

INDEPENDENT INVESTIGATION

**INTO THE CARE AND TREATMENT
PROVIDED TO MR M BY 5 BOROUGH
PARTNERSHIP NHS FOUNDATION
TRUST**

CONSEQUENCE UK LTD

MARCH 2013

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

The requirement is for an independent investigation of the care and services offered to mental health service users involved in adverse events, defined as including the commission of homicide, where there has been contact with specialist mental health services in the six months prior to the event.

The Independent Investigation Team members were:

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- Mr Justin O'Brien, Head of Patient Safety, South West London and St George's Mental Health Trust.

Acknowledgements

The Independent Team wishes to thank Mr M (the mental health service user whose care and treatment is the subject of this report) for his consent that enabled access to his mental health and relevant records held by Cheshire Police.

The Independent Team also wishes to thank:

- The sister-in-law of the deceased for her patience over the length of time it has taken from the time of the incident to the delivery of this investigation report;
- The staff working for the now 5 Boroughs Partnership NHS Foundation Trust [the Trust] who provided information to the Independent Team;
- The Criminal Justice Liaison Team [CJLT] CPN who, although retired, agreed to meet with the Independent Team and who provided valuable information to it.

Throughout this report, the Independent Investigation Team is referred to as the Independent Team.

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EXECUTIVE SUMMARY

Incident overview

On 26 September 2006, while under the influence of alcohol, Mr M took a knife and set out to injure his victim. Mr M pursued his victim along the street of his local community and stabbed him twice. The injured gentleman subsequently died of his injuries.

Purpose of the investigation

Two weeks prior to the incident that occurred, it had been determined by a consultant psychiatrist and Community Psychiatric Nurse [CPN] that Mr M was not psychotic, and that his (Mr M's) decision to cease medication, although concerning, was something he could be self-determining about. Because Mr M presented with no signs of psychosis or any deterioration in his mental state, the mental health professionals involved did not consider Mr M to pose a risk to the public or himself, and there was, they considered, no basis for conducting an assessment of Mr M under the Mental Health Act 1983 to establish whether or not he could be treated on a compulsory basis.

At the time of the incident, Mr M had a notable and extensive criminal history, and it had been previously documented in his mental health record in 2000 that, un-medicated, he may pose a risk to others. This fact was reportedly unknown to the mental health professionals responsible for the care and treatment of Mr M at the time he became medication non-compliant.

Because of the above facts, and the fact that the internal investigation initially conducted by the then 5 Boroughs Partnership Trust did not explore as deeply as it should have the core aspects of Mr M's clinical care and treatment in the six months preceding the incident, it was agreed between the Independent Team and the North West SHA that a targeted re-investigation of specific aspects of Mr M's care and treatment was required to enable it to discharge its responsibilities under Health Circular Guidance (94)27.

Conclusions of the Independent Team

Following its own investigation, the conclusions of the Independent Team are that:

- ❑ The decision in April 2006 to support Mr M in changing from depot anti-psychotic medication to oral anti-psychotic medication was reasonable, as was the choice of oral medication made by Mr M's consultant psychiatrist.
- ❑ The lack of assertive follow-up of Mr M in May 2006, and the lack of communication to Mr M's then CPN, when he defaulted from his outpatient appointment, was not acceptable. This appointment was the one at which an assessment was to be made of Mr M's response to the changes made to his medication one month earlier.
- ❑ The decision of Mr M's CPN in September 2006 to organise a meeting with Mr M's consultant psychiatrist on learning that Mr M had stopped his medication was sensible and good practice.

- ❑ The decision to accept Mr M's decision to only meet with his CPN on a six-weekly basis after stopping his medication was not a good decision in the presenting circumstances, or in relation to Mr M's documented risks if un-medicated.
- ❑ Mr M had been on enhanced CPA [Care Programme Approach] at the time of his transfer of care from CPN [1] to the CJLT CPN in April 2003. However, after March 2003 there were no CPA reviews for Mr M. This constitutes a lack of adherence to the Trust's statutory responsibility to Mr M at the time.
- ❑ There was no contemporary risk assessment, risk management or crisis contingency plan in place for Mr M at the time of the incident. This was a significant lapse in the professionals' adherence to the then local and national standards of practice.
- ❑ At the time Mr M decided not to continue with medication, and not to meet with the mental health professionals at a greater frequency than every six weeks, there were no justifiable reasons to have assessed him under the Mental Health Act (1983). Mr M simply did not meet the criteria for this at the time. Furthermore, from the information gathered by Cheshire Police, and made available to the Independent Team, there is no information that suggests that Mr M met the criteria for assessment under the Mental Health Act (1983) at the time of the incident or his arrest.

With regards to predictability, Mr M's past history shows that, un-medicated, he could be aggressive and violent. Therefore, it was predictable that, when un-medicated, he could become aggressive and violent again. However, even though Mr M had a notable history of criminality stretching back to 1974, including some incidents of extreme violence, the Independent Team does not believe that it was predictable that Mr M would set out to grievously harm an individual unknown to and unconnected with himself.

With regards to preventability, the Independent Team has treated this issue with care. The Independent Team knows from the information provided by Cheshire Police that, having stopped his medication, Mr M became sleep-deprived and started to use alcohol as a means of self-medication. The Independent Team also knows that Mr M's alcohol intake steadily increased as a consequence of this. The Independent Team considers that, had Mr M's CPN and consultant psychiatrist:

- ❑ conducted a thorough risk assessment, including a complete perusal of all Mr M's past medical and nursing records and forensic history;
- ❑ contacted Mr M's family, in particular his sister, to seek her co-operation in alerting the mental health service to any deterioration in Mr M's well-being;
- ❑ asked Mr M specifically about any changes he had experienced in his activities of daily living as a consequence of stopping his medication, including changes to his sleep pattern; and strongly recommended to Mr M that there was contact between him and his CPN on a weekly basis;

then there would have been the opportunity for the mental health team to have become aware of the adverse impact that stopping medication was having on Mr M, if any such information was to be forthcoming from him or his family. For example, it may have come to light that Mr M's alcohol intake had markedly increased. This was a known relapse indicator for Mr M.

However, even had the mental health professionals carried out the activities set out above, the Independent Team has seen no information to suggest that there would have been sufficient concern about Mr M in the weeks preceding the incident to warrant the conduct of an assessment of Mr M under the Mental Health Act (1983). This perspective is based on the following:

- ❑ the length of time Mr M continued to refuse medication in prison;
- ❑ the length of time post-arrest that Mr M showed no signs of psychosis; and
- ❑ the length of time he resided in prison before being transferred to a medium secure unit for treatment of his mental health disorder.

Consequently, even though the Independent Team considers that the management of Mr M in the two weeks preceding the incident was insufficiently assertive, and that the lack of knowledge held by the CJLT CPN and Mr M's consultant psychiatrist about Mr M's vulnerability to impulsive and aggressive behaviour when un-medicated was unacceptable, the Independent Team cannot say that, had Mr M's management been appropriately assertive and had the CJLT CPN and consultant psychiatrist been risk-aware, the incident would not have occurred. The circumstances of it suggest that it may still have occurred. However, the Independent Team is mindful that there were missed opportunities to have increased monitoring of Mr M from April 2006 when his medication was altered. It is not possible to say what difference it would have made to subsequent events had these lapses not occurred.

Recommendations

Since 2006, the systems and processes in the now 5 Boroughs Partnership NHS Foundation Trust have improved significantly. 5 Boroughs Partnership NHS Foundation Trust assures the Independent Team that it now has a sufficiently robust performance-monitoring framework which engages local and service managers and that the significant lapses in policy and procedure adherence that occurred between 2003 and 2006 would be unlikely to occur today. The Independent Team have confidence in this assurance with regards to the community mental health team Mr M was a service user of. It cannot comment on the robustness of systems trust wide.

In addition to the above, the Independent Team is confident that the Trust's approach and conduct of serious untoward incident investigations has improved. Consequently, the Independent Team has only two recommendations to make:

Recommendation 1:

It is recommended that 5 Boroughs Partnership NHS Foundation Trust commissions an audit across its adult services to determine the reliability with which service users are monitored appropriately following a change from depot anti-psychotic medication to an oral equivalent.

The Independent Team suggests that the data fields and scope of the audit are agreed jointly between:

- the Drugs and Therapeutics Committee
- the medical leads for each Business Unit

Clearly once the audit is completed it is expected that the Trust will address any issues of concern identified (if any).

The Independent Team expects that the Trust's commissioners will be provided with a copy of the audit tool and the report setting out the results.

Target Audience: The Medical Director; the Chair of the Clinical Governance and Clinical Risk Committee.

Timescales: The Independent Team considers that some thought may be required as how best to conduct the above audit. Consequently it suggests that 5 Boroughs Partnership NHS Foundation Trust should be able to advise its commissioners on its approach to the above and the time table for completion within the eight weeks following publication of this report.

Recommendation 2:

In this case even though Mr M's consultant psychiatrist had reviewed all his records, that were available to her, before changing his medication she did not identify that Mr M was a known potential risk of harm to others when un-medicated. The Independent Team accepts that 5 Boroughs Partnership NHS Foundation Trust now has an embedded electronic records system and that this can produce a risk summary that details all historical risk for the service user. Because the quality and completeness of information on the system is dependent upon the staff inputting the information, the Independent Team recommends that the Trust's Clinical Governance and Clinical Risk Committee considers whether there is merit in undertaking any of the following:

- Surveying its consultant psychiatrists and care coordinators to determine:
 - the frequency with which they undertake a longitudinal review when they accept a new 'but known' service user onto their care load.
 - the frequency with which they rely on the latest risk assessment and care plan as being complete and thus containing the essential information they need to know
- Taking a sample of cases where a service user has moved teams and/or care coordinator and reviewing the care and risk plans at the time of

case transfer to determine the reliability with which all salient historical information was included as part of the transfer process.

The Independent Team considers longitudinal assessments to be worthwhile.

Target Audience: The Clinical Governance and Clinical Risk Committee and the medical lead for each business unit.

Timescales: The Independent Team considers that 5 Boroughs Partnership NHS Foundation Trust should be able to advise its commissioners of the outcome of its consideration of the above within eight weeks of the publication of this report.

1.0 INTRODUCTION

Consequence UK Ltd (CUK), hereafter referred to as the Independent Team, was commissioned by NHS North West Strategic Health Authority to undertake an independent review of the care and treatment of Mr M, who was a patient of the Trust at the time of his index offence on 26 September 2006.

Although the incident occurred in 2006, the independent investigation of it was not commissioned until April 2010. At that time, Mr M had not provided his consent to NHS North West to enable access to his mental health records and other records required for the investigation process. This led to a further delay in the conduct of the investigation process. Because of the legacy nature of the case, and the fact that care and treatment expectations in mental health services have changed since 2006, a decision was made to initially conduct a quality assurance review of the investigation initially conducted by the then 5 Boroughs Partnership Trust in 2007. This process resulted in an advisory report to NHS North West in August 2011. As a direct consequence of these activities, a further targeted investigation was commissioned, focusing on specific issues and in particular the last six months of Mr M's care and treatment prior to the death of the victim. In anticipation of the further investigatory activities, Mr M's consent was again pursued and achieved on 11 July 2011. The subsequent investigation was commissioned on 27 November 2011.

The incident

On 28 September 2006, Mr M attacked and stabbed a gentleman. Witness statements collected by Cheshire Police show that Mr M followed his victim along local streets and stabbed him more than once before leaving the scene of the crime. Mr M's victim subsequently died of his injuries. On 28 September 2006, Mr M attended at his local police station to report and confess to the crime committed. He was initially remanded into one of Her Majesty's prisons and subsequently transferred eight months later to a medium secure mental health hospital. He was sentenced on 30 October 2007 and pleaded guilty to manslaughter.

Mr M's forensic history

Mr M has a considerable forensic history, with his first offence dated May 1974. By the time he had reached the age of 20 years, Mr M had been convicted on 17 occasions. Almost all of his convictions were for burglary and theft.

Between 1982 and 1991, Mr M was convicted on 22 occasions. On four of these occasions he was convicted of causing harm to others. The charges were:

- "Assault Occasioning Actual Bodily Harm"*;
- "Wounding"*;
- "Assault Occasioning Actual Bodily Harm"*;
- "Grievous Bodily Harm with intent"*.

All of these convictions occurred prior to Mr M being diagnosed with a mental health disorder, which did not occur until 1992. Furthermore, it is stated in the pre-sentencing psychiatric report prepared for the Crown Prosecution Service

(dated 27 July 2007) that Mr M reported to the assessing psychiatrist that “*all of [his] convictions for violence have always occurred in the context of being intoxicated with alcohol*”.

Past psychiatric history, 1992-2000

In 1992, when in prison, Mr M was assessed by a visiting psychiatrist and found to be suffering from auditory hallucinations and paranoid ideas. He was treated with anti-psychotic and anti-depressant medication, but was found to be resistant to treatment and was transferred under the provisions of section 47/49 of the Mental Health Act 1983 to a medium secure hospital for treatment in March 1994.

March 1994: Mr M was diagnosed with Paranoid Schizophrenia. He was treated with a range of anti-psychotic medications, none of which was successful at treating his symptoms, and he was subsequently commenced on Clozapine.

The principal features of Mr M’s presentation at this time were:

- ❑ somatic hallucinations;
- ❑ passivity of feeling; and
- ❑ retrospective secondary delusional interpretations of many aspects of his life, all of which he attributed to a “*myelin God*”.

During Mr M’s admission to the medium secure hospital, there was no evidence of psychopathic behaviour and he was not involved in any violence. It was also reported in the clinical records that his symptoms improved with Clozapine.

December 1995: Mr M was returned to Her Majesty’s prison to complete his sentence. Following this, Mr M stopped taking his medication for a while. He was, however, persuaded to re-commence this on a lower dose that seemed to maintain his mental stability. Mr M was at this time reported to be able to ignore occasional auditory hallucinations and showed no evidence of a return to a depressed mood.

January 1997: Mr M was transferred to another of Her Majesty’s prisons, where it is reported that his Clozapine was replaced with Olanzapine, a medication he remained on until the end of 1998.

October 1998: Mr M was assessed by a consultant in forensic psychiatry, who reported that Mr M had previously shown evidence of a severe dissocial personality disorder characterised by disruptive and antisocial behaviour, and inability to form or maintain a trusting relationship, poor employment record, poor impulse control, lack of self-esteem and an inability to consider the consequence of his actions and a lack of remorse. However, whilst in prison Mr M developed a severe mental illness, Paranoid Schizophrenia, the symptoms of which were largely resistant to anti-psychotic medication other than Clozapine.

March 1999: There was a multi-disciplinary meeting regarding the aftercare required for Mr M on his release from prison. Mr M had been granted parole, a condition of which was that he received psychiatric care. The meeting was to

establish his needs and the mental health professionals responsible for him. It was clearly noted in the minutes of this meeting that Mr M was at the time serving a 14-year sentence for wounding, assault and criminal damage, and that this offence was unrelated to his subsequent mental health diagnosis of schizophrenia. While adequate aftercare arrangements were agreed, Mr M's parole was suspended.

A letter written by the forensic psychiatrist who had assessed Mr M to the medical officer in Her Majesty's prison said:

"Although [Mr M] continues to show some evidence of his schizophrenic illness in the form of auditory hallucinations, he has now been settled for at least three years, albeit in a protected environment. I could find no evidence, from his history or examinations, that he is a high risk either to himself or to others due to his illness. I have already stated that he would appear to be of a lower risk of violence since developing his illness, than previously."

October 1999: Mr M was released from prison.

5 November 1999: Mr M was brought by the police to a local psychiatric hospital and admitted to the low secure unit under the provisions of section 2 of the Mental Health Act (1983), after being arrested for an offence of shoplifting and assaulting a shop assistant. Mr M was described as hostile, aggressive and grossly deluded with persecutory and grandiose religious delusions, including the belief that he was the creator of everything on earth and, as such, everything should be free to use. Mr M was noted as reporting that he had stopped his anti-psychotic medication six weeks prior to his release from prison, so around 9/10 September 1999.

2 February 2000: A consultant clinical psychologist wrote to Mr M's then consultant psychiatrist and reported that Mr M *"continued to refuse psychology sessions"*, but that he and a colleague had assessed Mr M's risk for possible violence to others should he be resident in the community. Key features of this assessment were:

- "although the most recent incident of violence may be related to 'mental illness', generally his past criminality and violent behaviour does not appear to be directly related to 'mental illness'.*
- Even if his mental state is stable, there is a possibility that he may re-offend in the community if he is not very closely supervised; if he were to re-offend, then the most likely offences would probably be theft and/or violence.*
- If his mental state was 'unstable' in the community, then he may pose a risk to others, especially if suffering from delusions."*

The consultant clinical psychologist emphasised that the assessment was provisional and needed to be discussed by the ward clinical team.

7 March 2000: The consultant psychiatrist for Mr M compiled a report about him. The salient points in relation to this independent investigation were:

- ❑ *“Risk assessment shows moderate to severe risk of violent behaviour in the future.*
- ❑ *In view of [Mr M’s] history and poor compliance with medication, in order to protect him and the public from further deterioration in his mental state, I have made recommendations to detain him on Section 3 of the Mental Health Act for further treatment.”*

5 April 2000: Mr M’s solicitors challenged the legality of his detention under the Mental Health Act, as the Trust had wrongly identified his nearest relative and that Section 11(4) of the Mental Health Act had not been complied with. In the solicitors’ correspondence, it is made clear that Mr M would like to be transferred to a rehabilitation unit if his Section 3 Order was rescinded. Furthermore, the correspondence stated that Mr M *“would remain in hospital as an informal patient until his RMO ... feels he is ready for discharge, and to allow a full package of care to be provided for him”*.

As a consequence of the above, Mr M was discharged from Section 3 of the Mental Health Act and remained on the low secure unit until a placement could be organised on the rehabilitation unit.

2 June 2000 to January 2001: Mr M was transferred to the rehabilitation unit on 2 June 2000. His stay on this unit is noted as largely uneventful, with periods of leave that all went well. In total, he spent seven months on the unit.

30 January 2001: Mr M was discharged into the community with a community appointment booked for two weeks after discharge. At this time he was prescribed Fluphenazine Deconate 50 milligrams fortnightly. Mr M was discharged into the community with Section 117 support and aftercare from both health and social services.

13 February 2001: Mr M was reviewed by his then community psychiatric nurse; he was noted to be symptom-free.

February 2001 to April 2003: Mr M’s mental health management was uneventful. Mr M was compliant with his treatment and attended reliably for his depot medication. In **April 2002**, he experienced a change in consultant psychiatrist; however, this consultant remained his consultant psychiatrist until the time of the incident in September 2006. Of note are the following:

In a clinical record made on **12 October 2001**, following attendance at outpatients on 3 October 2001, the assessing SHO wrote,

“He is aware if he stops taking his medications his mental state will deteriorate, so he has promised to be compliant with his medications.”

Also, on **8 October 2002**, following medical assessment on 2 October 2002,

“We discussed increasing his Modecate, but he has had a higher dose in the past and this didn’t help his hallucinations. I have explained things to him and told him that they probably wouldn’t go away, but as he is coping well with them and not wishing to increase his medication, I have kept

him on the same medication, [this] being Modecate 50mg every two weeks, Lithium 1000mg and Procyclidine 10 mg [three times a day].”

In the clinical record dated **7 April 2003**, following attendance at outpatients on 2 April 2003, Mr M’s consultant psychiatrist wrote,
“In his mental state examination he was pleasant, calm, smiling and displayed good eye contact and rapport. His speech was normal in volume and rate, with no evidence of thought disorder. He was Euthymic objectively and subjectively, with no self-harm ideation. He was not deluded and admitted to still having auditory hallucinations, but he said he could cope with this and they were not stressful for him. ... [T]he plan [was] discussed and [what was] agreed was to maintain the CPA arrangements, continue on the same medication ... he will be reviewed in one year’s time if the necessity doesn’t arise before.”

Mr M attended for subsequent medical reviews on:

- 31 March 2004
- 17 March 2005.

At both appointments Mr M was noted to be stable, continuing to experience hallucinations, but at a level he could manage. The letter from his consultant psychiatrist to the GP on **16 March 2005** said:

“He still hears a single male voice daily, which he believes is the voice of God. This voice apparently talks about all sorts of things and he finds this quite irritating. Sometimes the voice repeats his thoughts out loud as he is thinking them. However, he feels on the whole his medication is helping him and makes the voices quieter and improves his sleep. He denied suffering from persecutory delusions.”

April 2003 to March 2006: Nursing records: Mr M experienced a change in community psychiatric nurse at the end of March 2003. The nurse who had met with him between 2001 and 2003 left the service and the community psychiatric nurse working in the criminal justice liaison team (CJLT) was asked to provide CPN cover to Mr M, as the community mental health team to which he was attached was experiencing staffing shortages at the time. The CJLT CPN continued with the six-weekly visiting pattern that had been established and remained as the CPN for Mr M throughout the period March 2003 to September 2006, although this was not the original or intended plan.

The nursing progress records show that Mr M was fully compliant with his treatment plan throughout this time period, attending for his depot injection on a fortnightly basis and meeting with the CJLT CPN every six weeks for approximately 60-90 minutes at his home. Mr M’s presentation was always noted as stable and that he exhibited no signs of any deterioration in his mental health.

The most relevant antecedent period leading to the incident

15 March 2006: At this outpatient appointment, Mr M advised his consultant psychiatrist that he wished to change from depot medication to oral medication. At this time, Mr M had proven reliability with oral medication, as he had been taking Lithium reliably for six years and his blood screen showed the expected Lithium levels. It was agreed between Mr M and his consultant psychiatrist that she would review his medical records to determine which oral medication would suit him best, and a further appointment was made for April.

4 April 2006: Mr M attended to meet with his consultant psychiatrist as planned. In the subsequent letter to his GP, it is noted that, after reviewing Mr M's clinical records, *"the only clear evidence of responding to treatment was with Clozaril and Modecate. He asked to stop the Clozaril due to drowsiness and on a high dose he developed encephalopathic-type symptoms. Due to his past forensic history and there being no response to any other anti-psychotic, I suggested to [Mr M] we change the Fluphenazine Deconate to Fluphenazine Hydrochloride on a dose of 5mg" twice a day.*

This letter was copied to the nurse who had the main oversight across all depot clinics and was the practitioner most frequently present at depot clinics.

3 May 2006: Mr M did not attend for his planned outpatient appointment. Correspondence from his consultant psychiatrist to Mr M's GP stated that a further appointment would be sent to him *"in three months' time"*.

17 May 2006: Mr M attended at the depot clinic, but refused his injection. The record states Mr M *"refused his medication as is now on Respiridone medication and [Mr M] stated that he no longer wants to have the injection – ([Mr M's] consultant informed)."*

30 May 2006: Mr M was visited by the CJLT CPN as planned. Mr M was noted to be *"objectively and subjectively well"*. At this visit, Mr M asked the CPN if he would visit him again on 6 June, as his sister had invited him for a meal, and therefore he could not spend his usually allocated time with his CPN. The CPN agreed to this.

6 June: Mr M was visited by the CJLT CPN as planned. Mr M was again noted to be objectively and subjectively well. It was also noted that there was no evidence of psychotic phenomena, and that Mr M remained abstinent from alcohol, and was socialising with his family. At this visit, Mr M told the CPN that he was *"seeking to gain employment, albeit on a part-time"* basis. He was going to attend the job centre to look at his options. The CPN noted that there were no problems with Mr M's housing and that he (Mr M) informed the CPN that he was not in debt. The record also noted (as on all previous meetings) that Mr M continued to await a replacement CPN from the community mental health team and that the CJLT CPN would continue to monitor Mr M's well-being until such time as a member of the community mental health team was allocated to him.

25 July 2006: The CJLT CPN attended a meeting with Mr M at home as planned. The records state that there was *"no evidence of thought disorder or*

thought insertion, no paranoid ideation". The CPN also noted that Mr M continued to have regular contact with his sister, which seemed to have a positive effect on Mr M. The CPN also noted that Mr M's flat remained clean and tidy. Mr M reported to the CPN that he had drunk some alcohol whilst watching sport on TV, but no more than two cans. The clinical record shows that the CPN counselled Mr M about the possible negative effect of alcohol on him and the effectiveness of his medication. Mr M was noted to insist that he had only drunk a very small amount and only occasionally. The records also show that the CPN looked for signs in the flat, but found nothing to suggest that Mr M was drinking excessively. Furthermore, the CPN noted that there were "*no negative behaviours on display*". The clinical record also shows that Mr M and the CPN discussed the timing of the next visit as he (the CPN) was going to be on holiday at the scheduled time. Mr M was noted as preferring to wait until the CJLT CPN had returned from annual leave for his next visit. He did not want a visit from someone he did not know.

5 September 2006: The CJLT CPN visited Mr M as planned. He was, as on previous visits, noted to be well. At this visit, Mr M informed the CPN that he had not taken any medication since his last visit on 25 July 2006. His rationale was recorded as "*he wishes to become a worthwhile member of society, gain employment and contribute as normal people do*". The records show that the CPN advised Mr M that stopping his medication was not an appropriate way to deal with his intention to seek employment. The CPN was noted to have advised Mr M that he should "*consider a gradual reduction and establish the effects of this over a period of time*". The CPN also recorded that Mr M was "*insistent. He would not reconsider and no longer wanted any psychiatric input*". An appointment was made for Mr M to see his consultant psychiatrist, and the CPN noted that he would be attending with Mr M.

13 September 2006: The CPN picked up Mr M and accompanied him to the outpatient appointment. Mr M was noted by the CPN to be "*objectively and subjectively well*" and that there was "*no evidence of any psychotic phenomena, no paranoid thoughts, no thought disorder, no thought insertion*". The extra pyramidal effects of his medication were noted to be diminished and Mr M was noted to have reported that he "*felt better in himself*" and that his "*thoughts were less muddled*". The record also said: "*Despite our insistence that this was only the early stages of his non-compliance with medication, he would not reconsider. However, he did concede about total disengagement, as agrees to see myself in six weeks to monitor his progress*" and thereafter until his next outpatient appointment in March 2007. The record also noted that Mr M agreed that if the CPN was at all concerned about him at his next visit then he would agree to be seen more frequently than six-weekly.

Note: The record made by the consultant psychiatrist mirrors the above nursing record. The additional points her letter to Mr M's GP made are as follows:

Mr M "*denied suffering from Schizophrenia and has only been unwell when under drugs and alcohol*" and "*we couldn't convince him to commence anti-psychotic medication and as there is no evidence of psychotic symptoms or any risky behaviour to him or others we had no grounds for use of the Mental Health Act at this time.*"

The consultant psychiatrist also noted that *“since his release from prison he has not used alcohol or drugs and has not been involved in any criminal activity as far as we could be aware”*.

She also made an entreaty to Mr M’s GP: *“if you have any means of close monitoring of him ... let us know if you have any concerns”*.

28 September 2006: The incident occurred. At this time, Mr M had been non-compliant with his medication treatment plan for a period of nine weeks (25 July to 28 September 2006).

2.0 TERMS OF REFERENCE

The terms of reference for this HSG (94)27 investigation are as follows:

To undertake a validation review of the internal investigation report provided by the then 5 Boroughs Partnership NHS Trust (now 5 Boroughs Partnership NHS Foundation Trust) into the care and treatment provided to Mr M.

The Independent Team was asked to:

- Establish whether the timeline was accurate and all-encompassing, ensuring that the Trust has considered all the relevant evidence; for example, Trust documentation, key witness statements and interviews.
- Undertake a scoping exercise to identify whether all necessary agencies have been considered and included in the internal investigation. Where this has not been the case, to assess whether the inclusion of the information into the timeline could affect the findings.
- Assess whether the analysis undertaken was reasonable and proportionate and accurately reflects the issues identified with the quality of health and social care provided to Mr M.
- Review the Trust's relevant policies and procedures to validate their compliance and that this was accurately reflected in the internal investigation report, paying particular attention to:
 - The Care Programme Approach;
 - The risk assessment process;
 - Care plans; and
 - The Mental Health Act assessment.
- Establish whether the recommendations identified in the Trust's internal investigation report were appropriate and would mitigate against any issues identified.
- Identify any additional learning from this investigation through applying root-cause analysis tools and techniques as applicable.
- Report the findings of the quality assurance review to NHS North West Strategic Health Authority, now NHS North.

Subsequent to the delivery of the initial advisory report to NHS North West, the above terms of reference were expanded to incorporate the following:

To determine:

- Whether Mr M's medication management between April 2006 and 26 September 2006 was reasonable?
- Whether Mr M's care and treatment complied with the statutory requirements of the Care Programme Approach between April 2003 and September 2006?

- Whether there was a suitable risk management plan in place for Mr M from April 2006 to September 2006?
- Whether or not the decision by mental health professionals in September 2006 to accede to Mr M's position of not meeting with them at a frequency greater than six-weekly was reasonable at the time?
- Whether there was reasonable scope for assessing Mr M under the Mental Health Act in the two weeks preceding Mr M's index offence?

These were the questions that the Independent Team considered had not been adequately explored in the Trust's own investigation.

3.0 COMMUNICATION WITH THE SERVICE USER, MR M, HIS FAMILY AND THE FAMILY OF THE VICTIM

In June 2006, the Independent Team established contact with Mr M with the support of his mental health social worker. A letter was provided to Mr M setting out the work the Independent Team had been requested to undertake and seeking consent for access to his medical and other records, if considered relevant, such as the assessments undertaken in custody after his arrest.

Mr M responded to the Independent Team and provided consent on 21 July 2011.

At this time, Mr M made clear his view that he did not wish to meet with the Independent Team.

In February 2012, the Independent Team contacted Cheshire Police to try and effect contact with the family of Mr M's victim. Cheshire Police agreed to forward correspondence to the victim's family on behalf of the Independent Team. As a result, the Independent Team was able to make direct contact with this family. It was agreed between them that the main contact point would be the sister-in-law of the victim and that, once the report was complete in draft, a face-to-face meeting would occur. This took place on 12 June 2012.

Because of the reticence of Mr M to meet with the Independent Team, a decision was made to delay contact with his family. However, as the investigation process was nearing its conclusion, and having had access to information provided by Cheshire Police, contact with Mr M's family was considered to be necessary, a) so that they were made aware of the soon-to-be-published report; and b) so that they could be informed of the content of the report and have the opportunity to make any contribution they deemed necessary.

A letter was written to Mr M's sister on 28 April 2012. At the time of writing, no response to this had been received.

4.0 THE FINDINGS OF THE INDEPENDENT INVESTIGATION

To deliver the terms of reference for this HSG investigation, the Independent Team undertook a detailed analysis of Mr M's clinical records from March 2003 to the date of the incident in September 2006. The investigation tool used to support this analysis was a structured analytical timeline. The replication of Mr M's chronology, using this tool, enabled the Independent Team to forensically examine the care and treatment provided to Mr M by the specialist mental health services at the then 5 Boroughs Partnership NHS Trust.

In addition to its analysis of Mr M's clinical records, the Independent Team also had access to:

- The written interview records made by the Trust's own internal investigation team which related to the following staff:
 - The CPN who met with Mr M between April 2003 and September 2006;
 - Mr M's consultant psychiatrist.
- 5 Boroughs Partnership Trust's CPA and risk assessment policies.
- Information from Cheshire Police, which included:
 - The custody record;
 - The psychiatric report provided to Cheshire Police by Mr M's consultant psychiatrist;
 - An officer's report compiled by a detective constable following a review of the medical notes;
 - The case summary compiled by the Cheshire Constabulary.
- Interview records conducted by the Independent Team with:
 - Mr M's consultant psychiatrist;
 - The CPN in contact with Mr M at the time of the incident;
 - The Community Mental Health Team managers in post in the period leading to and after the incident (one full-time and one part-time);
 - The operational manager/service manager for what was Mr M's community mental health team; and
 - A social care manager in post at the time the incident occurred.
- A telephone conversation with, and written information provided by, the community mental health team manager who was on a secondment to the post between 2004 and 2005.
- The Pre-sentencing Psychiatric Report requested by the Crown Prosecution Service, dated 25 July 2007.
- The Pre-sentencing Psychiatric Report prepared for the defence, dated 9 July 2007.
- The report for the Mental Health Review Tribunal, dated February 1996.
- Correspondence between the regional forensic service and Her Majesty's Prison Service in 1995 requesting Mr M's re-admission back to prison following the successful treatment of his mental health issues.
- A parole report, dated August 1996.

- ❑ A psychiatric report compiled by a forensic consultant psychiatrist in November 1998.
- ❑ Correspondence from the above forensic consultant to the Medical Officer at Her Majesty's Prison, dated 1 March 1999.
- ❑ A report by the consultant psychiatrist at the low secure unit, dated 10 November 1999.

The Independent Team did attempt to make contact with the CPN who had dealt with Mr M between 2000 and April 2003. However, she had moved some eight years ago from her last-known address. The Independent Team also contacted the line manager (now retired) of the CJLT CPN in contact with Mr M at the time of the incident. This individual was about to embark on a number of months' absence from the country at the time the Independent Team made contact with him and he considered that the length of time that had passed and his retirement status precluded his ability to participate.

As a consequence of its analysis of all of the above, the Independent Team was unanimous in its conclusion that the care and treatment of Mr M up to and including April 2003 was of good quality and met with the expected standards at the time in respect of the Care Programme Approach, and risk assessment practice. The requirements of Mr M's section 117 aftercare status were also fully delivered. In fact, Mr M remained subject to section 117 aftercare until 9 March 2004, when he was discharged from this by the local authority. Because of the above, there was no justification to conduct a full independent re-investigation of Mr M's mental health care and treatment over this period. In this regard, the findings of the independent analysis reflected the findings of the Trust's own internal investigation.

With regards to Mr M's care and treatment between April 2003 and the date of the incident in September 2006, for the most part the day-to-day care and treatment Mr M was afforded was of a good standard. He was seen by the CJLT CPN every six weeks and the records demonstrate that reasonable periods of time were spent with Mr M at these times. He also received the necessary medical reviews that he should have and was fully compliant with his medication plan up to 17 May 2006. However, there was nothing in Mr M's records to show that the Trust's responsibilities in relation to Mr M's Care Programme Approach enhanced status were delivered, or that there was any reconsideration of the continued relevance of his 2001 risk assessment at any time. Furthermore, the Independent Team was concerned at the seeming lack of appropriately assertive action following:

- ❑ Mr M's non-attendance/refusal to stay at outpatients on 6 May 2006;
- ❑ Mr M's refusal of his depot injection on 17 May 2006;
- ❑ Mr M's refusal to meet with the CJLT CPN any more frequently than six weekly after he informed him and his consultant psychiatrist that he had ceased all medications on or around 25 July 2006.

Consequently, the following sections of this independent report set out the findings of the Independent Team in respect of:

- The aspects of Mr M's care and treatment it found to be reasonable or good.
- The five key questions agreed with the North West Strategic Health Authority as being essential to the delivery of its obligations under Health Circular Guidance (94)28; and
- The independent assessment of the then 5 Boroughs Partnership's internal investigation.

4.1 The aspects of Mr M's care and treatment the Independent Team considered met or exceeded the standard of reasonableness between March 2003 and September 2006

Although the Independent Team is clear in its perspective that there were some aspects of policy compliance, risk assessment practice and medication monitoring that could and should have been better in the delivery of mental health care and treatment to Mr M there were also aspects of his care and treatment that met and exceeded expectations. It is important that these are acknowledged within the context of this report.

The CJLT CPN although clearly engaged to provide 'temporary' CPN cover to Mr M undertook and achieved a good level of engagement with Mr M for the majority of his contacts with him. The clinical records of the CJLT CPN show that he reliably spent between 60 and 90 minutes with Mr M on a six-weekly cycle. The Independent Team suggests that it is unlikely that Mr M would have achieved this length of visit from the Community Mental Health Team at the time.

By engaging Mr M in games of scrabble the CJLT CPN employed a subtle and clever approach to engaging with Mr M, and assessing his overall mental health. Doing so enabled the CJLT CPN to assess Mr M across a number of issues, e.g. response to losing, response to winning, cognition, etc.

In 2004 when Mr M was discharged from section 117 aftercare arrangements by the local authority The CJLT CPN appropriately thought to increase his level of contact with Mr M while he became accustomed to the change in his care and treatment package. Up until March 2004 Mr M had been in receipt of a visit from his social worker every six weeks. This meant that in practice he had contact with a health or social care professional every three weeks.

Prior to and after March 2003 both of the CPNs involved with Mr M provided him with the support he required to achieve appropriate re-allocation of his housing. This support enabled him to be successful on the occasions that alternative housing was necessary for the continuance of his mental well health.

Both CPN [1] and the CJLT CPN demonstrated diligence in respect of the extra Pyramidal symptoms that Mr M persistently experience on anti-psychotic depot medication.

Mr M did receive a medical review at least once a year between 2003 and 2006.

4.2 The five key questions agreed with the North West Strategic Health Authority as being essential to the delivery of its obligations under Health Circular Guidance (94)28.

The previous section of this report sets out those aspects of Mr M's care and treatment the Independent Team considered met or exceeded the expected standards of the time. This section specifically addresses the five questions agreed between North West SHA and the Independent Team as requiring further analysis to determine whether or not the care and treatment of Mr M was reasonable over the three years leading to the incident, and in particular over the immediate preceding six months.

4.2.1 Was Mr M's medication management between March 2006 and 26 September 2006 reasonable?

Summary response:

The Independent Team is satisfied that the medication management of Mr M was reasonable up to and including April 2006. However, after April 2006, when his medication was, at his request, changed from fortnightly depot injections to monthly injections and oral medication, there was insufficient monitoring of the impact of this change for him. In fact, there is no evidence that the process of changing Mr M's medication was completed, or progressed safely. When Mr M informed his CJLT CPN on 5 September 2006 that he had ceased all medication after his last visit on July 2006, the response of the CPN in booking an early medical appointment for Mr M was an appropriate response to the situation.

The forensic history and the chronology of Mr M's contact with the mental health services provided by 5 Boroughs Partnership NHS Trust, presented on pages 9-16 of this report, show clearly that Mr M had a notable criminal history prior to any diagnosis of a severe and enduring mental health disorder. The chronology also shows that, following diagnosis and treatment with medication, Mr M's chronic history of criminality ceased. The Independent Team considers it notable that in 1999, when Mr M was released from prison without any parole conditions and having ceased his medication approximately six weeks prior to his release, he re-offended quickly, on 5 November 1999. A consequence of this was his assessment and detention under the Mental Health Act. Mr M was initially stabilised and managed in an intensive psychiatric unit, and then underwent a considerable period of rehabilitation before being discharged back into the community in January 2001.

Mr M did challenge the legalities of his detention under the Mental Health Act and a report prepared for the Mental Health Review Tribunal, dated 21 March 2000, highlighted *"that were [Mr M] to cease to comply with medication he would deteriorate and become a risk to others"*.

All of the nursing and medical records subsequent to that date report Mr M as being medication-compliant and recognising that he required the medication to stay well. All of the nursing progress records also report that Mr M was reliable

in attending for his depot medication, never missing one. His mental state throughout was noted to be stable, even though he continued to experience hallucinations. He was also noted to be amiable.

When, on 15 March 2006, he sought the support of his consultant psychiatrist in changing the medication he had successfully received for six years, the Independent Team considers that it was reasonable that she supported this request.

The statement the consultant psychiatrist provided to Cheshire Police stated:

“On his scheduled appointment on 15 March 2006, he came to clinic adamant that he didn’t want to continue having his injection each fortnight as it would mean to him that he spends a good ninety minutes between walking to the clinic, having the injection done, and then turning up to his home. He said the area (around his home) over the last 12 months had become really rough and there had been so many incidents of burglary in houses and he felt he could easily be a victim of this as every couple of weeks at the same day and time he wouldn’t be home for ninety minutes. He said that as well as this he is having a tablet each day (Lithium) he wouldn’t have any problems in taking the anti-psychotic (Flupenazine Deconate) but in tablet form. He said he wouldn’t mind being reviewed in our clinics as before and he will still have contact with his community psychiatric nurse.”

Mr M’s consultant psychiatrist advised Mr M that before making any change to his medication, she would review his medical records to see what medications he had been given in the past so that she could determine what would be most suitable for him. In the meantime, Mr M agreed to continue with the established medication regime and an appointment was made for him to re-attend to meet with his consultant on 4 April 2006.

At her interview with the Independent Team, the consultant reported that *“it is always easier with the injection as he was getting a steady dose and there were fewer side effects. He was already taking tablets, so there was no argument about him not remembering to take them as he already was”*. The consultant also told the Independent Team that Mr M’s Lithium levels were always *“fine”*.

The Independent Team agrees that in Mr M’s circumstance it would have been very difficult not to have supported him in changing from injection-based to an oral anti-psychotic medication.

The medical records reviewed informed the consultant that Mr M had previously responded to two different medications, one of these being Clozaril. This had been stopped owing to drowsiness; furthermore, when on a high dose Mr M had developed encephalitic-type symptoms. The other medication he had previously responded to was Fluphenazine Deconate, the medication he was at the time prescribed. The consultant psychiatrist therefore determined that the most appropriate medication would be the oral equivalent of this. The Independent Team considers that Mr M’s consultant psychiatrist undertook a reasonable approach to determining what medication would work best for Mr M and that her eventual choice of Flupenazine Hydrochloride was appropriate.

Mr M re-attended to meet with his consultant psychiatrist on 4 April 2006. At this appointment, his consultant recounted to him her assessment of his past medication and his current medication needs. She advised him that, in her opinion, the most appropriate oral anti-psychotic for him was Flupenazine Hydrochloride at a dose of 5mg twice a day. Her subsequent letter to Mr M's GP said Mr M *"agreed to take the tablets and he seemed to be very committed to follow the oral prescription as he is very much worried about leaving his house empty"*. Her letter also said: *"he understood the risks of stopping his oral medication and he is willing to be followed up more often until the dose is adjusted"*. The consultant psychiatrist concluded this letter with: *"I would be grateful if you could prescribe for him Flupenazine Hydrochloride 5mg bd. His Deconate will remain on 50mg IM, but on a monthly basis instead of fortnightly until his next review on 3 May 2006."*

The Independent Team considers all of the above to have been reasonable practice and appropriate in the presenting circumstances.

A letter of 5 May 2006 to Mr M's GP shows that Mr M did not attend for his outpatient appointment on 3 May 2006. However, the information in the Trust's internal investigation report conflicts with this, saying,

"Staff Grade conducted out-patient clinic, but [Mr M] only wanted to see [his consultant psychiatrist]. Next appointment with [Mr M's consultant] originally made for August 06, but was subsequently 'rescheduled'. Next seen by Dr D on 13.09.06 with [CJLT CPN]."

There is no entry in Mr M's clinical record of him attending at his outpatient appointment on 3 May, or of his refusal to meet with the staff grade, that the Independent Team could locate. Furthermore, the statement provided by Mr M's consultant psychiatrist to Cheshire Police simply says: *"he didn't attend his appointment arranged for him in May 2006"*. (The report is undated.) The weight of information suggests that Mr M did not attend. A review of the Trust's own interview with Mr M's consultant psychiatrist on 28 February 2007 revealed that she was the source of the information about the staff-grade doctor. In her 'Trust' interview, she told the internal investigation team:

"On 3/5/06 the staff grade did the clinic, but [Mr M] didn't want to see anyone but myself. The appointment was 1st rearranged to Aug 06, but was then rescheduled. I think it was possibly due to staff shortage/sickness."

As the above indicates, the response to Mr M's non-attendance was to send him another follow-up appointment for a further three months' time. It is at this juncture that the Independent Team considers that Mr M's care and treatment fell below expected practice standards, and deviated from the plan documented by Mr M's consultant on 4 April 2006, i.e. closer follow-up until his new medication regime was established.

Mr M's consultant psychiatrist took no positive action to establish how Mr M was responding to his new medication regime; furthermore, the CJLT CPN who was visiting Mr M on a six-weekly basis told the Independent Team that at the time he was not aware that his medication had been changed. The Trust's own interview with Mr M's consultant psychiatrist validates this, as she did not know

whether the CJLT CPN knew, when it would have had to have been her or one of her team that informed him.

Mr M's consultant psychiatrist told the Independent Team that, reflecting on the case now, she could appreciate that there was a long gap between April 2006 and September 2006, which was when she next met with Mr M. She recalled that at the time there were insufficient flagging systems in place; a situation that is very different now in 2012. Furthermore, the now-established system of weekly team meetings in the community mental health team, and the co-location of the community mental health and criminal justice liaison teams, means that timely communications between team members is immeasurably easier than they were in 2006. The robustness and breadth of contemporary monitoring systems was commented on by all interviewees. Mr M's consultant psychiatrist considered that, with the benefit of hindsight, although the decisions made with regards to Mr M's medication would remain largely unchanged, what would be different in 2012 would have been the follow-up surveillance of the impact of the medication change.

The Independent Team suggests that the following should have happened when Mr M did not attend on 3 May:

- ❑ Contact with the depot clinic to ascertain whether or not he had attended for his depot;
- ❑ Contact with the CJLT CPN to visit Mr M at home to establish how his new medication regime was suiting him;
- ❑ A follow-up medical appointment arranged within at least a month.

The then 5 Boroughs Partnership Trust's internal investigation report noted that, on 17 May 2006, Mr M attended for his depot injection but refused it, informing the depot nurse that he had commenced on oral medication. The internal report noted that the OTTER record at the time stated that the depot nurse informed Mr M's consultant psychiatrist of Mr M's refusal. When interviewed by the Trust's own investigation team on 28 February 2007, Mr M's consultant was reported as saying that she did not:

"recall being informed. But anyway, I was reviewing/changing the medication regime, and he was due to commence oral medication instead, so it would not have mattered. I wrote to the GP."

The Independent Team considers this to have been an insufficient response to the Trust's investigation team, who had asked Mr M's consultant if she was concerned that Mr M had missed one of his depot injections. It is the view of the Independent Team that, had those staff conducting the investigation been more experienced in doing so, and had there been an 'independent' consultant psychiatrist present, this issue could have been explored more thoroughly at a time when staffs' memory recall was more reliable; for example, Mr M's consultant says that she wrote to Mr M's GP. The only letter was following the April 2006 appointment. There was no further advisory communication to the GP after Mr M refused to stay/did not attend for his May appointment.

Mr M was visited by the CJLT CPN on 30 May 2006, 6 June 2006 and 25 July 2006. The record made of the visit on 6 June says: “[Mr M] continues to engage with his treatment pathway and remains compliant”.

On 25 July, treatment compliance is not mentioned in the clinical record; however, the CJLT CPN did record that he counselled Mr M about the negative effects of alcohol on the effectiveness of his medication, on learning that Mr M had partaken of some alcohol while watching the football.

Having interviewed the CJLT CPN, the Independent Team is confident that, had this nurse been informed:

- ❑ about the change in Mr M’s medication regime;
- ❑ that Mr M had not attended at his May outpatient appointment; and
- ❑ that Mr M had refused his depot injection on 17 May 2006;

he would have:

- ❑ visited Mr M more frequently during the change-over period (i.e. moving from depot to oral medication);
- ❑ explored with Mr M why he did not attend for his outpatient appointment.

When the CJLT CPN was informed by Mr M on 5 September 2006 that he had stopped all medication after his last visit to meet with him on 25 July, the CPN arranged an appointment with the consultant psychiatrist at the earliest opportunity, which was 13 September 2006.

The CPN’s clinical record also shows clearly that he counselled Mr M about the risks of suddenly stopping his medication. The record also shows that Mr M was “insistent that he would not reconsider and no longer wanted any psychiatric input”. Nevertheless, following persuasion by the CPN, Mr M did agree to see his consultant psychiatrist on 13 September 2006.

Both the CJLT CPN and Mr M’s consultant psychiatrist have consistently reported:

- ❑ in the contemporaneous clinical record;
- ❑ to the Trust’s own investigation team;
- ❑ to Cheshire Police; and
- ❑ to the Independent Team;

that, when they met with Mr M on 13 September 2006, they spoke frankly with him about the need to re-engage with his medication regime, but that Mr M refused. At this stage, and based on what the Independent Team knows about Mr M’s presentation at the time, it is satisfied that, on 13 September 2006, Mr M would not have been detainable under any section of the Mental Health Act.

The 13 September 2006 meeting was the last contact the CJLT CPN or Mr M’s consultant psychiatrist had with him.

4.2.2 Whether Mr M's care and treatment complied with the statutory requirements of the Care Programme Approach between April 2003 and September 2006?

Summary response:

Mr M's clinical records show that he was an Enhanced CPA patient and that there were annual CPA reviews in 2001, 2002, 2003 and 2004. However, there is no information to suggest that there was a CPA review in 2005 or in 2006. This means that Mr M's care and treatment was not compliant with the statutory requirements of CPA in those two years. Although the annual reviews did not occur as they should have, Mr M was seen by his CJLT CPN every six weeks between 2003 and 2006, a pattern of contact that had been established with CPN [1]. He also received medical assessments on seven occasions between 2002 and 2006, which met with the then CPA standards of at least yearly assessments for all service users on CPA. Had Mr M received his CPA reviews in 2005 and 2006, it is possible that it would have triggered his consultant psychiatrist to have copied the CJLT CPN in on correspondence between the psychiatrist and Mr M's GP. Had this occurred, the CJLT CPN would have been informed of the change in Mr M's medication regime in April 2006. How much difference this would have made to Mr M's overall management plan or to the surveillance of Mr M is difficult to say. The Independent Team suggests it is more likely than not that there would have been a short period of enhanced surveillance, but that in all likelihood the established pattern of six-weekly contact visits would have resumed before July 2006.

The main reason why Mr M did not receive his annual CPA reviews in 2005 and 2006 seems to be attributable to the fact that Mr M was not entered fully on to the electronic records system OTTER in 2005 and that the CJLT CPN who took over the provision of CPN services to him in 2003 had handed Mr M's care over to the newly appointed CMHT care co-ordinator on 24 July 2004. This individual soon after went on sick leave and then maternity leave. In agreeing to do this, the CJLT CPN did not appreciate that he was also expected to assume the care co-ordination responsibility.

As events transpired, the appointed CMHT care co-ordinator did not return to work and in December 2005 the CJLT CPN was asked to continue providing a service to Mr M until such time as another care co-ordinator could be allocated. At the time the incident occurred, no care co-ordinator had been allocated.

Prior to 2007 the then 5 Borough Partnership NHS Trust's Care Programme Approach Policy stated that the responsibilities of the care coordinator were to:

- Ensure all assessment documentation is completed.
- Ensure that a care plan was agreed with the service users. Where a service user met enhanced CPA requirements to ensure that there had been multi-professional engagement in the formulation of the care plan.
- Ensure that there were clear instructions provided to the service user regarding contact points 'out of hours'.
- To ensure that the care plan was reviewed at "*regular intervals or when there was a change of circumstances, or cause for concern*".

- ❑ Where risks were identified in an assessment to ensure that the risk and the agreed management plan was documented in the care plan.

With regards to the frequency of reviews, the policy said that these “*were likely to be held every three to twelve months after the initial CPA meeting.*” And that “*everyone on standard CPA must be reviewed at least once in twelve months*” For service users on enhanced CPA the policy stipulation was that a CPA review should occur every six months with a new care plan formulated every twelve months regardless.

The Independent Team’s analysis of Mr M’s records revealed that there were regular CPA reviews conducted for Mr M, which included the multi-disciplinary team, including Mr M himself. These occurred on:

- ❑ 22 May 2001
- ❑ 20 December 2001
- ❑ 17 June 2002
- ❑ 7 January 2003
- ❑ 12 March 2003 (Mr M’s records noted that his CPA reviews went to annual instead of six-monthly reviews after 1 January 2003.)
- ❑ 7 January 2004 (That this review occurred is documented in the CJLT CPN’s record; however, the Independent Team has not been provided with any of the formal paperwork that should have been completed. It appears that none was completed.)

Overall, the CPA documents completed were comprehensive, addressing:

- ❑ Mr M’s access to outreach services and his social worker;
- ❑ the continuance of community psychiatric nurse input;
- ❑ the continuance of depot medication;
- ❑ the reliability of Mr M in collecting his Lithium medication and his adherence to the prescribed medication regime;
- ❑ Mr M’s attendance at outpatient appointments, which was always considered to be reliable;
- ❑ Mr M’s contact with his family, which was noted to be regular and enjoyable; and
- ❑ Mr M’s social and accommodation needs and how he was managing with independent living.

The CPA documents provide a clear chronology of Mr M’s steadiness in the community and also his increasing confidence and ability for self-care and independence between 2001 and March 2003.

As indicated above, the CPA review of 2004 was clearly identified in the community mental health nursing record as conducted with Mr M’s then social worker. The CJLT CPN record also noted that Mr M’s consultant psychiatrist

was unable to attend. The Independent Team sought to communicate with the CPA administrator in post at the time; however, this individual has now retired and, because neither the local managers nor the internal investigation team were able to locate any formal CPA documents for 2004, the Independent Team did not consider it reasonable or proportionate to the independent process to approach the then CPA administrator in her retirement years. It is the Independent Team's impression, as a consequence of interviewing the CJLT CPN who was providing CPN input to Mr M at the time, that no paperwork was completed.

From January 2004, there is no information demonstrating that the professionals engaged with Mr M complied with CPA requirements until after the incident. This occurred on 13 October 2006, when a CPA assessment was completed by a social worker in the criminal justice liaison team. Mr M's CPA level at this time was identified as standard.

In light of the regular contact Mr M's CJLT CPN had with him between 2003 and September 2006, and the fact that he was present at the CPA review of January 2004, the Independent Team was interested to know why no CPA review was arranged in January 2005 or January 2006.

The CJLT CPN told the Independent Team that he was not invited to any CPA reviews for Mr M in 2005 and 2006. Had he been invited, he would have attended. He told the Independent Team that he did not perceive it as his responsibility to be organising the CPA reviews, as he was not Mr M's substantive CPN or care co-ordinator. The Independent Team appreciates that in 2004 a substantive CPN had been allocated to Mr M as a care co-ordinator, but that this individual soon after became unwell and did not return to work. The CJLT CPN was asked to continue to provide a CPN service to Mr M. The Independent Team considers that the CJLT CPN should have realised that, as he was the professional having the most substantive contact with Mr M, and because he knew he was covering all CPN duties, he should have appreciated that it was his responsibility to ensure that Mr M's care and treatment was in line with CPA requirements.

Interviews with the CMHT managers who came into post in Mr M's CMHT in 2005 underlined for the Independent Team that its above perspective was reasonable. The CMHT managers considered that, in light of the CJLT CPN's level of experience, he did have a responsibility for delivering the CPA reviews. Furthermore, it is the impression of the Independent Team that it was the general expectation in the Trust at the time that any CPN substantially engaged with a service user knew that it was their responsibility for delivering CPA requirements.

The current CJLT manager who was working in the then 5 Boroughs Partnership Trust prior to 2006 also told the Independent Team that now and at the time, the CJLT staff did act in a care co-ordination capacity, so they were familiar with what the roles and responsibilities of a care co-ordinator were.

However, in 2003, the CJLT was a fragmented team and, although it worked closely with the CMHTs, it was not linked to them. The CJLT CPN who was working with Mr M was an experienced autonomous worker who had established good relationships with the police and would have delivered what he considered was necessary in his regular contacts with Mr M. The current CJLT manager also told the Independent Team that, although the CJLT CPN *“may not have been formally handed over the case, he was very experienced, operating at (the now) Band 7 level (then Grade G)”*. She told the Independent Team that *“[it is her] perspective that the CJLT CPN should have realised that, in taking Mr M’s care, he had also assumed care co-ordination responsibility and all that went with it”*.

Although the Independent Team knows that this is not how the CJLT CPN interpreted the situation, it agrees with the current CJLT manager that the CJLT CPN *“did in fact develop a good rapport with Mr M between 2003 and the incident date”*. The current Operations Manager, who was not at all connected with the service at the time, also concurs.

Mr M’s consultant psychiatrist told the Independent Team that, at the time Mr M was a service user of the Trust, there was not as much emphasis on a service user’s CPA status in the community. She recalled that she would *“discuss with the attending CPN any changes with regards to CPA, but that was as far as it would go”*.

The Independent Team considers that, had the Trust had effective local and corporate performance-monitoring systems in place between 2003 and 2006, then the omission with regards to the CPA requirements would not have occurred. Interviews with the CMHT managers in post between 2005 and 2006 informed the Independent Team that, prior to 2005 there had been a period of instability for the CMHT with regards to CMHT leadership. In 2004, a member of staff was seconded into the position, but then moved back to her substantive post. It was not until 2005 that permanent team leadership was achieved. During this period there were significant developments occurring within the Trust with the reorganisation of CMHT boundaries and the implementation of the Trust’s electronic system. These activities would have been dominant for the local managers at the time.

Mr M’s CMHT was a test site for the new electronic system (OTTER) and all service users were entered on to this. The CMHT team were provided with specific training and administration support to enable the details of all service users, including their CPA status, to be entered on to the system.

It is the understanding of the Independent Team, from interviews with the CMHT manager and the current CJLT manager that the CJLT CPN had not been on the OTTER training. At the time, he continued to maintain handwritten records in the traditionally styled community records, which he kept with the records of other CJLT service users that he was assigned to. The Independent Team also understands that the CJLT CPN did not receive the management

supervision that he should have done. He informed the Independent Team that, although appointments for this were often booked, they were frequently cancelled. It is the impression of the Independent Team that, because of his experience and the nature of his work, the CJLT CPN was very much left to 'get on with it', with the assumption made that if there were any concerns about Mr M then the CJLT CPN would raise them appropriately.

Because Mr M was not on the caseload of any of the CMHTs at this time, and the new team leaders were not aware that he was being managed out of team until the incident occurred, they were i) unaware of him or that he belonged to the CMHT; and ii) unaware that CPA requirements were not being delivered to him. One of the team leaders, who remains as the current CMHT team leader, advised the Independent Team that, with the implementation of OTTER, it became immeasurably easier for a team manager to audit which service users were on CPA, whose CPA reviews were overdue, and which service users had not received any clinical visit in the last six months, etc. These were performance checks she instituted in her team, and had Mr M been on the OTTER system she would have been able to follow-up with the CJLT CPN what the situation was in relation to CPA and also to have better managed bringing Mr M back into the CMHT, which clearly had been on the mind of her predecessor.

The presenting circumstances at the time raised a question for the Independent Team about how decisions were made about service users who need to be managed out of team.

The Independent Team was informed that, at the time Mr M's day-to-day case management was passed to a professional outside of the CMHT, the team were experiencing sustained periods of short staffing and difficulties in recruitment. To have asked someone as experienced as the CJLT CPN to have adopted the CPN responsibility for Mr M was therefore appropriate. It is also clear from the clinical record, and the Independent Team's interview with the CJLT CPN, that the line manager for the CJLT had been involved in the decision to place Mr M 'out of team', as it was he that asked the CJLT CPN if he would act as CPN to Mr M. In this respect the process was reasonable.

However, the process did lack robustness as:

- ❑ there was no handover between CPN [1] and the CJLT CPN;
- ❑ there were no time boundaries set for reviewing the situation;
- ❑ there was no consideration once it was clear that the arrangement was medium- to long-term to formally transfer Mr M to the CJLT CPN; and
- ❑ expectations of the CJLT CPN were assumed rather than explicitly stated.

Because of these factors, the situation was in many respects allowed to drift, and this was and remains unacceptable.

The Independent Team is reassured that this situation would not occur today (2012) (see section 5.0 of this report).

Opinion of Independent Team

The lack of CPA reviews for Mr M in 2005 and 2006 was not acceptable. What material difference would have been to Mr M's care and treatment had CPA requirements been complied with is difficult to say at this retrospective distance. However, the Independent Team considers it reasonable to suggest that the CJLT CPN would have been more informed by Mr M's consultant psychiatrist about the changes occurring to Mr M's medication regime. Whether knowledge of this would have resulted in more assertive management of Mr M when he refused all medication in September 2006 is not possible to say. On the basis of the interviews conducted with Mr M's consultant psychiatrist and the CJLT CPN, the Independent Team suggests that Mr M's management at the critical time would have remained less assertive than that which was required.

4.2.3 Whether there was a suitable risk management plan in place for Mr M from April 2006 to September 2006?

Summary response:

Subsequent to the risk assessment conducted in January 2001, and the updates to this that occurred in the same year, the clinical records show that it was the consideration of Mr M's mental health team that, up to and including March 2003, the updated risk assessment of July 2001 remained relevant to the contemporary care and treatment of Mr M. The Independent Team has neither seen nor learnt of any information that suggests that this was not the case. After March 2003, Mr M's risk assessment was due to be reviewed on an annual basis, to determine whether or not changes to it were required or whether the *status quo* remained. Although the 2001 risk assessment remained relevant up to and including March 2006, there was no formalised consideration of this as Mr M did not receive any CPA reviews between March 2003 and March 2006. The significant change in Mr M's circumstance in April 2006 when his medication was altered should have prompted a review of his risk assessment. Furthermore, his default from the outpatient clinic and refusal of depot medication in May 2006 should have also prompted a review of his risk assessment. Finally, even if his risk assessment was not reviewed in April or May 2006, it absolutely should have been reviewed between 5 and 13 September 2006, when Mr M first reported being medication non-compliant and then continued to refuse medication. That there was no review of Mr M's previous risk assessments at this time, and no formulation of an up-to-date risk management and contingency plan, fell below the practice standards of the time.

The primary responsibility for ensuring that the risk assessment for a service user is reviewed and updated as appropriate generally falls to a service user's care co-ordinator, or most frequently attending professional. In this case, there is no doubt in the minds of the Independent Team that the professional who should have ensured that Mr M's risk assessment was reviewed was the CJLT CPN. The Independent Team accepts that this individual was asked to provide a CPN service to Mr M on a temporary basis and that it was never the intention that he would be providing this service for as long as he did. Nevertheless, the CJLT CPN was a very experienced professional and was well versed in the expected professional practice standards. Whatever the weaknesses in the systems and processes at the time, the CJLT CPN should have made it his business to review the risk assessment documentation contained in the CPN community records he had. He should also have noted his professional opinion as to the currency of the risk assessment of 2001, based on his own assessment of Mr M. However, it is clear from the clinical records made that the CJLT CPN was aware of some of Mr M's risks and took appropriate measures to determine whether or not there were any indicators in evidence, such as observing Mr M's living accommodation for signs of neglect and any excessive alcohol intake, or any alcohol intake at all. The CJLT CPN told the Independent Team that the main reason he did not conduct a formalised risk assessment with Mr M was because his presentation was constant for the entire time he had contact with him, excepting September 2006.

However, it is notable that the CJLT CPN felt he was not fully aware of the risks or forensic history of Mr M as no-one had informed him that there were risks. The Independent Team learned of Mr M's previous risk assessments by reading the community nursing file, a file that was held by the CJLT CPN for the three years he was acting CPN for Mr M.

In this file was a document entitled "*Care Programme Approach Screening Form/Register of Risks*". On 21 February 2001, this form identified that:

- ❑ There was evidence of past serious personal neglect.
- ❑ There was evidence that Mr M had been subjected to past ill treatment/abuse.
- ❑ Mr M had attempted (in the past) to physically harm others and had been successful in doing so.
- ❑ Mr M had been charged with and served a sentence for assault.
- ❑ Mr M suffered from hallucinations/delusions.
- ❑ Mr M had been known to be non-concordant with medication and that he had been receiving depot injections for the last 12 months.
- ❑ That Mr M was at risk of refusing treatment after discharge.
- ❑ Mr M required more than two services to address his needs and behaviours.
- ❑ Mr M could maintain a safe environment.

The outcome of Mr M's assessment at this time was that he required an enhanced CPA care package and that "*there [was a] high risk element which will require ongoing multi-agency support from health and social services, including outreach service*".

On another document referenced as *CPN/ASS2.DOC*, which was contained in the same file, it stated: "*Main risk areas: Non-compliance with medication and engagement with services plus potential harm/injury to others.*"

Also contained in Mr M's community file were the Care Programme Approach "form 1" documents for

- ❑ 2001 (x3 – January, May and August).
- ❑ 17 June 2002. This document states that there was no risk assessment undertaken as there was no change to the already formulated risk assessment.
- ❑ 12 March 2003. This document specifically notes that no risk assessment was undertaken and that Mr M remained subject to section 117 aftercare.

On 12 March 2003, it was recorded that the next CPA review for Mr M was to be on 7 January 2004. This did not occur.

In addition to the above, there was a detailed risk assessment form in Mr M's community records, also completed in January 2001. This identified:

- Mr M was at risk of impulsive behaviour and violence to others and self. This risk was at the time identified as high.
- Mr M was at risk of a deterioration in his mental health owing to his own lack of insight into his mental health difficulties and his difficulty in finding an acceptable way of discussing 'voices' with anyone. This risk was at the time identified as high.
- Mr M was identified as at risk of treatment non-compliance, both contact and medication. This risk was noted as high.

There was a clearly structured risk management plan also documented.

However, by July 2001, Mr M's risks had been re-graded to low across the board in light of his complete compliance with his treatment plan. At a review in January 2003, there was noted to be no change in this assessment and Mr M's risks remained low for all of the above. A handwritten note in January 2003 said: *"Client remains well, no change in risk assessment. Client is positively achieving and to ask him to sign the risk assessment we feel would be detrimental to his mental health."*

The Independent Team notes that, at the time and currently, the practice of a rolling risk assessment and risk management plan is acceptable, providing that there is a clear demonstration that the relevant mental health team/professional has formally considered the currency of the plan and has documented this.

Clearly, understanding why the CJLT CPN did not inform himself of Mr M's risk history was important to the Independent Team. When the Independent Team interviewed the CJLT CPN, he told the Independent Team that, when he agreed to act as a temporary CPN for Mr M, he was advised that *"there were no risks and [he] was led to believe [Mr M's] risk assessment was low to medium, but he was given no formal handover"*. The CJLT CPN also told the Independent Team that he was not aware of Mr M's previous forensic history. He reported that one of the reasons he did not further explore Mr M's care in the intensive psychiatric unit was that, at the time he accepted CPN responsibility for Mr M, he had been visited for some time by an unaccompanied female CPN; this fact further re-enforced for the CJLT CPN Mr M's low-risk status at the time. This impression was further underlined when the CJLT CPN met with Mr M. He found him to be *"pleasant, sociable, charming and likeable"*.

This CJLT CPN was asked by the Independent Team whose responsibility it was to *"ensure that a nurse is aware of risk history and relapse indicators for a service user?"* To this question the CJLT CPN responded:

"Ultimately, it is my responsibility to ensure a client's risk history and I would do this for every new client I see. However, when I was asked to 'caretake' Mr M and informed him that he would be seen every six weeks by myself until a care co-ordinator had been appointed, the indications were that the risks were

minimal and I did not expect to have remained in contact with [Mr M] for the length of time I eventually did.”

As indicated above, although the Independent Team can understand the perspective of the CJLT CPN he was suitably experienced and of a sufficiently senior grade to have appreciated that Mr M would have needed a CPA and risk assessment review. The Independent Team accepts that the circumstances under which the CJLT CPN was asked to provide CPN services to Mr M were not at all ideal. However the Independent Team does not consider this practitioner’s perspective that he was providing a ‘temporary service’ negated his professional responsibility to ensure that CPA requirements were delivered. In 2005 and 2006 respectively the CJLT CPN had been providing a CPN service to Mr M for 21 months and 33 months respectively.

In stating the above, the Independent Team also considers that the manager of the CJLT and the then community mental health team manager also lapsed in their duties. The CJLT CPN should have been receiving regular supervision from his line manager, which he was not, and both the CJLT and CMHT managers should have been monitoring the situation and ensuring that all features of Mr M’s care package were being delivered. None of the managers involved discharged their duties in this respect. There is therefore shared culpability for the lapse in the adherence to policy standards.

Because of the lapse adherence to the then policy standards, the question of most relevance to the terms of reference for this independent investigation is: *“What difference would it have made to Mr M’s day-to-day management, and what possible difference would it have made to the sequencing of events 13 September to 26 September 2006 had the CJLT CPN been more risk aware?”*

The opinion of the Independent Team

With regards to Mr M’s day-to-day management, it is the perspective of the Independent Team that there would not have been material difference to Mr M’s day-to-day management plan. Furthermore, it is unlikely that the professional perspective about Mr M’s risk factors being low would have changed. The reason for this is that Mr M complied fully with his treatment plan. The CJLT CPN’s progress records provide ample information to show that Mr M’s condition remained stable, as it had done between 2001 and 2003. The Independent Team also considers that, whilst treatment-compliant, Mr M’s risks were low.

The aspect of Mr M’s day-to-day care that may have differed, had the CJLT CPN read Mr M’s community mental health records, was a greater attention to exploration of Mr M’s voices and the extent to which they were troubling him. The persistence of Mr M’s voices, in spite of his medication, was well reported in his nursing and medical records, as was Mr M’s occasional reticence in discussing them. However, the nursing records up to March 2003 also show that the CPN (2001-2003) did periodically ask Mr M about his voices and how he would rate them on a scale of 1-10. The records suggested that he would

generally rate them as a 4/10, and that he could manage them. The CJLT CPN's records do not demonstrate that he asked Mr M about his voices in a direct way, or considered the presence of voices on a regular basis.

Following its interview with the CJLT CPN, the Independent Team is satisfied that this professional was mindful that Mr M experienced hallucinations. This professional told the Independent Team that he did not specifically ask Mr M about these because there was nothing in his presentation at the time of their meetings that suggested in any way that Mr M was either experiencing hallucinations, or was being troubled by any hallucinations he may have been having. The CJLT CPN considered that the length of time he was spending with Mr M (60-90 minutes) was sufficient that any concerning signs would have materialised. Although the Independent Team can appreciate the CJLT CPN's perspective, it does not consider his reliance on his interactions with Mr M, in the absence of any direct questioning about hallucinations, as representing a sufficiently robust assessment of Mr M. This being said, the Independent Team accepts that, had direct questioning been employed, it is by no means certain that Mr M would have revealed any changes in his experience of his voices.

In spite of its perspective, the Independent Team wishes to make clear that it considers that the engagement of Mr M in regular games of Scrabble represented a clever and subtle form of assessment that was mostly appropriate for Mr M. Engagement in this board game would have enabled the CJLT CPN to have assessed:

- ❑ Mr M's alertness;
- ❑ the appropriateness of Mr M's conversation;
- ❑ Mr M's reactions to winning and losing;
- ❑ Mr M's levels of concentration and his ability to sustain this;
- ❑ Mr M's thought processes; and
- ❑ Mr M's cognitive function.

A second specific aspect of Mr M's care that the Independent Team considers would have changed had the CJLT CPN familiarised himself with Mr M's past history was the assertiveness of follow-up for Mr M once he became medication non-compliant. As previously stated, the CJLT CPN took appropriate action when he was first informed by Mr M that he had ceased all medications after his appointment in July 2006. The CJLT CPN arranged for an urgent outpatient appointment with Mr M's consultant psychiatrist and collected Mr M and took him to the appointment on 13 September 2006. The Independent Team has no criticism of this. It is the actions after 13 September that the Independent Team considers would have been managed differently had the CJLT CPN possessed a more complete understanding of Mr M's history.

At interview, the CJLT CPN himself suggested that, had he known more about Mr M's history, he would not have been satisfied with the six-weekly contact Mr M agreed to on 13 September. He (the CJLT CPN) would have wanted to have achieved this on an at least three-weekly basis. The Independent Team

considers that, in light of Mr M's history, and the fact that there was information in his accessible records that indicated a causal link between Mr M's medication compliance and the stability of his mental health, one would in fact have wanted to have made more of an effort to meet with and assess Mr M on at least a weekly basis.

Because the perspective of the Independent Team differed from that of the CJLT CPN, it asked three other professionals (one CPN, one approved mental health practitioner, one social worker) what frequency of visits they would have expected in a similar circumstance. All three professionals said that they would have wanted to have tried to have achieved weekly contact with Mr M, and that they would have wanted to have assertively pursued this, even if Mr M was reluctant. The CJLT CPN accepts that this would have been ideal. He also feels that his colleagues are able to confidently state this with the benefit of hindsight and not having dealt with the situation on the ground as it was in September 2006. The CJLT CPN advised the Independent Team that he had developed a good rapport with Mr M and did not want to irreparably damage this and lose any opportunity for persuading Mr M to re-engage with his medication. However, if he had been more aware about his risk history he would have been even more assertive that he was.

The reason why the Independent Team considers that weekly follow-up was essential following the outpatient appointment of 13 September is because face-to-face observation with Mr M was the only assessment tool available to the mental health service. The only other avenue of enquiry would have been to communicate with Mr M's family, particularly his sister, to ask her and other family members to let the mental health team know if they saw signs of deterioration in Mr M. The potential risks to others as a consequence of Mr M being un-medicated and unobserved were such that the duty of confidentiality was overridden by the need to protect the safety of Mr M and also the safety of others. Had contact with Mr M's family occurred, it is possible that mental health services may have become aware that Mr M's *"alcohol consumption had increased since he stopped his medication and that he was more pre-occupied than normal and seemed more frustrated and anxious"* (information provided by family members and detailed in the pre-sentencing psychiatric report prepared for the solicitors acting for Mr M, dated 9 July 2007).

Mr M's consultant psychiatrist

The CJLT CPN was not the only professional aware that Mr M had stopped his medication. His consultant psychiatrist at the time had been his consultant since 2002. She was aware that he had:

- ❑ A previous forensic history;
- ❑ A period of time in low secure services following his detention under Section 3 of the Mental Health Act.

Her experience of him between 2002 and 2006 was that he was *"a normal guy. ... He had normal follow-up with not many problems. He was happy and easy*

going, wouldn't go into much detail about himself, he was very factual. He was never happy at taking medication, but accepted that he had to ... I do not remember any communication from the care co-ordinator about him being high risk; he was not that type of client at all. I felt very confident in him; he was always there for his clinic appointment and there were no 'did not attends', apart from the last one. There was no guarding; he made pleasant conversation. He would talk of voices, but they didn't worry him much; we talked about distraction techniques, but he said they didn't work, so he just doesn't listen to the voices."

Mr M's consultant psychiatrist also told the Independent Team that she became fully acquainted with Mr M's history only when he requested a change of medication in March 2006. She then undertook a review of all of his records so that she could address his request safely. As identified in the previous section, on the appropriateness of Mr M's medication management, the Independent Team considers that it was appropriate and prudent that Mr M's consultant undertook the review of his past history as she did. However, from a risk management perspective, the Independent Team was concerned that at that stage she had been Mr M's consultant for four years. To not have undertaken a longitudinal review of Mr M's contacts with mental health services and his forensic history until March 2006 does not represent good practice. The Independent Team says this, knowing that it is by no means standardised practice for consultant psychiatrists and their teams to conduct a systematic review of a mental health service user's history when they are 'new to the team' but already known to the service. The Independent Team suggests that the lack of formalisation of this aspect of practice does, from time to time, leave mental health teams vulnerable. Perhaps of greater concern was the fact that, even after her review of Mr M's past records, his consultant psychiatrist (2002 to 2006) was not aware that non-compliance with medication was listed as one of Mr M's risk factors and an indicator of increased risk in relation to harm to self and others. A contributory factor to this knowledge gap may have been the storage of the detailed care programme approach and risk assessment forms in the nursing and not the medical records. Furthermore, both sets of records were stored separately with the respective professionals. Now, with OTTER, all risk assessments are filed on the electronic record and are therefore readily accessible to all professionals engaged in the care and treatment of a service user.

The Independent Team asked Mr M's consultant what difference it would have made to her management of Mr M had she had been aware of the risk Mr M presented when un-medicated. She told the Independent Team that she would have offered him at least monthly appointments and requested notification from the depot clinic staff of any deviation in his agreed pharmacological plan. At the time Mr M was changing from depot to oral medication, the consultant reiterated that this was her plan. When Mr M did not attend to meet with her in May 2009 she was not involved in the re-arrangement of his revised outpatient appointment. Furthermore the consultant informed the Independent Team that had she been more aware of Mr M's potential risks she would have "*tried as much as she did to keep Mr M engaged with their services. However Mr M was extremely adamant that he would not agree with anything different to one contact every six weeks.*"

The Independent Team considers that, although more assertive follow-up would have represented an appropriate clinical response to the presenting situation, it cannot be said that the above actions would have resulted in:

- ❑ Identification of any signs of deterioration in Mr M's mental state requiring an assessment of him under the Mental Health Act (1983).
- ❑ Information that could have predicted the imminent risk Mr M posed to the public, in particular his victim.

Underpinning this perspective are the facts that there is no information in:

- ❑ any of the witness statements that the Independent Team has read;
- ❑ the pre-sentencing psychiatric report prepared for The Crown Prosecution Service; or
- ❑ the pre-sentencing report prepared for Mr M's solicitors that contains any information;

which suggests that, prior to the incident, Mr M was exhibiting any signs or behaviours that would have enabled him to have been assessed under the Mental Health Act (1983). It is notable that it was not until 9 May 2007 that Mr M was referred from the prison in which he had been remanded to a medium secure hospital for a mental health assessment regarding his need for transfer to hospital services. And it was not until 23 May 2007 that Mr M re-commenced anti-psychotic medication.

All of the above suggests that, even with an optimal response to Mr M's medication non-compliance and non-agreement to be assessed at a frequency that would have allowed for reasonable and timely assessment of his mental state (to detect early signs of deterioration), the incident that did occur, in all likelihood, would still have occurred as it did.

4.2.4 Whether or not the decision by mental health professionals in September 2006 to accede to Mr M's position of not meeting with them at a frequency greater than six-weekly was reasonable at the time?

Summary response:

The above section regarding the adequacy of Mr M's risk assessments and risk management plan largely addresses the question of the management of Mr M after 13 September 2006 by the then 5 Boroughs Partnership Trust. For clarity, the Independent Team does not consider that the frequency of visits agreed to with Mr M were sufficient. The Independent Team accepts that Mr M was not agreeable to more frequent meetings with the CJLT CPN. However, because of Mr M's history, and because it was recorded in the clinical records at the then 5 Boroughs Partnership Trust that Mr M posed a predictable risk to self and others if un-medicated, the professionals involved should have and could have taken more assertive actions to try and achieve more frequent monitoring of Mr M, aiming for at least weekly contact.

4.2.5 Whether there was reasonable scope for assessing Mr M under the Mental Health Act in the two weeks preceding Mr M's index offence?

Summary response:

It is the contention of the Independent Team that on the balance of probabilities there was insufficient deterioration in Mr M's mental state to justify assessment of him under the Mental Health Act in the period 17 September to 26 September 2006. The Independent Team therefore supports the decision made by the then 5 Boroughs Partnership Trust's mental health professionals in not progressing an assessment of Mr M under the Mental Health Act.

When an individual is detained under the Mental Health Act, three qualified mental health practitioners (two doctors, one of whom must be section 12 approved, and one approved mental health practitioner) must agree that the individual needs to be detained in hospital (there are exceptions in urgent situations). The two doctors must agree that the individual is suffering from a mental disorder of a nature or degree which warrants their detention in a hospital for assessment or treatment and that the individual ought to be detained in the interests of their own health, their own safety or with a view to the protection of other people. It is good practice if one of the assessing doctors is known to the individual being assessed.

In this case, there is no question that Mr M was suffering from a mental disorder, as he had a clear diagnosis of schizophrenia. However, as previous sections of this report have set out, although it was known that Mr M could pose a risk when un-medicated, at the time he ceased his medication his mental health team could detect no signs of deterioration in him that would have

reasonably caused concern for him or others. Consequently, there were insufficient clinical reasons to utilise the Mental Health Act in this case.¹

However, the lack of exploration regarding the non-use of the Mental Health Act by the then 5 Boroughs Partnership Trust in its own internal investigation was a key trigger for the further independent investigation required to discharge the Strategic Health Authority's responsibilities under Health Circular Guidance (94)27. At interview, Mr M's consultant psychiatrist told the Independent Team that, at the time Mr M did not wish to continue with medication, he came across very well. He was reported as *"rational, not violent, engaging; he had agreed to continue to see CPN [2], albeit in six weeks. It was true that he had just stopped his medication, but it was not enough grounds, because he was complying in other ways. I felt there would be enough monitoring and I would be contacted if there were any concerns."*

Managers currently working for 5 Boroughs Partnership NHS Foundation Trust considered that *"in similar type circumstances to those presented by Mr M, if a service user was not agreeable to face-to-face assessment at a time interval to enable reliable mental state assessment, then they would expect staff to consider and undertake a door step challenge"*. The Independent Team agrees with this perspective. In the circumstance that a service user then refused entry to the mental health professional, then it would be expected that the mental health professional would gather *"intelligence"* about the welfare of the service user, using whatever networks they were aware of; for example, family members. The Independent Team also concurs.

Managers also told the Independent Team that, if sufficient information raising concern about the mental health of the service user was gathered, then the advice of an approved mental health practitioner should be sought with regards to the reasonableness of effecting assessment under the Mental Health Act (1983). Again, the Independent Team concurs.

However, as detailed in the summary response above, on the basis of all of the information that has been made available to the Independent Team, it does not consider it very likely that, in the thirteen-day period between Mr M spending an hour with his consultant psychiatrist and the CJLT CPN, and the date of the incident, Mr M had become so unwell as to have justified usage of the Mental Health Act. As previously stated in section 4.2.3 (page 35) of this report, the fact that Mr M remaining in the general prison population before being referred to a medium secure mental health hospital in May 2007 perhaps underlines the fact that even at the time of arrest he was not detainable under the Mental Health Act (1983).

¹ Information taken from the Rethink information leaflet *"Detention under the Mental Health Act fact sheet"*.

5.0 THE INDEPENDENT ASSESSMENT OF THE 5 BOROUGH PARTNERSHIP TRUST'S INTERNAL INVESTIGATION

The following assessment is set out under the headings the Trust used in its own report. The Trust's investigation was conducted by the Head of Service for Occupational Therapy and the 'MDO' Team Manager, Wigan and Leigh. There was a short but clear terms of reference for the investigation; and the investigation process utilised by the investigators was set out clearly, which reflects contemporary good and expected practice.

The Trust's investigation team

Although a senior member of staff was tasked with the investigation of Mr M's care and treatment by 5 Boroughs Partnership Trust, a consultant psychiatrist not involved with Mr M should also have been asked to contribute to the investigation process. There were practice issues that should have been explored as part of the investigation process that would not have been credibly achievable without the input of a consultant psychiatrist.

The Independent Team knows that the way in which the now 5 Boroughs Partnership NHS Foundation Trust organises its contemporary internal investigations is very different to the process that was in place in 2006, and that greater consideration is given to the skills and competencies required for each internal investigation it commissions.

The stated aims of the Trust's Review

The Trust's report stated:

"This review aims to determine whether the care [Mr M] was receiving (at the time of the incident) from mental health services was appropriate, delivered in accordance with Trust policy and procedures, and met legislative requirements. It also aims to objectively assess whether [Mr M's] mental state could have been a contributory factor leading to the incident on 28.09.06. Conclusions are drawn from the findings, and along with the recommendations an action plan is completed, in order to address any areas for improvement to ensure any 'lessons learnt' are shared."

Excepting the aim to "objectively assess whether [Mr M's] mental state could have been a contributory factor leading to the incident on 28.09.06", the terms of reference for the Trust's internal investigation were reasonable. It would not have been within the power of the Trust's investigation team to access the required information to determine whether or not Mr M's mental state could have been a contributory factor leading to the incident that occurred. Neither were the members of the Trust's internal team qualified to make such an assessment.

The terms of reference could have been improved by being more specific and asked for commentary on the appropriateness of Mr M's medication regime and whether or not there were any grounds on which to assess him under the Mental Health Act at any point in advance of the incident. Furthermore, the

terms of reference provided to the Trust's investigation team did not ask them to comment on the predictability or the preventability of the incident that occurred.

Overview of Mr M's offending behaviours

The Independent Team has set out a comprehensive list of these in the introduction to this independent report. In the Trust's own report, a succinct overview of these was provided which the Independent Team considers to have been reasonable.

Overview of Mr M's mental health history

The overview of Mr M's mental health history presented in the Trust's report would have been sufficient had there been a more detailed chronology contained elsewhere in the Trust's report. However, a detailed chronology of Mr M's care and treatment was not presented. The absence of this makes it more difficult for the reader of the report to have confidence that all aspects of the service user's care and treatment had been considered in an appropriate depth.

The chronology of greatest significance in this case was the six-year period prior to the incident of September 2006. Having assessed a more contemporary investigation report of the Trust's (2011), the Independent Team is satisfied that the Trust has evolved its process to ensure that more comprehensive chronologies are included as an integral component of their internal investigation reports.

The Independent Team did note that the Trust's investigators included a 'significant events' table in section 4 of their report, which also presented a succinct chronological overview. This was a positive inclusion and had this been expanded upon it would have provided the depth of chronology required.

Findings of the review

This section of the Trust's report (section 5) did not contain the depth of information the Independent Team was expecting to find. It was clear to the Independent Team that the Trust's investigators had attempted to embrace the National Patient Safety Agency's (NPSA's) Human Factors Analysis framework; however, the way the information was presented suggested to the Independent Team that the Trust's investigators did not fully understand how the NPSA framework is best applied.

The narrative presentation of the information in the Trust's report did not demonstrate:

- adherence to an effective investigation process; or
- any detailed analysis of Mr M's care and treatment.

Nowhere did the 'findings' section of the Trust's report set out the authors' perspective regarding:

- the reasonableness of Mr M's care and treatment;
- the compliance with CPA policy and procedures;
- the appropriateness of medication management;

- ❑ the reasonableness of Mr M's risk assessments, and contingency and crisis planning;
- ❑ the appropriateness of his care plan;
- ❑ the quality of his contacts with CPN [2] (the CJLT CPN);
- ❑ the assessment of risk when Mr M decided to stop his medication;
- ❑ the appropriateness of the plan agreed with Mr M once it became clear to CPN [2] (the CJLT CPN) and his consultant psychiatrist, on 16 September 2006, that Mr M was not going to re-engage with medication; or
- ❑ whether or not it was a reasonable conclusion on 13 September 2006 that there were no grounds to assess Mr M under the Mental Health Act at that time.

The above represents the minimum expectation of an investigation report setting out the investigation findings of such a serious incident.

The Independent Team noted that the authors did include under various headings comments that suggested that some of the above was in their minds. For example, under the heading 'communication' it says: *"neither [Dr X] nor [CPN [2]] highlighted any connection between non-compliance with medication and subsequent aggressive behaviour"* and *"careful examination of the medical notes reveals that there had been past incidents of non-compliance with medication where [Mr M] had subsequently exhibited aggression towards others."*

However, there was no coherent presentation of the information and, as stated above, nothing in the report to show that a critical analysis of Mr M's care and treatment had been undertaken. Following discussions with the Director of Nursing and the Trust's Risk Advisor, the Independent Team is confident that the Trust's team did undertake the best quality investigation they could, but at the time were not sufficiently experienced or trained in the conduct of this type of investigation. The Independent Team is reassured that the investigation of serious untoward incidents now has a greater profile within the Trust and that staff are provided with more comprehensive guidance on how to conduct and deliver an investigation to the required standard using systems analysis methodologies. The Independent Team, based on its analysis of a more contemporary serious incident report of the Trust, does, however, highlight that 5 Boroughs Partnership NHS Foundation Trust need to further develop the understanding and capability of its investigation staff in structured information analysis using the NPSA's frameworks and in a deeper understanding of what 'root-cause analysis' is and how it can be meaningfully applied to mental health investigations which tend to be less straightforward than incidents occurring in secondary acute care.

Positive practice

The Trust's authors identified a range of good practice. The Independent Team agrees with some of the points listed, but not entirely with the following:

- I. Appropriate written records were kept after each contact with [Mr M]. Although not on the OTTER system, the quality of the records was good.*
- II. Overall, the service being delivered at the time of the incident was appropriate and addressed the specific mental health needs of [Mr M].*
- III. The medication regime had been reviewed recently, and arrangements were in place for [Mr M] to be monitored following the cessation of his medications.*

The Independent Team has already set out its thoughts in relation to points i and iii in sections 4.2.1 (page 24), and 4.2.3 (page 35) of this independent report.

At this juncture, the Independent Team draws the now 5 Boroughs Partnership NHS Foundation Trust's attention to the fact that the authors of its report did not present any information to support their opinion that Mr M's care was appropriate at the time of the incident and addressed his specific mental health needs. It is important that if an investigator is going to report that the care and treatment of a service user was 'OK', then the information supporting the assertion is clearly set out. The lack of information in the Trust's report contributed to the residual significant questions the Independent Team was left with regarding Mr M's care and treatment following its own re-analysis of the information the Trust had gathered.

Actions already taken

The actions detailed in the then 5 Boroughs Partnership investigation report, bar CPN [2] receiving OTTER training, were all related to the management of the incident with the media, and prison-in-reach. There appeared to have been no identification of any practice issues that required immediate remedy as a consequence of the incident.

Conclusion of the Trust's investigation

For ease of reference, the Independent Team has detailed the Trust's conclusion on a paragraph-by-paragraph basis and detailed its observations underneath.

Trust paragraph 1: *"The review panel have assessed that, at the time of the incident, the service provided by 5 Boroughs Partnership NHS Trust met the statutory obligations, and (excepting the use of the OTTER system) complied with local operational policies and procedures."*

Independent Team comment: The Trust’s investigators presented no evidence in their report to support the above statement. Furthermore, having now conducted its own analysis of Mr M’s clinical records, the Independent Team concluded that, although Mr M did receive a medical review on an annual basis, he did not receive a Care Programme Approach review, nor any review of his risk assessment at any time in the two to three years preceding the incident. This means that the Trust did not comply with local operational and policy procedures.

Trust paragraph 2: *“Despite records not being available on the electronic system, the notes held in the Medical Case Notes and the CMHT file were comprehensive and included relevant care plans and risk management plans.”*

Independent Team comment: The Independent Team found information that contradicts this element of the Trust’s own conclusion. The Independent Team agrees with the statement as up to and including April 2003. However, thereafter it is not possible to say that there were “*relevant care plans and risk management plans*”, as there were no such records.

Trust paragraph 3: *“There were some ‘system’ problems in relation to the sharing of information held by the respective parties, as the files were housed separately, and the staff were not based together.”*

Independent Team comment: Although the Trust’s report contains information that supports this conclusion, the information was not as precise as it could have been regarding the following issues:

- ❑ The length of time Mr M was without an allocated care co-ordinator;
- ❑ The perception by the CPN involved with Mr M in September 2006 that he was not his care co-ordinator and was not responsible for the delivery of CPA obligations.
- ❑ The complete lack of management supervision for this CPN.
- ❑ The lack of safety systems in place to identify patients who had not been fully entered on to the new electronic record-keeping system OTTER between 2005 and 2006, a system on which team managers relied to conduct their local performance and compliance audits.

Trust paragraph 4: *“Although Nurse ‘E’ was not aware of the forensic history of [Mr M], the care provided was of a good standard, with evidence of an appropriate therapeutic relationship being maintained throughout.”*

Independent Team comment: The Independent Team concurs with the Trust’s team that the quality of care contact ‘Nurse E’ had with Mr M appeared to be of good quality and that an “*appropriate therapeutic relationship was maintained*”. However, it does not agree that this professional’s clinical record demonstrated the range of exploration of Mr M’s symptoms, specifically his voices, at his six-weekly contact visits.

Trust paragraph 5: *“In light of [Mr M] having ceased all medication, and presenting with NO mental health symptoms or evidence of relapse, Dr D [the consultant psychiatrist] has expressed that it would not be appropriate to reconsider Mr M’s mental health diagnosis.”*

Independent Team comment: It is the perspective of the Independent Team that the scope for utilising the Mental Health Act was insufficiently explored in the Trust’s investigation and that the Trust’s investigators should have set out its consideration of this and not simply the perspective of Mr M’s consultant psychiatrist.

Trust’s paragraph 6: *“[Mr M] had been reviewed by Dr D and Nurse E [the CJLT CPN] only two weeks prior to the incident; at that time there was no evidence of any psychiatric presentation, no grounds for treatment under the Mental Health Act, and appropriate arrangements were made for Nurse E to continue monitoring [Mr M’s] progress at regular appointments.”*

Independent Team comment: This aspect of the Trust’s conclusion shows an inadequate consideration of what was reasonably required following Mr M’s last contact visit on 13 September 2006. The Trust’s investigation does not demonstrate any consideration of the fact that more frequent assessment visits were required, and acquiescing to Mr M’s wishes to maintain the established six-weekly contact visits was not appropriate in the presenting circumstance. The acceptance of this conclusion by the then 5 Boroughs Partnership NHS Trust calls into question the robustness of the quality assurance process for serious untoward investigation reports at the time. The Trust’s current Director of Nursing and the Trust’s Risk Advisor have confirmed that in 2006 the quality assurance and review of serious untoward incident report was not as robust as it should have been. Now the process has changed and they are confident that a ‘SUI’ report of the calibre of the Mr M case would not now be accepted without substantial improvements to its content. Specific changes to the way in which 5 Boroughs Partnership NHS Foundation Trust review investigation reports are as follows:

- The draft report is submitted to the appropriate Clinical Lead, Business Manager and Matron in the Business Stream for approval.
- The Business Manager/Clinical Lead Review Team and Risk Management Team meet to critically review the ‘root causes’ identified to any care and/or service delivery problems. Following this the Risk Management Team completes a final quality assurance check.
- The report is then submitted to the Trust’s Patient Safety Panel. This was introduced in 2009 and is chaired by the Assistant Director of Nursing and Safeguarding. The group comprises service user and Carer representation, representation from the Trust’s commissioners and the Trust’s risk management team. The investigation team are required to present their report to this panel.

In addition to the above the Trust’s Clinical Governance and Clinical Risk Committee now completes a “*deep dive*” of a serious untoward incident report. The report is chosen by the Non-Executive Director Chair.

Trust's paragraph 7: *"In light of this presentation the review panel have concluded that it seems unlikely that Mr M's mental state would have been a contributory factor leading to the incident on 28.09.06."*

Independent Team comment: The Independent Team cannot see how the Trust's investigators have drawn this conclusion. It had been documented in the clinical records prior to Mr M's transfer to community services that, un-medicated, he might pose a risk to others. It also seems that his risk factors had been contained on medication, as he accrued no offending history after his engagement with mental health services and re-establishment on medication in 2001. In 2005, it is clearly recorded, following Mr M's outpatient appointment, that medication quietened Mr M's voices and enabled him to sleep better. Given that at the time of writing its report the Trust's investigators did not know the sequence of events after 13 September 2006, it would have been better if their final conclusion had said something along the following lines:

"Because the Investigation Team is not;

- aware of the sequence of events after Mr M's attendance at outpatients on 13 September: and*
- has not had access to the findings of any assessment of his mental state at the time of his arrest,*

the Investigation Team cannot comment on whether there was a causal relationship between any deterioration in Mr M's mental state and the incident which occurred on 28 September 2006."

This would have been a more factually accurate conclusion.

6.0 ACTIONS TAKEN SINCE THE TRUST'S OWN INTERNAL INVESTIGATION

At the time this incident occurred, a number of organisational and systems changes were underway within 5 Boroughs Partnership Trust. One example of this was the implementation of the Trust's electronic record-keeping system OTTER.

The Independent Team is not setting out all of these changes in this report. Its interest was in those changes that have occurred that are most likely to have prevented the system lapses identified in relation to the care and treatment of Mr M. The most significant was him becoming 'lost' to the community mental health team's monitoring systems because he was being managed 'out of team'.

The Independent Team is satisfied on the basis of interviews it has conducted that it is now an exceptional occurrence for service users to be managed 'out of team'. Furthermore when this occurs there is now a robust process in place to ensure that the relevant managers are fully appraised of the situation and satisfy themselves that an effective hand-over of care process has been achieved. One component of the current process is that both the transferring manager and the accepting manager must sign off the agreement in the service user's clinical records. Another component of the process is that the contemporary care co-ordinator for a CPA service user is clearly identified on the OTTER system; this means that, when local managers conduct their regular CPA audits to ascertain those service users who are either overdue regarding a CPA review or have not been seen for six months, they can follow up any queries with the correct professional and/or relevant manager. This degree of audit was not fully operational when Mr M was a service user of the Trust.

In addition to the tightening up of systems as depicted above, when a service user is transferred between teams or professionals, even on a temporary basis, it is a requirement that care co-ordination responsibility is also transferred. Although this was considered as assumed between 2003 and 2006, it was not explicitly stated or expected, which led to ambiguity in the case of Mr M. This ambiguity no longer exists.

With regard to a team manager maintaining a track of those service users being managed 'out of team', in addition to the facilities provided via the OTTER system, the Independent Team was advised that the following avenues enabled monitoring not only of who was being managed 'out of team' but also monitoring of the appropriateness of their care management:

- Management supervision – this now occurs reliably for staff.
- Case note audit. This occurs as a component of management supervision and as a separate activity.
- Professionals' meetings. All team managers attend this for complex case discussions.

The operations manager interviewed also confirmed to the Independent Team that today it would be very difficult for a service user to become lost to 'the system'.

With regards to the monitoring of compliance with the frequency of Care Programme Approach reviews, the Independent Team is reassured that, following the Trust's investment in its performance-monitoring framework, and the development of key quality performance indicators, the Trust is in a much more robust position to conduct effective local and corporate performance-monitoring activities. Currently, when a manager identifies that a service user on 'CPA' has not been seen by their care co-ordinator over a six-month period, further investigation of the circumstances of this is triggered. Although it was the experience of the manager the Independent Team interviewed that there was usually a reasonable explanation for the lack of contact, such as the service user being in residential care, she reported that having the depth of detail available for routine local performance monitoring was invaluable.

With regards to the assessment of risk, the Trust has with relevant partner agencies developed a range of forums where high-risk service users are discussed in order to develop effective risk management strategies where it is possible to do so. An example of this is the Complex Persons Panel. This was set up in 2011 to review the risks presented by service users whose risk profile does not meet the requirements of the Multi-Agency Protection Panel (MAPP), but where there remains a concern that the service user is a potentially dangerous person. At the Complex Persons Panel there is input from the police, the Criminal Justice Liaison Team, general mental health services and social services. The meeting is chaired by the police. Although the Independent Team applauds such initiatives, in the case of Mr M it would not have impacted on his care and treatment as he would not have met the criteria for the Complex Persons Panel at the time the incident occurred. Now he would meet the criteria for MAPP.

The recording of risk assessments on the OTTER system now does mean that the history of a service user's risk history is readily accessible to all relevant mental health professionals, regardless of their geographical location. Had such a system been *in situ* at the time of Mr M's care and treatment, it may have enhanced the awareness of the professionals; however, the information was at the time easily available, albeit in written format.

One of the issues the Independent Team and the managers interviewed did acknowledge was that, in spite of the many improvements in the reliability of systems and processes at the now 5 Boroughs Partnership NHS Foundation Trust, the conduct of the risk assessment will always be human-orientated and there must be a reliance on the skills and insight of the professionals to conduct an accurate assessment of a service user. It is also incumbent on the individual professional to ensure that they are aware of historical risk factors, relapse indicators, and any previously known consequences of these indicators for the service users on their caseload, as it is these factors that enable a meaningful assessment of contemporary risk. No amount of legislation, or automated documentation systems, can assure that each and every professional will

deliver their professional responsibilities 100% of the time. However, the Trust's performance-monitoring framework does mean that the Trust has the means to continually test the effectiveness of its systems, and to identify weakness in the practice of individuals and attend to these in a timely way. The Independent Team is therefore satisfied that the improvements implemented do mean that the Trust is doing all that it can to prevent the lapses in standards that occurred in Mr M's case.

7.0 CONCLUSIONS AND RECOMMENDATIONS FROM THE INDEPENDENT TEAM

Following its own investigation, the conclusions of the Independent Team are that:

- ❑ The decision in April 2006 to support Mr M in changing from depot anti-psychotic medication to oral anti-psychotic medication was reasonable, as was the choice of oral medication made by Mr M's consultant psychiatrist.
- ❑ The lack of assertive follow-up of Mr M in May 2006, and the lack of communication to Mr M's then CPN, when he defaulted from his outpatient appointment, was not acceptable. This appointment was the one at which an assessment was to be made of Mr M's response to the changes made to his medication one month earlier.
- ❑ The decision of Mr M's CPN in September 2006 to organise a meeting with Mr M's consultant psychiatrist on learning that Mr M had stopped his medication was sensible and good practice.
- ❑ The decision to accept Mr M's decision to only meet with his CPN on a six-weekly basis after stopping his medication was not a good decision in the presenting circumstances, or in relation to Mr M's documented risks if un-medicated.
- ❑ Mr M had been on enhanced CPA at the time of his transfer of care from CPN [1] to the CJLT CPN in April 2003. However, after March 2003 there were no CPA reviews for Mr M. This constitutes a lack of adherence to the Trust's statutory responsibility to Mr M at the time.
- ❑ There was no contemporary risk assessment, risk management or crisis contingency plan in place for Mr M at the time of the incident. This was a significant lapse in the professionals' adherence to the then local and national standards of practice.
- ❑ At the time Mr M decided not to continue with medication, and not to meet with the mental health professionals at a greater frequency than every six weeks, there were no justifiable reasons to have assessed him under the Mental Health Act (1983). Mr M simply did not meet the criteria for this at the time. Furthermore, from the information gathered by Cheshire Police, and made available to the Independent Team, there is no information that suggests that Mr M met the criteria for assessment under the Mental Health Act (1983) at the time of the incident or his arrest.

With regards to predictability, Mr M's past history shows that, un-medicated, he could be aggressive and violent. Therefore, it was predictable that, when un-medicated, he could become aggressive and violent again. However, even though Mr M had a notable history of criminality stretching back to 1974, including some incidents of extreme violence, the Independent Team does not believe that it was predictable that Mr M would set out to grievously harm an individual unknown to and unconnected with himself.

With regards to preventability, the Independent Team has treated this issue with care. The Independent Team knows from the information provided by Cheshire Police that, having stopped his medication, Mr M became sleep-deprived and started to use alcohol as a means of self-medication. The Independent Team also knows that Mr M's alcohol intake steadily increased as a consequence of this. The Independent Team considers that, had Mr M's CPN and consultant psychiatrist:

- ❑ conducted a thorough risk assessment, including a complete perusal of all Mr M's past medical and nursing records and forensic history;
 - ❑ contacted Mr M's family, in particular his sister, to seek her co-operation in alerting the mental health service to any deterioration in Mr M's well-being;
 - ❑ asked Mr M specifically about any changes he had experienced in his activities of daily living as a consequence of stopping his medication, including changes to his sleep pattern; and
- strongly recommended to Mr M that there was contact between him and his CPN on a weekly basis;

then there would have been the opportunity for the mental health team to have become aware of the adverse impact that stopping medication was having on Mr M, if any such information was to be forthcoming from him or his family. For example, it may have come to light that Mr M's alcohol intake had markedly increased. This was a known relapse indicator for Mr M.

However, even had the mental health professionals carried out the activities set out above, the Independent Team has seen no information to suggest that there would have been sufficient concern about Mr M in the weeks preceding the incident to warrant the conduct of an assessment of Mr M under the Mental Health Act (1983). This perspective is based on the following:

- ❑ the length of time Mr M continued to refuse medication in prison;
- ❑ the length of time post-arrest that Mr M showed no signs of psychosis; and
- ❑ the length of time he resided in prison before being transferred to a medium secure unit for treatment of his mental health disorder.

Consequently, even though the Independent Team considers that the management of Mr M in the two weeks preceding the incident was insufficiently assertive and, that the lack of knowledge held by the CJLT CPN and Mr M's consultant psychiatrist about Mr M's vulnerability to impulsive and aggressive behaviour when un-medicated was unacceptable, the Independent Team cannot say that, had Mr M's management been appropriately assertive and had the CJLT CPN and consultant psychiatrist been risk-aware, the incident would not have occurred. The circumstances of it suggest that it may still have occurred. However, the Independent Team is mindful that there were missed opportunities to have increased monitoring of Mr M from April 2006 when his medication was altered. It is not possible to say what difference it would have made to subsequent event had these lapses not occurred.

8.0 THE INDEPENDENT TEAM'S RECOMMENDATION REGARDING THE FURTHER INVESTIGATION OF MR M'S CARE AND TREATMENT

Recommendations

Since 2006, the systems and processes in the now 5 Boroughs Partnership NHS Foundation Trust have improved significantly. 5 Boroughs Partnership NHS Foundation Trust assures the Independent Team that it now has a sufficiently robust performance-monitoring framework which engages local and service managers and that the significant lapses in policy and procedure adherence that occurred between 2003 and 2006 would be unlikely to occur today. The Independent Team have confidence in this assurance with regards to the community mental health team Mr M was a service user of. It cannot comment on the robustness of systems trust wide.

In addition to the above, the Independent Team is confident that the Trust's approach and conduct of serious untoward incident investigations has improved. Consequently, the Independent Team has only two recommendations to make:

Recommendation 1:

It is recommended that 5 Boroughs Partnership NHS Foundation Trust commissions an audit across its adult services to determine the reliability with which service users are monitored appropriately following a change from depot anti-psychotic medication to an oral equivalent.

The Independent Team suggests that the data fields and scope of the audit for are agreed jointly between:

- the Drugs and Therapeutics Committee
- the medical leads for each Business Unit

Clearly once the audit is completed it is expected that the Trust will address any issues of concern identified (if any).

The Independent Team expects that the Trust's commissioners will be provided with a copy of the audit tool and the report setting out the results.

Target Audience: The Medical Director; the Chair of the Clinical Governance and Clinical Risk Committee.

Timescales: The Independent Team considers that some thought may be required as how best to conduct the above audit. Consequently it suggests that 5 Boroughs Partnership NHS Foundation Trust should be able to advise its commissioners on its approach to the above and the time table for completion within the eight weeks following publication of this report.

Recommendation 2:

In this case even though Mr M's consultant psychiatrist had reviewed all his records, that were available to her, before changing his medication she did not identify that Mr M was a known potential risk of harm to others when un-medicated. The Independent Team accepts that 5 Boroughs Partnership NHS Foundation Trust now has an embedded electronic records system and that this can produce a risk summary that details all historical risk for the service user. Because the quality and completeness of information on the system is dependent upon the staff inputting the information the Independent Team recommends that the Trust's Clinical Governance and Clinical Risk Committee considers whether there is merit in undertaking any of the following:

- Surveying its consultant psychiatrists and care coordinators to determine:
 - the frequency with which they undertake a longitudinal review when they accept a new 'but known' service user onto their care load.
 - the frequency with which they rely on the latest risk assessment and care plan as being complete and thus containing the essential information they need to know
- Taking a sample of cases where a service user has moved teams and/or care coordinator and reviewing the care and risk plans at the time of case transfer to determine the reliability with which all salient historical information was included as part of the transfer process.

The Independent Team considers longitudinal assessments to be worthwhile.

Target Audience: The Clinical Governance and Clinical Risk Committee and the medical lead for each business unit.

Timescales: The Independent Team considers that 5 Boroughs Partnership NHS Foundation Trust should be able to advise its commissioners of the outcome of its consideration of the above within eight weeks of the publication of this report.

Appendix 1 THE CHRONOLOGY

The detailed chronology constructed during the Independent Team's assessment of Mr M's care and treatment is detailed in this appendix.

1 **Mr M: Tabular Timeline**

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Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
9/3/1994	Mr M admitted to Ward 1 from HMP Full Sutton Yorkshire. A diagnosis of Paranoid Schizophrenia is 'most likely diagnosis'.	Mr M transferred on a Section 47/49. Mr M had been engaging in episodes of self-harm. Apparently, this was in response to the 'control of God' . Mr M noted to have no insight to his illness and did not think himself mentally ill. However, <i>"God had been persecuting him for the past 18 months"</i> . Evidence of thought insertion. No thought withdrawal or broadcasting.	
15/10/1998 HM Prison Wymott	Interview of Mr M by a consultant forensic psychiatrist for provision of psychiatric report.	<p>Concurs that Mr M had a diagnosis at the time of the offence of a psychopathic personality disorder. Whilst serving his sentence, he had developed a mental illness, namely paranoid schizophrenia.</p> <p>The consultant forensic psychiatrist had also undertaken a psychiatric report before on Mr M in HMP Shrewsbury in January 1991. Mr M was serving a 14-year sentence for wounding and robbery.</p> <p>Between March 1994 and December 2005, Mr M was treated under section 47 at the Munro Clinic under Dr X, where he was commenced on Clozapine, following which, whilst in prison, he remained mentally stable. Stated that Mr M does not have full insight into his illness; however, he recognises the benefits of regular medication.</p> <p>The consultant forensic psychiatrist concluded that Mr M <i>"currently appears to be at low risk of future violence than previously. Also, he has not been violent (except to himself) as a result of his mental illness."</i></p>	Good practice: A clear and extensive psychiatric report.

Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
21/10/1999	Released from prison after serving nine and a half years of a 14-year sentence.	Was not released on parole, and unclear where he was living. ?? Salvation Army hostel.	
5/11/1999	Mr M admitted to Hollins Park Hospital under section 2 MHA, handcuffed and escorted by police. He was very aggressive following his arrest as a result of attempted theft from a shop and assault of a member of staff.	<p>On admission, Mr M was described as grossly deluded, hostile, expressing persecutory delusions. He also had pressure of speech.</p> <p>Previous history of offending behaviour included: 1982: Assaulted fellow inmate at Salvation Army hostel. 1985: Convicted of wounding assaulted ex-girlfriend's ex-boyfriend with a hammer. 1990: Convicted of assault and criminal damage after fight in pub and police officer bitten on the leg.</p>	
5/11/1999	Rapid tranquilisation.	On admission, required to be transferred to another unit, where he had to be given rapid tranquilisation and secluded due to his aggressive and threatening behaviour (seclusion record). Seclusion lasted for 7 hours and 45 minutes.	
10/11/1999	Reviewed by Dr A.	Dr A described Mr M with florid psychotic symptoms with grandiose delusions. The content included: Mr M <i>"believed that he was God and Jesus Christ who was crucified for the sins of other people. He believed everything should be free for all people as he was creator of the earth."</i>	
11/11/1999	Section 2 transferred to section 3 MHA.	Current medication was: Lithium Carbonate 1000mg Nocte; Benperidol 500mg tds; Modecate 75mg weekly; Plus prn medication.	
18/11/1999	Mental Health Review Tribunal	Turned down Mr M's appeal and maintains that he remained on section 3. Note: On 16 November, a Dr I suggested that Mr M might have a temporal lobe abnormality with schizophrenia and psychopathy.	

Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
2/12/1999		Referral for a forensic psychological assessment refused because of a lack of resources.	
2/2/2000	Section 17 leave granted to Mr M with escort twice weekly.	<p>On this day also: A letter to the Chesterton Unit from a consultant clinical psychologist noted that Mr M continued to refuse psychology sessions. They noted, however, that his risk in the community was in the 'high to moderate' range. They also noted that:</p> <ul style="list-style-type: none"> - Although his last incident of violence was related to mental disorder, previous criminality did not appear to be related. - Even if his mental state was stable, he may still re-offend in the community if he is not closely supervised. - If he were unstable in the community then he may pose a risk to others, especially if suffering from delusions. 	
9/2/2000	Section 17 leave granted.	Mr M allowed to visit sisters twice weekly as part of his care plan.	
16/2/1999	Section 17 leave granted.	Mr M granted leave for 3 days to go to his sister's home 9am until 5pm.	
07/3/2000	A medical recommendation is made <i>re.</i> section 3 of MHA.	This was to detain Mr M under this section.	
21/3/2000	A report is provided by Mr M's social worker for the mental health review tribunal.	The social worker reported that Mr M's care was proceeding well. All nursing restrictions have been removed, his medication is suiting him and Mr M was medication-compliant. He has been granted leave to his sister's home 3 times a week without incident. The author cites previous psychiatric and nursing reports: when Mr M is medication-compliant he is viewed as co-operative, thoughtful, and capable of making appropriate and pleasant relationships. They also mention that, were he not to comply with medication on discharge, he would deteriorate and become a risk to others.	

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Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
3/4/2000	Section 3 was rescinded by responsible medical officer.		
2/6/2000	Transferred to the rehabilitation unit.	Mr M was transferred from the low secure unit to the rehabilitation unit prior to settlement in independent accommodation which was being sought by social services.	
26/7/2000	Referral made to community team.	This stated that Mr M requires a CPN for depot injection and monitoring mental health. Mr M accepted that he will need to continue to take medication and have a depot. The referral also cites that Mr M didn't need any help and that it was possible that his uptake of services will be poor. Another record stated his main risk as being non-compliant with medication and engagement with services, with potential harm injury to others.	
6/10/2000	Visit by member of community team.	CMHT CPN [1] to begin developing contact with Mr M.	
11/10/2000	Informed that Mr M will require social worker.		
31/10/2000	CMHT CPN [1] visited Mr M on ward.		
14/11/2000	CMHT CPN [1] attended ward reviews.	Mr M had been allocated some housing and he is awaiting decision on community grant. The risk assessment was discussed; there was little to be added to that previously identified. It was commented that Mr M is likely to decline medication shortly after he is discharged.	
12/12/2000	CMHT CPN [1] visited unit.	It was noted that Mr M was still awaiting some furniture from his flat. This date was cited as a section 117/CPA meeting.	Note: Couldn't locate any records of this meeting, apart from the earlier entry.

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Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
8/1/2001	CMHT CPN [1] discusses Mr M with social worker.	<p>Risk assessment was discussed along with the care plan dated January 2001. A comprehensive risk assessment was completed in January 2001 by Mr M's care co-ordinator. One aspect of the report describes one risk area as non-compliance with treatment both contact and medication. The hazard section of the assessment form noted: (1) the previous history of non-compliance, (2) refusing support and gradual non-compliance with medication. (3) subjective complaints about current medication. The risk is cited as high.</p> <p>Note: One area of risk described in the assessment was deterioration in mental health. It describes in part of the risk assessment that Mr M lacked insight into his own mental health difficulties and had difficulty in finding an acceptable way of discussing voices with anyone.</p>	<p>Good practice: This was clearly and thoughtfully described risk assessment.</p>
12/1/2001	Mr M was seen at home by his social worker.	Noted that Mr M was coping. He had been spending time at his sister's house.	
19/1/2001		Leave arrangements have been extended to one week.	
26/1/2001	Home visit by CMHT CPN [1].	Mr M reported as quite friendly in mood and appeared to be coping fairly well.	

Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
30/1/2001	Ward review.	<p>CMHT CPN [1] fed back Mr M's progress to Ward review. Agreed to proceed with the discharge of Mr M. Plan: To complete CPA documentation and care plan; Mr M to be seen in 2 weeks' time by Dr A.</p> <p>CPA documentation dated January 2001: cites risk assessment as stating that Mr M has a high risk of impulsive behaviour and harm to others, non-compliance with treatment both contact and medication and deterioration in mental health, both likelihoods rated as high.</p> <p>The risk management plan documents that Mr M should be visited by 2 staff at all times and he should not be allocated a female. This was the advice given by the court liaison service.</p> <p>Plan: (1) To monitor compliance and arrange administration of depot at home address. (2) Support Mr M through transition from hospital to permanent accommodation. (3) Offer support with domestic/financial tasks via outreach and social worker. (4) Ensure all relevant parties are fully aware of care plan and contingency plan. (5) Explore aspects of engagement/assessment to address psychotic symptoms. (6) Ensure Mr M is aware how to access crisis services.</p>	
30/1/2001	Fax from Cheshire Probation Service.	<p>This notes that Mr M is a high-risk offender. His probation officer and his prison probation officer expressed their extreme concern over Mr M's ability to reside in the community.</p> <p>Mr M was also discharged from the rehabilitation unit on this day. Medication was Flupenazine Deconate 50mg 2/52.</p>	

Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
8/2/2001 until 13/7/2001		<p>3-weekly home visits were made to see Mr M at home. He was consistently noted as well, mental state stable. Receiving depot injections and taking medication.</p> <p>By July 2001, Mr M was attending the depot clinic for his injections. Mr M also received weekly outreach support.</p> <p>Mr M did not wish to attend any mental health community programme activities.</p>	
July 2001	CPA review.	<p>Mr M remained well; there was no change in the detail of the risk assessment, although Mr M's risks were now rated as low. Mr M was noted as positively achieving.</p> <p>New additions included:</p> <p>Now attending depot clinic for injection;</p> <p>Gradual relaxation from two-person visit to one-person visit.</p> <p>Explore aspects of psychosocial assessment; any ongoing positive psychotic symptoms.</p> <p>Mr M can choose this option if required.</p>	
3/10/2001	OPA – SHO.	<p>Mr M noted to be doing well. He was noted to have insight that medication was required to keep him well. He was noted to be in contact with his family and that it was easy to establish a rapport with him. The outreach team were noted to visit Mr M 3-weekly and that his care co-ordinator and social worker alternated visits on a 3-weekly basis also.</p>	
20/12/2001	CPA review.	No changes to management plan.	
January 2002 until 2/9/2002	CMHT CPN [1] was the main contact for Mr M.	<p>Contact occurred every 3 weeks. The CPN monitored Mr M's mental state and appeared to engage with him effectively.</p> <p>Mr M requested a reduction in outreach support over this period.</p> <p>The CPN noted that Mr M was experiencing extra pyramidal symptoms (EPS), i.e. scraping of teeth, etc, which was being monitored with assessment tool and to be addressed at next outpatient appointment.</p> <p>Risk was assessed on each visit, i.e. psychotic symptoms present are explored. Health and social care aspects also covered. Mr M</p>	<p>Good practice:</p> <p>Very clear and comprehensive record keeping reflecting a holistic approach to care and support by CPN. This CPN's standards of</p>

		remained stable. Also noted that 'with support' was considering move to other accommodation.	record keeping throughout her contacts with Mr M were very good.
Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
3/4/2002	OPA consultant clinic.	Mr M again noted to be well. Side effects of medication were noted; however, Mr M did not want to stop or change his meds " <i>as he considered that he was doing well</i> ". Meds were: Modecate 50mg 2/52; Lithium 1000mg; Procyclidine 10mg tabs. Mr M was noted to have a good rapport; no thought disorder evident, no delusions admitted to. Outreach continues. CPN once a fortnight, social worker once every three weeks.	Good practice: Mr M was very well supported in the community.
2/9/2002	CPN [1] accompanies Mr M to outpatient clinic.	No change to current medication. Currently on Lithium 1000mg, Modecate 50mg 2/52, Procyclidine 10mg tabs. Mr M disclosed that he hears voices most of the time. Voices come from God telling him " <i>he's going to hell</i> "; on a ratio of 1 to 10, they are on a 4 most of the time. Mr M did not wish to have his medication increased. He felt that he was over-medicated and did not wish to experience this again. Appetite was good, sleep good, mood euthymic. It was noted that he got " <i>pissed off</i> " with the voices at times. The risk assessment noted that Mr M had no plans or intent to harm self or others at this time. Comment: Good quality notes, especially in relation to auditory hallucinations.	
2/10/2002	OPA consultant led.	Mr M noted to continue to do well. Outreach now visit fortnightly, the CPN and social worker continue every 3 weeks now. Auditory hallucinations continue as they have done for 10 years, but Mr M noted to be coping well with them. An increase in medication was discussed, but Mr M preferred not.	

Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
2/11/2002	Letter.	Letter from Mr M's consultant regarding re-housing. Comment: Evidence of supportive care.	
26/11/2002 to 25/03/2003	CPN [1] visited Mr M approximately 10 times.	<p>Mr M continued to experience auditory hallucinations, but was unwilling to go into any depth about this. The CPN described him as guarded. Mr M's physical health and social care needs are monitored. The CPN was organising an application for alternative accommodation.</p> <p>The CPN described Mr M's conversation and behaviour as appropriate. Mr M continued to visit his family and was noted to be happy with his current medication. Also noted by the CPN that there were no ideas of harm to self or others. In March the CPN informed Mr M of her plan to leave her current post for another job.</p> <p>The CPA record dated 12/3/2003 stated Mr M's objectives as (1) to reduce stress; (2) for Mr M to promote his independence; (3) to maintain good mental health; (4) to improve his home environment; and (5) improve his self-esteem.</p> <p>Visits included 2-weekly outreach visits.</p> <p>At Mr M's request, he has also been allocated a new consultant.</p> <p>Comment: A high standard of care was provided by CPN [1].</p>	
2/4/2003	OPA consultant led.	Mr M noted to be stable. He was noted to be compliant with medication and experiencing no mood swings. Speech was noted to be normal and there was no evidence of thought disorder. Mr M was noted not to be deluded and admitted to still having auditory hallucinations. He was noted to say that he could cope with these as they were not stressful for him. Next medical review was planned for one year hence. The GP was requested to carry out a full blood screen in view of Mr M's Lithium.	

Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
24/4/2003	A new CPN (CJLT CPN) visits Mr M.	No change in presenting behaviour, as described in records. The CJLT CPN has been dealing with social security benefits. The plan is to continue to look for alternative accommodation.	
This date-to-date of incident is the period of care of most importance regarding HSG (94)27			
3/5/2003 until March 2005	CJLT CPN visited every 6 weeks.	<p>Mr M consistently described as having no psychotic symptoms; that he expressed no paranoid or negative thoughts. There was no evidence of thought insertion. Mr M consistently noted to be compliant with treatment.</p> <p>It was regularly noted that Mr M was experiencing EPS. The CJLT CPN noted that he had been supporting Mr M with practical needs; e.g. they went to an electrical store together to purchase a new washing machine and dryer. Mr M's accommodation was always observed as clean and tidy. The CJLT CPN also noted that Mr M regularly visited his family.</p>	Concern 1: There was insufficient documentation during these visits that the content of Mr M's auditory hallucinations was explored.
31/3/2004	OPA consultant led.	Mr M noted to be doing well. He was applying for a change in his accommodation, but denied problems in his neighbourhood. Mr M had been discharged from his social worker's caseload; but he can refer back if necessary. Mr M noted to deny drug or alcohol use. EPS symptoms continue, but Mr M did not want to change his medication. GP asked to do full physical check (good practice). Next medical appointment made for 2005.	

Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
15/3/2005	Visited by CJLT CPN.	Reported that Mr M remained mentally well and is compliant with treatment.	
16/3/2005	OPA – staff grade.	Mr M noted as describing his mood as generally good, although reported feeling bored and lonely sometimes. Noted to rarely drink alcohol. Auditory hallucination continued. A male voice daily; still believed it was the voice of God. The voice was noted to remain irritating, but that on the whole he was managing it OK. Mr M noted to deny other persecutory delusions. Medication: Lithium 1000mg and Modecate 50mg 2/52. Next OPA in 2006.	
26/4/2005	CJLT CPN home visit.	No change with presentation. No paranoid thoughts expressed. Flat remains tidy and well kept.	
6/6/2005 19/7/2005	CJLT CPN home visits.	On both occasions the CPN reported that Mr M continued to comply with his treatment pathway. Mr M noted to have confided to his CPN that he won't get meaningful employment for some time. Continues to have EPS.	
20/9/2005	CJLT CPN home visit.	CJLT CPN reported that Mr M continued to comply with treatment. No paranoid thought or psychotic phenomenon expressed. Noted that Mr M said that he wished to remain on current medication as <i>"he said he feels the benefits"</i> .	Good practice: Evidence of Mr M's view of his treatment and issues around concordance.
1/11/2005 13/12/2005	Home visits by CJLT CPN.	Reported no thought disorder, no paranoid delusions, no thought insertion, no evidence of mental illness.	Concern 2: The CJLT CPN does not demonstrate rigour in his assessments through his record keeping.
24/1/2006	CJLT CPN visited Mr M.	Reports that Mr M is objectively and subjectively well. With regards to Mr M's EPS, the CJLT CPN reported that on occasions Mr M felt bothered and embarrassed sometimes with the shakes.	

Date and time	Chronology	Summary detail of record content	Care/ service delivery issues and/or good practice
7/3/2006	Mr M reported to CJLT CPN an incident of a neighbour drug user who was drunk and rude and aggressive to Mr M.	Mr M did not respond to this incident and remains positive. The CJLT CPN reported that Mr M was doing something each day practically to fill his time.	Good practice: In response to this incident, the CJLT CPN reassured Mr M if he had any further difficulties with neighbours that he could ring him any time.
16/3/2006	OPA consultant clinic.	Mr M noted to be frustrated that he is on injections and is wasting a lot of time coming to clinic as it takes 90 minutes for him to come and go back and he has been doing this for five years. Mr M wanted to return to oral medication. Mr M's consultant noted that she told Mr M that tablets may not be as effective as depot and that it may take some time for him to switch over. Mr M agreed and <i>"is ready to take this chance"</i> .	Concern 3: No note of contingency planning; e.g. what Mr M wanted if he became unwell. What the medics would do if he became unwell. Good practice: The consultant's decision to go through Mr M's notes to see what oral medication might work best for him.

Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
4/4/2006	OPA consultant clinic.	<p>Mr M attended for his follow-up re. his request to alter his medication. His consultant noted that, following her case notes review, she only found Clozaril and Modecate as medications Mr M responded to. She also noted that Mr M had previously asked to stop Clozaril due to drowsiness, and that on a high dose he developed encephalopathic symptoms. Because of his past forensic history and there being no response to anti-psychotic medication, Flupenazine Hydrochloride on a dose of 5mg twice a day was recommended.</p> <p>It was noted that Mr M appeared to be very committed to following the regime.</p> <p>The consultant noted no evidence of relapse in psychosis or mood disorder and that Mr M understood the risks of stopping the oral medication. The consultant also noted that Mr M was agreeable to be followed up more often until the dose was adjusted.</p> <p>Mr M's depot injection was reduced to monthly until 3 May 2006.</p>	
4/5/2006	DNA.	Mr M did not attend his OPA; a further appointment was sent for three months time.	<p>Concern 5: This was Mr M's first missed appt and his oral medication was not established. It is not at all clear from the records what level of monitoring had been put in place as a consequence of the medication change.</p> <p>Concern 6: Mr M's non-attendance should have been followed up with a request for a CPN home visit.</p>

Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
18/4/2006 6/6/2006	CJLT CPN visited on both occasions.	The CPN noted Mr M's intentions to be abstinent from alcohol. Noted that Mr M last had a drink in March 2006. Noted that Mr M continued to experience EPS and that he stated that this was not bothering him. Mr M was also looking for employment.	
25/7/2006	CJLT CPN visit.	No further incidents with neighbours reported. No paranoid ideation expressed; no thought insertion. Flat noted to remain clean and tidy. Mr M reported as saying that he drinks alcohol when he watches sport. Only 2 cans of lager.	
5/9/2006	CJLT CPN home visit.	<p>No evidence reported of thought insertion, paranoid thoughts or thought disorder.</p> <p>Mr M informed his CPN that he stopped taking his medication as of 25 July 2006.</p>	<p>Good practice: CJLT CPN arranged an appointment for Mr M to be seen by consultant on 13 September 2006.</p>
13/9/2006	Appointment with the consultant psychiatrist.	<p>At the appointment, Mr M insisted that he would not re-start his anti-psychotic treatment. Now off medication for 9 weeks. There is no evidence of any psychotic phenomenon or paranoid thought, no thought disorder, no thought insertion at this time.</p> <p>Note: Mr M reportedly told the consultant Dr NM that he did not have schizophrenia, and that he had only been unwell when using drugs and alcohol.</p>	<p>Concern: Consultant considered that there may still be some medication in Mr M's system from the depots. He was off depot in May 2006 as far as we are aware. This was very unlikely at this stage.</p> <p>Concern: The consultant psychiatrist and the CPN, albeit after 'lengthy' discussion, accepted Mr M's position of six-weekly visits and asked GP if she had any means of 'close monitoring'. This whole area was not sufficiently explored in Trust's report.</p>

Date and time	Chronology	Summary detail of record content	Care/service delivery issues and/or good practice
28/9/2006	Mr M fatally stabbed a neighbour with a knife.	Witness accounts report that Mr M chased his victim and attacked him on more than one occasion.	Concern: Mr M had been without medication for between 8 and 10 weeks at the time of the incident.

25 **APPENDIX 2: INVESTIGATION METHODOLOGY**

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

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The investigation tools utilised were:

- Structured timelining.²
- Triangulation and validation map.
- Investigative interviewing.
- Affinity mapping.
- Qualitative content analysis.

Documentary information:

- Mr M's clinical records (copies and originals).
- Information provided by Cheshire Police.
- Statements from the family of the deceased.
- 5 Boroughs internal investigation report and accompanying interview records.
- Relevant policies and procedures (local and national).

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

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