 On 4th October 2003 Mr A was informally admitted to an inpatient psychiatric unit wearing blood stained clothes. He stated he had been up for several days as he had stopped taking his Quetiapine a week before as he had run out of Procyclidine. He said he had been drinking to help with the psychotic symptoms. He was accompanied to the hospital by his teenage son who Mr A claimed had pushed him, causing him to fall down the stairs, in an argument prior to admission. Mr A is reported as having told staff he had been avoiding his CPN's visits as he did not want anyone to see him.

Comment

11.70 Mr A's teenage son was staying at Mr A's home on occasions at this time. It was known to clinicians that Mr A was drinking to excess on occasions and was experiencing psychotic symptoms. It is unclear whether his son in fact pushed him down the stairs or, if he did, the

antecedents to this incident. It is the view of the Independent Investigation Team, however, that this incident should have prompted a referral to local child protection services but there is no evidence in the clinical records that this happened or that the circumstances of this incident were explored in any way.

2003 (continued)

11.71 Mr A was prescribed an alcohol detoxification during his admission to hospital. He was also detained under Section 5(2) of the Mental Health Act[14] during this admission following an attempt to abscond from the hospital but this was lifted the following day.

11.72 On discharge, on 22nd October 2003, Mr A was prescribed Quetiapine 700mgs each day and a six month trial of Acamprosate (a medication to help patients to sustain abstinence from alcohol after they have stopped drinking).

11.73 After discharge, structured sessions with the ACT Team were put in place to help Mr A look at his drinking behaviour. On 27th October 2003 it was noted that Mr A had not consumed alcohol for the previous four weeks, since prior to his admission to hospital. Mr A was seen regularly at home following his discharge and reported drinking on occasions. He said that these incidents were not sustained and that he did not get as much affect from them due to his medication.

19th January 2004

11.74 Mr A was seen at home and reported that he had had a relapse and had drunk two bottles of vodka and twelve cans of beer but that he had been able to stop before his money ran out. He stated that the support that he had been getting, coping strategies and the medication he had been prescribed had enabled him to exert more control over himself than usual and he had been pleased about this.

28th January 2004

11.75 Mr A was accompanied, by a worker from the ACT Team, to an interview at the day hospital regarding his wish to attend the day hospital and was able to articulate his feelings and goals well. His father was present and they were able to discuss some of their difficulties. MR A was very happy about this and felt they had ''cleared the air''.

1st March 2004

11.76 Mr A was visited by an ACT worker. He reported feeling well and more empowered due to improved family relationships, particularly with his father. He stated he was being given more control over his finances by his parents which he was enjoying. He stated that his mother was unwell and that he was giving increased support to his father and his children. He said he had had a drink but that it had not resulted in binge drinking.

29th March 2004

11.77 Mr A is reported to have ceased taking prescribed Acamprosate stating that he no longer required it.

[14] *Mental Health Act 1983.* (c.20)

18th May 2004

11.78 Mr A had been unavailable when contacted by ACT workers for most of May 2004. When seen on 18th May at home by an ACT worker he described a return of his psychotic symptoms which had resulted in him isolating himself for some time in the flat but denied drinking alcohol. A plan was agreed with Mr A of what they should do when he was denying them access or appeared to be out consistently.

2nd June 2004

11.79 Mr A reported feeling low and stated he had not eaten for three days. Clinicians were concerned about this due to his diabetes and requested urgent blood glucose and urine tests. Mr A's psychiatric medication was also increased to Paroxetine (an antidepressant medication) 30mgs and Diazepam (a medication used to reduce anxiety) up 10mgs per day.

16th June 2004

11.80 Mr A attended an outpatient appointment with the Consultant Psychiatrist accompanied by an ACT worker. He reported feeling a little better and agreed to take part in a research project regarding voice hearing.

23rd June 2004

11.81 Mr A attended an outpatient appointment and was told by the Consultant Psychiatrist not to take Diazepam whilst he was prescribed antidepressants. Mr A agreed to this.

30th June 2004

11.82 An ACT worker and person involved in the research project attended Mr A's home to carry out an assessment related to the research project that Mr A had agreed to be involved with. Mr A requested to rearrange the assessment as he stated he '*didn't feel up to it*'. He said he had had a stressful week due to a row with his son. Mr A said his parents had not telephoned him since the incident and that this had made him angry. He stated he had had urges to drink and harm himself and that he had restarted Acomprosate (a medicine used in alcohol dependence used to help maintain abstinence in people who have successfully overcome drinking problems) and was using the fact that he had a sore mouth due to dental issues as a strategy to distract him from drinking alcohol. It was noted that there was a risk of Mr A drinking to excess when his mouth got better. Mr A stated that his appetite and sleep were reduced but that he was managing to go out to the shops at non busy times. Mr A said he was taking Paroxetine 20mgs as prescribed. It was agreed that the ACT worker would attempt to expedite MR A's dental appointment and for an appointment with the Consultant Psychiatrist to be made for the following week.

2nd July 2004

11.83 Mr A was not at home when his CPN and the Consultant Psychiatrist visited his home as agreed.

11.84 Mr A was also unavailable when visited by an ACT worker on 6th, 7th and 8th July 2004 although it appeared that he had been at home between visits. On 8th July the worker spoke to Mr A's mother who said that Mr A was staying with a friend, Ms B. It was also noted that Mr A's television was gone from the flat.

9th July 2004

11.85 Mr A told his CPN on the telephone that he had been staying with his recent friend Ms B since the row with his son which remained unresolved. Mr A said that he had not been contacted by his parents for some days and discussed the changes in his relationship since he had become more assertive and had taken on a more parental role with his son. Mr A admitted to occasional drinking but not to excess. The CPN commented that Mr A generally seemed very well during the visit.

16th July 2004

11.86 Mr A introduced his CPN to Ms B and stated she was a new friend who he had been staying with. MR A said he still had some anxiety but had been able to go out. He also said he was drinking but within normal limits.

19th July 2004

11.87 Mr A was visited at home by an ACT worker. He reported feeling better and that his mood had lifted. He said that his new relationship was going well, that he was going out more and his sleep was improving. The possibility of a carer's assessment for his parents was also discussed.

Comment

11.88 The Independent Investigation Team found no evidence that a carer's assessment was offered to or completed with Mr A's parents.

11.89 In 2004 the Carers (Equal Opportunities) Act was implemented nationally.

11.90 Guidance issued by Social Care Institute for Excellence (SCIE)[15] in 2005, and updated in 2007, defines carers as follows;

11.91 The word 'carer' refers to people who provide unpaid care to a relative, friend or neighbour who is in need of support because of mental or physical illness, old age or disability. It does not include people who work as volunteers or paid carers; these people should be referred to as 'care workers'.

11.92 And in England and Wales that Act applies to;

11.93 Carers who provide or intend to provide a substantial amount of care on a regular basis for another individual aged over 18

It states;

11.94 The government has increasingly recognised the contribution that carers make to society and has passed legislation that acknowledges their needs and entitles them to assessment and services in their own right (1,2). The Carers (Equal Opportunities) Act 2004 seeks to ensure that:

[15] Social Care Institute for Excellence (2005) *Practice Guide 9: Implementing the Carers (Equal Opportunities) Act 2004* (Updated 2007)

- *carers are identified and informed of their rights*
- *their needs for education, training, employment and leisure are taken into consideration*
- *public bodies recognise and support them.*

11.95 Given that Mr A's parents were very involved with supporting him, particularly in the years before Mr A was in a relationship with Ms B, it is the view of the Independent Investigation Team that they should have been offered a carer's assessment and whatever support such an assessment identified as deemed necessary.

30th July 2004

11.96 Mr A reported to the ACT worker that his relationship continued to go well. The CPN noted that this seemed to have been a real boost to his confidence. It was noted that relationships between Mr A and his family continued to be strained but that he was continuing to remain assertive within the family.

13th August 2004

11.97 Mr A telephoned police saying Ms B was drunk and would not leave his home. Ms B was arrested for slapping Mr A across the face.

16th August 2004

11.98 Mr A was visited at home by an ACT worker. He reported that things were going well apart from some anxiety when he played snooker with his son and his friends as Mr A suspected that the friends had been smoking cannabis. Some anxiety and relaxation techniques were discussed with Mr A during the session.

17th August 2004 – 15th September 2004

11.99 Mr A was not contactable despite several attempts by ACT workers both by telephone and home visits.

16th September 2004

11.100 Mr A seen at home by his CPN. He stated that he felt increasingly stressed. He also expressed concern that his partner Ms B had recently suffered from a bout of depression. As a result Mr A said that his voice hearing and drinking had increased. He said he had been drinking up to seven cans of beer each day over the past month.

22nd September 2004

11.101 Mr A was collected from home by a member of the ACT and was taken to an outpatient appointment with the Consultant Psychiatrist. He talked about the problems he had had with his son and his father. Holding Mr A's appointments outside of his home was agreed as Mr A stated he needed the support and needed a break from Ms B. He said she was increasingly anxious and dependent on him due to what he thought were her mental health problems.

Comment

11.102 It is not the remit of the Independent Investigation Team to investigate Ms B's health problems nor does it have any access to any clinical information or records which may or may not be held regarding her. However, it is not apparent from Mr A's records that the extent of her health problems, in the context of the potential effect on Mr A's fragile mental state, were explored with either him or Ms B at this stage.

27th September 2004

11.103 Mr A seen at home by an ACT worker, and some work done practising walking to the venue of the Hearing Voices Group. Mr A reported that he had had a difficult weekend due to Ms B's problems. He also said that he did not like drinking currently as he needed to be supportive to Ms B.

5th October 2004

11.104 Mr A seen at home by an ACT worker. Mr A raised the ongoing issues around Ms B potentially having her child back to live with her as her ex-partner said he could not have her with him anymore. Mr A and Ms B attending meetings with Social Services regarding this. Mr A reported needing extra support due to this but also stated he had not been drinking for the previous few days.

6th October 2004

11.105 Strategies to help Mr A to cope with the increasing dependency from Ms B discussed between him and his CPN.

18th October 2004

11.106 Ms B and her young child moved in with Mr A on a temporary basis until they could be rehoused.

Comment

11.107 Mr A's mental health problems and alcohol use was well known to the mental health services. Additionally Mr A had stated on several occasions that Ms B had mental health issues of her own. It is the view of the Independent Investigation Team that Ms B's child moving in to the home should have prompted a clinical risk review and consideration given to potential child protection referral. There is no evidence in the clinical records that this happened or that this was considered in any way.

27th October 2004

11.108 Mr A was visited at home by his CPN so that he could be accompanied to the dentist. However on arrival the CPN discovered that Mr A was looking after Ms B's child. Mr A said that Ms B had started drinking again and that the previous night she had been drunk and had been verbally aggressive to the child and had attempted to hit her. Mr A said that he had locked Ms B out and had called the police who attended. Mr A told the police that he had schizophrenia and they referred the case to the Social Services Child In Need team with a view to finding Ms B's child accommodation as Mr A's mental state appeared to be deteriorating and he told them he had been drinking. Mr A was offered a short respite admission to a mental health ward but he refused this so short term Diazepam was

prescribed. Ms B was arrested and remained in police cells overnight. When Ms B called Mr A on her release she was told by him not to return to Mr A's home.

12th November 2004

11.109 Mr A was accompanied to the dentist by an ACT worker. The dentist told him he needed extensive dental work over a one to two year period. Mr A also went through his CPA paperwork with his CPN following his CPA meeting. Some amendments were made including changing Ms B's status to ex-partner.

24th November 2004

11.110 Mr A reported feeling low in mood over his birthday as he had received no cards. He said he had drunk eight cans of lager but was pleased that he had not binged. The CPN agreed to contact Mr A's father and to help facilitate discussion between them.

29th November 2004

11.111 An ACT worker took Mr A to the GP surgery for some blood tests. Mr A asked the ACT worker for Acomprosate to be prescribed as he felt vulnerable to drinking due to his difficult family relationships. They agreed to discuss this with other team members.

1st February 2005

11.112 Mr A's Occupational Therapist facilitated a meeting between him and his father. There were some disagreements as Mr A was saying that he wanted to be informed of all issues pertaining to his children. His father disagreed with this stating that he should not be informed in case it made him start drinking again. Mr A said he has only seen his parents twice in five months and was unsure if he still wanted his father as his named carer.

8th March 2005

11.113 Mr A was reported to look like he was losing weight by the ACT worker who visited him at home. She recorded that Mr A stated that due to his ongoing dental work he felt an inability to eat comfortably as a result. He said his alcohol intake had gone up over the previous three weeks due to isolation and stress and pain as a result of his teeth.

9th March 2005

11.114 Ms B alleged assault by Mr A which had caused bruising to her face and mouth. Mr A was arrested by the police.

10th March 2005

11.115 Telephone call from the ACT Team to the police to communicate about the alleged assault. Police told the ACT worker that Mr A had met up with Ms B and they had had an argument after drinking. Ms B alleged that Mr A had assaulted her but Mr A told police he had no memory of this.

18th March 2005

11.116 Telephone call from the police to the ACT Team saying that Ms B is still in touch with Mr A and she has expressed concerns that he is drinking and not taking his medication. This was

discussed with Mr A by an ACT worker. Mr A admitted being in touch with Ms B but said that he was coping well.

23rd March 2005

11.117 In a letter to Mr A's GP, Mr A's Consultant Psychiatrist informed him of the alleged assault on Ms B by Mr A. In this letter he informed the GP that Ms B had had an alarm fitted in her home and changed the locks on her door. The Consultant Psychiatrist states in the letter *''it is not clear why the police have seen fit to take these steps in the account that Mr A has given me''* later in the letter he states *''I see no link between Mr A's history of mental health problems and this alleged assault''* and ……. *''I have to say Mr A does not present to me as somebody who would normally attack anyone, let alone his ex-partner''*

6th April 2005

11.118 Mr A admitted to the ACT worker who saw him that he was drinking up to six cans of lager a day due to stress about his forthcoming appearance at the police station. He also said he had received a letter from Ms B which he had not read and had put in the bin.

7th April 2005

11.119 Mr A charged with common assault on Ms B and criminal damage. Mr A was due to attend court on 18th May 2005.

8th April 2005

11.120 Mr A was visited at home by two ACT workers. He told them that Ms B had called him saying that she was going to drop the charges as she had no intention of going to court. Ms A said he was not sure whether to believe this as he was concerned she might change her mind. Ms A stated that he wanted no contact with Ms B unless she sought help and made changes. He said he had stopped his Acomprosate and was still drinking six cans of lager a day.

20th April 2005

11.121 Ms B contacted the police whilst distressed and stated she wanted charges against Mr A dropped or she would contemplate suicide. Ms B's GP was contacted by police but declined to communicate with the Crown Prosecution Service in line with Ms B's wishes.

11.122 Mr A's Consultant Psychiatrist wrote a file note saying that Mr A had defaulted on his outpatient appointment that day. He commented in file note that MS B had stated she had dropped criminal charges against Mr A and that he (the Consultant Psychiatrist) had concerns that MS B may 'exacerbate the situation' and that Mr A was seen by the team as a 'vulnerable and easily manipulated individual'.

Comment

11.123 The text in the clinical records states that Mr A denied any memory of hitting Ms B but there is no evidence in the clinical records that he denied the assault altogether.

11.124 It is the view of the Independent Investigation Team that the circumstances and antecedents of this incident should have been explored by clinicians with Mr A and his risk assessment adjusted accordingly. There is no evidence that this happened.

20th – 29th April 2005

11.125 Mr A was not contactable by the ACT workers despite several attempts by telephone and in person.

3rd May 2005

11.126 Mr A admitted to an ACT worker that he was seeing Ms B again but stated he was maintaining his 'space'. He reported anxiety about his forthcoming court appearance. He stated he had recommenced Acomprosate and was drinking between four and eight cans of beer once a week.

9th May 2005

11.127 Mr A seen at home by an ACT worker. Mr A expressed that he was pleased with outcome of court case. He was bound over for one year and ordered to pay for a new mobile telephone for Ms B. Mr A exhibiting some anxiety about a hospital appointment about his teeth but generally well. Mr A reported taking medication and not drinking to excess.

27th May 2005

11.128 An ambulance was called to Mr A's home. They requested police assistance as back up as it was reported that Mr A had kicked MS B. Police officers accompanied paramedics to hospital after Mr A had a ''medical episode''. No further action was taken by the police following this incident.

28th May 2005

11.129 Ms B contacted the ACT Team requesting help for Mr A. He had attended the Accident and Emergency Department the night before but had discharged himself after a few minutes. Apparently he had been at Ms B's house and an ambulance had been called as he was experiencing palpitations. Mr A admitted to the ACT Team Leader, who visited him with another ACT worker the following day as a result, that he had not been taking his medication for the previous three months.

31st May 2005

11.130 Mr A admitted to the ACT worker who visited him at home that he had not been honest about his mental state of late. He also said that despite the problems in his relationship with MS B, he saw her as a stabilising factor. He said he wanted increased support and to recommence medication.

14th – 29th June 2005

11.131 Mr A was not contactable by ACT workers despite several attempts by telephone and in person.

22nd June 2005

11.132 Ms B went to the police station with facial injuries claiming Mr A had assaulted her. When followed up by the police she said that nothing had happened and that she did not want to speak to the police.

30th June 2005

11.133 The ACT worker managed to make contact with Mr A whilst delivering medication to his home Mr A said his telephone had been out of order which was why he was not contactable.

1st July 2005

11.134 The Mental Health Worker arrived at the flat to accompany Mr A to his outpatient appointment with the Consultant Psychiatrist as agreed. The door was opened by MS B who appeared drunk. She said that she and MR A had had a row and that he had left the flat some hours earlier.

15th July 2005

11.135 MR A was visited by an Occupational Therapist. Mr A spoke to him through the window as he said that MS B was asleep in the living room. No problems were reported by Mr A but the worker noted concern as Mr A had asked him the same question three times during the conversation.

22nd July 2005

11.136 A mental health professional arrived at Mr A's for a home visit at 10am as Mr A was returning from the shops with a bottle of vodka. He said he was drinking up to four bottles each week since he was arrested on 12th July 2005 following an alleged assault on Ms B. He said that Ms B had fallen over whilst drunk and split her lip and that he had not assaulted her. He said that he had been sober. He was kept in custody for five hours before the charges were dropped. Mr A reported being traumatised by this and a subsequent increase in auditory hallucinations and that he had punched the wall a few days earlier in response to this.

11.137 A meeting was held that day between ACT workers and the ACT Team Leader to hand Mr A's case to a new Care Co-ordinator within the team. As part of this a review of the risks relating to Mr A took place. They deemed there had been an increase in his drinking and auditory hallucinations, noted that he punched a wall in response to hallucinations and noted a decrease in self esteem and a change. It was also identified that the fact that Mr A's Care Co-ordinator had changed presented a risk. It was agreed that these risks would be monitored during weekly contacts with Mr A.

Comment

11.138 The Independent Investigation Team found no reference to Mr A being arrested on 12th July 2005 in police records that were examined. Therefore the accuracy of the date of this incident, and its nature and outcome is unknown.

28th July 2005

11.139 Mr A seen at home by an ACT worker. Mr A reported that he had ended his relationship with Ms B and that he recognised that the relationship was destructive. He said she had influenced his drinking and that this had reduced since the end of the relationship. He said that he expected Ms B to turn up at some point.

4th August 2005

11.140 Mr A was seen at home by the ACT Team Leader. He reported to be taking medication and some reduction in voice hearing.

11th – 19th August 2005

11.141 Mr A not seen by ACT workers despite several attempts. Mr A contacted the ACT Team Leader by telephone on 19th August and said that he was going away for the weekend but did not say where.

22nd August 2005

11.142 Mr A was informally admitted to hospital. The notes say he was brought in by his girlfriend after stopping his medication a few days earlier as he said he felt better. He had consumed a lot of alcohol and was experiencing an increase in auditory hallucinations. Mr A was put on a detoxification regime and close observations on the ward. After five days Mr A discharged himself before fully completing his detoxification programme. He appeared well when he left the hospital.

5th September 2005

11.143 Mr A seen at home by an ACT worker. MR A appeared well and reported that he was not drinking since leaving the hospital. MS B reported that she was drinking but not in front of Mr A.

30th September 2005

11.144 Mr A arrested after damaging his own property. He was taken to hospital by police under Section 136 of the Mental Health Act[16]. Police were alerted to this situation when Ms B called police after Mr A 'trashed his room'. Ms B said Mr A had been drinking. Mr A said he was upset as his son had told him that he did not want to see him. Mr A was admitted to the Psychiatric Intensive Care Unit under Section 2 of the Mental Health Act[17]. On admission Mr A appeared to be experiencing auditory and visual hallucinations. Clinicians reported that he did not smell of alcohol. Mr A was physically aggressive at times during this admission and required one to one observations. Ms B visited the ward on the day of admission, expressing concern that Mr A had been drinking heavily and that he was violent when drunk. She showed bruising on her arm and reported further bruising on her legs. She said she feared ''what he (Mr A) may do''.

11.145 On admission Mr A was seen on the ward by a Senior House Officer (SHO) who noted that Mr A had been drinking vodka and had found out that his son no longer wished to see him which had resulted in Mr A damaging his home. A doctor who saw him in the police cells reported that Mr A was incomprehensible and having persecutory ideas in the police cells.

11.146 The nursing records show that Mr A was clearly very suspicious of staff and was feeling persecuted and was experiencing auditory and visual hallucinations. A risk assessment took place, whilst Mr A was on the ward, which concluded that Mr A was at moderate to high risk

[16] *Mental Health Act 1983.* (c.20)
[17] *Mental Health Act 1983.* (c.20)

of harm to others, moderate risk of self neglect, low risk of harm to self and low risk of absconding.

11.147 The management plan devised in respect of Mr A potentially harming others detailed strategies about how he should be managed on the ward. There is no evidence in the clinical records that strategies to manage risk to Ms B, due to the identified risk to others, were considered at that point.

11.148 An alcohol detoxification regime was commenced.

6th October 2005

11.149 Mr A was regraded to informal status on the ward. He agreed to stay in hospital until the following weekend and during this time have escorted leave off the ward. Ward staff recorded that the detoxification programme was going well and that Mr A's psychotic symptoms were diminishing.

12th October 2005

11.150 MR A commenced home leave with Ms B.

Comment

11.151 There is no evidence in the clinical records that indicate that any risks to Ms B were considered or discussed with her or Mr A prior to him going home with her for leave from the ward.

13th October 2005

11.152 An entry in the notes made by one of the nurses on the ward states that Mr A remains on home leave.

17th October 2005

11.153 Mr A was visited at home by a member of staff from the ACT Team. He reported that he had not been drinking.

Comment

11.154 The Independent Investigation Team are not able to establish what date and in what circumstances Mr A was discharged from the ward as there is no reference to this in the clinical records.

20th October 2005

11.155 Police records confirm that they were called to a domestic argument at Mr A's home, which was over before police arrived.

20th November 2005

11.156 Police called to Mr A's home and found Ms B to have a black eye and a split lip. She claimed that Mr A had tried to strangle her. Mr A was arrested and cautioned for common assault. Police referred Ms B to the Domestic Violence Support and Advocacy Project (GDVSAP)[18].

21st November 2005

11.157 A fax was received by the ACT Team from the Emergency Duty Team (EDT) saying Mr A had been arrested the night before after an allegation of assault from Ms B. Mr A stated he had slapped her in self defence but denied the bruising that police photographed. Mr A rang the ACT Team on his release saying that Ms B now had joint tenancy on his flat and that she was not allowing him back in to the flat as she had his keys. He said he had gone to stay with his parents. Mr A was seen at his parents' home and stated that he and Ms B had been drinking and he went to bed. He said while he was in bed Ms B came up and scratched him. Mr A showed staff the scratches. He was released from police custody with a caution. He continued to deny harming Ms B other than slapping her when she was scratching him and said he thought that the bruises to her face were probably caused by her falling. He said that she often tripped on the steps into the living room when drunk. Mr A stated he remembered everything about the incident. Mr A said he had not been drinking to excess in the days up to the incident as Ms B claimed and said he had only missed a couple of doses of medication. He said he wanted to end the relationship with Ms B but was concerned as she had joint tenancy of the flat. He was advised to talk to the landlord about possibly evicting her.

11.158 MR A's Consultant Psychiatrist noted in a letter to the ACT Team that the police told him Mr A had drank six pints of strong lager prior to this incident. Ms B apparently acted as 'appropriate adult' for Mr A at the police station.

20th December 2005

11.159 A CPA review took place. Mr A, Ms B, the Consultant Psychiatrist and a worker from the ACT Team were present. Mr A and Ms B reported things were better between them and a reduction in their drinking. No problems reported by Mr A except for Ms B's drinking. Mr A was noted to be on enhanced CPA. His medication at that time was listed as Quetiapine 600mgs per day, Paroxetine 10mgs per day, Procyclidine 10mgs per day and Acamprosate 666mgs three times per day.

25th December 2005

11.160 Police records show that Mr B was evicted from the flat by Mr A. The police agreed to find a refuge in Wales for her. Police gained entry to the flat to get Ms B's clothing as Mr A would not open the door. A refuge place was found due to her alcohol use and threats to self harm.

[18] GDVSAP is a charitable organisation that exists to help women and men, throughout Gloucestershire, who are affected by domestic abuse

30th December 2005

11.161 Mr A seen at home by the ACT Team Leader. Mr A told her that Ms B had left as there were problems with her drinking, that she had threatened him with a knife over Christmas and he had called the police and she had left.

12th January 2006

11.162 Mr A seen at home by an ACT worker. Mr A said that he was happy that Ms B had left the flat and reported his drinking levels at 30 units per week, which he said he was happy with.

30th January 2006

11.163 Mr A told an ACT worker that Ms B was back at the flat and had been for a week and a half. He said he was continuing to take medication 'despite Ms B's worries about it' and was drinking approx 16 cans of lager a week but no spirits. He said he was still experiencing some voice hearing.

1st February 2006

11.164 Police records show that due to an argument Ms B was moved to the police station with a view to returning her to the refuge in Wales. Ms B stated Mr A telephoned her when she was in the refuge previously, saying that he had self harmed and she had returned to Gloucester as a result of this. She said their argument was a result of this not being true. It appears that Ms B did not go to a refuge following this intervention. The reasons for this are unclear and unascertainable.

25th April 2006

11.165 Mr A and Ms B both seemed well and were decorating the kitchen when visited by ACT staff. Mr A reported continuing to go out alone and with Ms B. Mr A wanting to restart work opportunities project once a week.

2nd May 2006

11.166 Mr A reported neither he nor Ms B appeared to be drinking although Ms B said she was missing it.

Comment

11.167 The information that was received by the Independent Investigation Team from GDAS shows that Mr A was not seen by them until July 2006.

17th July 2006

11.168 Mr A and Ms B reported to the ACT worker who visited Mr A, that her young child had turned up at the house unannounced and that Ms B had 'followed procedures and called the police'.

24th July 2006

11.169 Mr A spoke to an ACT worker on the telephone and said he'd run out of his psychiatric medication for a few days and admitted to not always taking his Acamprosate. He said he had had a bad weekend as his son's car had broken down and he had pushed it whilst drunk and bumped a couple of cars on the way. He was arrested and charged with drunk driving

and spent the night in police cells. He stated he was on bail on the condition that he contact GDAS. Mr A stated that his voices had increased prior to drinking and was requesting a medication review.

Comment

11.170 The information supplied to the Independent Investigation Team by GDAS shows that they saw Mr A for the first time, on one occasion, in July 2006 after he was referred through the alcohol arrest referral scheme for an alcohol related driving offence.

27th July 2006

11.171 Police records show that Ms B was found to be drunk in a newsagent's shop saying Mr A had locked her out and that she was scared of him. Police returned her to Mr A's address. He was calm having taken medication.

4th August 2006

11.172 Mr A appeared in court for his driving offence which resulted in a 28 month driving ban and a £295 fine.

12th September 2006

11.173 Police records show that they were called as Ms B was smashing windows at Mr A's home and threatened him with a knife. As a result of this Ms B was arrested for breach of the peace. Mr A went to stay with his sister as a result of this incident.

22nd September 2006

11.174 Mr A reported to the ACT Team that he was back in the flat with Ms B. When seen Mr A said that his voices had been worse for the previous three days. He denied drinking to excess but smelled of alcohol.

Comment

11.175 Mr A reported an increase in voice hearing when seen by staff from the ACT Team on 22nd September 2006 but was not seen again by the team for almost six weeks.

2nd November 2006

11.176 Letter sent to GP from the Consultant Psychiatrist outlining the outcome of Mr A's CPA review. He said that Mr A was doing well and was going to be transferred to Standard Level CPA and asking the GP to take over prescribing and care for MR A. He advised that help be sought via GDAS if alcohol intake became problematic.

9th January 2007

11.177 Mr A seen for a home visit. Mr A reported by the ACT worker to be mentally well and his and Ms B's drinking said to be within normal limits. The worker spoke to MR A's GP on the telephone and it was agreed that Mr A be discharged to the care of the GP surgery as long as MR A attends all his appointments every six months for diabetes and mental health monitoring. It was agreed that Mr A's Consultant Psychiatrist, Mr A and his GP meet on 18th January 2008 to handover the case.

18th January 2007

11.178 An ACT worker, the Consultant Psychiatrist and Mr A visited Mr A's GP and handed over his care to him.

11.179 Mr A was discharged from the ACT Team following this.

27th February 2007

11.180 Police records show that Mr A was arrested and charged with actual bodily harm against Ms B. They suggested she go to a refuge. She declined this. She had been drinking.

March 2007

11.181 Police records show that the Police Domestic Violence Unit assessed Ms B as being at medium risk due to the violence she was experiencing at the hands of Mr A.

Comment

11.182 The information supplied to the Independent Investigation Team by GDAS states that Mr A was seen once by them in March 2007 following a referral from Mr A's GP.

13th September 2007

11.183 Mr A was informally admitted to a mental health ward. He had been taking his medication sporadically and was drinking two litres of vodka and beer daily. He said he was hearing voices which were telling him to throw himself out of the window and solve mathematical problems. Ms B said that Mr A had not eaten for two weeks prior to admission. The doctor admitting Mr A to the ward stated that he had a caution for domestic violence that occurred seven or eight months previously. Mr A was prescribed an alcohol detoxification regime and to recommence on Quetiapine.

18th September 2007

11.184 The ward team referred Mr A to the Recovery Team within 2gether NHS Foundation Trust. He was discharged from the ward three days later on 21st September 2007.

24th September 2007

11.185 Mr A did not attend the outpatient appointment with the Specialist Registrar which had been made for him on discharge from the ward.

2nd October 2007

11.186 Mr A was visited at home by his Care Co-ordinator from the Recovery Team. Mr A was assigned one of the same workers that he saw when previously open to the team. Ms B was present but was reported not to be living at the flat since being evicted by Mr A's family who own the flat. Mr A and Ms B were unhappy about this and it appeared to have caused rifts between Mr A and his parents. Mr A informed the worker that he no longer wanted information about him sharing with his family.

16th October 2007

11.187 Call made by the Care Co-ordinator to Mr A's telephone which was answered by Ms B. She stated that Mr A did not want a visit and that he had been drinking and had hit her. The

Care Co-ordinator documented that they advised Ms B regarding her safety and a further appointment was arranged for 25th October 2007.

Comment

11.188 It is not clear from the clinical records what advice was given regarding Ms B's safety. The clinical records simply state that such advice was given.

17th October 2007

11.189 Police records show that they were called to an argument between Mr A and Ms B when she refused to leave his premises. He head-butted the window and smashed it in frustration. Ms B was found to be distressed outside the premises. She had no injuries following this incident.

30th October 2007

11.190 A carer's assessment was arranged for Ms B. Mr A said he had started drinking again after receiving a letter from a debt collection agency. This led to him threatening Ms B who left. The police were called by neighbours. On discussion about the incident Mr A blamed his aggression on Ms B for not leaving when he was angry. She said she stayed to help. The Recovery Team Worker advised Ms B about how to protect herself in these situations and to leave the flat if the situation arose. She was advised about potentially seeking help from Alanon[19]. Mr A was reminded about GDAS, which remained open to him. Ms B stated she would leave Mr A if he drank vodka again.

9th November 2007

11.191 Telephone call to the Recovery Team from Ms B expressing concern about Mr A. She said he was drinking two bottles of vodka a day and she had left the flat the previous morning for her own safety. She said she had gone back to the flat to check he was ok that morning but that he had double locked the door and was not answering his telephone. The Recovery Team Manager advised that the police were called to carry out a safety check on Mr A. Mr A apparently opened the door to the police and said that he was fine. MS B gave her key to the flat a Recovery Team worker asking that it be returned to Mr A as she no longer wanted it.

13th November 2007

11.192 Home visit to Mr A by his Care Co-ordinator. He said he had not drunk for twelve hours and was upset as he had been informed that a family member had an illness and because Ms B had left him and he wanted her back.

27th November 2007

11.193 MR A was telephoned by his Care Co-ordinator about his scheduled visit that day. Ms B answered the telephone asking the worker not to attend as MR A was drunk. The worker recorded that Ms B sounded slurred on the telephone. Next visit planned for 3rd December 2007.

[19] Alanon is a voluntary agency which supports people affected by other people's alcohol consumption

3rd December 2007

11.194 Telephone call from Ms B to his Care Co-ordinator saying Mr A had smashed her telephone and that she had left him and would not go back. Mr A was referred to the Crisis Resolution and Home Treatment Team (CRHTT) by the Care Co-ordinator as a result of this information with a view to conducting a joint visit to assess the need to send Mr A to hospital. The CRHTT worker taking the referral said she knew Mr A from a hospital admission and felt that his problems were alcohol related. The Recovery Team Worker referred her to Mr A's mental state examination information from his recent admission but CRHTT worker felt this was related to alcohol as he recovered so quickly and suggested the Care Co-ordinator do a joint visit with a member of her own team.

6th December 2007

11.195 Mr A seen at home by the Care Co-ordinator. Mr A said he was seeing Ms B three times a week as a friend and reported increased voice hearing and heavy drinking all the time he was awake. He said that there had been no recent aggression to Ms B except for smashing her telephone. Contacting the Substance Misuse Team about his alcohol use was suggested to Mr A as a possibility and he agreed to this. Mr A stated he had given his money to Ms B so that he would not have it around the house to spend on alcohol. His Care Co-ordinator told him that she would be advising Ms B that if MR A asked for his money back she should give it to him. The worker mentioned her concerns about the risk to Ms B but Mr A denied this was an issue as he would not be drinking.

11th December 2007

11.196 Mr A reported to not be drinking. He agreed for the Recovery Team Worker to discuss him with the Dual Diagnosis Nurse.

13th December 2007

11.197 Violence risk assessment and risk management plan completed by the Recovery Team Worker. The risk management plan was detailed as follows;

- To see Consultant Psychiatrist for assessment and medication review
- Dual Diagnosis Nurse to be contacted for advice
- To continue being seen by the Recovery Team, reduce stress levels by problem solving, helping with bills etc
- Carers Support Worker to offer Ms B a second appointment as supporting her might have a positive effect on Mr A
- Encourage Mr A to make use of GDAS
- If Mr A does not answer the door or is known to be drinking, try telephoning or visiting every day or two until he has stopped drinking
- If psychotic he may need admission
- He may come to the attention of the police because of arguments to Ms B or damaging his house

24th December 2007

11.198 On 24th December 2007 a telephone call was made to Mr A by the Care Co-ordinator which was not answered. A home visit was also attempted with no response.

28th December 2007

11.199 Mr A was contacted by telephone. He stated that he had not answered the door on 24th December 2007 as Ms B was unwell and was fearful that she would pass on her illness. He was reported to have sounded bright in mood during this conversation. The worker advised Mr A to contact the team if he found it difficult to cope whilst his assigned worker was on leave.

21st to 22nd January 2008

11.200 Mr A not contactable despite attempts by telephone and in person by the Care Co-ordinator.

24th January 2008

11.201 Mr A contacted by telephone by the Care Co-ordinator. The call was answered by Ms B who was in tears and was expressing concern about Mr A's drinking. She said he had been drinking approximately two bottles of vodka each day since Christmas and had told her *'leave or I'll kill you'* and had said *'bring it on'* to her neighbours when he was at her flat. The clinical records record that MS B '*suggested he'd threatened them* (the neighbours) *but refused to say how'.* Ms B reported that Mr A tells her to leave if she will not have sex with him. The Care Co-ordinator advised Mr B to stay away from MR A for her own safety. The worker asked Ms B if Mr A was experiencing psychosis and she replied '*he must be hearing voices because he says he hates me'.*

11.202 The Care Co-ordinator attempted a home visit later that day but the door was not answered. The Care Co-ordinator left a card reminding Mr A of his forthcoming appointment with the Consultant Psychiatrist the following Monday and stating she was very concerned about him.

28th January 2008

11.203 Mr A was seen as an outpatient by a Consultant Psychiatrist and Recovery Team Worker for a CPA review. Risks associated with Mr A were assessed to be to others and self neglect. His Paroxetine was increased to 40mgs daily. Mr A to be referred to a Social Worker from the Substance Misuse Team.

11.204 A care plan was developed as a result of this. This involved;

- Increase in medication
- Referral to Substance Misuse Team
- Recovery Worker to continue to make weekly contact
- Discussion to take place with Mr A regarding whether an Occupational Therapist would be helpful to him
- Mr A to be encouraged to attend his GP surgery for overdue diabetes check up

11.205 The accompanying crisis and contingency plan suggested that Mr A contact his Recovery Team Worker if in crisis in office hours.

5th February 2008

11.206 Mr A reported to the Recovery Team Worker to have had a seizure on the street after being in the post office. He refused to go with the ambulance to hospital afterwards and went home with Ms B. He was advised to see the GP as he had not been seeing him regularly. Mr A stated he did not feel that the seizure was alcohol related as he had not drunk alcohol for two and a half weeks.

26th February 2008

11.207 Mr A reported to the Care Co-ordinator to have not drunk alcohol for five weeks. Mr A stated he still had not been to see his GP since his seizure and also reported having stomach pains. As he had not seen the GP he also had not commenced on the increased dose of antidepressants prescribed at his CPA review.

4th March 2008

11.208 Telephone call to Mr A by the Care Co-ordinator. Mr A reported that he was drinking and that Ms B had left him.

25th March 2008

11.209 Ms B now back at the flat and both she and MR A drinking. He said that his stomach pain had continued and that he was vomiting blood and had blood in his stool. MR A advised to stop drinking, but not suddenly in case of seizure, and to see his GP.

3rd April 2008

11.210 Mr A seen by his Recovery Team Worker and Social Worker from the Substance Misuse Team. MR A said he had not been drinking for some weeks due to stomach problems. Mr A given advice about physical health. The possibility of residential rehabilitation to help with his alcohol dependence was discussed which Mr A refused stating that he had resumed contact with his family and that he would not want to leave Ms B. He was advised to engage with GDAS. The Social Worker stated that she would continue contact if Mr A decided that he wanted constructive support.

18th – 20th April 2008

11.211 Police records show that they were called to the flat. Mr A had drunk two bottles of vodka. Ms B had facial injuries and was drunk. Police advised Ms B not to have contact with Mr A. Mr A was arrested for assault and later charged with common assault following Crown Prosecution Service advice despite Ms B not supporting the action.

21st April 2008

11.212 Mr A did not attend his scheduled outpatient appointment.

22nd April 2008

11.213 Mr A seen at home by Recovery Team Worker. Mr A said that in the previous few days he had been charged with common assault on Ms B. They had argued about his son who had been present at the time. Ms B had told police that MR A had knocked out her dental plate. Both he and Ms B were drinking at the time. Mr A was bailed on the condition that he did not see Ms B. He said he was due in court regarding this offence in early May and the

Recovery Team Worker agreed to contact the Court Liaison Worker. The notes show that she did this on the same day.

8th May 2008

11.214 Telephone call between the Recovery Team Worker and Mr A. He said he needed to return to court for sentencing and it was possible that he would get a custodial sentence. He said that Ms B had contacted him but that seeing her was a breach of his bail conditions. Mr A reported that he had not drunk alcohol since the incident and had had a seizure. He was advised to see his GP again. The Recovery Team Worker recorded that Mr A was taking his psychiatric medication and 'sounded good'.

15th May 2008

11.215 Mr A seen at home by the Recovery Team Worker. He reported no alcohol use and no contact with Ms B. His mental state is recorded as presenting no concerns. The Recovery Team Worker advised that she would make an appointment for Ms A with a Consultant Psychiatrist prior to his impending court appearance on 17th June 2008.

29th May 2008

11.216 Email from a Community Support Worker in clinical file saying that Mr A had again badly physically assaulted his partner to the extent that his knuckles were bleeding. The email stated that Mr A had assaulted Ms B again, that Mr A's son had left the house after receiving violence and that Mr A's father had been threatened with a knife on his last visit. The Community Support Worker states in the email that this information was received from Mr A's father and that he had relayed it to the Recovery Team Manager who suggested that workers should not attend MR A's home unaccompanied due to risk of violence if Mr A had been drinking. The email also stated that Mr A was due in court on 9th June 2008 due to a previous assault charge.

Comment

11.217 It appears that this information was received by the Recovery Team Manager from the Community Support Worker that was involved clinically with a close associate of Mr A's.

2nd June 2008

11.218 Telephone contact made with Mr A by the Recovery Team Worker. He denied another assault on Ms B and said that he had argued with family members. He said he had smashed a mirror and paramedics were called but that he was not charged with anything. Mr A stated that he withdrew his consent for workers to share information about him with anyone at this stage. Previously he had allowed information sharing with Ms B and his parents. Mr A said he had not drunk for ten days and his mental state appeared good. He denied further seizures but said that his feet hurt.

9th June 2008

11.219 The Recovery Team Worker made a retrospective entry into the notes saying that on 3rd June 2008 she had contacted the police to ascertain the details of the alleged recent assault and threats to Mr A's father, but that they had refused to share information under the Data Protection Act. She recorded that she would try again to make contact with the Court Liaison Officer.

Comment

11.220 The Independent Investigation Team found no evidence in the clinical records that the Court Liaison Officer was contacted by the Recovery Team Worker and were informed that the reason for this was that it was not considered relevant for inclusion as Mr A had not been before the court at this stage.

9th June 2008

11.221 Mr A in custody after MS B found dead by the police. Prior to this Mr A apparently went to a neighbour's home on the evening of 8th June 2008 and told them that he had killed Ms B. After Mr A's arrest he was assessed under the Mental Health Act and was deemed not to be detainable under the Act and was deemed fit for interview. Police told the Recovery Team that he had gone to his neighbour's house whilst drunk at 5pm the previous day and asked him to come and identify the body of his girlfriend. The police were immediately called by the neighbour.

11.222 The Consultant Psychiatrist saw Mr A whilst in police custody. He states in the clinical records that Mr A gave a coherent account of the incident and said that Ms B had come to his house despite the fact he was on bail related to some charges of a recent assault on her. Mr A stated he and Ms B drank together before the homicide occurred. Mr A said he had been drinking heavily in previous weeks. The Consultant Psychiatrist stated in the clinical records that there were no features of biological depression or symptoms of psychosis evident on interview of Mr A.

11.223 The Consultant Psychiatrist wrote to Mr A's GP on 9th June 2008 informing him of the allegation of murder and stating that Mr A had been aggressive in the past couple of weeks, especially towards his family and that his Recovery Team Worker had been aware of this.

12.0 ASSESSMENT, TREATMENT AND CARE THAT MR A RECEIVED FROM 2GETHER NHS FOUNDATION TRUST

12.1 Diagnosis, clinical formulation and multidisciplinary team assessment

12.2 During his care Mr A was referred to in the clinical notes as suffering from a variety of conditions and disorders including schizophrenia, schizo-affective disorder, depression, paranoid illness with recurrent depressive disorder and alcohol related psychosis. He has received a variety of medical treatments related to these diagnoses including consistent use of antipsychotic medication and antidepressants. The clinical records show that Mr A experienced psychotic symptoms since 1999. It is unclear whether these were the result of a psychotic illness or related to excessive alcohol use. It is, however, apparent from the clinical records that Mr A reported that his psychotic symptoms were on occasions alleviated by the use of antipsychotic medication.

12.3 In October 2007, when Mr A was accepted under the care of the Recovery Team, he was allocated to one of the workers who had been involved in his care when he was seen by the ACT Team. This worker was a qualified Social Worker who was working in a generic role

within the team.

12.4 The Independent Investigation Team were told by interviewees that Mr A's case was allocated to this worker as the worker already knew Mr A and had a professional relationship with him. There is no evidence in the clinical records that Mr A was subject to a full multidisciplinary assessment, by the Recovery Team, at this time. The Independent Investigation Team was told at interview that Mr A's diagnosis was perceived by the team to be primarily of excessive alcohol use, despite him being continually treated for psychosis. However, there is no evidence that action was taken to try and develop a deeper understanding of what Mr A's primary diagnosis was, and formulate an appropriate treatment plan as a result of this.

12.5 The Trust's CPA Policy[20] states;

12.6 'On referral to a specialist mental health, substance misuse or learning disability service, the allocated worker will undertake a formal assessment of need known as an Integrated Assessment. The information required on this assessment will vary according to the specialist area it is being applied to. In some areas it will be one assessment that will be updated periodically; in others it will be a modular assessment (see Section 19).

12.7 The aim is to provide baseline information which can reliably inform further evidenced based assessments relating to presenting mental health concerns and associated difficulties.

12.8 This assessment is designed to be undertaken by professionally qualified mental health workers and will follow the service user through mental health services. It should not require frequent updating. It should only be repeated or updated if clinically indicated e.g. ***prior to an admission*** *to an inpatient unit, as a* ***referral to another team*** *or to assist in the* ***transfer*** *of a service user to another area.*

12.9 The assessment is generally divided into sections to include mental health, social and physical health screening. The latter is about recognising the interrelationship between mental and physical wellbeing as well as being designed to satisfy Essence of Care and physical health screening. It is designed to find out which areas present a difficulty and concern and will inform mental health workers about the level of care which needs providing'.

12.10 The Independent Investigation Team found no evidence that an integrated assessment was carried out, by the Recovery Team, when Mr A was accepted under the care of the team in October 2007 and that therefore, Trust policy was not complied with. It is the view of the Independent Investigation Team that a thorough assessment and diagnostic review at this stage would have resulted in a clear treatment plan for Mr A.

[20] Gloucestershire Partnership NHS Foundation Trust (2007) *Policy & Procedures for Care Coordination (CPA)* – version 3

Recommendation

The Trust should ensure that a thorough assessment takes place for all service users newly admitted to the service even if they have had historic involvement with the Trust.

12.11 Alcohol use and access to substance misuse services

12.12 It is the view of the Independent Investigation Team that a key issue in this case has been that workers did not have a clear understanding of Mr A's alcohol use and what his use represented to him and the origins of this. In the Independent Investigation Team's view, Mr A exemplified all the key difficulties of managing an individual who has a mental illness and misuses alcohol. Research has clearly demonstrated a relationship between alcohol and violence, mental illness and violence and the combined effects of the two. The links are complicated; alcohol can act as an intoxicant but also has considerable other effects that impinge on those with mental illness, for instance affecting compliance with medication. A common response is to recommend greater involvement of substance misuse services or, if available, dual diagnosis teams, and this seems part of the response the Recovery Team used to help in the management of Mr A. Alcohol and substance misuse is a recognised component of most risk assessment protocols and this is clear within those used by the services in the case of Mr A with recognition at a number of points that alcohol was linked directly to the risk that Mr A was to others, including Ms B.

12.13 Mr A had demonstrated on a number of occasions the link between his alcohol use and violence in earlier assaults, threats and also destructive behaviour. It is also clear from the information available that there was a relationship between his mental illness and violence independent of his use of alcohol; thus in the admission to hospital in 2005 he had been physically aggressive at a time when he was experiencing auditory hallucinations and also apparently not under the influence of alcohol. However on the majority of occasions the risk that he presented was more directly related to alcohol. There was therefore evidence of an increased risk of violence combining the effects of alcohol and mental illness, though in the Independent Investigation Team's opinion the risk tended to be perceived in one dimension, that of alcohol use.

12.14 The risk from his alcohol use had been recognised by services, Ms B, Mr A's family and potentially even Mr A himself. In the admission to hospital in 2005, Ms B had raised the risk of violence when Mr A had been drinking.

12.15 The Independent Investigation Team formed the impression from the information available that, considering the traditional view of autonomy and motivation around alcohol, the net effect was that mental health services waited for, or expected, Mr A to approach statutory or voluntary services for management of his alcohol use.

12.16 These issues are without doubt relevant in terms of the management of Mr A during his time within mental health services. The Independent Investigation Team note that Mr A's use of alcohol tended with time to eclipse and assume greater prominence than the underlying mental illness which had been thought present. Even after the Ms B's death, alcohol continued to be the primary focus.

12.17 Looking at the time of his initial contact with mental health services in 1992, alcohol at that time was not seen as an issue. It was not until around 1999 that alcohol began to be identified as an issue, but even then it was seen more as an example (along with self harm) of a coping strategy.

12.18 Looking at Mr A's use of alcohol it can be seen that his use had been problematic for many years. In many individuals, alcohol intake is a means of addressing distress from an underlying mental illness. However, even late on, interviewees commented that alcohol as self medication for Mr A was a potential issue.

12.19 This was also noted in the admission in September 2007, when Mr A clearly said that he had been drinking more to cope with hearing voices. This seems to have less and less currency as involvement with services continued. Over the subsequent years alcohol began to be seen as more of the primary problem and the underlying mental illness, which had been identified on a number of occasions, began to lose its emphasis and relegated to a secondary issue. There were, in the Independent Investigation Team's opinion, a number of occasions and examples when Mr A's mental illness was more controlled and his alcohol use began to diminish. The Independent Investigation Team note that as far back as 2000, the use of a depot antipsychotic medication had clearly led to a reduction in Mr A's alcohol use. There were other examples of when his psychosis had lessened or worsened and there had been a consequent reduction or increase in his alcohol use.

12.20 As time went on the entries in Mr A's medical records were far more skewed to the relationship with Ms B and also the presence and effects of alcohol. The Independent Investigation Team formed the impression from the information available that a significant factor on Mr A's alcohol use was that of the victim. It is not uncommon in those who use alcohol heavily to have partners who also have problematic use. The Independent Investigation Team noted that alcohol consumption tended to occur within Mr A's own accommodation.

12.21 The presence of and alcohol use by Ms B would have had marked difficulties in the success of strategies, from either services or Mr A himself, to address alcohol use or abstinence. It is not clear whether there was encouragement of alcohol use either from Mr A or Ms B or both. At points mental health services had recognised this and the Independent Investigation Team note the comment in the clinical notes made in December 2005, that the concern at that time was Ms B's drinking. There is little doubt that mental health services had recognised the difficulties in the relationship between Mr A and Ms B and this can be seen in entries in 2005. It is clear also that Mr A himself had recognised the difficulties that MS B presented in his mental health and alcohol use (thus ending the relationship with Ms B in July 2005 and also in the interview which the author of the note in the clinical record had with Mr A where he stated he was keen to avoid Ms B). The Independent Investigation Team note that in November 2005 Mr A said he had wanted to end the relationship with MS B but had concerns over joint tenancy. Later, and after another separation, Mr A said he was happy that Ms B had gone. Despite a number of separations and considerable difficulties in the relationship between Ms B and Mr A, they continued to remain involved with each

other; it would be speculative to consider who might have been responsible for the instigation of the violence between them and it is likely to be a combination of the two.

12.22 Another key issue is the effect of withdrawal of alcohol; the authors noted a number of occasions that Mr A had required formal detoxification and thus the positive direction of suddenly stopping alcohol could have actually been more problematic and impacted upon his fragile mental state. Often those who use alcohol considerably underestimate their actual use; it is likely that Mr A's use was possibly greater than realised. Thus the seizure that he experienced in February 2008 (when he reported not having drunk for two and a half weeks) may have been withdrawal related. It is not clear that, beyond one acknowledgement of this (when he was advised to not suddenly stop drinking), mental health services took this factor into consideration in their management of Mr A.

12.23 Overall the Independent Investigation Team formed the impression from the information available that, although there was acknowledgment of the issues, i.e. alcohol, mental illness and the relationship with Ms B, there was no significant formulation to pull these issues together and the information available to the Independent Investigation Team suggests a monitoring role rather than that of active intervention. This might have been better considered within a case conference. A case conference would also have potentially pulled together the different teams and even those that had been involved in Ms B's care. The CPA documentation is very limited in its attempts to pull together these issues. The lack of a meaningful formulation with regards to Mr A had a number of effects. Significantly it meant that mental health services had entered a state of inertia in their management of Mr A. Crucially it did not see or develop opportunities and seemed to wait for this to occur of its own accord.

12.24 In earlier years the interrelationship between alcohol use and symptoms had been recognised and there were concerted efforts to address this. As an example the Independent Investigation Team noted the use of Acamprosate in 2003 following an admission to hospital and a detoxification. Following this there was a period of stability in the early part of 2004. In the later years the monitoring seemed much more passive and one of recording only rather than developing a plan of action. The Independent Investigation Team recognise that individuals who use alcohol often run such a course where autonomy and responsibility is a good indicator of motivation. The Independent Investigation Team consider that the presence of Mr A's mental illness made this position less sure.

12.25 Considering that Mr A had complex needs that did not fall entirely within one service, it is still not clear as to what role the dual diagnosis services had, and how these were accessed and could play a meaningful role in the management of Mr A. The role of GDAS remains unclear and seems to, at some points, be seen as a service in itself or having an advisory role to be consulted. Mental health services pointed Mr A towards GDAS in October 2007 but they did not have an assertive role in the management of Mr A. Mr A had been referred to GDAS on a couple of occasions but he did not attend for any interventions, other than assessments, and the workers who were providing mental health care were unaware of this.

12.26 The Independent Investigation Team was told during the interviews that before 2002 there had been no dual diagnosis specialist within the Trust. It was also explained that GDAS was

not a statutory service but a non statutory voluntary service commissioned by the local Drug and Alcohol Team (DAAT). This service comprised of the Substance Misuse Service, a statutory and a prescribing service, and GDAS (a voluntary service) though both commissioned by the NHS Trust and both involved in triaging patients.

12.27 The Dual Diagnosis Specialist Nurse for the Trust told the Independent Investigation Team that he did not receive any written referral or log of a referral regarding MR A and that every person is referred to him personally. A telephone call in December 2007 was made to him by the Recovery Team Worker to request his involvement, but the Dual Diagnosis Specialist Nurse was not there at the time and had been off sick. Later attempts were made by him to contact the Recovery Team Worker to no avail. The Care Co-ordinator told the independent investigation team that when she learned that the Dual Diagnosis Nurse was off sick she referred MR A to a colleague who at that time worked both in the Substance Misuse Service and a Recovery Team. The Dual Diagnosis Specialist Nurse reported that he provided a supervisory and advisory service to the various teams but would not see everyone himself and links with them by means of a link worker system which has been developed since MR A's offence. He clarified that this was to utilise existing skills in the teams, but if complicated enough then he might get directly involved. Looking at the role with GDAS he clarified that there were communication issues and thus GDAS could not access records from the statutory services or provide information to them.

12.28 Mr A told the Independent Investigation Team that he would have welcomed the offer of residential rehabilitation to help him overcome his alcohol dependency. It is noted that this was offered to Mr A in April 2008 and that he refused this stating that he did not wish to leave Ms B. However the Independent Investigation Team found no evidence that such an intervention had been considered or offered to Mr A earlier. Some of the workers involved with Mr A told the Independent Investigation Team that they did not think that he was highly motivated to change although there is no evidence that this was formally assessed in any way.

12.29 Throughout Mr A's care the Independent Investigation Team found that there were often references placing the onus of responsibility on Mr A himself to gain help for his alcohol problems. The Independent Investigation Team are of the view that there was an over reliance on this and his assurances that he was engaging with GDAS. The Independent Investigation Team is of the view that the extent of Mr A's alcohol issues, and the added presence of mental illness, meant that sustained motivation to initiate self help was unlikely. It is acknowledged that communication between GDAS and the Trust, and about service users accessing GDAS, is a complex issue, but the Independent Investigation Team is of the view that if workers had known Mr A was not accessing GDAS as reported by him, they may have attempted to offer alternative provision or support.

Recommendation

Commissioners of local substance misuse services should review the communication protocols between statutory and non statutory commissioned substance misuse services and agree a minimum standard of communication and liaison with regard to shared service users.

12.30 The Journal of Psychopharmacology[21] makes recommendations for patients with schizophrenia and co morbid substance use;

- *A comprehensive assessment, including why and how substances are taken, as well as objective biological markers of substance misuse should be undertaken routinely in all patients.*

- *Antipsychotic medication should be optimized and Clozapine considered in patients with persisting substance misuse.*

- *Treatment focused on substance misuse should be offered. Whilst psychosocial approaches will be the mainstay, pharmacotherapy should be considered and offered where possible, e.g. nicotine substitution/withdrawal, alcohol detoxification and relapse prevention.*

Recommendation
The Trust should review services offered to services users with dual diagnosis to ensure that they are receiving treatment consistent with national guidance and that the organisation has a training programme in place to ensure this can be consistently delivered.

12.31 Medication compliance

12.32 Mr A's compliance with prescribed medication was a key issue as his concordance with antipsychotic medication was erratic throughout his care. The Independent Investigation Team found no evidence that Mr A's actual lack of concordance was explored in any constructive manner with him or how alcohol played a part in this. It appears that only when he had been on an antipsychotic depot injection was there complete confidence that Mr A was getting the antipsychotic medication he was prescribed. Concordance with any form of psychotropic medication is often poor, but with Mr A this seemed to be far more obvious and taken at face value. Even after the offence and in the police station there seemed to be passive acceptance from Mr A's account that he had been taking his medication and thus once more, alcohol eclipsed his mental illness.

12.33 In the Journal of Psychopharmacology[22] it states;

12.34 'factors that may impact negatively on adherence to antipsychotics are illness-related factors such as delusions, disorganisation and depression, having a poor relationship with the prescriber, denial of illness, negative attitudes towards medication from family members or peers, having comorbid substance misuse problems and being young and male (Bebbington, 1995; Mutsatsa et al., 2003; Perkins et al., 2008; Valenstein et al., 2006)'

[21] Thomas RE Barnes and the Schizophrenia Consensus Group of the British Association of Pharmacology (2011) Evidence-based guidelines for the pharmacological treatment of schizophrenia: recommendations from the British Association of Pharmacology. *Journal of Psychopharmacology,* May 2011, 25(5), pp.567-620

[22] Thomas RE Barnes and the Schizophrenia Consensus Group of the British Association of Pharmacology (2011) Evidence-based guidelines for the pharmacological treatment of schizophrenia: recommendations from the British Association of Pharmacology. *Journal of Psychopharmacology,* May 2011, 25(5), pp.567-620

12.35 Barnes et al recommend the following to improve medication adherence by service users;

- *Where possible offer a choice of medication, based on the known relative liability for adverse effects. Take into account the known adverse effect profiles of individual antipsychotics, a patient's past experience of adverse effects, and the risk of drug interactions and past medical history.*
- *Wherever possible, the prescriber should agree jointly with*
- *The patient on the choice of, and desired outcomes from pharmacological treatment and how these can be achieved.*
- *The medication regimen should be kept as simple as possible with respect to both the number of tablets to be taken and the number of times each day.*
- *The efficacy of medication should be monitored and any identified side effects should be actively managed as appropriate.*
- *The patient should be asked at regular intervals how much of their medication they have taken in the last week, and their view sought regarding the efficacy of this medication.*
- *Consideration should be given to using one of the validated rating scales or checklists to assess a patient's attitudes towards medication.*
- *In patients with a history of non-adherence leading to relapse, consideration should be given to using more objective methods to monitor adherence to oral medication regimens such as pill counts, and for some antipsychotics, plasma drug levels.*
- *A depot/long-acting injection formulation should be considered when this is preferred by the patient, previous non-adherence has led to frequent relapse or the avoidance of non-adherence is a clinical priority.*
- *Interventions to improve adherence should be patient specific, in that they should target the barriers to achieving adherence as perceived or noted by the clinical team to be present in that patient.*

Recommendation
The Trust should ensure that there is guidance and training available to staff detailing a consistent approach to manage service users who are not concordant with their prescribed medication and monitor the efficacy of its use by a process of clinical audit.

12.36 Relationship issues

12.37 The Independent Investigation Team has little doubt that the dynamic between Mr A and Ms B, and their mutual and consistent alcohol use, contributed to the violence in their relationship. The violence between them was regular and attracted a significant amount of

police involvement. Mr A expressed on many occasions his ambivalence about the relationship and its volatility was well known to CAT Team and Recovery Team workers involved with Mr A.

12.38 National guidance[23] states that mental health services providing care to those with psychotic illnesses should;

12.39 'Offer family intervention to all families of people with schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings'.

12.40 The Independent Investigation Team note that family interventions were offered and delivered to Mr A and his father during the period of his care. This constitutes good practice and is in accordance with the guidance. However, there is no evidence that a similar approach was offered to Mr A and Ms B.

12.41 Clinicians and workers who were interviewed, and the written evidence reviewed by the Independent Investigation Team, demonstrates that they did not feel that it was appropriate for them to attempt to intervene in Mr A and Ms B's relationship in any way and the Independent Investigation Team have some sympathy with this view. Whilst some exploration may have taken place it was not done in the framework of structured family intervention work. The independent investigation team are of the view that if family work had been offered to Mr A and Ms B, in accordance with the national guidance, this may have gone some way in assisting them to talk about their relationship and the stressors, and develop some constructive coping mechanisms.

Recommendation

The Trust should ensure that workers are aware of their responsibility to offer family intervention to all service users with schizophrenia, and their significant others, and compliance with this should be subject to regular audit.

[23] National Institute for Health and Clinical Excellence (2002) *Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care* [CG1] replaced in 2009 by National Institute for Health and Clinical Excellence (2009) *Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care* [CG82]

13.0 CARE PLANNING AND RISK ASSESSMENT POLICY AND PROCEDURES

13.1 Safeguarding Issues

13.2 Throughout Mr A's care there were many occasions when he had his children or Ms B's child to stay at his home. There are also documented occasions of MR A having conflict with his child whilst under the influence of alcohol. It is noted by the Independent Investigation Team that there was an occasion when the local authority were involved with Ms B and Mr A with regards specifically to Ms B's child. However the Independent Investigation Team found no references in the clinical records to suggest that the potential risks to children in the home, given that Mr A and Ms B's relationship was violent and alcohol regularly used to excess, were considered or addressed.

13.3 Trust policy[24] states;

13.4 ''There is a strong link between domestic violence and child protection.

- *Nearly 75% of children on the Child Protection Register live in households where domestic violence occurs (DoH 2002a)*
- *62% of children who witness domestic violence are likely to be physically abused by the same perpetrator (Hester C and Pearson C 1998)*
- *76% of children who were ordered by the courts to have contact with a violent parent, were said to have been further abused as a result of contact being set up. (Radford, Sayer & AMICA, 1999).*

13.5 An amendment of the Adoption and Children Act 2002 extended the legal definition of harm to include the impairment suffered from seeing or hearing the ill treatment of another. This is significant, as in a study of incidents involving domestic abuse, 90% of children were in the same room or next door (Hughes 1992),

13.6 It is important to consider the long term effects of witnessing domestic violence. A study of 64 children aged 7-12 years who had witnessed domestic violence towards their mother during the previous year, showed traumatic symptoms e.g. unwanted remembering of traumatic events and hyper-vigilance in 52% of cases. Longer term, children who had witnessed domestic violence had significantly worse psychosocial outcomes, similar to those of physically abused children (Kitzmann et al, 2003). Those children who have been both physically abused as well as witnessing the violence tend to show the highest levels of behavioural and emotional disturbance (Sternberg et al. 1993; O'Keefe, 1994)''

And

13.7 ''Substance misuse by parents does not, by itself, necessarily lead to concerns about parenting, child abuse and neglect. However, children are more at risk of harm and neglect if

[24] Gloucestershire Partnership NHS Trust (2006) *Children Protection Toolkit* – version 4

parents misuse drugs or alcohol. The category of neglect now includes the impact on the unborn child as a result of maternal substance abuse.

- *It has been estimated that there are between 200,000 and 300,000 children in England and Wales where one or both parents have serious drug problems (Hidden Harm 2003)*

- *Alcohol Concern (2001) estimate that almost a million children are living with an alcoholic parent*

- *Two thirds of children involved in care proceedings have parents with substance misuse problems.*

13.8 Impact on Children:

- *Serious effect on unborn child due to poor nutrition and lifestyle*

- *Lack of basic care and poor school attendance*

- *Child taking on caring role of siblings or parents*

- *Exposure to criminal or other inappropriate behaviour*

- *Impact on Parent/s: Can affect:*

  - *Parent's caring skills*
  - *Perception and judgement*
  - *Attention to basic physical needs*
  - *Control of emotion*
  - *Attachment to child*

- *The risk is greater where the substance misuse is chaotic and out of control and where both parents are misusing.*

- *Parent's needs may be prioritised above their children's needs and there may be less money available.*

- *There is a risk of physical harm if drugs and paraphernalia or alcohol are not kept safely out of a child's reach*

- *Children may also be at risk from adults who are visiting the house when parents are not in a position to protect them''*

13.9 National guidance pertaining to the families of people with mental health problems[25] states;

13.10 'The responsibility for safeguarding children does not only lie with children's services. It is a requirement of safeguarding children policy that adult services, including mental health services, know whether their service users have children or are in contact with children. This again highlights the importance of routinely identifying and recording which people who use mental health services are parents and which children have parents with mental health problems.

13.11 This is not to imply that adult mental health problems are the only serious risk factor for children's safety. The research evidence suggests that other factors (e.g. parental drug and alcohol misuse, domestic violence, and/or learning disability) are often present in serious child abuse or neglect situations. It is therefore important to be able to recognise and understand what contribution adult mental health problems make to an assessment of overall risk of harm to children.

13.12 The lessons from cases where children have been killed by their parents, or suffered significant harm, suggest it is also important to train and support for staff so that they are:

- *constantly vigilant*
- *open and inquisitive, regardless of any assumptions based on previous assessments*
- *aware of the need to reassess following new or increasing numbers of incidents and following changes in circumstances*
- *able to challenge colleagues within partner agencies if required*
- *aware of their responsibility to pass on concerns about the welfare of a child to Children's Social Care'*

And

13.13 In a successful service:

- *Staff quickly identify the most vulnerable families, and intervene to prevent a crisis. All assessments comment on the mental health of both parents and any other adult member of the household, and record whether the parents live together and the degree of contact with children.*
- *All staff are equipped to identify cases where children are suffering, or are likely to suffer, significant harm and are able to respond quickly and effectively*.

13.14 The Trust Clinical Risk Assessment Policy[26] refers staff to local safeguarding procedures in general terms but does not make reference to the need for staff to consider the needs of children living at, or regularly visiting, the homes of service users with severe mental health problems.

[25] Social Care Institute for Excellence (2011) *Think Child, Think Parent, Think Family: a guide to parental mental health and child welfare*
[26] Gloucestershire Partnership NHS Foundation Trust (2007) *Clinical Risk Assessment and Management Policy*

13.15 The Independent Investigation Team acknowledge that neither Mr A or Ms B's children lived with the couple full time but they visited the home and stayed overnight on a number of occasions. The Independent Investigation Team found no evidence that consideration to the potential risks to the welfare of the children was documented in care or risk assessment or management plans and consider this to be a failing.

Recommendation

The Trust should ensure that the welfare of any children living with, or regularly visiting a service user, is considered as part of the risk assessment process and audit compliance with this on an annual basis.

13.16 Community clinical risk assessments

13.17 Summary of community clinical risk assessments in respect of MR A;

March 1999	Medium risk of suicide	
July 1999	Low risk violence to others, medium risk self neglect and suicide	
April 2002	Low to medium risk self harm and suicide, medium risk of suicide, low risk of violence	
July 2005	Medium risk of suicide, violence and self neglect	
Oct 2005	The independent investigation team have been informed that a risk assessment was carried out but have not been able to locate this within the clinical record.	
December 2007	Medium risk of self neglect and suicide and low risk of serious assault	Management plan; To see Consultant Psychiatrist for assessment and medication review Dual Diagnosis Nurse to be contacted for advice To continue being seen by the Recovery Team, reduce stress levels by problem solving, helping with bills etc Carers Support Worker to offer MS B a second appointment as supporting her might have a positive effect on MR A Encourage MR A to make use of GDAS If MR A does not answer the door or is known to be drinking try telephoning or visiting every day or two until he has stopped drinking If psychotic he may need admission He may come to the attention of the police because of arguments to MS B or damaging his house

13.18 The Trust policy on clinical risk assessment[27] dictates that clinical risk assessment should be completed on admission to services and that clinical risk assessment should then be reassessed as follows;

- *When there is a change in location or nature of treatment, e.g. prior to discharge from in-patient status, discharge from service.*
- *When transferring care from one team to another.*
- *When there is evidence of progressive increase in risk, e.g. repeated assaults or suicide attempts.*
- *Any significant change in clinical or social factors.*

13.19 On admission to inpatient units via the integrated care pathway.

13.20 The Independent Investigation Team were surprised to find that Mr A was assessed as being low risk of serious assault in December 2007, and that the risk management plan despite specific violent incidents having been recorded, did not address the issue of risk of violence to Ms B despite the Care Co-ordinator discussing with Mr A the risk he posed to Ms B only a week earlier.

13.21 On interview, the Care Co-ordinator told the Independent Investigation Team that she recorded that the subjective assessment of risk of serious assault was low because Mr A's violence to Ms B had not resulted in serious injury so did not constitute serious assault. The Independent Investigation Team accepts that the allegations from Ms B about Mr A's violence were not as severe as they later became in 2008 at the point that this clinical risk assessment was completed. He had, at that point, however, been arrested several times for allegedly assaulting Ms B, had been charged with Actual Bodily Harm and had shown aggression towards members of nursing staff whilst in hospital. It is well known that the frequency and severity of domestic violence often increases as a relationship goes on and it is the view of the Independent Investigation Team that continuation of the violence towards Ms B, and potential increase in its intensity at times of stress or mutual alcohol use, could and should have been predicted.

13.22 It is the view of the Independent Investigation Team that the quality and frequency of clinical risk assessment with regard to Mr A fell below the accepted standard. Mr A was not reassessed at the junctures outlined within the policy, as outlined above. Additionally, key risk issues, such as the ongoing risk of violence between Mr A and Ms B, were not included in the management plan and no specific management strategies identified.

Recommendation
The Trust should carry out an audit of the quality and relevance of clinical risk assessments and management plans that are in place for current service users within three months of publication of this report.

[27] Gloucestershire Partnership NHS Foundation Trust (2007) *Clinical Risk Assessment and Management Policy*

The Trust should ensure that all Care Co-ordinators receive regular caseload supervision that includes documented formal review of care plans, clinical risk assessments and clinical risk management plans.

13.23 CPA and care planning

13.24 Mr A was identified as being on Enhanced Level CPA since 2002, with the exception of a period of time from November 2006 when he was regraded to Standard Level CPA prior to being discharged from the CAT Team to the care of his GP in January 2007. When he was admitted back to the service by the Recovery Team in October 2007, Mr A was placed directly on Enhanced Level CPA.

13.25 The Trust CPA policy[28] outlines the criteria for Enhanced Level CPA as follows;

1. Complex and/or fluctuating care needs

13.26 Service users will be allocated this level of care if:

- *They have multiple care needs including housing, occupation etc requiring inter-agency co-ordination;*
- *They are only willing to co-operate with one professional or agency but they have multiple care needs because of risk of violence, self neglect or suicide;*
- *They are likely to require more frequent and intensive interventions from specialist mental health workers due to their mental health issues;*
- *They have a dual diagnosis;*
- *They are more likely to disengage with services;*
- *They have a severe mental illness and are a lone parent or live only with a dependent disabled person.*

2. An Enhanced level of care will be applied for service users who are subject to:

- *Section 117 MHA (1983);*
- *Section 25A MHA (1990);*
- *Section 37/41 MHA (1983);*
- *Receiving treatment as an Inpatient, or from the Assertive Community Treatment, Early Intervention Service and/or Crisis Resolution and Home Treatment Team.*

[28] Gloucestershire Partnership NHS Foundation Trust (2007) *Policy & Procedures for Care Coordination (CPA)* – version 3

13.27 Mr A clearly met the criteria for Enhanced Level CPA, prior to his discharge from the CAT Team, as he had a severe mental illness, a dual diagnosis and was receiving care from the ACT Team.

13.28 The Independent Investigation Team has been unable to understand the rationale for Mr A's sudden regrade to Standard Level CPA and then discharge at end of 2006/early 2007. At that time, he still met the criteria for Enhanced Level CPA and had reported an increase in voice hearing and had denied drinking although he smelled of alcohol only a few weeks earlier.

13.29 Mr A's GP told the Independent Investigation Team that at the point Mr A was discharged to his care, he was informed that Mr A had a psychotic illness and drank to excess but that he was not made aware of any issues of violence. He says he did not find out about this until he spoke to Ms B when Mr A was admitted to hospital in 2007. The independent investigation team were told that the statement that Mr A '*could be aggressive'* was included in discharge documentation but the GP states this was never conveyed to him during the meeting with clinicians from the CAT team.

13.30 The internal investigation report, commissioned by the Trust following the incident, contains references to the fact that the CAT team were under pressure to reduce caseloads at the time of Mr A's discharge from the service. The Independent Investigation Team is unable to establish the reason that Mr A was discharged from the service at that point specifically or to establish whether this was linked to the reduction of caseloads or not. However it is the view of the Independent Investigation Team that the GP was not furnished with the appropriate risk information at the point of discharge to his care.

13.31 Mr A's Care Co-ordinator told the Independent Investigation Team at interview;

13.32 'I would have been happier if he had gone (from the ACT team) to a Recovery Team, which is where I was going. I moved at that point in the reorganisation by choice, from the team to the Recovery Team, and I would have preferred that to have happened, but I respected the psychiatrist's decision, that the GPs were taking on people with serious mental illness and there had been a period of stability'.

13.33 The Independent Investigation Team note that since this incident the Trust have included specific standards for discharge in their most recent policy[29].

13.34 "If it is appropriate that person discharged from services at the end of treatment then the following this must discussed and agreed with the service user. An appropriate hand over to the person continuing the care input must be competed including any support or contingency plans. This must happen and be evidenced in the notes

- *A discharge summary completed to the approved Trust format*
- *An appropriate review and handover to primary Care worker / GP*
- *Exchange of appropriate information with all concerned, including with carers;*
- *Plans for review, support and follow-up, as appropriate;*

[29] 2gether NHS Foundation Trust (2008) *Care Management/Care Programme Approach (CPA) Policy* – version 4

- *A clear statement about the action to take, and who to contact, in the event of relapse or change with a potential negative impact on that person's mental well-being.*
- *The case closed on the Trust information system''*

14.0 COMMUNICATION BETWEEN AGENCIES, SERVICES, FRIENDS AND FAMILY INCLUDING THE TRANSFER OF RELEVANT INFORMATION TO INFORM RISK ASSESSMENT

14.1 Communication and case management in the two months preceding the offence

14.2 Mr A assaulted Ms B at the end of April 2008. This led to Mr A's arrest and being released on bail on the condition that he would not see Ms B. On 8th May 2008 he told staff that Ms B had contacted him but that seeing her was a breach of his bail conditions, he continued to deny that he had seen Ms B when seen by his Care Co-ordinator on 15th May 2008.

14.3 Just over a week later, a Community Support Worker in the team who knew Mr A's family reported that Mr A had again badly physically assaulted Ms B to the extent that his knuckles were bleeding. The email communication stated that Mr A had assaulted Ms B again, that Mr A's son had left the house after receiving violence and that Mr A's father had been threatened with a knife on his last visit. The Community Support Worker states in the communications that this information was received from Mr A's father and that he had relayed it to the Recovery Team Manager who suggested that workers from the team should not attend Mr A's home unaccompanied due to risk of violence if Mr A had been drinking. The email also stated that Mr A was due in court on 9th June 2008 due to a previous assault charge.

14.4 MR A was not seen by the Recovery Team again following this and the only other contact was by telephone on 2nd June 2008 when telephone contact was made with Mr A by his Care Co-ordinator. He denied another assault on Ms B and said that he had "kicked out'' his son and threatened to kick out his father. He said he had smashed a mirror and paramedics were called but that he was not charged with anything although the police attended the scene. Mr A stated that he withdrew his consent for Recovery Team workers to share information about him with anyone at this stage. Previously he had allowed information sharing with Ms B and his parents. Mr A said he had not drunk alcohol for ten days and his mental state appeared good. He denied further seizures but said that his feet hurt.

14.5 The Independent Investigation Team is of the view that the response of the Recovery Team Manager to the information received from the Community Support Worker was inadequate. The Recovery Team Manager was concerned enough about the potential level of risk from Mr A to tell workers in his team to not visit Mr A at home alone and to ensure he had not been drinking first, but no attempt was made to discuss the issues or verify the information with Mr A's father, son or Ms B herself after the receipt of this information. The information provided indicated that Mr A and Ms B were potentially still in contact and as this was a breach of bail conditions, and potentially a risk, this should have been further explored with Mr A's family and Ms B, and communicated to the police. It is acknowledged that Mr A had withdrawn his consent for professionals to share information about him with his family or Ms B but the obvious risk concerns involved in this situation would, in the opinion of the Independent Investigation Team, have made communication justifiable in this case

Recommendation
The Trust should ensure that staff are aware of their responsibility to communicate potential risk information and the conditions in which consent to share and confidentiality restrictions should be overridden.

14.6 The Independent Investigation Team were told during the interviews that the Care Co-ordinator tried to corroborate the information provided by the Community Support Worker by telephoning the police but information was not forthcoming from the police due to data protection concerns.

14.7 It is the view of the Independent Investigation Team that the Recovery Team Manager, following the refusal of the police to provide information, should have contacted more senior colleagues in both the Trust and the police and escalated this situation on grounds of potential risk to Mr A, Ms B, Mr A's family and Recovery Team workers visiting Mr A.

14.8 It is also the view of the Independent Investigation Team that visits to Mr A should not have ceased on the grounds of risk to workers when the information was received from the Community Support Worker on 29th May 2008. The Recovery Team Manager's concerns about the risk to his staff were justified but the Independent Investigation Team consider that visits should have not only have continued, but been increased, with risk management measures put in place to ensure staff safety during the process.

14.9 This incident was not reported within the Trust's incident reporting process.

Recommendation
The Trust should ensure that all Community Team Managers are aware of their responsibilities under the Trust's incident reporting procedure and the criteria for the escalation of concerns through the management structure.

14.10 Communication between mental health services and the police

14.11 Multi Agency Risk Assessment and Management procedures (MARMAP)

14.12 Some of the interviewees interviewed as part of the internal investigation told the investigation's investigator that in hindsight it may have been beneficial to instigate Multi Agency Risk Assessment and Management Procedures (MARMAP) in relation to Mr A and Ms B.

14.13 MARMAP is a multi agency process which was in use in Gloucester since 1999 and at the time of the incident involving the Trust, health services, the local authority, voluntary and third sector organisations and the police.

14.14 The process provided a framework for a multi agency approach to addressing adult safeguarding issues and monitoring those who could potentially be at risk of harm or cause harm to others.

14.15 The referral criteria were:[30]

14.16 'mentally ill adults, adults with personality disorders, adults with learning disabilities, dual diagnosis of the above

And

14.17 Whose behavior presents a risk of serious harm to themselves or others

14.18 Other considerations are;

- *The mental illness, personality disorder, learning disability, and/or a dual diagnosis of these contributes significantly to the behavior that is causing concern*
- *This risk of serious harm remains, despite structured attempts to manage risk*
- *This must have included the completion and initiation of a formal risk assessment and management plan, which must consider both actuarial and clinical indicators of risk*
- *Multi-agency input will enhance the management of risk*

14.19 The Independent Investigation Team was told during the interviews that the MARMAP process no longer exists in the area but that the process outlined within it should still be being used as part of the adult safeguarding procedures.

14.20 However it is unclear if this case would have been able to have been dealt with under current adult safeguarding procedures as local procedures[31] state the definition of a vulnerable adult as;

*14.21 A vulnerable adult is a person "who is or may be in need of community care services by reason of mental or other disability, age or illness, **and** who is or many be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation*

And

14.22 What does not come under the policy;

14.23 Risks Arising from Self-Neglect or a Person's Own Behaviour or Lifestyle

*14.24 A vulnerable adult will be considered under this procedure where they are unable to provide adequate care for themselves **and** one or more of the following situations apply:*

- *They are unable to obtain necessary care to meet their needs.*
- *They are unable to make reasonable or informed decisions because of their state of*

[30] Adult Protection Unit (2006) *Marmap News Bulletin*
[31] Gloucestershire Safeguarding Adult Boards (2010) *Professional Guide for Alerter's & Reporters – 2010: Safeguarding vulnerable adults from abuse*

mental health or because they have a learning disability or an acquired brain injury.

- *They are unable to protect themselves adequately against potential exploitation or abuse.*

- *They have refused essential services without which their health and safety needs cannot be met.*

14.25 The application of the above criteria would be open to interpretation in Ms B's case. It appears that she misused alcohol and there are several references in Mr A's clinical records to her suffering from depression. Her involvement with services regarding these issues, however, is not known.

14.26 In the view of the Independent Investigation Team there is little doubt that Ms B met the criteria for being considered a vulnerable adult. However this is open to interpretation and it is the view of the Independent Investigation Team that the vulnerabilities that Ms B experienced were not recognised by the Recovery Team and the risks to her because of these, and Mr A's violence, were continually underestimated.

Recommendation

The body responsible for adult safeguarding in the area, and the agencies who are involved with it, should consider this case in detail, to ascertain if there is any learning or implications for future practice, particularly in cases where it is not clear which procedure best applies.

The Trust should ensure that staff are aware of the appropriate referral pathways to utilize for service users who are experiencing, or are the perpetrators of, domestic violence.

14.27 Multi Agency Risk Assessment Conference (MARAC)

14.28 MARAC is a process led by the police in response to domestic violence. Local police policy[32] states;

14.29 The specific aim of Multi Agency Risk Assessment Conferences (MARACs), is to prioritise the safety of victims who have been risk assessed at high or very high risk of harm, whilst also working with the aims stated above.

14.30 The MARAC is an integral part of the Specialist Domestic Violence Court Programme, and information will be shared between the MARAC and the Courts, in high and very high risk cases, as part of the process of risk management.

14.31 It is the purpose of this agreement to facilitate the exchange of information between partner agencies that will enable the partnership to fulfill its statutory duty and work together (Section 17 of Crime and Disorder Act 1998) to ensure public safety and for the prevention of crime and disorder.

[32] Gloucestershire Constabulary (2008) *Multi Agency Risk Assessment Conference (MARAC) Information Sharing Agreement*

14.32 Specifically the aims are to achieve the following:

- *Reduce and manage risks to victims of domestic violence, in a multi agency setting to prevent and deter incidence of domestic violence.*
- *Share personal information relating to individual incidence of domestic violence to enable actions by Partners that reduced the fear of crime (domestic violence).*
- *Share information to support and encourage partnership working.*
- *Share information relating to families experiencing domestic violence to enable work that reduces the impact of crime on children and young people.*
- *Share information that will enable Partners to hold perpetrators accountable for their actions.*

14.33 Due to the ongoing violence towards Ms B, the local police called a MARAC conference in respect of Ms B in the few months preceding her death. Police told the Independent Investigation Team that health services involved in the care of Mr A were invited to participate in the conference but did not attend.

14.34 Police told the Independent Investigation Team that in 2008 the MARACs were held in individual police divisions and that, as a result, processes were not standardised, as they are now, and a detailed list of invitees, attendees and apologies not always kept. They state an attempt was made to find out who the Care Co-ordinator was for Mr A by contacting the local psychiatric unit by fax but there are no apologies or record of a response noted in the MARAC meeting minutes.

14.35 There is no evidence to suggest that the invitation to the MARAC was received by the Recovery Team, or that they had any knowledge of the police holding a MARAC conference in respect of Ms B. The Recovery Team Manager told the independent investigation team that he had no knowledge of an invitation to a MARAC meeting.

14.36 Police state that mental health services were not regular attendees of MARACs at the time, and that this remains the case, but that links with the Trust have since been made and there is now a contact point for the police to access both adult and children mental health services.

14.37 Police told the Independent Investigation Team that at this stage this is an information sharing portal but that they continue to work to encourage attendance at the MARAC meetings by health services on an ongoing basis.

Recommendation

The Trust should work with the police to agree a robust process for ensuring that the police are able to identify Care Co-ordinators who need to attend MARAC meetings swiftly and monitor the effectiveness of this by a process of annual audit.

14.38 Carers

14.39 The Carers Act 2000 guidance[33] states that all carers of people receiving mental health services have the right to be offered a carer's assessment.

14.40 Ms B was offered a carer's assessment which is good practice. She refused. However Mr A's family were never offered an assessment of their support needs as carers, despite offering substantial support to Mr A for long periods during his span of care.

Recommendation
The Trust should ensure that all eligible carers receive a carer's assessment.

14.41 Staff supervision

14.42 Mr A's Care Co-ordinator was a qualified Social Worker working in the Recovery Team in a generic role. Her supervision arrangements were such that she received caseload supervision from her Team Manager, clinical supervision from a Clinical psychologist and specific practice supervision from a more senior Social Worker. However, in the weeks preceding the homicide her social care practice supervisor was off sick but the Care Co-ordinator told the independent investigation team that she could access social work supervision from the Social care Specialist, at this time, if she had needed it.

15.0 DOCUMENTATION AND RECORDING OF KEY INFORMATION

15.1 The Independent Investigation Team found Mr A's clinical records to be comprehensive and informative. There are some areas where assessments, risk assessments and care plans were not completed or missing but these issues have been addressed elsewhere in the report.

16.0 REVIEW OF TRUST INTERNAL INVESTIGATION OF THE INCIDENT INCLUDING TIMELINESS AND METHODOLOGY TO IDENTIFY WHETHER ALL KEY ISSUES AND LESSONS LEARNED HAVE BEEN IDENTIFIED, RECOMMENDATION ARE APPROPRIATE AND COMPREHENSIVE AND FLOW FROM THE LESSONS LEARNED

16.1 Investigation process

16.2 The Trust's internal investigation report was benchmarked using the National Patient Safety Agency's "*Investigation credibility and thoroughness criteria*[34]. The Trust's internal report did not score well against the criteria. The main reason for this was that the investigation was limited in its scope. There was no executive summary and the report did not contain information relating to the care and support of the victim's family or the perpetrators

[33] Department of Health (2005) *Carers and Disabled Children Act 2000 & Carers (Equal Opportunities) Act 2004 Combined Policy Guidance*
[34] National Patient Safety Agency (2008) *RCA Investigation Evaluation Checklist, Tracking and Learning Log*

family, support and engagement of staff in the internal review, liaison with police or use Root Cause Analysis methodology.

16.3 The care and service delivery problems, contributory factors, root causes, lessons learned, a summary of the recommendations and the arrangements for shared learning are not specifically identified and there is no evidence that a systematic Root Cause Analysis or other equitable method of analysis was used. The main body of the report did not have the usual subheadings that one would expect. The chronology, although limited, was clear and was of a good standard. There was no comment on the implementation, monitoring and evaluation arrangements in the report.

16.4 The National Patient Safety Agency (NPSA) issued guidance in 2008[35] outlining the investigation process that should take place following a serious patient safety incident.

16.5 The three stages of the independent investigation process are described in detail:

1. *Initial service management review: an internal trust review within 72 hours of the incident being known about in order to identify any necessary urgent action.*
2. ***Internal NHS mental health trust investigation:*** *using root cause analysis (RCA) or similar process to establish a chronology and identify underlying causes and any further action that needs to be taken. This would usually be completed within 90 days.*
3. ***SHA independent investigation:*** *commissioned and conducted independently of the providers of care.*

16.6 The NPSA state that when carrying out an internal investigation Trusts should take into consideration the following issues, which should be addressed in local policies:

- *management of patient safety incidents;*
- *consent;*
- *confidentiality;*
- *data protection;*
- *freedom of information.*

16.7 Depending on the nature of the incident, there may be other relevant policies such as vulnerable adult and safeguarding children policies and procedures that need to be taken into account.

16.8 An internal investigation oversight group should be established in the most serious incidents. This group should:

- *identify senior individuals to carry out the trust's internal investigation and decide whether any other agencies or organisations need to be included;*
- *agree a communications plan, which will include drawing up a briefing paper for the trust board;*

[35] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*

- *agree who will be the contact person for the victims, perpetrators and families;*
- *oversee the internal investigation;*
- *liaise with the SHA so that discussions about the potential need for an independent investigation occur early;*
- *include the commissioning PCT in discussions;*
- *liaise with the police, and through the police the Crown Prosecution Service (CPS), to determine how the investigation will take place without compromising any legal process.*

16.9 Reference should also be made to the DH/ACPO/HSE Memorandum of Understanding at this stage. If the Memorandum is invoked then an incident co-ordination group comprising senior stakeholders should meet to ensure co-ordination of investigations and communications. The membership of the internal investigation oversight group and the incident co-ordination group will have some overlap, although their functions differ.

16.10 The internal investigation should be completed as soon as possible after the event, usually within 90 days. It is important that this process takes place promptly so that any changes needed to policy or practice to enhance patient safety can be made and the independent investigation, if there is to be one, is not delayed. This process is a necessary precursor to the independent investigation. It will ensure that early action can be taken where needed, within a timescale in which it would not be feasible to have commissioned and completed an independent investigation. It is also a means of informing the scope and terms of reference for the independent investigation.

16.11 A systematic approach to investigation, such as RCA, should be used (see appendix 3 and the NPSA website for further details on RCA). The staff conducting the investigation should be of appropriate seniority and fully trained in the techniques used.

16.12 The internal investigation should follow the process described below:

1. *Scope the incident, and decide how far back to investigate.*
2. *Decide on the terms of reference.*
3. *Gather information and map events, including developing a detailed chronology.*
4. *Analyse the available information to determine any underlying causes.*
5. *Recommend solutions, for example potential changes to the environment, practice, policies, procedures or staff.*
6. *Produce a final report outlining clear and sustainable recommendations.*

It may be necessary for the trust investigation team to obtain external advice on certain issues; however, it should be unusual for individuals from outside the employment of the trust to be members of the investigation team.

16.13 In this case, the Trust commissioned an independent doctor to conduct the internal investigation on their behalf. The terms of reference were as follows;

16.14 Review the care of Mr A since he was under the care of the current trust and its predecessors. This will include an assessment of risk assessments and risk management

strategies adopted by the Trust[36].

16.15 It is the view of the Independent Investigation Team that the internal investigation was completed promptly and met the terms of reference set out by the Trust.

16.16 However the terms of reference were limited in scope and did not fulfil the requirements set out in the NPSA guidance[37] and did not follow Root Cause Analysis or evidence based analysis methodology.

16.17 During interviews, the Independent Investigation Team was told by managers within the Trust that they are aware of the limitations of the terms of reference set in this case and have learned lessons about method and process of investigation since the incident.

16.18 The Independent Investigation Team has been provided with the Trust's current policy, which outlines governance and incident investigation processes and the Independent Investigation Team are satisfied that the policy has been updated in line with good practice.

16.19 Summarised key findings and recommendations in the Trusts internal investigation

1. The investigator who conducted the Trust's internal investigation stated in his report that he was impressed by the dedication of the staff and the intensity of follow up in this case and added that he found very little to criticise in terms of the management of MR A. He states that his findings are made with the benefit of hindsight, but that care could be improved.
2. There was an over reliance on poor and incomplete personal and family histories. The investigator stated that training for junior doctors and other mental health practitioners should be improved in the areas of history taking and recording.
3. That a full enquiry should be made into the histories of those with alcohol dependence including patterns of drinking and consequences of problematic use.
4. Patients with long standing histories and multiple diagnoses would benefit from diagnostic reviews which can guide management and risk assessments. Also those taking a variety of medications require an unbiased view to assess necessity of continuing medication.
5. Improvements required in the clinical risk assessment process.
6. Thresholds need to be defined as to when a patient is presenting a sufficiently serious risk to trigger a case management review.
7. Care Co-ordinators should take responsibility for preparing an incremental chronology of risk events to be displayed at the front of the notes for ease of access and use at CPA reviews. They should also store care plans in case notes in chronological order.
8. When risk behaviour is noted the trigger factors should be explored and incorporated into the management plan and discussed with all parties concerned.
9. A prompt internal evaluation is required regarding recent organisational structural

[36] 2gether NHS Foundation Trust (2008) *Internal Investigation Report*
[37] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*

changes and the size of teams to ensure they are functioning and communicating effectively.

16.20 In the internal report[38] the Trust's internal investigator references the recommendations within The Royal College of Psychiatrists Scoping Group on Risk to Others in June 2008 as follows;

1. *The contribution of substance misuse to risk must be recognized. Co morbid substance misuse problems must be adequately treated and improved prevention and treatment made available.*

2. *The content of discharge letters to GP's must be audited regularly. Discharge letters to GP's, copied to patients and carers as agreed must include; details of risk to self or others; diagnosis; treatment; indicators of relapse; and the details of any agreed risk management plan.*

3. *Risk assessment forms should be evidence based. Mental health trusts should ensure that all risk assessment forms in use in the organisation are validated for use with each specific patient group and reflect the current evidence base.*

4. *A national standard approach is required to risk assessment. A standard approach to risk assessment should be developed throughout all the mental health services nationally, with adaption to suit different patient groups. The College recommends that the National Institute for Health and Clinical Excellence (NICE) and SIGN Health give consideration to the development of specific guidelines on the management of risk to others. The development of guidelines would require a framework for the assessment and management of risk, underpinned by a set of key principles. The framework should constitute a tiered approach with a standard set of questions. The need for further tiers would be determined by responses to an initial screening process as well as the context in which the psychiatrist works and the particular patient group.*

5. *Working collaboratively with carers and service users to reduce risk. Risk management should be conducted in a spirit of collaboration between the mental health team, the service users and the carers. Service users experiences and views of their level of risk, and their personal risk triggers, should be fully considered.*

6. *Quality improvement networks should include risk assessment. The College Research and Training Unit has been asked to consider the feasibility of incorporating structured risk assessment audit into all quality improvement networks. The Risk Management Authority in Scotland has developed 'traffic light' indicators for assessment tools, which will inform practice in Scotland, and these can be developed for use in the rest of the UK.*

7. *Urgent mental healthcare must be commissioned appropriately. The Academy of*

[38] 2gether NHS Foundation Trust (2008) *Internal Investigation Report*

Royal Colleges (2008) has published a paper calling for improvements in the provision of urgent medical health care in acute hospitals, which is relevant to this report. The recommendations of this report should be implemented by commissioners.

8. *The psychiatric curriculum must include training in risk assessment and management. Risk assessment and management must be core competencies in the curriculum for specialist training in psychiatry and the training of other mental health professionals.*

9. *Continuing professional development should include regular updates on risk assessment and management. All members of mental health teams should undergo regular training in understanding, assessing and managing risk as part of their continuing professional development.*

10. *Information sharing protocols are essential. Organizations involved in the care and treatment of mental health patients should have interagency risk management protocols in place for information sharing about potential risks.*

16.21 The Independent Investigation Team note the relevance of these recommendations to this case.

16.22 Liaison with the police after the incident

16.23 The Independent Investigation Team found no evidence to suggest that there was liaison between the police and the Trust throughout the investigation process.

16.24 In 2006 a Memorandum of Understanding[39] was agreed by the Association of Chief Police Officers, Health and Safety Executive and Department of Health laying out multi agency procedures to be followed in the event of patient safety incidents that cause death or serious harm.

16.25 The protocol specifies that in the event of a serious incident that will require police, health service and potentially Health and Safety Executive investigation, an incident co-ordination group should be set up that incorporates the appropriate bodies to provide strategic oversight and investigation co-ordination. The protocol specifies that the group should be attended by senior representatives from each organisation and each meeting be formally be minuted.

16.26 The need for the establishment of an incident co-ordination group and the responsibility for health service managers to initiate this within five days of the incident is not specified in the Trust's current incident investigation policy[40].

[39] Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006) *Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm*

[40] 2gether NHS Foundation Trust (2011) *Incidents Policy & Procedure (Including the Management of Serious Incidents)* – version 10

Recommendations

A high level discussion between the Trust and local police needs to take place to agree to implement the components outlined within the Memorandum of Understanding; *Investigating patient safety incidents involving unexpected death or serious untoward harm* published by Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006)

The Trust should ensure that senior managers and Trust directors are aware of their responsibilities outlined within the Memorandum of Understanding and these should be made explicit within Trust policy.

17.0 REVIEW OF PROGRESS AND AGAINST ANY ACTION PLAN

17.1 Actions outlined within the Trust's action plan following the internal investigation

1. Based on the review there was an over reliance on poor and incomplete personal and family histories. Training for Junior Doctors and other mental health practitioners needs improving.

17.2 Comments on progress on Trusts action plan;

17.3 Trust CPA Training for all practitioners emphasises the need for full histories. Input to medical induction from August 2009

17.4 Action taken by the trust since the incident;

17.5 The Trust has produced evidence detailing that training on the taking of medical histories is included in the junior doctors' induction programme.

17.6 CPA audit is carried out regularly within the Trust. The most recent evidence supplied is a comprehensive audit carried out in March 2011. This audit does not measure whether full personal and family histories have been carried out. It does however measure the completion of core assessments which, if completed correctly and thoroughly, should contain said histories. The audit demonstrates that 95% of the files audited in 'Working Age Adults' services contained core assessments and the figure was 92% for Recovery Team patients specifically. The Independent Investigation Team is mindful of the fact that such measures demonstrate the presence of a completed core assessment but that quantitative audit does not facilitate an assessment of the quality of the content or indeed the quality and accurateness of the personal and family histories within.

2. Patients with histories of alcohol dependence require a full inquiry into the detail of their pattern of drinking and the consequence of problematic alcohol use, both physical, psychological and behavioural. This should be an essential part of history and recorded in the notes.

17.7 Comments on progress on Trust's action plan;

17.8 Dual Diagnosis Strategy for the Trust in place.

17.9 Action taken by the Trust since the incident;

17.10 The Trust has developed two Dual Diagnosis Strategies[41] since this incident. An action outlined in the action plan within this is as follows;

17.11 To ensure that substance misuse screening for inpatient/community services is implemented in the mental health assessment

17.12 It states within the strategy that a screening tool was piloted within inpatient services in 2008.

17.13 The strategy stipulates the requirement for regular audit.

17.14 The Independent Investigation Team found no evidence to suggest that an audit relating to compliance with the standards outlined within the strategy has yet been carried out so are unable to assess the Trust's progress with regard to this action.

Recommendation

The Trust should carry out quantitative and qualitative audit to establish performance against the standards outlined within the Dual Diagnosis Strategy.

The Trust should carry out qualitative audit to establish the quality, comprehensiveness and relevance of the content of core assessments with specific reference to personal and family histories.

The Trust should ensure that a process is in place to ensure families and carers are appropriately involved in care planning and risk assessment.

3. Patients with long standing histories and multiple diagnoses would benefit from diagnostic reviews which can guide management and risk assessments. Equally, patients who have been taking a variety of medications for their condition require an unbiased review to assess the necessity of continuing on medication

17.15 Comments on progress on Trusts action plan;

17.16 Dual Diagnosis Strategy for the Trust in place.

17.17 Action taken by the Trust since the incident;

17.18 The Independent Investigation Team has been unable to ascertain progress against the implementation of this action by reviewing the evidence supplied. It is unclear to the Independent Investigation Team how this action links to the Trust's Dual Diagnosis Strategy

[41] 2gether NHS Foundation Trust (2010) *Dual Diagnosis Strategies 2008-2012 and 2112-2016*

which the Trust has identified as the control document within their homicide action plan.

17.19 The Independent Investigation Team was able to ascertain, however, that the Trust audit of their compliance with NICE Clinical Guideline 82 in 2009[42] found that 83% of service user files audited showed that service users and carers who seek a second opinion on diagnosis were supported in doing this. However this only applies to second opinion diagnostic reviews and those initiated by service user and carer request.

Recommendation
The Trust should develop a process for ensuring that diagnostic reviews take place for patients with long standing histories, multiple diagnoses and who have been taking a variety of medications, who are not responding to treatment, and establish processes for monitoring compliance with this.

4. It is vital that staff in the Trust in all teams adhere to the same format and criteria when assessing risk

17.20 Comments on progress on Trust's action plan;

17.21 Covered within the Clinical Risk Assessment and Management Policy.

17.22 Action taken by the Trust since the incident;

17.23 The Trust's current Clinical Risk Assessment and Management Policy[43] outlines the Trust's approach to clinical risk assessment and defines the monitoring and review arrangements as follows;

17.24 As part of a 3 year CPA audit cycle the appropriate use of risk assessment procedures will be audited. This will involve auditing a random sample of in-patient health & social care records and discharge summaries. The audit criteria will include assessing compliance against the following standards.

- *Duties*
- *Requirements for risk assessment and management within the care planning process*
- *Tools/processes authorised for use within the organisation*

17.25 It is expected that all documents audited will comply with this guidance. The results of the audit will be presented to the Governance Committee who will be responsible for the development and monitoring of any identified actions within the scope of the audit.

17.26 Attendance at risk assessment training will form part of the monitoring of statutory and mandatory training.

17.27 CPA audit is carried out regularly within the Trust. The most recent evidence supplied is a comprehensive audit carried out in March 2011. This audit measures whether clinical risk

[42] 2gether NHS Foundation Trust (2009) Audit log number 10-016 report
[43] 2gether NHS Foundation Trust (2010) *Clinical Risk Assessment and Management Policy*

assessments have been carried out but does not facilitate the evaluation of the quality of the content, quality or relevance of the assessment or the subsequent risk management plan. The audit demonstrates that 90% of the files audited in 'Working Age Adults' services contained clinical risk assessments and the figure was 93% for Recovery Team patients specifically.

5. *When levels of risk change it will be based on evidence which is clearly stated in the notes*

17.28 Comments on progress on Trusts action plan;

17.29 Covered within the Clinical Risk Assessment and Management Policy.

17.30 Action taken by the Trust since the incident;

17.31 The Trust's current Clinical Risk Assessment and Management Policy[44] outlines the Trust's approach to clinical risk assessment and defines the process for addressing changes in risk as follows;

17.32 In understanding 'changeable' risk factors, it is important to recognise that likelihood of a negative or adverse event occurring can change over time. As a minimum a Standard Risk Assessment (as outlined in Section 7.7 should be repeated at a CPA review, a referral to Crisis Resolution and Home Treatment Teams, and/or an inpatient admission.

17.33 A review of the management plan should occur in the following circumstances:

- *If the clinical presentation changes*
- *If there is an adverse event/ outcome*
- *If the service user or carer requests it*
- *Leave/transfer or discharge from the current inpatient unit*

17.34 Subsequent risk taking meetings should recorded on the continuation sheets of the health record. They should be clearly marked with red underline for paper records and flagged as a risk entry for electronic entries.

Recommendation
The Trust should carry out qualitative audit to establish the quality of clinical risk assessments in relation to current risks outlined in clinical records and CPA review notes and the responsiveness and relevance of the subsequent risk management plans.

6. *Staff will need to be aware and prepared to avoid a tendency to minimise risky behaviour by the nature of being familiar with a case.*

17.35 Comments on progress on Trust's action plan;

[44] 2gether NHS Foundation Trust (2010) *Clinical Risk Assessment and Management Policy*

17.36 Team managers to ensure all their staff are aware of this requirement through team meetings and supervision.

17.37 Action taken by the Trust since the incident;

17.38 The independent investigation team were informed by the Trust that all community teams for working age service users received a briefing regarding this and signed a return stating that they had read and understood the requirements.

17.39 Action taken by the Trust since the incident;

17.40 The Trust clinical Supervision Policy[45], which is undated, but has a review date of 2005, states;

17.41 Supervision has three main objectives:

- *Support*
- *Education*
- *Monitoring standards to improve care.*

17.42 It is important that the following are included when making your supervisory contract arrangements:

17.43 The support objectives include:

- *Creating a safe climate for the worker to look at his/her practice and its impact on them as a person.*
- *Supporting workers who are subject to any form of abuse either from clients or from colleagues, whether this is physical, psychological or discriminatory.*
- *A safe place to raise personal issues from outside the workplace which may impact on their work.*

17.44 The educational objectives include:

- *The development of the professional competencies of the worker.*
- *An exploration and appreciation of the worker's skills, knowledge and individual contribution to the work of the team and the organisation.*
- *A time to focus on the worker's training, personal and professional development needs and how they can be met.*
- *The workers ability to reflect on their work and interaction with service users, colleagues and other agencies.*
- *Engaging everyone in developing lifelong learning opportunities.*

17.45 The monitoring standards objectives include:

[45] 2gether NHS Foundation Trust. *Supervision Policy* – undated but for review in 2005

- *Performance management and improving quality*
- *Allocation of workload*
- *Management of time and workload*
- *Monitoring of records and record keeping within supervision*
- *Setting of priorities and agreed targets, linking this with appraisal.*
- *Checking work done against agreed targets through line management supervision and appraisal.*
- *Ensuring consistency between the individual's goals and the standards of the team and organisation*

17.46 (The term workload rather than caseload has been chosen to widen the guidance to include non-clinical staff.)

Recommendation
The Trust should identify key performance issues that should be covered in caseload supervision and include the requirements, monitoring and audit arrangements in the Trust policy regarding clinical supervision.

7. Case Co-ordinators should take responsibility for preparing an incremental chronology of risk events tabulated at the front of the notes for easy reference and use when discussing risk management at CPA meeting

17.47 Comments on progress on Trust's action plan;

17.48 Covered within the Clinical Risk Assessment and Management Policy. CPA audits established on continuous cycle

17.49 Action taken by the Trust since the incident;

17.50 The Trust's current Clinical Risk Assessment and Management Policy[46] outlines the Trust's approach to clinical risk assessment and defines the process for detailing risk events chronologically as follows;

17.51 In cases of significant ongoing risk concerns evidence should be available in the health record that individual practitioners have sought the support of appropriate other professionals in making decisions regarding risk management. Additionally a 'Chronology of Risk Form' should be completed and filed appropriately in the health record/ electronic record to reflect details of all critical incidents relating to risk.

17.52 The Independent Investigation Team have examined the Trust's CPA audit criteria and have not found evidence that this is specifically audited as part of that process so performance against this action cannot be measured.

8. Care Co-ordinators should take responsibility to ensure that care plans are kept in chronological order in the notes and eventually on electronic records

[46] 2gether NHS Foundation Trust (2010) *Clinical Risk Assessment and Management Policy*

17.53 Comments on progress on Trust's action plan;

17.54 CPA audits established on continuous cycle

17.55 Action taken by the Trust since the incident;

17.56 The Independent Investigation Team have examined the Trust's CPA audit criteria and have not found evidence that this is specifically audited as part of that process so performance against this action cannot be measured.

18.0 REVIEW OF PROCESSES IN PLACE TO EMBED ANY LESSONS LEARNED

18.1 Trust Governance

18.2 The current Incidents Policy and Procedure[47] outlines its procedure for the governance of serious incidents as follows;

1. *This policy requires approval by the Governance Committee and will be reviewed at least annually and sooner if required.*

2. *The Governance Committee is responsible for ensuring that compliance against the standards defined by the NPSA within the National Framework for Reporting & Learning From Serious Incidents Requiring Investigations is followed by receiving a quarterly report from the Assistant Director of Clinical Governance*

3. *An audit of the implementation of the policy will be undertaken every two years, commissioned by the Director of Quality & Performance. The audit criteria will include assessing compliance against the following standards.*

    - *Duties of individuals and committees*
    - *process for reporting all incidents/near misses, involving staff, service users and others*
    - *The process for reporting to external agencies*
    - *The processes for staff to raise concerns e.g. whistle blowing/open disclosure*

4. *It is expected that implementation of all these elements will comply with this guidance. The results of the audit will be presented to the Governance Committee who will be responsible for the development and monitoring of any identified actions within the scope of the audit.*

18.3 The Independent Investigation Team found evidence that this incident, and the subsequent action plan, was monitored by the Governance Committee within the Trust but the process for verifying evidence to ensure all actions have been completed is not clear. There is

[47] 2gether NHS Foundation Trust (2011) *Incidents Policy & Procedure (Including the Management of Serious Incidents)* – version 10

evidence that the actions and outputs of the Trust Governance Committee are regularly reviewed by the Trust Board and that the internal investigation findings and the action plan were reviewed in 2008 by the Practice Standards Committee.

18.4 At the time of the incident this function was covered by the Practice Standards Committee which included both Executive and Non Executive Trust board members. The Trust have supplied evidence to the Independent Investigation Team demonstrating that the internal investigation report with regard to this incident was reviewed by the Practice Standards Committee in October 2008 and that it was agreed at the committee that the action plan would be received by them for scrutiny the following January, 2009.

18.5 There is evidence that the minutes from the October 2008 Practice Standards Committee, including details of the internal investigation findings were reviewed by the Trust board at the end of November 2009.

18.6 On 10th February 2009 the incident was discussed at the Working Age Adults Operational Management Board meeting and a note made to ascertain progress against the action plan.

18.7 In July 2009 and March 2010 the progress against Trust action plans, including the action plan for this incident, was discussed and noted.

18.8 During the interviews the Independent Investigation Team were told that action plans are signed off by the Medical Director or delegate. The Independent Investigation Team is of the view that a more formal process is required.

18.9 The Independent Investigation Team found, from the evidence provided, that the internal investigation report was scrutinised at a high level within the Trust, and that progress against the action plan was monitored by the Governance Committee periodically. There is no clear evidence, however, that there was a robust action plan sign off process in place to enable the Trust Board to assure themselves that the evidence was in place demonstrating that all actions had been completed to a satisfactory standard.

Recommendation
The Trust Board should confirm and challenge the outputs from the reports and the actions arising.

18.10 A paper was submitted to the Trust Governance Committee on 24th March 2010[48] .

18.11 This recognises the need to improve Trust processes for ensuring the completion of actions outlined within internal investigation action plans as follows:

- *Ensuring internal completing of actions has proved challenging, so to improve upon this and promote timely follow up, a sub-committee of the Clinical Risk Management Committee will be formed in April 2010 to act as a "task group" to ensure robust*

[48] 2gether NHS Foundation Trust (2010) *Trust board paper*

completion of all actions arising from SUI reviews. This task group will meet monthly and its core members will consist of the Deputy Chief Operating Officer, Assistant Director of Clinical Governance, Head of Quality Care Management.

18.12 The Independent Investigation Team is satisfied that the Trust recognised shortfalls in processes at the time that this incident was investigated and the action plan implemented and made proactive plans to attempt to improve procedures to address the issues.

18.13 The following themes remain consistent with the previous quarter when considering the "lessons learned" and the Action Plans seen shows how these are being addressed and progressed.

1. *Contact with relatives/carers post incident can be improved*
2. *Access to centrally held electronic records should improve information available to clinicians when considering care/treatment options*
3. *Subsidiary health record files which are not linked to the main health record continue to be identified*
4. *Completion of all relevant documentation within health records could be improved, most notably CPA and risk assessment documents.*
5. *The sharing of information regarding service user care when they are in transition between functional teams could be improved.*
6. *Communication between statutory agencies within the county could be improved.*
7. *Risk assessment processes require revision to ensure that actuarial indicators are fully considered.*

18.14 Sharing of lessons

18.15 The Trust have shared the learning of lessons from this incident through their governance forums. They have also facilitated a well attended learning event which constitutes good practice.

18.16 The Governance Committee monitors implementation of action plans and there is evidence of proactive work to improve investigation processes and the dissemination of learning.

18.17 A paper was submitted to the Trust Governance Committee on 24th March 2010[49] outlining recurring themes and trends for which an action plan was in place.

18.18 The following themes remain consistent with the previous quarter when considering the "lessons learned" and the Action Plans seen shows how these are being addressed and progressed.

18.19 Contact with relatives/carers post incident can be improved.

18.20 Access to centrally held electronic records should improve information available to clinicians when considering care/treatment options.

[49] 2gether NHS Foundation Trust (2010) *Trust board paper*

18.21 Subsidiary health record files which are not linked to the main health record continue to be identified.

18.22 Completion of all relevant documentation within health records could be improved, most notably CPA and risk assessment documents.

18.23 The sharing of information regarding service user care when they are in transition between functional teams could be improved.

18.24 Communication between statutory agencies within the county could be improved.

18.25 Risk assessment processes require revision to ensure that actuarial indicators are fully considered.

18.26 The Trust's procedure for Learning from Incidents, Complaints and Claims[50] outlines that aggregated reports detailing themes and trends of learning are reviewed by the Governance Committee on a quarterly basis.

18.27 The procedure[51] details that learning detailed in the quarterly report influences changes in organisational culture and practice as follows;

18.28 Each quarter, following publication of the reports, the Assistant Director of Governance & Compliance will meet with the Head of Quality Care Management/ other parties where appropriate to review clusters/trends/lessons identified through the analysis of incidents, complaints and claims. This may promote possible areas of work for future care pathway development. Implementation of care pathways and compliance with these is supported through the clinical audit cycle.

18.29 When lessons learned indicate a training requirement, the Assistant Director of Governance & Compliance will liaise with the Head of Training to establish how this may best be implemented. All changes to the delivery of training, additions to the Training Prospectus and the monitoring of attendance at training sessions will be via the Delivery Committee.

18.30 All actions arising from serious untoward incidents will be incorporated into the Trusts audit work plan to establish compliance with changes in culture and practice. NHS Gloucestershire & NHS Herefordshire also monitor the implementation of these action plans and are the responsible agencies for "signing off" completed actions by closing the incidents logged on STEIS

18.31 The Independent Investigation Team are satisfied that the Trust has put processes in place to ensure the ongoing learning of lessons and use information gained from investigations to attempt to change culture and influence practice. However the efficacy of these processes is as yet unknown and has not yet been measured.

[50] 2gether NHS Foundation Trust (2011) *Learning from Incident's Complaints and Claims*
[51] 2gether NHS Foundation Trust (2011) *Learning from Incident's Complaints and Claims*

Recommendation
The Trust should undertake a review to examine the efficacy of the processes in place for the learning and sharing of lessons learned to establish their efficacy.

19.0 REVIEW ANY COMMUNICATION AND WORK WITH FAMILIES OF VICTIM AND PERPETRATOR

19.1 Despite the requirement for appropriate liaison to take place with families and victims and perpetrators of homicides being well documented in national guidance such as the Being Open framework[52] the families involved in this case were not contacted by the Trust.

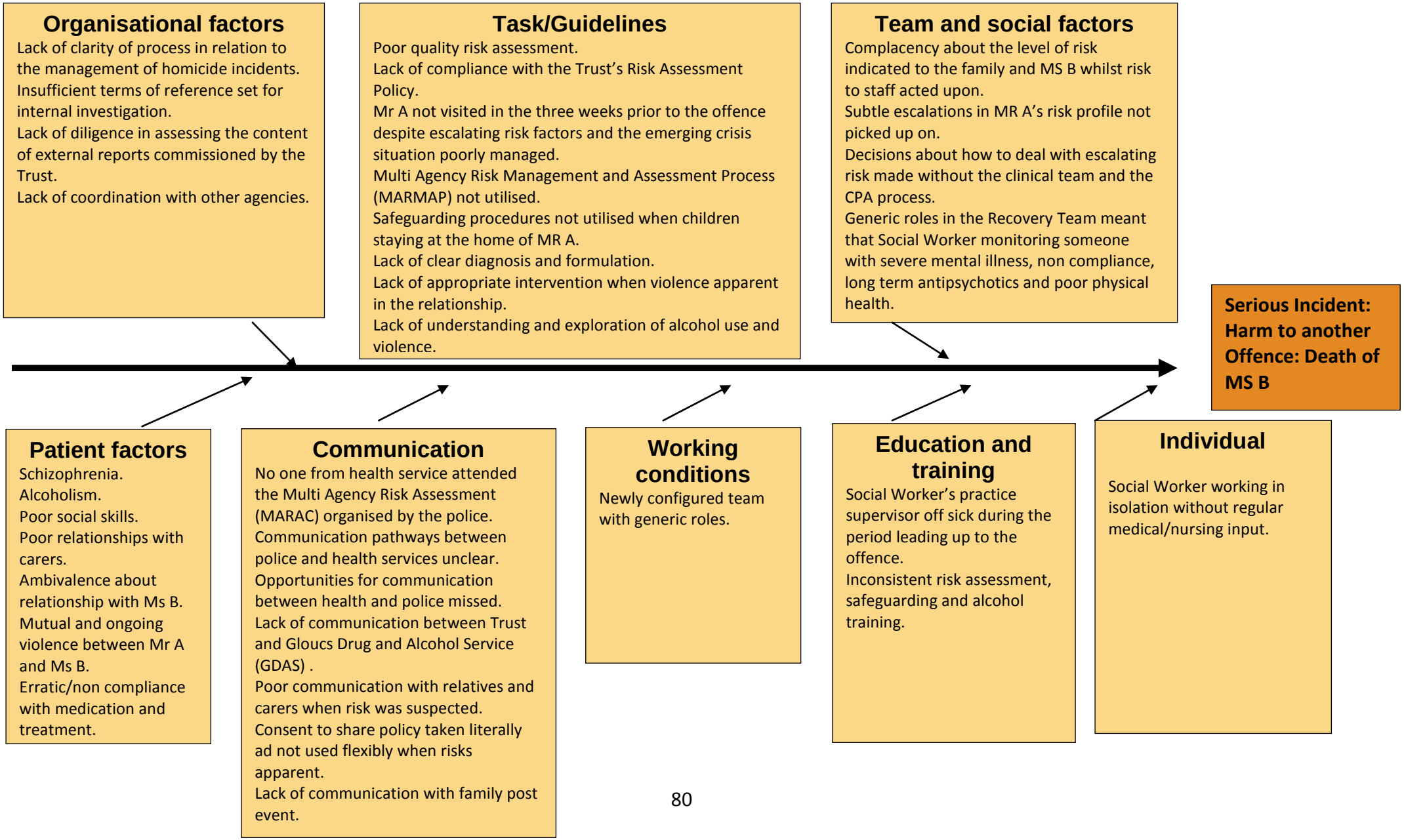
19.2 It is acknowledged that this is challenging when the Trust internal investigation runs concurrently with the police investigation. However, in most circumstance this should not prevent identified persons within the Trust contacting families to offer support and inform them of the processes in place and the agreements that have been made by the Trust or multi agency incident co-ordination group.

Recommendation
The Trust should ensure that one of the functions of the incident co-ordination group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way.

20.0 ROOT CAUSE ANALYSIS

20.1 This analysis follows NPSA guidance. In essence, an attempt is made to identify root causes in organisational process, how those directly resulted in specific care and service delivery problems and how those led to the documented actual or potential effect on the outcome. The issues below identify sub optimal processes as identified by using this technique. These issues are not causative but are highlighted for organisational learning.

[52] National Patient Safety Agency (2004) *Being Open* (Updated Nov 2009)


Organisational factors
Lack of clarity of process in relation to the management of homicide incidents.
Insufficient terms of reference set for internal investigation.
Lack of diligence in assessing the content of external reports commissioned by the Trust.
Lack of coordination with other agencies.
Task/Guidelines
Poor quality risk assessment.
Lack of compliance with the Trust's Risk Assessment Policy.
Mr A not visited in the three weeks prior to the offence despite escalating risk factors and the emerging crisis situation poorly managed.
Multi Agency Risk Management and Assessment Process (MARMAP) not utilised.
Safeguarding procedures not utilised when children staying at the home of MR A.
Lack of clear diagnosis and formulation.
Lack of appropriate intervention when violence apparent in the relationship.
Lack of understanding and exploration of alcohol use and violence.
Team and social factors
Complacency about the level of risk indicated to the family and MS B whilst risk to staff acted upon.
Subtle escalations in MR A's risk profile not picked up on.
Decisions about how to deal with escalating risk made without the clinical team and the CPA process.
Generic roles in the Recovery Team meant that Social Worker monitoring someone with severe mental illness, non compliance, long term antipsychotics and poor physical health.
Serious Incident: Harm to another Offence: Death of MS B
Patient factors
Schizophrenia.
Alcoholism.
Poor social skills.
Poor relationships with carers.
Ambivalence about relationship with Ms B.
Mutual and ongoing violence between Mr A and Ms B.
Erratic/non compliance with medication and treatment.
Communication
No one from health service attended the Multi Agency Risk Assessment (MARAC) organised by the police.
Communication pathways between police and health services unclear.
Opportunities for communication between health and police missed.
Lack of communication between Trust and Gloucs Drug and Alcohol Service (GDAS) .
Poor communication with relatives and carers when risk was suspected.
Consent to share policy taken literally ad not used flexibly when risks apparent.
Lack of communication with family post event.
Working conditions
Newly configured team with generic roles.
Education and training
Social Worker's practice supervisor off sick during the period leading up to the offence.
Inconsistent risk assessment, safeguarding and alcohol training.
Individual
Social Worker working in isolation without regular medical/nursing input.

21.0 CONCLUSIONS

21.1 Mr A had been involved with mental health services for eighteen years prior to the offence when he killed his partner, Ms B, at his home after drinking alcohol. During this period of care he was admitted to psychiatric inpatient facilities on several occasions and received care from both the Assertive Community Treatment (ACT) Team and latterly, the Recovery Team in the community.

21.2 Mr A reported psychotic symptoms and excessive use of alcohol on an ongoing basis throughout the time he was receiving care.

21.3 Mr A received mental health care from the ACT Team and had occasional inpatient stays between 1999 and 2007 when he was discharged to the care of his General Practitioner (GP). During this time Mr A's medication compliance was erratic and his alcohol consumption increased characterised by long periods of excessive drinking followed by periods of abstinence. He did, however, cease using cannabis. Access to Mr A for home visits was on occasion problematic, as he sometimes refused to answer the door when he was drunk or feeling particularly unwell or anxious.

21.4 In 2004 Mr A commenced a relationship with Ms B and she moved into his flat to live with him in the subsequent months. Ms B also used alcohol to excess on occasions and the couple used to drink together. Although the relationship was supportive and loving, at times there was some violence between the couple whilst they were under the influence of alcohol. The first recorded incident of the police being called to the home was in August 2004, when Ms B was arrested for slapping Mr A.

21.5 Police were also called to the home in March 2005 when Mr A allegedly assaulted Ms B. Mr A was arrested on this occasion. He stated after the incident that he had no memory of assaulting Ms B. Mr A was charged with common assault and causing criminal damage but MS B dropped the charges and told the police that she would consider suicide if they proceeded.

21.6 On 27th May 2005 police and ambulance services were called to the home after Mr A kicked Ms B. They later took M A to hospital as he stated he was experiencing palpitations but he discharged himself shortly after arriving at the hospital. He told clinicians that he had not been taking his psychiatric medication for three months.

21.7 On 22nd June 2005 Ms B went to the police station with facial injuries stating that Mr A had hit her. However, when this was investigated by the police Ms B withdrew her allegation.

21.8 On 22nd July 2005 Mr A was arrested and held in police cells after reports that Ms B had split her lip. He claimed he had not assaulted her, that he had been sober and that she had been drunk. No charges were pursued on this occasion.

21.9 On 22nd August 2005 Mr A was informally admitted to hospital after increasing his drinking and stopping his medication which led to an increase in psychotic symptoms. He underwent

an alcohol detoxification programme whilst in hospital but discharged himself before this was completed.

21.10 Mr A was taken to hospital on Section 136 Mental Health Act[53] on 1st October 2005 after damaging his own property. On arrival at hospital Mr A was taken to a Psychiatric Intensive Care Unit and was admitted under Section 2 of the Mental Health Act. During this admission Mr A was observed to be experiencing psychotic symptoms and was physically aggressive. Ms B told clinicians on the ward that Mr A had been drunk prior to admission and showed bruising on her limbs, which she said he had caused. However clinicians in the inpatient service admitting Mr A recorded that he did not appear to be drunk on admission.

21.11 On 20th November 2005, whilst on leave from hospital, Mr A was arrested and cautioned for assaulting Ms B.

21.12 In December 2005 Mr A evicted Ms B from the flat but she returned in January 2006.

21.13 In July 2006 Mr A ran out of his psychiatric medication for a few days. He said he had had a bad weekend as his son's car had broken down and he had pushed it whilst drunk and bumped a couple of cars on the way. He was arrested and charged with drunk driving and spent the night in police cells. Mr A stated that his voices had increased prior to drinking and was requesting a medication review.

21.14 At a Care Programme Approach (CPA) review which took place in November 2006 it was agreed that Mr A should be regraded to standard CPA status and that discharge back to the care of his GP be arranged. A handover meeting with the GP took place on 18th January 2007.

21.15 On 27th February 2007 Mr A was arrested and charged with actual bodily harm after an assault on MS B. He was bailed on the condition that he did not see her but she called at his home whilst bail conditions were in place.

21.16 On 13th September 2007 Mr A was informally admitted to hospital. He had been taking his medication sporadically and was drinking two litres of vodka and beer daily. He said he was hearing voices telling him to throw himself out of the window and solve mathematical problems. Ms B said that he had not eaten for two weeks. Mr A was prescribed an alcohol detoxification regime and to recommence on antipsychotic medication. On discharge he was referred to the 2gether NHS Trust Recovery Team.

21.17 In February 2008 Mr A started to experience alcohol related seizures.

21.18 In April 2008 Mr A was seen by his Recovery Team Worker and Social Worker from the Substance Misuse Team. Mr A said he had not been drinking for some weeks due to stomach problems. The possibility of residential rehabilitation was discussed, which Mr A refused stating that he had resumed contact with his family and that he would not want to leave Ms B. He was advised to engage with local alcohol services.

[53] *Mental Health Act 1983.* (c.20)

21.19 At the end of April 2008, Mr A was seen at home by a Recovery Team Worker. He said that in the previous few days he had been charged with common assault on Ms B. They had argued about his son who had been present at the time. Ms B had told police that MR A had knocked out her dental plate. Both he and Ms B were drinking at the time. He said he was due in court regarding this offence.

21.20 On 29th May 2008, the Recovery Team Manager received an email from the worker who was supporting another member of Mr A's close associates saying that Mr A had physically assaulted his partner badly to the extent that his knuckles were bleeding. It stated that Mr A's son had left the house after receiving violence and that Mr A's father had been threatened with a knife on his last visit. The Recovery Team Manager issued a directive stating that workers should not attend Mr A's home unaccompanied due to risk of violence if Mr A had been drinking.

21.21 On 6th June 2008, the Recovery Team Worker contacted the police to ascertain the details of the alleged recent assault and threats to Mr A's father but they refused to share information with her under the Data Protection Act. She recorded that she would try again to make contact with the Court Liaison Officer.

21.22 On 9th June 2008 Mr A was taken into custody after Ms B was found dead. After his arrest he was assessed under the Mental Health Act and was deemed not to be detainable under the Act. He was deemed fit for interview. Police told the clinicians that he had gone to his neighbour's house whilst drunk at 5pm the previous day and asked him to come and identify the body of his girlfriend. The police were immediately called by the neighbour. The Consultant Psychiatrist who saw Mr A following his arrest stated that Mr A gave a coherent account and said that Ms B had come to his house despite the fact he was on bail related to some charges of a recent assault on her. Mr A stated he and Ms B drank together before the homicide occurred. Mr A said he had been drinking heavily in previous weeks. There were no features of biological depression or symptoms of psychosis evident on interview.

21.23 The violence between Mr A and Ms B commenced in August 2004 when Ms B was arrested for slapping Mr A. Following this, the police were called to the couple's home on a regular basis, usually due to violence to Ms B, from Mr A, and usually when he had been drinking. This culminated in the police calling a Multi Agency Risk Assessment Conference (MARAC) a few weeks prior to the offence due to the perceived escalating risk to Ms B following an assault on her by Mr A in April 2008. The MARAC was not attended by health service staff.

21.24 Risk assessments were carried out sporadically throughout Mr A's span of care but these did not address the risk of violence between Mr A and Ms B in any detail and subsequent risk management plans did not include this issue.

21.25 Mr A had a diagnosis of psychotic type illnesses throughout the period of his care and was treated for these with antipsychotic medication. His concordance with this was, however, erratic on occasions, particularly when he was drinking heavily. Despite this the Recovery Team were of the view that alcohol use was his primary problem and it is the view of the

Independent Investigation Team that Mr A's clinical diagnosis was not adequately explored and there was a lack of a clear management plan for him as a result.

21.26 Mr A assaulted Ms B in April 2008 and was charged by the police and released on bail. One of his bail conditions was not to see Ms B or have contact with her. However in May 2008 it came to the attention of the Recovery Team that Mr A had possibly assaulted Ms B again and had also made threats to his son and father. As a result of this the Recovery Team Manager asked his staff not to visit Mr A alone due the potential risk to them but no attempts were made to explore the validity of the information with the family or Ms B or discuss the potential risks to themselves with them.

21.27 The Care Co-ordinator did attempt to verify the information by calling the police but they were unable to do this due to the Data Protection Act. No further attempts were made to communicate further with more senior police officers regarding this matter.

21.28 Mr A was not seen by mental health services in the three weeks prior to his offence due to the perceived potential risk to staff.

21.29 It is the conclusion of the Independent Investigation Team that the tragic murder of Ms B was not predictable as Mr A had never displayed the level of violence towards MS B that he exhibited during the offence. However, the risk of ongoing, and potentially escalating violence towards her was an ongoing issue and therefore entirely predictable.

21.30 Mr A and Ms B were not supposed to be in contact at the time of the offence due to Mr A's bail restrictions so it is understood that the Recovery Team perceived that this restriction would eliminate risk to Ms B. However, given that they were in receipt of information in May 2008 that suggested that there had been further contact, a possible further assault on Ms B and threats to Mr A's father and son, it is the view of the Independent Investigation Team that the accuracy of this information, the nature of the contact between Mr A and Ms B and the potential risks should have been explored and investigated further by the Recovery Team and in the circumstances of this case and potentially escalating violence to Ms B, communicated to the police in clear terms. It cannot be known if this would have prevented the tragic outcome in this case, but there is the possibility that this could have led to Mr A's arrest for breach of his bail conditions, and consequently prevented tragic outcome at that point in time.

APPENDIX A: TABLE OF RECOMMENDATIONS

1a	**Assessment and clinical risk assessment**
1)	The Trust should ensure that a thorough assessment takes place for all service users newly admitted to the service even if they have had historic involvement with the Trust.
2)	The Trust should carry out an audit of the quality and relevance of clinical risk assessments and management plans that are in place for current service users within three months.
3)	The Trust should ensure that staff are aware of their responsibility to communicate potential risk information and the conditions in which consent to share and confidentiality restrictions should be overridden.
4)	The Trust should carry out qualitative audit to establish the quality of clinical risk assessments in relation to current risks outlined in clinical records and CPA review notes and the responsiveness and relevance of the subsequent risk management plans.
5)	The Trust should carry out qualitative audit to establish the quality, comprehensiveness and relevance of the content of core assessments with specific reference to personal and family histories.
6)	The Trust should develop a process for ensuring that diagnostic reviews take place for patients with long standing histories, multiple diagnoses and who have been taking a variety of medications, who are not responding to treatment, and establish processes for monitoring compliance with this.
2b	**Substance misuse**
1)	Commissioners of local substance misuse services should review the communication protocols between statutory and non statutory commissioned substance misuse services and agree a minimum standard of communication and liaison with regard to shared service users.
2)	The Trust should review services offered to services users with dual diagnosis to ensure that they are receiving treatment consistent with national guidance and that the organisation has a training programme in place to ensure this can be consistently delivered.
3)	The Trust should carry out quantitative and qualitative audit to establish performance against the standards outlined within the Dual Diagnosis Strategy
3c	**Medication**
1)	The Trust should ensure that there is guidance and training available to staff detailing a consistent approach to manage service users who are not concordant with their prescribed medication and monitor the efficacy of its use by a process of clinical audit.
4e	**Safeguarding**
1)	The Trust should ensure that the welfare of any children living with, or regularly visiting, a service user is considered as part of the risk assessment process and audit compliance with this on an annual basis.
2)	The body responsible for adult safeguarding in the area, and the agencies who are involved with it, should consider this case in detail, to ascertain if there is any learning or implications for future practice, particularly in cases where it is not clear which procedure best applies.
3)	The Trust should ensure that staff are aware of the appropriate referral pathways to utilize for service users who are experiencing, or are the perpetrators of, domestic violence.

5e	**Carers**
1)	The Trust should ensure that workers are aware of their responsibility to offer family intervention to all service users with schizophrenia, and their significant others, and compliance with this should be subject to regular audit.
2)	The Trust should ensure that all eligible carers receive a carer's assessment.
3)	The Trust should ensure that a process is in place to ensure families and carers are appropriately involved in care planning and risk assessment.
6f	**Clinical supervision**
1)	The Trust should ensure that all Care Co-ordinators receive regular caseload supervision that includes documented formal review of care plans, clinical risk assessments and clinical risk management plans.
7g	**Joint working with the police**
1)	The Trust should work with the police to agree a robust process for ensuring that the police are able to identify Care Co-ordinators who need to attend Multi Agency Risk Assessment Conference (MARAC) meetings swiftly and monitor the effectiveness of this by a process of annual audit.
2)	A high level discussion between the Trust and local police needs to take place to agree to implement the components outlined within the Memorandum of Understanding; *Investigating patient safety incidents involving unexpected death or serious untoward harm* published by Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006)
3)	The Trust should ensure that senior managers and Trust directors are aware of their responsibilities outlined within the Memorandum of Understanding and these should be made explicit within Trust policy.
4)	The Trust should ensure that one of the functions of the incident co-ordination group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way
8h	**Management and governance processes**
1)	The Trust should ensure that Team Managers are all aware of their responsibilities under the Trust's incident reporting procedure and the criteria for the escalation of concerns through the management structure.
2)	The Trust Board should confirm and challenge the outputs from the reports and the actions arising.
3)	The Trust should undertake a review to examine the efficacy of the processes in place for the learning and sharing of lessons learned to establish their efficacy
4)	Commissioners of Trust services should ensure that clear standards are set and quality outcomes are agreed and that service outcomes are routinely appraised and monitored.

APPENDIX B: STAFF INTERVIEWED

LIST OF STAFF INTERVIEWED

Team Manager – Recovery Team
Nurse Consultant for Dual Diagnosis
General Practitioner
Director of Nursing at the time of the incident
Director of Nursing, Quality and Performance currently
Social Worker and Care Co-ordinator – Recovery Team
Consultant Psychiatrist
Associate Director for Governance
Medical Director
Carers Support Worker
Senior Substance Misuse Worker
Social Care Lead

APPENDIX C: GLOSSARY OF TERMS

A & E	Accident and Emergency	
HMP	Her Majesty's Prison	
HSG	Health Service Guidelines	
MHA	Mental Health Act	
NPSA	National Patient Safety Agency	
RCA	Root Cause Analysis	The root cause is the prime reason(s) why an incident occurred. A root cause is a fundamental contributory factor. Removal of these will either prevent, or reduce the chances of a similar type of incident from happening in similar circumstances in the future
ACT	Assertive Community Treatment Team	
CPA	Care Programme Approach	The approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics
MARAC	Multi Agency Risk Assessment Conference	
MARMAP	Multi Agency Risk Assessment and Management Procedures	
EDT	Emergency Duty Team	
CPN	Community Psychiatric Nurse	
GDAS	Gloucestershire Drug and Alcohol Service	
	Depixol	An antipsychotic medication
	Olanzapine	An antipsychotic medication
	Fluoxetine	An antidepressant medication
	Procyclidine	A medication which helps alleviate the side effects of antipsychotic medication
	Chlorpromazine	An antipsychotic medication
	Trazadone	An antidepressant medication
	Quetiapine	An antipsychotic medication
	Paroxetine	An antidepressant medication
	Diazepam	A medication used to reduce anxiety
	Acomprosate	A medicine used in alcohol dependence used to help maintain abstinence in people who have successfully overcome drinking problems.

BIBLIOGRAPHY

NATIONAL DOCUMENTS

Mental Health Act 1983. (c.20)

Department of Health (1994) *HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community*

National Institute for Health and Clinical Excellence (2002) *Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care* [CG1]

National Patient Safety Agency (2004) *Being Open* (Updated Nov 2009)

Department of Health (2005) *Independent Investigation of Adverse Events in Mental Health Services*

Department of Health (2005) *Carers and Disabled Children Act 2000 & Carers (Equal Opportunities) Act 2004 Combined Policy Guidance*

Social Care Institute for Excellence (2005) *Practice Guide 9: Implementing the Carers (Equal Opportunities) Act 2004* (Updated 2007)

National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*

National Patient Safety Agency (2008) *Root Cause Analysis Investigation Tools: Investigation interview guidance*

National Patient Safety Agency (2008) *RCA Investigation Evaluation Checklist, Tracking and Learning Log*

National Institute for Health and Clinical Excellence (2009) *Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care* [CG82]

Social Care Institute for Excellence (2011) *Think Child, Think Parent, Think Family: a guide to parental mental health and child welfare*

Thomas RE Barnes and the Schizophrenia Consensus Group of the British Association of Pharmacology (2011) Evidence-based guidelines for the pharmacological treatment of schizophrenia: recommendations from the British Association of Pharmacology. *Journal of Psychopharmacology,* May 2011, 25(5), pp.567-620

LOCAL DOCUMENTS

Gloucestershire Partnership NHS Trust (2006) *Children Protection Toolkit* - version 4

Adult Protection Unit (2006) *Marmap News Bulletin*

Gloucestershire Partnership NHS Foundation Trust (2007) *Policy & Procedures for Care Coordination (CPA)* - version 3

Gloucestershire Partnership NHS Foundation Trust (2007) *Clinical Risk Assessment and Management Policy*

Gloucestershire Constabulary (2008) *Multi Agency Risk Assessment Conference (MARAC) Information Sharing Agreement*

2gether NHS Foundation Trust (2008) *Internal Investigation Report*

2gether NHS Foundation Trust (2008) *Care Management/Care Programme Approach (CPA) Policy* - version 4

2gether NHS Foundation Trust (2009) Audit log number 10-016 report

Gloucestershire Safeguarding Adult Boards (2010) *Professional Guide for Alerter's & Reporters - 2010: Safeguarding vulnerable adults from abuse*

2gether NHS Foundation Trust (2010) *Dual Diagnosis Strategy 2008-2012*

2gether NHS Foundation Trust (2011) *Incidents Policy & Procedures (Including the Management of Serious Incidents)* - version 10

2gether NHS Foundation Trust. *Supervision Policy* – undated but for review in 2005