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INVESTIGATIONS – REVIEWS – INQUIRIES

An independent investigation into the care and treatment of Patient E

A report for
NHS North West

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1. Introduction

The incident

1.1 On 19 March 2005 Patient E set fire to the house where Ms X lived. Ms X's carer and daughter, Ms Y, were with her at the time. Ms X and her carer escaped the fire, although Ms Y was injured.

1.2 Ms Y, 59, was pulled to safety from an upstairs window but died the next day.

1.3 Patient E was convicted of manslaughter in December 2005 and sentenced to life in prison with a minimum recommendation of six years. Trust staff were not asked to provide court reports.

1.4 Ms X was a service user of Cheshire and Wirral Partnership NHS Foundation Trust[1] (the trust). Her injuries were reported on the trust's serious untoward incident reporting system (STEIS). It was not known at the time that Patient E, another user of the trust's services, had started the fire.

1.5 The case came to the attention of the trust in November 2007 when it was contacted by the team from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness[2]. The trust undertook a 'reflective review' of Patient E's care in April 2008.

[1] The trust gained foundation status in July 2007.

[2]The Home Office notifies the confidential inquiry of everyone in England and Wales convicted of homicide – murder, manslaughter or infanticide.

2. Terms of reference

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

The investigation will examine:

1. The care and treatment provided to Patient E, from his first contact with services in 2004 to the time of the offence in March 2005 (including any from non-NHS providers e.g. voluntary/private sector, if appropriate), in particular:

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

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

    - the adequacy of risk assessments and risk management plans, taking into account Patient E's history;

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

    - the extent to which the various agencies worked together and communicated appropriately in providing Patient E with his mental health care;

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

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

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

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

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

- any areas of notable good practice;

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

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

3. Executive summary and recommendations

3.1 On 19 March 2005 Patient E set fire to the home of Ms X. Ms X, her carer and her daughter Ms Y were rescued from the fire, but Ms Y died the following day. Patient E was convicted of manslaughter in December 2005 and sentenced to life in prison with a minimum recommendation of six years.

3.2 Patient E's first contact with mental health services was at the age of 23 when he was admitted as an informal patient on 6 January 2004 to Adelphi Ward at Macclesfield District General Hospital suffering from a hypomanic episode. He stayed in hospital for six days and was discharged on 15 January whilst on leave.

3.3 Patient E was diagnosed with bipolar affective disorder while he was in hospital. His inpatient notes record that he was a frequent user of a range of illicit drugs. Whilst some of the drugs that Patient E used were known to produce symptoms similar to a bipolar disorder, this factor was not taken into account in arriving at the diagnosis.

3.4 Patient E was discharged to the care of a community team. He was visited regularly by his care coordinator and seen by a psychiatrist as an outpatient on a regular basis.

3.5 He lived with his family who were supportive of him. His mother attended outpatient appointments with him. Patient E and his mother wanted Patient E to be taken off his prescribed medication as they felt it impacted negatively on his life and college work.

3.6 Patient E's mental health improved throughout 2004, and he was subsequently discharged from the community team's care on 26 November 2004. At an outpatient appointment on 21 February 2005, it was agreed that Patient E would attend a further outpatient clinic on 23 May with a view to discharge. By this time Patient E was awaiting trial.

3.7 The key issues identified in our investigation was the failure of the medical and nursing team:

- to consider more carefully the impact of Patient E's illicit drug use and whether this was the cause of his presentation and symptoms and
- to produce a plan to help him reduce or stop his use of illicit drugs.

Findings

F1 SHO1's assessment of Patient E on admission to Adelphi Ward was not probed or challenged by consultant psychiatrist 1.

F2 The doctor(s) who reviewed Patient E in the outpatient clinic accepted the initial diagnosis and failed to ask further questions or review the initial assessment.

F3 Patient E's drug taking was not sufficiently taken into account in his care planning.

F4 In respect of CPA and risk assessment, Patient E's care was well managed and in accordance with national standards.

Recommendations

R1 The trust should issue a clinical update reminding staff that as drug use in young people is fairly common it should be a matter of routine to consider carefully the role of illicit drug use in a patient's presentation.

R2 The trust should amend its incident reporting policy to make it clear that all cases that fall within the criteria of HSG 94(27) will automatically be the subject of a 60-day incident (RCA) review following an initial reflective review.

4. Approach and structure

4.1 The Verita team comprised of Tariq Hussain and Lesley Sargeant. Dr Mostafa Mohanna provided professional psychiatry advice and their biographies are included at the end of this report.

4.2 We examined all the case notes, CPA review documentation, letters to GPs and relevant policies in force in 2004/5. We also looked at the trust's reflective practice review. A list of all the documentation reviewed can be found at the end of this report.

4.3 We took the following factors into account before deciding whether to interview trust staff.

- The trust was not made aware of Patient E's involvement in the fire that killed Ms Y on 19 March 2005 until November 2007 (almost three years later).
- The trust carried out a reflective review (rather than a RCA/60-day incident review) which was completed on 16 April 2008. No interviews were conducted as part of this review as would have occurred with a RCA/60-day incident review.
- The records, assessments and decisions made by staff were clearly and thoroughly recorded.

4.4 We concluded that interviewing staff seven years after an incident of which they were not aware until almost three years after it happened would not produce any reliable additional information.

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

4.6 The trust was given the opportunity to comment on the draft report and to provide an update on changes made to services in the light of its reflective review. A meeting was also held with Patient E to discuss the findings of the investigation.

Contact with Patient E and Ms Y's family

4.7 A member of the investigative team visited Patient E in prison to explain the purpose of the investigation and to receive any information that he wished to give.

4.8 Patient E was asked to give his consent for his clinical records to be made available for the investigation which he duly did.

4.9 A meeting was also held with representatives of Ms Y's family to explain the purpose of the investigation. NHS North West kept them informed with progress.

5. Background: Patient E's personal history

5.1 Patient E was born on 12 March 1980 in Hull. He was a slow talker, but was otherwise a bright and lively boy. He had difficulties at primary school, and his mother suspected he had educational problems.

5.2 The family moved to Newcastle when Patient E was eight years old and then to their current address at age 11. Patient E was diagnosed with dyslexia aged 11. His progress at school improved after this, but he was bulled because of his special needs. Patient E, between the age of 15 and 17, is reported to have attacked a boy who bullied him on three occasions.

5.3 He left school aged 19 with GNVQ passes in art and design. After leaving school he started a HND in photography.

5.4 By his early 20s Patient E was a regular drug user, frequently using ecstasy, cocaine, amphetamines, heroin and amyl nitrate.

5.5 Patient E had three hypomanic episodes before his first contact with mental health services in January 2004. The three earlier episodes had occurred in the previous three years and had lasted between a few days and two weeks. He had never previously seen a psychiatrist, had no history of deliberate self-harm and no previous episodes of depression.

5.6 He was admitted to hospital aged 23 with his fourth hypomanic episode. At that time he was working part-time at Tesco for 26 hours a week and going to college for three days a week. He was living with his father, a retired managing director of an engineering company, his mother, who ran an antiques shop, and his brother who was 15 years older. Patient E was described as having a sensitive and loving nature, a good sense of humour and good friends. He played pool for a team.

6. Summary chronology

6.1 Patient E was admitted as an informal patient to Adelphi Ward at Macclesfield District General Hospital on 6 January 2004. This was Patient E's fourth hypomanic episode but his first contact with mental health services. His mother had taken him to his GP that morning because of his erratic behaviour. He had not been sleeping, staying out all night, driving for up to 20 hours at a time, and spending thousands of pounds on photographic equipment. Patient E had been found earlier on a garage forecourt in a confused state by police who had noticed his damaged car.

6.2 Patient E is reported to have said that someone owed him a lot of money and that this made him very angry. He said that he was "*pushing my metabolism*" by taking large quantities (two tablets every hour) of ProPlus[3] all weekend, glucose tablets and cannabis. In the previous week Patient E said that he had been punching objects at work until his hands hurt.

6.3 He was diagnosed with bipolar affective disorder with manic episodes that was possibly drug induced. He was assessed as being of medium risk of severe self-neglect but no apparent risk of violence or harm to others, deliberate self-harm or suicide. He was also assessed using the Health of the Nation Outcome Score (HoNOS)[4]. He was given 15mg of olanzapine on admission and subsequently prescribed 15mg of olanzapine and 7.5mg of zopiclone at night.

6.4 On 12 January 2004 Patient E was referred from Adelphi Ward to the Millbrook Unit at Macclesfield District General Hospital. He was allowed home on leave where he was seen by CPN1, a community psychiatric nurse. His mood had levelled out since leaving Adelphi Ward and both Patient E and his mother asked for the olanzapine to be stopped or reduced.

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[3] ProPlus is a widely available stimulant containing caffeine.

[4] HoNOS *"…is an instrument with 12 items measuring behaviour, impairment, symptoms and social functioning"* *(Wing, Curtis & Beevor, 1996)*. The scales are completed after routine clinical assessments in any setting.

6.5 Patient E was discharged three days later on an enhanced care programme approach (CPA)[5]. He was assessed as being at no risk of violence or harm to others, deliberate self-harm, severe self-neglect or suicide. He was prescribed 15mg of olanzapine at night, and was to be seen once a week at home by CPN1, his care coordinator. An outpatient appointment was made for him for the following week.

6.6 On 20 January Patient E attended an outpatient appointment where he was seen by staff grade psychiatrist 1 (staff grade psychiatrist to consultant psychiatrist 1). Patient E appeared to be relaxed. He was to continue on olanzapine and be seen again as an outpatient in two weeks. On the same day he was discharged from the home treatment team[6].

6.7 CPN1 visited Patient E at home three times in the next month. On each of these visits Patient E asked for his medication to be either stopped or reduced. On her visit on 9 February CPN1 recorded in her notes that Patient E was *"desperate to be able to drive* [again] *and to either reduce or stop the olanzapine"*. He cancelled his second outpatient appointment because he said that he could not afford to take more time off college but was persuaded to attend a clinic held on a Monday by staff grade psychiatrist 1.

6.8 An interim review of Patient E's enhanced CPA plan took place on 12 February. It was noted that Patient E did not like taking his medication because he said that it affected the way that he was able to live his life and stopped him being able to go out drinking with his friends.

6.9 On 23 February Patient E's GP wrote to consultant psychiatrist 1 asking him to review Patient E in outpatients because he was concerned that, although more controlled since the last time he saw him, he was expressing grandiose business ideas

[5] Enhanced CPA is required for patients with a variety of care needs who require higher levels of support from more than one professional or agency.

[6] The home treatment team is multidisciplinary comprising of qualified mental health professionals who work with adults with acute mental health problems in their own homes as an alternative to inpatient care.

and seemed to have "*only limited insight into the importance of his diagnosis and the essential nature of continuing in at least the medium term on his current medication*".

6.10 CPN1 visited Patient E at home on 23 or 24 February (date not clear in the notes) and recorded that Patient E showed no obvious sign of illness and that the main problem was his lack of insight about his condition and his concordance with medication: "*he certainly doesn't believe he needs meds of any type permanently even if this means avoiding a future relapse*".

6.11 CPN1 made another home visit on 1 March. She spoke to Patient E's father about his son's grandiose business ideas. Patient E's father said these ideas were all viable. Patient E's father said that he administered Patient E's medication and that he had not given him any over the weekend because he had been drinking. When his parents left the room, Patient E told CPN1 that he had been arrested at the weekend in a bar over a row about a girl. He said that he wanted to come off or reduce his medication as soon as possible and certainly did not want to be taking it when we went on holiday to Ibiza with his friends in July.

6.12 On 15 March Patient E was seen in outpatients by staff grade psychiatrist 1. Patient E appeared well; he reported that he was sleeping and eating well and had no problems with his concentration or his behaviour. He admitted to not taking his medication on a couple of occasions when he had been out drinking with his friends. Patient E asked for his medication to be reduced, and said that he would like to start driving again. He also said he wanted to drink alcohol when he went on holiday in July. After considerable discussion, he agreed to stay on his current level of medication for another six weeks, and to contact his insurance company and the DVLA and await their response about resuming driving.

6.13 CPN1 called to see Patient E on three occasions over the next month but each time he was out.

6.14 On 26 April Patient E saw staff grade psychiatrist 1 in outpatients. He remained well but reported feeling tired and unable to focus on his college work from

3pm onwards. Staff grade psychiatrist 1 agreed to reduce his olanzapine by 2.5mg to 12.5mg at night with immediate effect.

6.15 Staff grade psychiatrist 1 saw Patient E and his mother in outpatients again on 24 May. He had injured his left elbow when he came off his mountain bike. He complained of being over sedated and having no energy which made it difficult for him to function at college. His mother supported these claims and confirmed that he had no energy to do anything and was not the son she knew. He had also gained one and a half stone in weight. Staff grade psychiatrist 1 agreed to reduce his olanzapine by 2.5mg a day until discontinued, and introduce risperidone, 0.5mg twice a day for one day and then 1mg twice a day until Patient E was seen again in eight days time.

6.16 CPN1 visited Patient E on 28 May. He reported feeling better since coming off olanzapine.

6.17 At Patient E's next outpatient appointment with staff grade psychiatrist 1 on 1 June, Patient E said that he felt less sedated and much more like his normal self. He was advised to keep taking his medication and to refrain from drinking too much alcohol. He was to continue on 1mg risperidone twice a day.

6.18 When CPN1 visited Patient E at home on 18 June, his mother said that Patient E was his usual self: *"the lively humorous boy they all love"*.

6.19 Patient E attended outpatients again on 28 June when staff grade psychiatrist 1 repeated his advice about continuing to take his medication and not drinking excessive amounts of alcohol.

6.20 In the next three weeks CPN1 visited Patient E twice, once before his holiday with his friends and again on his return. Patient E told CPN1 that although he had drunk alcohol while away he had not drunk to excess and had only missed a couple of doses of risperidone. Her notes indicate that both Patient E and his mother were reluctant for him to remain on long-term medication.

6.21 Patient E, accompanied by his mother, was seen in outpatients by staff grade psychiatrist 1 on 26 July. Patient E agreed to continue with medication for a further three months and then be reviewed. It was agreed that if he remained well during that period his medication could be reduced *"as both he and his mother were unhappy about long-term therapy"*.

6.22 On 6 August CPN1 agreed to reduce the frequency of her visits from weekly to monthly. On her monthly visit in October she agreed with Patient E that her next visit would be her last.

6.23 On 25 October Patient E saw staff grade psychiatrist 1 in outpatients. He said he had no problems whatsoever and was enjoying his second year at college. Patient E was insistent that in the long term he wanted to come off medication. Staff grade psychiatrist 1 agreed to reduce Patient E's risperidone to 0.5mg twice a day, and to see him again in two months with a view to stopping the medication altogether.

6.24 On 26 November CPN1 visited Patient E at home for the last time. He was discharged from the community mental health team and moved from enhanced CPA to standard CPA[7]. The CPA discharge documentation states that the plan was for Patient E to continue to see staff grade psychiatrist 1 at the outpatient clinic with a view to gradually reducing his medication until discontinued. Alcohol and drugs were recorded as 'specific triggers/factors that increase risk', as was the fact that Patient E wanted to stop taking medication because it restricted his alcohol intake. Patient E's poor insight and understanding of his bipolar disorder, and the fact that he was unlikely to pick up signs of a relapse, were also noted. His risk of violence or harm to others and of severe self-neglect were assessed as 'low', and of deliberate self-harm or suicide as 'zero'. His HoNOS assessment showed low risks.

6.25 Patient E did not attend his next outpatient appointment on 10 January 2005. A new appointment was made for 21 February which he did keep. Patient E told staff grade psychiatrist 1 that he was doing very well, but that a month before someone had

[7] Standard CPA is a level of care when a service user usually only needs to be seen by one mental health professional, this may for example be in an outpatient clinic or visited by a community nurse.

set fire to his car which had made him very angry. His father apparently felt that Patient E had been rather strange for a couple of weeks after the incident. The notes indicate no evidence of mental illness: *"Patient E was still attending college, taking his medication and not drinking much"*. Staff grade psychiatrist 1 agreed to reduce risperidone to 0.5mg at night (although in a letter to Patient E's GP, staff grade psychiatrist 1 said that he would have been happier for him to stay on a small dose of maintenance medication in view of recent events). Staff grade psychiatrist 1 agreed to see Patient E again in three months with a view to discharging him if he had remained stable.

6.26 On 19 March 2005 Patient E set fire to the house in which Ms Y suffered smoke inhalation and subsequently died.

6.27 On 23 May Patient E's mother phoned to cancel Patient E's outpatient appointment but did not give a reason why. There is no record of Patient E being offered a further appointment or him being formally discharged from the service. There is also no record that Patient E's mother informed the trust of his arrest.

7. Suitability of care and treatment

7.1 Patient E was assessed on admission as an informal patient to Adelphi Ward by senior house officer, SHO1. The notes include the following information. For example:

- *"extensive abuse of pro-plus this weekend"*
- *" ... ecstasy[8] ... Now when raving. 3 times/year. Previously used every weekend ... "*
- *"Previous use of cocaine"*
- *"cannabis: over the weekend. Previous occasional use".*
- *"organising a massive rave".*

7.2 As for previous episodes of hypomania, SHO1 recorded:

- *"Previous episodes: spending lots of money, driving fast, breaking the law: 1st 3 years ago"*
- *"3 episodes, 15-17, of attacking a bully at school".*

7.3 Beyond these two entries, there is nothing else in the handwritten notes regarding any possible previous episodes of hypomania.

[8] Ecstasy contains phenethylamine and amphetamine: both stimulant and euphoria-inducing drugs.

Comment

SHO1 carried out a fairly comprehensive initial assessment. The drug history is a case in point as SHO1 obtained a good initial outline of Patient E's drug use.

Furthermore, SHO1 – quite rightly – considers drugs as having possibly contributed to Patient E's presentation* ("drug-induced") *and he requests a drug analysis of Patient E's urine.

Initial nursing assessment on admission to Adelphi Ward

7.4 The notes of the initial nursing assessment on Adelphi Ward refer to Patient E's use of drugs: *"Excessive taking of Pro-plus ...? illicit substances"*. And earlier in the same assessment: *"Sniffing poppers[9]"*.

7.5 In the initial nursing assessment, under the HoNOS rating, 'problem drinking or drug taking' is ticked and given a score of '2'.

7.6 Like the medical reviews, there is no further mention of Patient E's drug taking until late in 2004, in an entry dated 26 November 2004, when the following is recorded: *"Use of illegal drugs and alcohol"*.

7.7 Patient E was discharged from the care of his CPN, on that same day.

Comment

It is clear from the clinical records that Patient E used mood and mind-altering drugs extensively.

[9] Poppers are a slang term for various alkyl nitrates, including amyl nitrate mentioned by the senior house officer. They are inhaled.

Impact of illicit drug use on Patient E's mental health

7.8 Under 'differential diagnosis' SHO1 mentioned, in addition to hypomanic episode, the words *"drug-induced"*. Later, under 'initial treatment', he requested a *"urine drug screen"*.

7.9 SHO1 reviewed Patient E on the ward on 7, 8, 15 January 2004, and again on the date on which Patient E was discharged from inpatient care. After the initial assessment on admission, there is no mention of Patient E's drug use in any of SHO1's handwritten entries relating to these reviews; nor is there any further reference to urinalysis. Rather, the diagnosis of hypomania and bipolar affective disorder (BPAD) is mentioned and confirmed several times.

7.10 After his discharge Patient E is reviewed in the outpatient clinic on 15 and 20 January, 15 March, 24 April, 24 May, 1 and 28 June, 26 July 2004, and on 21 February and 23 May 2005. Nevertheless the notes of these reviews make no reference to Patient E's use of (illicit) drugs or any re-visiting of the diagnosis.

Comment

The impact of Patient E's illicit drug use is not followed up in any way. Nor is Patient E's drug use considered in any way in his management plan, which focused exclusively on the diagnosis of bipolar affective disorder, treating the hypomanic episode, and ensuring that he remained free of the symptoms of this major mental illness.

SHO1 considered the drugs to have merely "induced" Patient E's presentation, instead of considering the possibility that the presentation could have been caused entirely by the drugs used. This possibility was also not included in SHO1's initial differential diagnosis.

Having established the possible role of illicit drug use in causing Patient E's presentation at the time of his admission, there should have been a retrospective

look at Patient E's previous 'hypomanic episodes' and consideration given as to whether these too were related to drugs.

Discharge letter to GP

7.11 Patient E was discharged from inpatient care on 15 January 2004 and a discharge letter was sent by SHO1 to Patient E's GP (dated 4 February 2004). In the discharge letter there is a description of Patient E's taking of illicit drugs, similar to the entry in the handwritten notes.

7.12 Also in SHO1's letter to the GP is amplification on the idea that Patient E had had previous hypomanic episodes. He records Patient E's mother as saying:

> *"The mother did give a history that there had been three or four previous episodes where* [Patient E] *had spent lots of money, driven fast and broken the law lasting between a few days and a couple of weeks. These have settled down spontaneously. The first one was three years ago."*

7.13 This, and what has been quoted above from the handwritten notes, is the only reference to previous hypomanic episodes.

7.14 There is no mention of a 'drug-induced' condition in the letter to the GP. The only mention of any diagnosis is at the front of the letter, under 'Diagnosis on Discharge', stating *"Bipolar Affective Disorder: Manic Episode"*. There is no discussion of the diagnosis or mention of a differential diagnosis in the body of the letter.

Overview of care and treatment

7.15 The key issue in respect of Patient E's care and treatment is around his drug use. In particular the role it might have played in his presentation on 6 January 2004 when he was admitted as an inpatient, and therefore its relevance in making the final diagnosis and the related management plan.

7.16 SHO1's assessment on admission is the only recorded medical psychiatric assessment Patient E received throughout his contact with the trust. Though there is what appears to be a parallel assessment by the nursing staff, also on admission.

7.17 SHO1's assessment on Patient E's admission is not amplified in any way subsequently, either by SHO1 whilst Patient E was an inpatient, or by those who subsequently reviewed Patient E in the community, whether in the outpatient clinic or in the 'community' (i.e. by the CPN).

7.18 Two ward rounds with consultant psychiatrist 1 were held during Patient E's brief period of inpatient stay. SHO1 does not appear to have been challenged in his/her assessment of Patient E either time.

7.19 The drugs Patient E admitted to using – ProPlus, 'poppers', ecstasy, cocaine – which are all stimulants and, separately or in combination, could have caused Patient E's mental state on admission. Perhaps SHO1 was in his/her early training and may not have recognised this possibility, but discussion with the consultant should have brought this out more. Though Patient E's treatment may not have altered.

7.20 Having established the possible role of illicit drug use in causing Patient E's presentation at the time of his admission, the clinical team should have taken a retrospective look at Patient E's previous 'hypomanic episodes' and given consideration as to whether these too were related to illicit drug taking.

7.21 Patient E's mother was interviewed by SHO1 and was subsequently involved in reviews. There is nothing in the notes to show that Patient E's use of drugs was ever discussed with his mother. In this context it is of note that neither Patient E nor his mother were convinced that Patient E had a mental illness.

7.22 It is evident from our review that the management of Patient E was on the simple basis that he suffered from a bipolar illness and that he needed to be on medication. Any concerns about drugs seem to have been confined to alcohol and the summative effect it has with psychotropic drugs like olanzapine and risperidone.

There is no mention at all in the various entries of any other drug being discussed with Patient E and the possible effects of illicit drug taking on his mental state.

7.23 The notes record that Patient E had already suffered three episodes of hypomania before his first contact with the mental health services. It is not clear how this conclusion was arrived at, given that drugs such as cocaine can induce mental states similar to hypomania and indeed mania. Given that it was already known that Patient E used illicit drugs, a drug-induced condition should have been more seriously considered in the differential diagnosis.

Comment

We are fairly certain that Patient E's mental state will have been significantly influenced by his use of drugs, whether at the time of his admission to hospital or at any other time subsequent to this. It is clear from our review of the assessments and reviews undertaken with Patient E that a significant opportunity was missed in helping him recognise the effects of his drug-taking on his mental state and on his behaviour. This should have been considered more in the management plan whilst he was under the care of the trust in 2004-2005.

In the light of the failure to consider more thoroughly the impact of Patient E's illicit drug use, the diagnosis of bipolar is not convincing. It is possible that Patient E's presentation in 2004 was caused entirely by his drug taking: the ProPlus on its own could have caused the presentation, let alone the other drugs Patient E used.

The records indicate that the medical and nursing team were diligent in their reviews of Patient E both whilst an inpatient and subsequently in the outpatient setting, and kept Patient E's GP informed in a timely manner. In addition there was appropriate and helpful involvement of the family, in particular the mother, in the assessment and management of the case.

Findings

F1 SHO1's assessment of Patient E on admission to Adelphi Ward was not probed or challenged by consultant psychiatrist 1.

F2 The doctor(s) who reviewed Patient E in the outpatient clinic accepted the initial diagnosis and failed to ask further questions or review the initial assessment.

Recommendations

R1 The trust should issue a clinical update reminding staff that as drug use in young people is fairly common it should be a matter of routine to consider carefully the role of illicit drug use in a patient's presentation.

8. CPA and risk assessment and management

First CPA review and risk assessment

8.1 On 6 January 2004, on Patient E's admission to Adelphi Ward, an initial nursing assessment was undertaken which resulted in a 72-hour nursing intervention plan.

8.2 Between 6 and 9 January Patient E was also observed every 15 minutes and an observation record completed.

8.3 Following the initial assessment, a CPA assessment was undertaken by two members of staff. This was completed on 'Form 1: Care co-ordination registration' and 'Form 2: Assessment'.

8.4 This assessment was fully completed. A history was taken. There was a record of the:

- presenting symptoms
- previous illicit drug use *("positive result for cannabis abuse on admission")*
- social and family circumstances
- physical health
- mental state examination.

8.5 A risk assessment questionnaire was completed. This was supplemented by four free-text boxes dealing with:

- historical evidence of risk
- current warning signs of risk
- specific triggers/factors that increase risk
- early warning signs and relapse signs.

The ratings given to the risks assessed were:

- risk of violence/harm to others 0
- risk of deliberate self harm 0
- risk of suicide 0
- risk of severe self-neglect 2 (significant or medium risk)

8.6 An HoNOS assessment was also completed. This assessment has 12 questions covering 5 areas. Patient E scored the following:

- problem drinking or drug taking 2 (mild)
- cognitive problems 1 (minor)
- problems with relationships 1 (minor)
- problems with activities of daily living 3 (moderately severe)
- problems with hallucinations or delusions 2 (mild)
- sleeping 3 (moderately severe)

8.7 The CPA assessment also records the views of Patient E's mother. These assessments were supplemented by a fully-recorded five-page assessment by the psychiatric SHO. As a result of these assessments, Patient E was placed on the enhanced level of CPA care.

8.8 The records do not contain a copy of a care plan arising from this assessment. This may have been because he was only in hospital for three days before being sent home on leave for a week. He returned to be seen on the ward round on 15 January 2004 when he was discharged from hospital.

Comment

It is clear from the records that the nursing staff on Adelphi Ward carried out their work in a thorough and diligent manner. Additionally Patient E's CPA assessment was thorough and professional.

CPA plan

8.9 CPN1, Patient E's care coordinator, completed an enhanced care plan following the ward round on 15 January 2004. For illustration the following were included:

Actions required:

"regular out-patients appts, CPN home visits, home treatment team initially on discharge. Address education & compliance issues during visits & parents have poor understanding & insight."

Possible problems:

"Relapse in mental health. Reduced concordance with prescribed medication & reduced insight into his mental health."

Actions to be taken in a crisis:

"Mental state [assessment], by CP. Family [supported by], staff grade psychiatrist 1, GP. Involve home treatment team if necessary. Action according to the mental health assessment."

Comment

This was a thorough plan which set out all reasonable steps consistent with the matters identified in the assessment on 6 January 2004.

Second CPA review and risk assessment

8.10 This review was undertaken on 12 February 2004. CPN1, Patient E's care coordinator, Patient E and his parents were involved. Staff grade psychiatrist 1 sent his apologies and said he would see Patient E at the outpatient clinic.

8.11 This review again identified Patient E's use of illicit drugs, increased alcohol consumption, tendency to drive fast and for long distances, poor sleep and grandiose ideas. It stated that "[Patient E] *and family fail to recognise signs becoming unwell"*.

8.12 The review was completed thoroughly. It included a risk assessment, HoNOS rating but no care plan (though as one had been done on 15 January 2004 there was no need to complete a new plan).

Final CPA review and risk assessment

8.13 The final review was undertaken on 26 November 2004. CPN1, care coordinator, Patient E and his parents were involved. Staff grade psychiatrist 1 gave his apologies but had seen Patient E on 25 October 2004.

8.14 The review included a re-appraisal of the previous risk assessment. The following sections of the report were all completed thoughtfully:

- historical evidence of risk
- current warning signs of risk
- specific triggers/factors that increase risk
- early warning signs and relapse signatures
- service user's view
- principal carer's views.

8.15 The section on specific triggers/risk factors identified his use of illegal drugs and alcohol, and that Patient E was *"keen to stop risperidone tablets as soon as possible then he doesn't have to restrict alcohol intake"*. In the 'principal carer's view' section it states: *"Both parents supportive but* [Patient E] *hasn't told them of his illegal drug use"*.

8.16 The review documentation assessed Patient E's risk as:

- risk of violence to others — low risk
- risk of deliberate self-harm — no apparent risk
- risk of suicide — no apparent risk

- risk of severe self neglect low risk

8.17 The outcome of this review was that Patient E:

- needed no further involvement with secondary mental health services
- could have his CPA level reduced from enhanced to standard
- could be *"discharged today by the community mental health team"*
- would be seen by staff grade psychiatrist 1 at outpatients.

Comment

"No further involvement with secondary services" ***is confusing as Patient E was still to be seen at outpatients and was therefore still receiving standard CPA and still under the care of secondary mental health services.***

Care coordinator reviews

8.18 Patient E was visited by CPN1 16 times between his discharge from hospital and when he was discharged from her care on 26 November 2004.

Comment

This record of visits along with the reviews and assessments undertaken by CPN1 identify that Patient E received consistent and regular support as was consistent with being on enhanced CPA.

Outpatient reviews

8.19 Along with the support given by the care coordinator Patient E was seen in outpatients nine times between January 2004 and February 2005.

Comment

It was clear from the records that Patient E and his family were seen regularly by the staff grade psychiatrist who along with Patient E's GP sought to encourage Patient E to continue with an appropriate medication regime for his bipolar diagnosis, without this affecting his lifestyle of college and work.

Findings

F3 Patient E's drug taking was not sufficiently taken into account in his care planning.

F4 In respect of CPA and risk assessment, Patient E's care was well managed and in accordance with national standards.

9. Trust's internal report and action

9.1 The trust did not realise that Patient E had started the fire that led to the death of Ms Y until it was notified by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in November 2007.

9.2 It was not until April 2008 that it completed a *"reflective review pro forma for serious untoward events"* and on the basis of this decided that a trust 60-day incident review was not necessary. The form was completed by the director of nursing, therapies and patient partnership.

9.3 The summary of the trust's reflective practice review states:

> *"Care appears to have been well managed and clinically appropriate. There is evidence of service user and carer involvement in decision making. Care had been transferred from enhanced CPA to standard and there was a step down care plan in place. Risk assessment and management plan were up to date."*

9.4 The review goes on to raise two areas of concern. One was that some early aggression in Patient E's teens was not recorded in the risk screening document but was included later on in November 2004. Also that there was no record that Patient E's GP had been informed that he had been changed from enhanced to standard CPA and no evidence of attempts to contact Patient E after his cancelled appointment in May 2005.

9.5 Finally the report says:

> *"There is no evidence that the homicide related to Patient E's mental health state. He had presented as well during several months of contacts and his discharge was planned. Patient E was sent to prison and there was not a health outcome."*

9.6 The report lists four learning points:

- *"Any history of aggression needs to be taken into account regardless of whether there is evidence linking it to mental disorder.*

- *The DNA* [did not attend] *policy does not cover situations where patients cancel an appointment. Whether appointments are cancelled by the patient or the team to ensure there is a plan to re-establish contact.*

- *Rolling reviews need to be checked to ensure that they operate effectively.*

- *When patients' care status changes the CPA policy is not being fully implemented."*

Comment

As the trust did not carry out an internal investigation the conclusions arrived at in the report are the ones likely to have been drawn from its reflective review.

We agree that there is no evidence that the homicide related to Patient E's mental health state but we have drawn some additional conclusions about his initial assessment that may have been picked up if the trust had gone on to carry out a more comprehensive internal investigation.

9.7 We have reviewed the trust's current incident reporting policy (May 2009) and note that it says:

> *"Level Two – Reflective Review*
> *In all incidents categorised as A, B or C (SUIs) a Reflective Review must be completed within 72 hours. The aim of this review is to identify any immediate actions that need to be taken to reduce the risk of recurrence. It further establishes whether a Root Cause Analysis (RCA) is required."*

"A proforma has been developed to assist in this process and is contained within Appendix 7."

9.8 In cases of known homicide by a service user where the case would fall within the parameters of the requirements of HSG 94(27), *Guidance on the discharge of mentally disordered people and their continuing care in the community,* and the updated paragraphs 33-6 issued in June 2005, an independent investigation would be required to be set up. Therefore it is appropriate for a trust to automatically undertake an internal 60-day incident (RCA) review rather than just a reflective review. Undertaking such a review as close to the incident as possible enables an independent investigation to be better focused, proportionate and probably less disruptive to the trust at a later stage.

9.9 The proforma at appendix 7 of the policy was used as part of the reflective practice review completed in April 2008. It scores a number of questions in two columns: 'RCA/60 Day review likely to be required' and 'RCA/60 Day Review not likely to be required'.

9.10 This approach to assessing whether a 60-day incident (RCA) review is required may be useful for a wide range of serious untoward incidents but where a service user has committed a homicide and the incident fulfils the criteria of HSG 94(27) then the trust policy should make it clear that it will carry out a 60-day incident (RCA) review as a matter of routine.

Recommendation

R2 The trust should amend its incident reporting policy to make it clear that all cases that fall within the criteria of HSG 94(27) will automatically be the subject of a 60-day incident (RCA) review following an initial reflective review.

Current position on the learning points

9.11 The trust's 2011 updated action plan attached at Appendix A shows that all actions related to the four learning points have been completed.

10. Multiagency working

10.1 No other agency was involved in Patient E's case other than the police when he was found in a confused state on a garage forecourt just before his admission on 6 January 2004. We therefore make no comment on multiagency working.

11. Engagement of carers

11.1 CPN1, Patient E's care coordinator and his CPN, had regular contact with Patient E's parents, and Patient E's mother (and his father on at least one occasion) who accompanied him to outpatient appointments. The clinical notes make it clear that Patient E's mother in particular supported her son in wishing to reduce or stop his medication right from the very start. Both parents were very supportive of their son – but they did not know about his illegal drug use.

Appendix A

Trust action plan following investigation into Patient E

Initial Learning / Recommendation	Learning applicable to	Action	Time frame / responsibility	Progress / Assurance
To ensure that Managing Aggression Training includes point that all previous history of aggression should be taken into account regardless of whether there is evidence that it was linked to mental disorder	Learning & Development	Review training and ensure issue addressed	September 2008 Head Of Learning	This action was completed as per initial timeframe. **Update as at 2011** Staff have mandatory training regarding managing aggression, including PSTS training and C&R training (as per regulatory requirements). PSTS training incorporates this action, advising staff to take into account past behaviour / events including aggressive incidents.
Teams to agree who will inform the relevant people when patients moved from enhanced to standard CPA and ensure this is recorded once done	Adult Mental Health	To review implementation of the policy and ensure clarity of roles	September 2008 Divisional Director/ Divisional Clinical Director	This action was completed as per initial timeframe. **Update as at 2011** This was superseded by the Care Programme Approach Policy in Jan 2009, which reflected the change from enhanced/standard to either CPA or non CPA (as per national practice). There is a CPA review at least every

Initial Learning / Recommendation	Learning applicable to	Action	Time frame / responsibility	Progress / Assurance
				year and an amended care plan is disseminated to all within a maximum of 2 weeks from the date of the review. This is monitored s part of the annual audit programme (as an internal quality priority and contractual requirement) within the Trust and the results and action plan are reported to the CPA clinical network.
Review DNA policy to ensure that cancellations are included	Adult Mental Health	Establish lead to review policy	October 2008 Divisional Director	This action was completed as per initial timeframe. **Update as at 2011** The current DNA policy incorporates process for DNA with flowchart. If DNA occurs, staff: Establish whether this is a DNA or cancellation Discuss within MDT meeting or earlier if required Refer to Care Plan for contingency plan If cancellation, staff can consider whether to offer a new appointment or whether to treat as DNA. All of these are reviewed and discussed within MDT, the outcomes of which are documented.
To review effectiveness	Adult Mental Health	Review practice of rolling	October 2008	This action was completed

Initial Learning / Recommendation	Learning applicable to	Action	Time frame / responsibility	Progress / Assurance
of team rolling reviews of patients		reviews and identify actions to improve effectiveness	Divisional Director	as per initial timeframe. **Update as at 2011** Rolling Reviews are conducted weekly by CMHTs at the end of their weekly meeting to identify people who have not had a review by a Consultant within an appropriate timeframe. All staff also have Clinical Supervision where cases can be discussed and issues raised re care and treatment issues.

Appendix B

Biographies

Tariq Hussain

Senior consultant Tariq is a former nurse director who brings to Verita his considerable experience of leading change management in the fields of learning disability and mental health services. Tariq has undertaken a wide range of projects for Verita which have included mental health homicide investigations and an investigation into sexual abuse by an eating disorder clinic manager. In September 2010 he completed a three year term of appointment as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Prior to Tariq's appointment with Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting.

Lesley Sargeant

Lesley Sargeant is one of Verita's founding directors. Since joining Verita as an executive director in February 2009, she has taken an active role in a number of high-profile reviews, including an independent management review related to the care of Baby P, an investigation into criminal record bureau checks for a foundation trust and several mental health homicide investigations. She also advises on all aspects of communication relating to investigations including media handling. Before joining Verita, she was a director of Freshwater Healthcare (formerly CLEAR), a consultancy offering specialist communication advice and training to public sector organisations. Between 1984 and 1994 she held senior communication posts in the NHS specialising in issue and crisis management, and before that she worked as an editor for the World Health Organisation in Geneva.

Dr Mostafa Mohanna

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

Appendix C

Documents reviewed

Health records policy	March 2004
Risk management policy statement	April 2004
Post incident review	April 2003
Incident reporting policy	February 2004
Incident reporting policy	May 2009