The Report of an Independent Mental Health Inquiry

into

Care and Treatment received

By Mr P

September 2005

Contents

Acknowledgements

The process of reviewing tragic events inevitably generates distress for those people most closely involved. Whilst our methodology was designed to minimise this effect, we are aware of the effort required from those who supported our work so that the public interest could best be served.

The Panel is grateful to all those who gave evidence both orally or in writing – front-line staff and their managers from all agencies locally and at the Strategic Health Authority. We were helped in particular by the member of Ms E's family who met with us and one of her former colleagues who each provided valuable insights into the circumstances surrounding her death.

For the purpose of our report this inquiry will be referred to as the Independent Inquiry and the Internal Inquiry undertaken by East Sussex County Healthcare NHS Trust as the Internal Review.

Executive Summary

General Introduction

On the evening of 27th March 2003 Mr P killed his former girlfriend Ms E at her flat. He later pleaded not guilty to murder, but on 6th October 2003 was convicted of that offence and the court ordered that he should be detained in prison under a life sentence. Mr P had been in receipt of mental health services from East Sussex County Healthcare NHS Trust from 17th March until his arrest on 28th March. Mr P was referred to East Sussex County Healthcare Trust after an episode of deliberate self harm on 16th March 2003.

In July 2004 Surrey and Sussex Health Authority established an independent mental health inquiry under Health Service Guidance HSG (94)27 "Guidance on the discharge of mentally disordered people and their continuing care in the community". This requires that an independent inquiry is set up to examine the care and treatment of individuals in receipt of mental health services who commit a homicide.

Purpose of an Independent Inquiry

The purpose of an inquiry is to review a patient's care and treatment in order to establish whether there are lessons to be learnt to minimise the likelihood of a similar events reoccurring and to make recommendations to improve the delivery of mental health services both locally and nationally in the future. The aim is to incorporate an analysis of the individual case.

Chronology

Background

Mr P was born in Northern Ireland on 9th July 1971, the middle child of three. He has two sisters. His parents divorced during his teenage years and his mother moved to Sussex while his father remained in Ireland. Initially Mr P stayed with his father.

In 1990 he came to England to visit his mother for a holiday. He decided to remain in the UK and settled with relatives in, Berkshire. During this year he was seen by a GP having allegedly taken magic mushrooms and alcohol. The GP noted that he was very aggressive and had been violent towards his mother. No treatment was given.

In 1991 at the age of 20 Mr P met his future wife, they married six years later. But the marriage broke down after seven months and they divorced in 1998. They had two sons but since the divorce Mr P has had no further contact with them nor his ex-wife. During this period Mr P reported having taken an overdose and he was seen in the A & E department at Wycombe General Hospital.

Relationship with Ms E

At some point in early 2002 Mr P moved to Sussex. In the late summer of that year he met the victim, Ms E.

They subsequently formed what was described to the Panel as a turbulent relationship which lasted approximately seven months.

Relationship Breakdown

During the ten days prior to Ms E's death it was reported that Mr P repeatedly tried to contact Ms E, ringing her at work and on her mobile phone.

It was also reported in court that Mr P had on two occasions hid under Ms E's bed waiting for her to return home, once before and once after their relationship break-up.

Mr P's contact with Mental Health Services – 16th to 27th March 2003

Mr P was seen in A & E having taken between 32 – 48 paracetamol tablets and vodka on 16th March 2003 at approximately 21.00 hours. He had apparently recently split up from Ms E on the night of 14th and 15th March.

He discharged himself from A & E during the night before being seen by the liaison psychiatrist but was later brought back from his mother's flat to the department by the police, as his paracetamol level test results were high.

Contact with the Access and Response Team

Mr P was contacted by CPN 1 to arrange for a home assessment. Mr P was seen at his home later that day by a community psychiatric nurse (CPN 2) and psychiatrist Dr A from the Access and Response Team. Their assessment indicated that Mr P was experiencing an acute emotional crisis with some suicidal ideation and considered that he was at medium risk of suicide.

Mr P was offered and accepted a place at The Sanctuary.

During the next ten days, contact with Mr P by members of the Access and Response Team was made mostly by telephone. From a total of nineteen contacts, only six were made face to face.

On Monday 23rd March the Sanctuary discharged Mr P from their care and sent a letter to the ART.

On Wednesday 25th March psychiatrist, Dr B and CPN 6 saw Mr P at their team base for review. Mr P reported feeling very low, miserable and morose with poor appetite and low self esteem. He had suicidal ideation but no clear intent or plan. In Dr B's opinion Mr P had a diagnosis of a severe depressive episode with fleeting suicidal ideation but no intent and Adjustment Disorder as a result of a relationship breakdown. The plan was for Mr P to start treatment of an antidepressant, Mirtazapine 30 mgs and an anxiolytic, Flupenthixol 0.5 mgs, and to continue on Zopiclone 7.5 mgs.

Saturday 28th March

At 10.06 hours ART received a telephone call from the liaison nurse at A & E stating that Mr P had presented there the previous night having taken an overdose.

On arrival at A & E he had appeared to be semi-conscious and was not speaking. A small laceration was found on his

right arm but this did not account for the amount of blood found on Mr P's clothing.

The A & E staff were concerned about the quantity of blood on Mr P and contacted the police who examined the clothing and took some of the items away for further investigation.

Later in the day the police returned to the hospital and arrested Mr P on suspicion of murder.

Findings and Recommendations

The Independent Inquiry appreciates that the ART has been amalgamated into the Crisis Home Treatment Team and acknowledge that some of the following recommendations may have already been implemented. However the Trust is asked to consider the points made to ensure that the successor to ART reviews the systems in place.

Leadership

The Independent Inquiry found a team generously equipped with qualified nursing and social work staff but with inadequate consultant psychiatrist and clinical psychology input. In addition, the high utilisation of agency staff militated against team cohesion.

To secure improved performance, **it is recommended**:

- that the managers of the service ensure that plans and clear service standards are developed and implemented in the following areas that match the overall strategic direction of the Trust.

    - Supervision
    - Care Programme Approach
    - Clinical governance
    - Staff Development
    - Cross team working
    - Case review

In addition the Panel **recommends**:

- that the newly formed Crisis Home Treatment Team (CHTT) service policies and procedures are reviewed to ensure that they are consistent with the overall Trust strategy.

  - *that a system is implemented whereby the team formally reviews all case formulation, care plans and multi-disciplinary care review.*

  - *That a review of the handover process is undertaken to ensure that all decisions are documented in the individual's notes and that an ongoing team log of the handovers and review meeting is completed.*

  - *That a clearer process is established for the allocation and coordination of each case.*

Domestic violence

> "*Domestic violence accounts for a quarter of all recorded violent crime in England and Wales. Although such violence can occur irrespective of background and circumstance, sexuality or gender, it is predominantly women who suffer. One in four women experience some form of violence from a partner in their lifetime. Every week two women die as a result of it. Domestic violence is usually a hidden crime. Victims suffer silently, afraid for themselves and for their children.*
> Foreword by the Home Secretary, The Rt Hon David Blunkett MP, June 2003, Safety and Justice: The Government's Proposals on Domestic Violence

Domestic violence has slowly begun to have an increased profile within mental health services with the Royal College of Psychiatrists issuing "*Domestic Violence*", in April 2002 (6). Research from Women's Aid, *Struggle to*

Survive, (7), published in July 2004 found that between 50% and 60% of women mental health service users have experienced domestic violence, and up to 20% will be experiencing current abuse. However, mental health professionals have been found consistently to underestimate the proportion of their clients who experience domestic violence. Most recently, the *Domestic Violence, Crime and Victims Act* (8) was passed in November 2004 and all organisations will need to develop or review their domestic violence protocols and training strategy. (2)

In view of this and other cases that the Independent Inquiry is aware of where harm has come to a former partner following the break down of a relationship we **recommend:**

- that the mental health services should develop protocols with wider Domestic Violence services to assist in supporting and protecting ex partners.

(2) Taken with permission from the Report into the care and treatment of Mr A.

Interagency Co-operation

From the evidence received it is clear that interagency co-operation can be improved across a range of fronts, including:

The Sanctuary

Relationships with the Sanctuary should be strengthened, so we **recommend** that:

- Turning Point, the mental health trust and the PCT work together to jointly agree a care pathway which incorporates the Sanctuary service into the wider mental health services in order to:
  - ensure a shared value base between all parties
  - identify key staff to liaise between provider services and ensure co-ordinated care planning and delivery

- adequate funding be allocated for this new requirement and to meet the significant demands made upon services provided by the Sanctuary

Primary Care

ART members did not appear to routinely access primary care and other related records. We believe that both, in the case in question, and more broadly that the team would benefit from access to and use of this information. We **recommend:**

- that crisis services routinely access primary care and other available health and social care information within 24 hours.

A&E

We found that in this case there was not a clear handover of information between the A&E service and ART. We **recommend:**

- that a protocol for handover of clients is developed urgently, which contains information to ensure the safe transfer of patients to ongoing services and includes all patient documentation.

- that the Trust should consider whether A&E liaison service should be part of an integrated crisis service.

Clinical Psychology

We found that there was a lack of proactive use of Clinical Psychology by the ART, in order to address this we would **recommend:**

- That Clinical Psychology input is sought by team members to assist with the formulation of care plans and to participate in multi-disciplinary case reviews.

Substance Misuse Services

There were a number of indicators both in the medical records and in the client's history where clues about

alcohol misuse were apparent. In order to improve the quality of responses by the ART to potential substance misuse we **recommend:**

- that a member of the team be identified to receive training in substance misuse from the DAAT, and that they provide a continuing structured link between the DAAT and the CHTT

Medical Input

We found the medical input to the team and the medical leadership of the team to be both limited and reactive. In order to improve this situation we **recommend:**

- that the team has sufficiently resourced Consultant Psychiatrist input.

Serious Untoward Incidents

In the view of the Independent Inquiry the internal processes for addressing this Serious Untoward Incident (SUI) appeared to be inadequate. Most of the practitioners we spoke to did not have examples of how practice had changed as a result of the incident, or have examples as to how practice might develop in the future.

The internal investigation did not appear to have been completed in terms of developing recommendations, an action plan or an audit process to ensure that the recommendations had been implemented across the Trust.

The 2003/04 Trust annual report highlighted the need to improve Serious Untoward Incident processes and systems. We recommend:

- that the Trust reviews the process of dealing with Serious Untoward Incidents to ensure that the SUI policy is implemented consistently and comprehensively; that lessons are learned and cascaded effectively through the Trust; that audit systems are put in place to ensure that recommendations are implemented and that lessons from SUIs are considered by the Trust Board as part of overall Clinical and wider Governance structures.

Professional Supervision

The Independent Inquiry found that arrangements for supervision were inadequate for meeting the needs of both service users and developmental needs of staff.

It is recommended:

- that a more structured process for supervision is developed to ensure that there is a formal review of care plans for all members of the team including CPNs and psychiatrists as well as developing a multi-disciplinary team based approach to review cases. At these reviews it would be advisable to include other professionals such as substance misuse and housing.

Agency Staff

Whilst acknowledging the difficulties across all mental health services in recruiting and retaining of staff, the Independent Inquiry found that utilising such a high proportion of agency staff working in a crisis team such as ART was unacceptable. This was accentuated by the lack of induction and access to training and supervision for this staff group.

It is recommended:

- that all agency staff receive proper induction and access to statutory and mandatory training.

- that a care coordination system is systematically implemented which clarifies the role of agency staff within the team in circumstances where their employment is unavoidable.

Performance Management

During the period under review, management of mental health services in this locality was in transition. From the evidence before us, despite the best efforts of practitioners and managers the performance management framework both within and between agencies appeared to lack coherence. We recommend that

- the Strategic Health Authority, County Council and other relevant health bodies satisfy themselves that arrangements for performance management now in place meet the requirements of statute and best practice

1. General Introduction

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East Sussex County Healthcare Trust set up an internal review comprising a multi-agency panel in May 2003. It completed its report in October 2003 and made recommendations for action by both the Trust and East Sussex County Council.

In July 2004 Surrey and Sussex Health Authority established an independent mental health inquiry under Health Service Guidance HSG (94)27 "Guidance on the discharge of mentally disordered people and their continuing care in the community". This requires that an independent inquiry is set up to examine the care and treatment of individuals in receipt of mental health services who commit a homicide.

1.2 Purpose of an Independent Inquiry

The purpose of an inquiry is to review a patient's care and treatment in order to establish whether there are lessons to be learnt to minimise the likelihood of a similar events reoccurring and to make recommendations to improve the delivery of mental health services both locally and nationally in the future. The aim is to incorporate an analysis of the individual case.

It is intended that the process be constructive and positive for the individual members of staff, service providers and the general public. In addition it is important to ensure the families of both patient and victim be fully involved in the process, and be consulted on its outcomes

2. Terms of Reference

Independent Inquiry into the Care and Treatment of Mr P

1. To establish the chronology of the care received

2. To examine all circumstances surrounding the care and treatment of Mr P, in particular

- The quality of his primary healthcare, secondary healthcare, social care accommodation and risk assessment indicators and analysis.

- The circumstances relating to treatment, and to comment upon:

  - The suitability of the care in view of Mr P's assessed health and social care needs, and clinical diagnosis.
  - The clinical and operational organisation, and the quality of care provided in the community.
  - Assessment of the needs of carers/family

- The suitability of his treatment, care and supervision in respect of:

  - His assessed health and social care needs
  - His assessed risk of potential harm to himself or others
  - Any previous psychiatric history, including drug or alcohol abuse
  - Previous forensic History
  - How the service met his health and social care needs

- The extent to which Mr P's care corresponded to statutory obligations, the Mental Health Act 1983, and other relevant guidance from the Department of Health and local operational policies; and the extent to which his prescribed care plans were:

  - Effectively delivered
  - Complied with by Mr P
  - Monitored by the relevant agency
  - Coordinated by the agencies

- The internal enquiry completed by East Sussex County Healthcare NHS Trust and the actions that arose from this.

- Consider such other matters relating to the said matter as the public interest may require.

3. To consider the adequacy of both the risk assessment procedures applicable to Mr P and the relevant competencies and supervision provided for all staff involved in Mr P's care.

4. To examine the adequacy of the collaboration and communication between all the agencies involved in the care of Mr P, or in the provision of services to them, including East Sussex County Healthcare NHS Trust and primary care services.

5. To prepare an independent report, and make recommendations to the local health, and social care communities.

3. Panel Membership

The Independent Inquiry was undertaken by a panel of professionals who were independent of the local mental health services provided in East Sussex.

Panel Chair		
Ted Unsworth	–	A former Director of Social Services and national mental health charity chief executive, currently a director of Tribal Consulting and in service with the Mental Health Review Tribunal
Panel Members		
Dr Rosalind Ramsay	–	Consultant Psychiatrist, South London & Maudsley NHS Trust, London
Luke O'Byrne	–	Former Director of Nursing Berkshire Healthcare NHS Trust
Inquiry Manager		
Lynda Winchcombe	-	A management consultant who specialises in Serious Untoward Incident Reviews.

4. Methodology

The Independent Inquiry was commissioned by Surrey and Sussex Strategic Health Authority in July 2004 and undertaken in accordance with the Terms of Reference in section 2.

The family of Ms E were invited to meet with the panel before commencing the inquiry and Ms E's father was subsequently interviewed.

The panel visited Mr P in Prison. However after the panel introduced themselves and explained the purpose of the Inquiry and their visit, he declined to be interviewed further or for the panel to approach his family for their opinion of the events leading to the incident. Although Mr P gave permission for the Inquiry to have access to the information held by health, social and the police agencies, he refused access to his legal documentation.

The panel obtained relevant written documentation (see following section) and a chronology of the sequence of events was compiled.

The panel received oral and written evidence from seventeen people over five days during September, November and December 2004. A further two individuals were interviewed in March 2005 with one final interview taking place in April 2005. Each interview was recorded and the individual transcript sent to interviewee concerned in order to confirm its accuracy and to give interviewees an opportunity to provide additional information. The panel was unable to interview one member of staff who played a key part in Mr P's care and treatment as the individual had taken employment overseas.

This report was compiled during April and May 2005. It sets out a summary of the chronology of events together with an analysis of the evidence received and the panel's findings and recommendations.

5. Documents Seen

East Sussex County Healthcare NHS Trust

Internal Review
Multi-disciplinary notes
Notes of the Serious Untoward Incident meeting held 12th June 2004
Management Structures
Joint Policy and Procedures
Risk Management system
Support for staff document
Annual Report 2003/04
Integrated Supervision Policy
Care Programme Approach (CPA) Policy and Operational Guidelines
Risk Alert Form
Incident Report Form
Drug Error Report Form
CPA and Risk Management Forms
TB Action Plan
Protection of Vulnerable Adults Policy
Access and Response Team (ART) Operational Policy
Audit and Home Treatment Team Information
CNST Document
Psychiatric Report
Preventing Suicide Toolkit
ART Establishment and Activity

GP

Medical Records

Prison

Health Records
Prison Notes
Previous Convictions

Life Sentence Plan
Inmate Personal Records

Court

Sentencing Summary – Judge

Primary Care Trust

Mental Health Commissioning Services Strategy
Sanctuary Contract

Sussex Police

Records of Investigation

6. Service Profile

East Sussex County Healthcare NHS Trust (the Trust) was established in April 2002. It serves a population of 492,000 people and covers an area of 666 square miles on the south coast of England. The main centres of population are in Hastings, Bexhill, Rye, Eastbourne, Polegate, Lewes, Seaford, Newhaven, Peacehaven, Hailsham, Healthfield, Uckfield and Crowborough. The area encompasses five district and borough local authorities, East Sussex County Council, and four Primary Care Trusts (PCTs). Away from the coast, the area is more thinly populated and rural.

The five district and borough local authorities have varied demography and demonstrate a wide range of deprivation. Hastings is ranked at 37 out of 354 local authorities, making it one of the most deprived districts in the country. Within the population of each local authority there are a higher proportion of other black minority ethnic groups, most notably Asian Pakistani, Asian Bangladeshi, Black Caribbean and Black African.

Bexhill and Rother PCT has a significantly lower proportion of citizens aged under 44s compared with England and Wales. However, the proportion of the population in the 75-84 age group is almost double the national average. This pattern is repeated to a lesser degree in the other PCTs.

When the Trust was created in 2002 it absorbed mental health, learning disability, substance misuse and community dental services from Hastings and Rother NHS Trust. The same services in the Ouse valley area of South Downs Healthcare NHS Trust came into the Trust at the same time. The community health services formerly provided by Eastbourne and County Healthcare NHS Trust were transferred to the local PCTs in 2002.

The Trust was originally established on an interim basis, with the expectation that a new organisation integrated with social services would come into existence in April 2004. In the spring of 2003, it was proposed that a Care Trust be established, but not

all local health community partners supported this proposal.

In March 2004 an option appraisal exercise concluded that it would not be appropriate at that time to consult formally about a merger of the three Mental Health Trusts providing services across Sussex. However, it recommended the development of joint commissioning strategies and strengthened cooperation between partner agencies on achieving integrated service provision. A steering group to take this forward has been established and is chaired by the Chief Executive of Surrey and Sussex Strategic Health Authority.

The Trust provides specialist mental health, substance misuse and community learning disabilities services in partnership with East Sussex County Council social services department, and employs 1,414 staff. Care is provided from over 50 sites through a range of inpatient, outpatient, day care and community settings, as well as in people's homes. The average number of beds available in 2002/2003 totalled 292, of which 141 were for older people and 20 were for secure provision.

The Trust received a zero star rating in the July 2004 performance ratings, failing to achieve key targets relating to assertive outreach team implementation, CPA systems implementation, financial management and mental health minimum data set implementation. Targets relating to community mental health team integration, hospital cleanliness and improving working lives were successfully achieved.

Joint health and social care appointments have been made for all care groups at service manager level and joint commissioning arrangements are being progressed. *(Reproduced from the report by the Healthcare Commission December 2004)*

Plans for a further reconfiguration of services are currently being considered, one option being the creation of a single mental health and learning disability Trust to cover the whole of Sussex. The Chief Executive of the East Sussex County Healthcare

NHS Trust at the time of the incident left in 2004 and interim management arrangements have been in place since that time pending determination of the new organisation structure.

6.1 Hastings and Rother Working Age Adults Service

In March 2003 Mr P was under the care of the Hastings and Rother Working Age Adults Service based in Hastings. At this time the Hastings and Rother service included:

- Community Mental Health Teams
  - Nurses
  - Social Workers
  - Consultant Psychiatrists
  - Occupational Therapists
  - Psychologist
  - Administration Staff

- Access and Response Team
  - Associate Specialist Psychiatrists
  - Social Workers
  - Nurses
  - Psychologist – (advisory role)
  - Administration Staff

- Accident and Emergency Liaison Service

6.2 Access and Response Team

Except for the contact briefly on the 16th and 27th/28th March with the A & E Liaison Service, Mr P was seen exclusively by the Access and Response Team (ART). The ART provided an extended hour's service 09.00 – 20.00 hours seven days a week. The team comprises ten full time community mental health nurses, one senior social worker practitioner and four full time social workers with two associate specialist psychiatrists working on a sessional basis.

The maximum caseload was set at 20 for the team but Independent Inquiry Panel was informed that the average number on the team's caseload is usually eight to ten. According to the Operational Policy each patient is allocated a care coordinator. However in reality patients appeared to be managed by the whole

team dependent on duty rotas and the influx of new referrals for assessment. The Independent Inquiry heard that all staff on duty attend a morning handover meeting to decide the daily allocation of each patient on the caseload.

Current information relating to the care, treatment and allocation of individual patients is recorded manually on a 'white board' at the team's base.

The team acts as the gateway to Hastings and Rother mental health services for people who are experiencing mental health difficulties and their families and carers. In addition the team provides a rapid response to service users and their carers who are in crisis and require emergency or urgent assessment and care. The Inquiry heard that a high percentage of the ART's staff were provided by an agency.

Patients may remain on the ART's caseload for up to three weeks. After this, patients requiring ongoing support are transferred to the CMHT.

6.3 The Sanctuary Service - Profile

The Sanctuary is a short-term residential facility for people who are experiencing mental health problems and have reached crisis. The service is provided by Turning Point, a national mental health social care charity. It offers a non-medical alternative to hospital admission by focusing on the person's current situation and any risks to themselves or others involved in these circumstances. The Sanctuary aims to give people 'time out' of their living situation and provides an opportunity to reflect and recover in a supportive environment. The staff offer daily care planning sessions to facilitate the decision making process which can lead to resolution of the crisis in a positive way. The maximum duration of stay is generally 14 days.

The Sanctuary receives self-referrals from potential clients together with referrals from a range of other sources including health and other related professionals. The service will accept people who are in a mental health crisis and using substances, but

not people with a primary alcohol or substance misuse problem. A comprehensive risk assessment is conducted with the referrer at the time of referral. Those considered as posing too high a risk to themselves or others will not be accepted into the service. The Sanctuary works closely with the local ART and local CMHTs. The CPA is used to involve service users in their care, provide a plan for crisis and to coordinate care (operational policy, March 2002, due for review March 2003).

The Sanctuary is a statutorily registered care home with a registered mental nurse as manager. It is staffed 24 hours a day. Due to the short-term nature of the service and the rotating team a key worker system is not operated so clients see different staff to develop their care plans.

7. Chronology

7.1 Background

Mr P was born in Northern Ireland on 9th July 1971, the middle child of three. He has two sisters. His parents divorced during his teenage years and his mother moved to Sussex while his father remained in Ireland. Initially Mr P stayed with his father.

In 1986 aged 15 years Mr P left school without any qualifications and worked as a manual labourer.

In 1990 he came to England to visit his mother for a holiday. He decided to remain in the UK and settled with relatives in Marlow, Berkshire. During this year he was seen by a GP having allegedly taken magic mushrooms and alcohol. The GP noted that he was very aggressive and had been violent towards his mother. No treatment was given.

In 1991 at the age of 20 Mr P met his future wife, they married six years later. But the marriage broke down after seven months and they divorced in 1998. They had two sons but since the divorce Mr P has had no further contact with them nor his ex-wife.

In 1998 during the period of his marriage break-up Mr P attended the A & E Department at Wycombe General Hospital. He reported taking an overdose. A month later he saw his GP as he reported drinking a lot, feeling tearful, unable to sleep or work. The GP prescribed a short term hypnotic medication to take at night (Temazepam 20mgs) and gave him the telephone number of a counselling service. There was no contact with mental health services following this incident.

Mr P continued to drink heavily and he reported that he took illicit drugs from time to time.

7.2 Relationship with Ms E

At some point in early 2002 Mr P moved to Sussex. In the late summer of that year he met the victim, Ms E.

It is unclear as to how they met although it is thought that this happened at the club where Ms E [aged 19 years] was working part time. Mr P was aged 30 years at the time.

They subsequently formed what was described to the Panel as a turbulent relationship which lasted approximately seven months. It was reported that at one point they had considered a more permanent relationship, and possibly starting a family.

It was reported by witnesses who knew the couple that Mr P was possessive and jealous of any attention Ms E received and the break up of their relationship was allegedly caused by Mr P accusing Ms E of being unfaithful.

7.3 Relationship Breakdown

During the ten days prior to Ms E's death it was reported that Mr P repeatedly tried to contact Ms E, ringing her at work and on her mobile phone. Her mobile phone number was changed in order to prevent further calls from Mr P. Although her work colleagues were aware that Ms E was being harassed by Mr P this was not reported to the police and there was no suggestion to the panel that the mental health services were aware of this uninvited attention.

It was also reported in court that Mr P had on two occasions hid under Ms E's bed waiting for her to return home, once before and once after their relationship break-up. Furthermore the police reported that they believed that he was in Ms E's house waiting for her to return home on the night of her death.

7.4 Mr P's contact with Mental Health Services – 16th to 27th March 2003

7.4.1 Contact with Accident and Emergency

Mr P was seen in A & E having taken between 32 – 48 paracetamol tablets and vodka on 16th March 2003 at approximately 21.00 hours. He had apparently recently split up from Ms E on the night of 14th and 15th March.

On 16th March Mr P had apparently rung Ms E stating that she could collect her door key and leave his belongings at his mother's flat. He would not be there and a key was to be found in the door in order for Ms E to gain access.

When Ms E with members of her family went to the flat she found Mr P on the sofa with two empty bottles of Vodka and two empty bottles of paracetamol. She rang for an ambulance to take him to A & E.

He discharged himself from A & E during the night before being seen by the liaison psychiatrist but was later brought back from his mother's flat to the department by the police, as his paracetamol level test results were high. The Independent Inquiry were unable to establish whether he was seen by A & E or mental health staff at this time. Again he left the department at 09.00 hours on 17th March. The A & E Liaison service phoned Mr P's GP and requested that a referral was made to the community mental health team for an urgent assessment of Mr P's mental state. The GP faxed a referral to the ART service.

7.4.2 Contact with the Access and Response Team

Mr P was contacted by CPN 1 to arrange for a home assessment. Mr P was seen at his home later that day by a community psychiatric nurse (CPN 2) and psychiatrist Dr A from the Access and Response Team. Their assessment indicated that Mr P was experiencing an acute emotional crisis with some suicidal ideation and considered that he was at medium risk of suicide.

Mr P was offered and accepted a place at The Sanctuary. Mr P stated that he needs 'someone around him'.

A letter dated 24th March 2003 summarising the assessment was sent to Mr P's GP by Dr A. During his contact with ART no attempt was made by ART staff to access his primary care records.

During the next ten days the following contacts were made or attempted by members of the Access and Response Team (ART).

Tuesday 17th March
At 18.00 hours two members of the ART, CPNs 1 and 2 took Mr P to the Sanctuary

Wednesday 18th March
Mr P visited at The Sanctuary at 15.00 hours by CPN 2 who reported that the visit was brief as he was feeling 'tearful and devastated' and he had a visitor with him.

Thursday 19th March
Mr P visited at the Sanctuary at 12.00 hours by CPN 2. He was seen in his room, but was not receptive. He made little eye contact and was staring out of the window for most of the visit. As he was not engaging well the CPN felt concerned and decided to refer him to Survivors of Suicide (SOS) for support. She arranged a second visit for later that day.

At 18.10 hours CPN 1 telephoned Mr P who was tearful and finding it difficult to interact with other residents.

Friday 20th March
CPN 2 referred Mr P to S.O.S. but following discussion between the CPN and SOS it was agreed that the current service input was enough, and he could be re-referred at a later date when he felt more able to deal with his attempted suicide.

At 15.00 hours CPN 2 briefly visited Mr P at the Sanctuary. His mother was there. They agreed the following plan: Mr P would stay with friends that night and remain at the Sanctuary until the following Monday, 23rd March.

Saturday 21st March
At 14.00 hours CPN 1 telephoned the Sanctuary to review Mr P but he had not returned from friends/his mother.

At 18.00 hours, the CPN 1 phoned The Sanctuary and was informed Mr P's mother had been in contact with them to say he was okay and staying with a female friend that night. Mr P was to return to The Sanctuary the following day. CPN 1 asked the Sanctuary to contact ART if he failed to return by 14.00 hours on 22nd March 2003.

Sunday 22nd March

ART (CPN 3) telephoned the Sanctuary. Mr P had returned from leave – said he felt low and left to stay with his mother. He was advised to contact his GP to obtain a sick certificate for work.

At 20.20 hours CPN 3 again called Mr P on his mobile he stated that he thought about suicide all the time but denied intent. He felt happier staying at his mother's and was unsure whether he would return to The Sanctuary.

Monday 23rd March

The Sanctuary discharged Mr P from their care and sent a letter to the ART.

At 11.00 hours CPN 4 rang Mr P's mobile phone, but a friend answered and said that Mr P had gone to play football.

Tuesday 24th March

At 10.35 hours CPN 5 rang The Sanctuary to ascertain if Mr P was still there so was informed of his discharge on 23rd March. At 12.50 CPN 5 spoke to Mr P on his mobile who stated that he felt 'shit' and asked for a visit.

At 14.45 CPN 5 telephoned Mr P stating they couldn't visit him that afternoon but could go at 17.00 hours. Mr P agreed but stated that he was unable to sleep as he had run out of his Zopiclone. They arranged for another prescription.

At 17.00 CPNs 5 and 6 visited Mr P at his home as planned. The CPN's found it was difficult to engage him and assess his mental state as he was unable to express his thoughts and feelings. Mr P reported

finding it difficult to eat and sleep for the last 3 days. He denied thoughts of violence, but said that he was feeling jealous. It was decided to book an appointment with a psychiatrist.

Wednesday 25th March

Psychiatrist, Dr B and CPN 6 saw Mr P at their team base for review. Mr P reported feeling very low, miserable and morose with poor appetite and low self esteem. He had suicidal ideation but no clear intent or plan. Not on illicit drugs. In Dr B's opinion Mr P had a diagnosis of a severe depressive episode with fleeting suicidal ideation but no intent and Adjustment Disorder as a result of a relationship breakdown. The plan was for Mr P to start treatment of an antidepressant, Mirtazapine 30 mgs and an anxiolytic, Flupenthixol 0.5 mgs, and to continue on Zopiclone 7.5 mgs. CPN 6 telephoned Mr P later in the day and noted that he sounded brighter.

Thursday 26th March

At 11.00 hours CPN 1 phoned Mr P. He had just woken up and reported 'feeling pretty bad'. Mr P asked the CPN to phone back when he had woken up properly.

At 13.00 hours, CPN 1 phoned Mr P who said he was feeling a little better. He had commenced Mirtazapine the previous night and slept well. Mr P declined a visit.

Friday 27th March

At 12.45 hours CPN 7 phoned Mr P who sounded very flat and monosyllable. He reported not feeling too good. He had a friend there and requested a visit the next day. Dr A wrote to the GP informing him of the treatment and stated that Mr P might require admission to hospital if his mental health deteriorated.

Saturday 28th March

At 10.06 hours ART received a telephone call from the liaison nurse at A & E stating that Mr P had presented there the previous night having taken an overdose.

On arrival at A & E he had appeared to be semi-conscious and was not speaking. A small laceration

was found on his right arm but this did not account for the amount of blood found on Mr P's clothing.

The A & E staff were concerned about the quantity of blood on Mr P and contacted the police who examined the clothing and took some of the items away for further investigation.

Later in the day the police returned to the hospital and arrested Mr P on suspicion of murder.

8. Analysis of the Evidence

In order to complete this section and meet their Terms of Reference requirements the Independent Inquiry explored two main areas as follows: -

- the care and treatment of Mr P

- the operation of the Access and Response Team

8.1 The Care and Treatment of Mr P

8.1.1 Assessment and Contact

Mr P's first and only contact with the mental health services in East Sussex was as a result of an urgent referral from his GP following an attempted suicide. He was initially seen in the Accident and Emergency Department having taken between 32 – 48 paracetamol tablets and vodka on the 16th March 2003 after apparently breaking up with his girlfriend of seven months. He did not wait in A & E to be assessed by the Liaison Psychiatrist and therefore the Liaison CPN rang Mr P's GP requesting a referral to the mental health services as he was concerned about Mr P's mental state.

Mr P was initially assessed by one of the Access and Response Team's sessional psychiatrist (Dr A) and a Community Psychiatric Nurse, CPN 2.

8.1.2 Formulation of the case

The ART's first analysis of the case is given in the letter sent by Dr A to Mr P's GP, dated 24.3.03. This followed the assessment by Dr A and CPN 2 on 17.3.03 at Mr P's flat, his first contact with the ART. The assessment letter gives information about the recent incident and Mr P's personal and family history. In terms of risk, the letter states that he did not express any suicidal thoughts or ideas. It also includes some references to his ex-partner Ms E. The letter states *'clinical impression: is that he is suffering from an adjustment reaction. Proposed plan: he has been taken on to the ART caseload and admission to* [the] *Sanctuary was arranged. I have prescribed zopiclone 7.5mg nocte* [night sedation] *for two weeks.'*

This letter does not contain more detail about the possible formulation of the case, including discussion of any differential diagnoses, consideration of aetiological factors or an in depth analysis of any possible risk factors.

Further information about the ART's analysis of the case is given in the letter dictated on 25.3.03 (sent 27.3.03) by Dr B after his visit to Mr P with CPN 6 on 25.3.03. This letter states that Mr P '*has fleeting suicidal ideation, but definitely does not have any intentions or plans to do anything.*'

The clinical impression at this point is given as '*I think he is suffering from a severe depressive episode with fleeting suicidal ideation and has also* [an] *adjustment disorder due to a relationship breakdown at the moment'.* The management plan states '*he was reassured and counselled fully. He remained co-operative with the treatment plan. I have prescribed Mirtazapine 30mg to be taken at night. I have also prescribed Flupenthixol 0.5mg to be taken in the morning and at teatime. He can continue taking zopiclone 7.5mg at night on an as required basis. We will telephone or visit daily and we will respond to telephone calls. He may need a hospital admission if his mental health deteriorates.*'

This second letter does not contain more detail about the possible formulation of the case, including the change in diagnosis since the previous psychiatric assessment on 17.3.03 by Dr A. There is a suggestion of some consideration of increasing risk with the mention of hospital admission if Mr P's mental health deteriorates, but no exploration of the issues involved.

The Independent Inquiry team understand that the Access and Response team met on a daily basis and went through the caseload in the morning 'handover meeting'. The team manager told the Independent Inquiry, the team discussed patients '*almost all like the sections that one covers on a CPA assessment, and risk. We always talk about what the risk is. Why the person's on the caseload… Always the care plan… We have a brief history, current presentation and then whatever the plan is and then we look at what we are going to do today.*'

Staff reported to the Independent Inquiry that at this meeting, team members presented information about any

new patient taken on the previous day (or patients who were new to the team, for example if a member of staff had been on leave and missed the original presentation), and any concerns about existing patients. Key information about the current caseload was recorded on the whiteboard at the team base. Staff did not routinely record a summary of the morning meeting discussion of a new assessment or subsequent morning handover reviews either in individual patient's case notes or in any other way.

The case notes for Mr P have information about attempted and actual contacts with him, both face to face and over the phone. However, the Panel did not see evidence of any:

- clear presentation of a case summary with a recorded differential diagnosis and comment about the possible aetiology

- documented record outlining the rationale for his treatment plan and probable prognosis

- records noting the reasons for the change in diagnosis between the two psychiatric assessments.

- attempt to make a psychological formulation of his case which could inform his care plan further.

As can be seen by the previous section, contact with Mr P, whilst made on a frequent basis, was mostly by telephone. Only six face to face contacts were made out of an overall total of nineteen encounters over the ten days prior to the death of Ms E. Six members of the team saw Mr P over this time, and 8 team members had contact with him, six CPNs and 2 Psychiatrists. Dr A saw Mr P at the initial assessment and Dr B was asked by CPN 2 to review Mr P when she had concerns about a change in Mr P's mental state. It seemed to the Independent Inquiry that the two psychiatrists did not document their discussion with team members or each other about case formulation. So it was not clear to the Panel whether the

psychiatrists were members of the team or operated in parallel.

During the period of contact Mr P was seen or contacted by eight different members of the ART. It appeared that once the original CPN 2 went on leave nobody took overall responsibility for the case and there was no evidence of a proper case discussion with an effectively structured plan.

Evidence from different team members demonstrated that there was a lack of clarity amongst them as to whether a key worker system was in operation. This lack of clarity appeared to the panel to be unsafe. It is considered by the Independent Inquiry that in order to comply with CPA requirements, the ART operational policy, proper risk management processes, overall safe clinical care and good practice that each patient must have a key worker who is responsible for ensuring that their overall care package is coordinated.

8.1.3 The Sanctuary's formulation of Mr P's needs

Mr P was referred to the Sanctuary by the ART on 17th March and received a service there until 23rd March when he was discharged. Following Mr P's discharge from the Sanctuary, the manager summarised his contact with the service in a letter (dated 23.03.03) sent to CPN 2 at the ART team. The Sanctuary manager repeated the report of Mr P's overdose on 16.03.03, commenting that *'it was decided that a few days at our service might prove beneficial'*. After Mr P arrived at the Sanctuary, he *'explained to staff that the break up of his relationship had left him feeling devastated. He was not eating or sleeping and could only think of happier times that they had spent together.* He *'settled in to the project quite well but preferred to spend most of the time in his room. He continued to feel very low in mood.'* On one occasion he took *'four (sleeping) tablets instead of the prescribed one…His sleeping pattern, however did gradually improve throughout his short stay with us as did his dietary intake. On 21.03.04 Mr P decided that he would like to go on overnight leave'*. He *'returned to the project briefly and appeared to be very low in mood and tearful… he would prefer to remain with a friend.'*

At discharge on 23.03.03, he *'remained feeling low but preferred not to return to our service.'*

The Sanctuary's policy is to avoid the *'use of labels (medical or otherwise)'*, to prevent *'stereotyping and discrimination'*, preferring *'everyday language to describe a person's situation'.* In the Panel's opinion this philosophy could have limited the ability of staff at the Sanctuary to fully understanding the nature of Mr P's crisis and how to help him in resolve it.

8.1.4 Impact of alcohol use

The prevalence of substance misuse amongst mental health service users is well documented. It is also accepted that people under-report their consumption of alcohol and other substances. So any routine assessment process should normally include screening to identify potential problems in this area of behaviour.

From the evidence we heard it is clear that members of the ART in contact with Mr P at the relevant time did not believe his alcohol consumption to be problematic. Although references were made to his: -

- origins in a society where the regular and heavy consumption of alcohol was a cultural norm
- occasional 'laddish' behaviour
- use of alcohol at times of stress - most importantly linked with an attempted overdose

it was not thought necessary to seek expert advice in respects of Mr P's alcohol use. However, had his GP notes been interrogated at the time Mr P's excessive alcohol consumption would have been identified. In the report of his subsequent forensic psychiatric examination a pattern of heavy drinking is clearly portrayed.

8.1.5 The Quality of the Risk Assessment

In order to undertake a robust Risk Assessment and plan risk management it is important to obtain as much information as possible. This does include contacting other agencies and individuals with knowledge of the person being assessed.

From the records that we saw the Risk Assessment appears to have been superficial, for example a question in the Risk Assessment "Is there a high level of conflict in family and/or close relationships?" was answered yes. This did not then appear to result in more in-depth questioning or the formulation of what should be done as a result of this positive answer.

- There appeared to have been no attempt to gain access to GP or other medical records. Had the team viewed the records they could have identified a number of salient issues that may have assisted them with the formulation of a care plan.

- There did not appear to be any attempt to collate information from his family or friends to inform the risk assessment, in particular from Ms E who assisted him to make the initial contact with A&E

- He did not appear to have been asked about his feelings towards Ms E in any depth.

- There appeared from the records that we saw to have been reports of considerable variations in his mood which did not seem to have been questioned by team members.

- The checklist that formed the basis of the risk assessment was good. But in the example highlighted earlier from the information arising from the questions did not lead to a well formulated plan. It is vital that these sort of Risk Assessments are not just treated as a check list. Overall the quality of the risk assessment and risk management was considered by the panel to be very limited, superficial and fragmented. In order to avoid this situation recurring we **recommend** that this is reinforced to team members and Agency staff and that a mandatory annual training session on the

formulation of active and dynamic Care Plans from Risk Assessments is introduced.

8.1.6 Clinical Psychology input

It was reported to the Independent Inquiry that the Clinical Psychology input to the ART was limited, with no consistent intervention at regular review meetings. This is likely to have hindered the development of a fuller psychological understanding of cases accepted by the team.

The service manager commented to the Independent Inquiry that *'it would be helpful to have psychology input. Our only psychology input at the moment is somebody who screens all our referrals if we as a team feel that psychology is needed for this person. It would be very helpful if we could have more psychology input… to the team.'*

8.2 The Operation of the Access and Response Team

The access and response team operates a 9am to 8pm service taking referrals for initial assessment. It was considered by the Independent Inquiry to be a well resourced team (17), including 2 doctors, 10 CPNs, 1 senior social worker and 4 social workers covering a caseload and crisis management of between 8 – 20 clients at any one time. Since the incident this team has been amalgamated with the Crisis Resolution team to form a Crisis Home Treatment Team.

During 2004 the team had a total of 2847 referrals of which 177 were taken out of hours.

15% of the referrals (1478) came from GPs and 13% (375) were for Mental Health Act Assessments.

The ART team assessed 667 (23%) of the total referrals and of those: –

- 256 (39%) were diverted out of mental health services
- 208 (31%) were taken on the ART caseload
- 149 (22%) were referred on to the CMHT
- 54 (81%) were passed to other mental health services

40 were admitted to hospital informally after assessment and 222 after assessment under the Mental Health Act 1983.

8.2.1 Team Meetings

At the time of the incident and inquiry, individual cases were discussed at a daily handover meeting and each case was identified manually on a White Board, which set out the details of each individual and the care package in place for that day. No written record was kept of the general discussion although decisions regarding medication and changes in the care plan such as referral for other services or discharge were documented in the individual's case notes.

The Panel considered that this system was inefficient, continually repeating information for team members without apparent ownership or co-ordination of activity around individual cases leading to a lack of accountability. It was considered that a review of the handover process should be undertaken to ensure that all decisions are documented in the individual's notes and that an ongoing team log of the handovers and review meeting is completed.

There did not appear to be a culture of questioning team practice against evidence based good clinical practice, nor an opportunity for a clinical analysis of cases. Overall the Panel considered the ART to be a well resourced service that was performing in limited ways not significantly integrated with other mental health services in the area.

8.2.2 Professional Supervision

The Panel did not see evidence of an effective system of supervision in place within the ART. Although staff said that they met with their supervisors regularly, supervision sessions did not appear to be structured around the formulation and evaluation of client care plans and lacked the constructive challenge required. The team could, in the Independent Inquiry's view, have taken a much more proactive approach to developing the expertise of team members through

training and the development of consistent and proactive external links.

8.2.3 Medical contribution to the ART

Dr A was contracted to work 5 sessions a week, and Dr B, 8 sessions a week for the ART. Both are non-career grade psychiatrists.

Dr A commented that *'Dr C is the supervising consultant. So when we see patients if they are difficult patients we can contact him and get his advice… every fortnight we see him. Myself and Dr B see him for an hour and discuss about any difficult patients or any management problems… We discuss everything. Any complaint or any difficult cases or anything… He has told us that we can contact him any time if we need any opinion on anything. Only when we need an expert opinion we contact Dr C… We talk to him about difficult patients. Usually we don't take the files. We discuss the cases.'*

Similarly Dr B told the Independent Inquiry about supervision with Dr C, *'We see him for about an hour or so. Sometimes he comes with something in the journal which I haven't seen or something to be learned but usually if we have any difficulties then we discuss them.'*

Dr C commented *'I always manage to give them one hour. We endeavour to sort of keep in touch and they can always ring me for advice… They bring particular cases they want to discuss or I might have heard from MI about a tricky case that the team has been dealing with. Or sometimes I talk about something in my own practice.'*

These reports from the two psychiatrists attached to the ART and their supervising consultant indicate that the three psychiatrists met on a regular basis (an hour every fortnight), for discussion generally about current clinical issues, occasionally covering other related topics as they arose. All three valued the support and contact, but there was a lack of structure around the supervision sessions, with no attempt to summarise in writing the discussion about a particular

patient, or to check that all patients who may be presenting issues of concern for the ART were reviewed.

8.2.4 Agency Staff

A large proportion of staff working within the team were agency staff and therefore were not included within the Trust's mandatory training programme nor provided with an induction to the services. The Independent Inquiry considered this was unacceptable for both staff and the organisation particularly as so much of the work undertaken by the team involved the management of risk.

8.2.5 Medical Workforce

Dr C commented on the *'need for a full time consultant for the Crisis Home Treatment Team. All the consultants are in agreement, just a question of persuading higher management. A team like that [ART] which is at the blunt sharp end of service delivery needs a proper full-time consultant to steer it.'*

Similarly the service manager explained that the supervising consultant did not have any clinical input at all. *'He's not clinically involved with all the patients on the caseload. It certainly helped to have medical input. I think a consultant attached to the team is a very good idea. From the more political end - because it's a team where you are at the front end and you are dealing with high-risk situations.'*

Both these experienced members of staff recognised the ART as a team *'at the sharp end'* - dealing with crisis situations where decisions about an individual's management plan needed to be made promptly. In such a situation, not to have a consultant psychiatrist as an integral member of the team can lead to anxiety about managing the immediate clinical situation. This lack

of senior medical leadership also reduces the team's ability to operate strategically.

8.3 Internal Review

The Trust established an Internal Review which reported their findings in October 2003. Three overarching recommendations were made, (see below). However, there did not appear to have been a plan to develop recommendations and actions or an audit process to ensure that the recommendations were implemented across the Trust and its partner services.

(i) Continuity of Care

The Trust and the Social Services Department takes the opportunity to review models of service to individuals in crisis, in the context of its service modernisation programme. The review should take account of best practice locally and nationally.

(ii) Risk Assessment Training

The Trust and Social Services Department use the lessons learnt from this internal review to influence risk assessment training for all staff. Such training must be regularly available and audited.

(iii) Organisational Learning

The process within the Trust and Social Services Department needs to ensure that models of good practice are shared, together with areas of identified weakness.

It was unclear how the Trust intended to implement these. In addition the Independent Inquiry found that the issues raised within the report were not addressed within the above other recommendations. These were identified as:

- Clarity in regard to who was Mr P's Care Coordinator

- The lack of information in regard to Mr P's alcohol consumption although this was available within his GP records

- Staff relying fully on the information provided by Mr P

- Difficulty in deciphering staff signatures in the ART's case notes

The Independent Inquiry considers that the Trust should review the process of undertaking Internal Reviews after a Serious Untoward Incident to ensure that each review sets out the lessons to be learnt and that their recommendations are cascaded effectively through the Trust.

9. Findings and Recommendations

The Independent Inquiry appreciates that the ART has been amalgamated into the Crisis Home Treatment Team and acknowledge that some of the following recommendations may have already been implemented. However the Trust is asked to consider the points made to ensure that the successor to ART reviews the systems in place.

9.1 Leadership

The Independent Inquiry found a team generously equipped with qualified nursing and social work staff but with inadequate consultant psychiatrist and clinical psychology input. In addition, the high utilisation of agency staff militated against team cohesion.

To secure improved performance, **it is recommended**:

- that the managers of the service ensure that plans and clear service standards are developed and

implemented in the following areas that match the overall strategic direction of the Trust.

- Supervision
- Care Programme Approach
- Clinical governance
- Staff Development
- Cross team working
- Case review

In addition the Panel **recommends**:

- that the newly formed Crisis Home Treatment Team (CHTT) service policies and procedures are reviewed to ensure that they are consistent with the overall Trust strategy.

  - *that a system is implemented whereby the team formally reviews all case formulation, care plans and multi-disciplinary care review.*

  - *That a review of the handover process is undertaken to ensure that all decisions are documented in the individual's notes and that an ongoing team log of the handovers and review meeting is completed.*

  - *That a clearer process is established for the allocation and coordination of each case.*

9.2 Domestic violence

"Domestic violence accounts for a quarter of all recorded violent crime in England and Wales. Although such violence can occur irrespective of background and circumstance, sexuality or gender, it is predominantly women who suffer. One in four women experience some form of violence from a partner in their lifetime. Every week two women die as a result of it. Domestic violence is usually a hidden crime. Victims suffer silently, afraid for themselves and for their children.

Foreword by the Home Secretary, The Rt Hon David Blunkett MP, June 2003, Safety and Justice: The Government's Proposals on Domestic Violence

Domestic violence has slowly begun to have an increased profile within mental health services with the Royal College of Psychiatrists issuing "*Domestic Violence*", in April 2002 (6). Research from Women's Aid, *Struggle to Survive*, (7), published in July 2004 found that between 50% and 60% of women mental health service users have experienced domestic violence, and up to 20% will be experiencing current abuse. However, mental health professionals have been found consistently to underestimate the proportion of their clients who experience domestic violence. Most recently, the *Domestic Violence, Crime and Victims Act* (8) was passed in November 2004 and all organisations will need to develop or review their domestic violence protocols and training strategy. (2)

In view of this and other cases that the Independent Inquiry is aware of where harm has come to a former partner following the break down of a relationship we **recommend:**

- that the mental health services should develop protocols with wider Domestic Violence services to assist in supporting and protecting ex partners.

(2) Taken with permission from the Report into the care and treatment of Mr A.

9.3 Interagency Co-operation

From the evidence received it is clear that interagency co-operation can be improved across a range of fronts, including:

1. The Sanctuary

Relationships with the Sanctuary should be strengthened, so we **recommend:**

- that Turning Point, the mental health trust and the PCT work together to jointly agree a care pathway which incorporates the Sanctuary service into the wider mental health services in order to:

  - ensure a shared value base between all parties

  - identify key staff to liaise between provider services and ensure co-ordinated care planning and delivery

- that the Sanctuary funding is reviewed to ensure adequate resourcing to meet the significant demands placed upon them

2. Primary Care

ART members did not appear to routinely access primary care and other related records. We believe that both, in the case in question, and more broadly that the team would benefit from access to and use of this information. We **recommend:**

- that crisis services routinely access primary care and other available health and social care information within 24 hours.

3. A&E

We found that in this case there was not a clear handover of information between the A&E service and ART. We **recommend:**

- that a protocol for handover of clients is developed urgently, which contains information to ensure the safe transfer of patients to ongoing services and includes all patient documentation.

- that the Trust should consider whether A&E liaison service should be part of an integrated crisis service.

9.4 Clinical Psychology

We found that there was a lack of proactive use of Clinical Psychology by the ART, in order to address this we would **recommend:**

- That Clinical Psychology input is sought by team members to assist with the formulation of care plans and to participate in multi-disciplinary case reviews.

Overall the quality of the risk assessment and risk management was considered by the panel to be very limited, superficial and fragmented. In order to avoid this situation recurring we **recommend:**

- That this is reinforced to team members and Agency staff and that a mandatory annual training session on the formulation of active and dynamic Care Plans from Risk Assessments is introduced.

9.5 Substance Misuse Services

There were a number of indicators both in the medical records and in the client's history where clues about alcohol misuse were apparent. In order to improve the quality of responses by the ART to potential substance misuse we **recommend:**

- that a member of the team be identified to receive training in substance misuse from the DAAT, and that they provide a continuing structured link between the DAAT and the CHTT

9.6 Medical Input

We found the medical input to the team and the medical leadership of the team to be both limited and reactive. In order to improve this situation we **recommend:**

- that the team has sufficiently resourced Consultant Psychiatrist input.

9.7 Serious Untoward Incidents

In the view of the Independent Inquiry the internal processes for addressing this Serious Untoward Incident (SUI) appeared to be inadequate. Most of the practitioners we spoke to did not have examples of how practice had changed as a result of the incident, or have examples as to how practice might develop in the future.

The internal investigation did not appear to have been completed in terms of developing recommendations, an action plan or an audit process to ensure that the recommendations had been implemented across the Trust.

The 2003/04 Trust annual report highlighted the need to improve Serious Untoward Incident processes and systems. We recommend:

- that the Trust reviews the process of dealing with Serious Untoward Incidents to ensure that the SUI policy is implemented consistently and comprehensively; that lessons are learned and cascaded effectively through the Trust; that audit systems are put in place to ensure that recommendations are implemented and that lessons from SUIs are considered by the Trust Board as part of overall Clinical and wider Governance structures.

9.8 Professional Supervision

The Independent Inquiry found that arrangements for supervision were inadequate for meeting the needs of both service users and developmental needs of staff.

It is recommended:

- that a more structured process for supervision is developed to ensure that there is a formal review of care plans for all members of the team including CPNs and psychiatrists as well as developing a multi-disciplinary team based approach to review cases. At these reviews it would be advisable to include other professionals such as substance misuse and housing.

9.9 Agency Staff

The Independent Inquiry found that whilst acknowledging the difficulties in employment and retention of staff, to have such a high percentage of agency staff working in a crisis team such as ART was unacceptable. This was accentuated by the lack of induction and access to training and supervision for this staff group.

It is recommended:

- that all agency staff receive proper induction and access to statutory and mandatory training.

- that a care coordination system is systematically implemented which clarifies the role.

9.10 Performance Management

During the period under review, management of mental health services in this locality was in transition. From the evidence before us, despite the best efforts of practitioners and managers the performance management framework both within and between agencies appeared to lack coherence. We recommend that

— the Strategic Health Authority, County Council and other relevant health bodies satisfy themselves that arrangements for performance management now in place meet the requirements of statute and best practice

The Inquiry Panel commends this report to Surrey and Sussex Strategic Health Authority in the belief that our findings will assist in the continuing improvement of services essential for the health and well-being of our most vulnerable fellow citizens.

Our purpose has not been to apportion blame because we found none to be justified. Rather, we have systematically reviewed and analysed the evidence available in a way which is intended to help those providing, commissioning and managing the performance of local services achieve an improvement in their quality

Ted Unsworth
Panel Chair

September 2005