Independent Investigation

into the

Care and Treatment Provided to Mr. A

by the

Cornwall Partnership NHS Foundation Trust

Commissioned by NHS South West

Report Prepared by HASCAS Health and Social Care Advisory Service

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Contents

1. **Investigation Team Preface** **Page 4**
2. **Condolences to the Family and Friends of Mr. A** **Page 6**
3. **Incident Description and Consequences** **Page 7**
4. **Background and Context to the Investigation** **Page 8**
5. **Terms of Reference** **Page 10**
6. **The Independent Investigation Panel** **Page 12**
7. **Investigation Methodology** **Page13**
8. **Information and Evidence Gathered** **Page 20**
9. **Profile of Services** **Page 22**
10. **Chronology of Events** **Page 23**
11. **Timeline and Identification of the Thematic Issues** **Page 49**
12. **Further Exploration and Identification of Contributory Factors and Service Issues** **Page 63**

- 12.1.1 Diagnosis Page 64
- 12.1.2 Medication and Treatment Page 71
- 12.1.3 Use of the Mental Health Act 2007 Page 77
- 12.1.4 The Care Programme Approach Page 87
- 12.1.5 Risk Assessment and Management Page 94
- 12.1.6 Referral, Admission and Handover Processes Page 99
- 12.1.7 Service User Involvement in Care Planning Page 105
- 12.1.8 Carer Involvement and Carer Assessment Page 107
- 12.1.9 Documentation and Professional Communication Page 110
- 12.1.10 Adherence to Local and National Policy and Procedure and Clinical Governance Arrangements Page 118

13. Findings and Conclusions **Page 124**

14. Trust Response to the Untoward Incident **Page 148**

15. Notable Practice **Page 161**

16. Lessons Learned **Page 162**

17. Recommendations **Page 164**

18. Glossary **Page 166**

Appendix One: Recommendations by all Investigations **Page 169**

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. A was commissioned by NHS South West Strategic Health Authority pursuant to HSG (94)27[1].

This Investigation was asked to examine a set of circumstances associated with the death of Mrs. A and her son in a fire at their home on 18 January 2010 which had been caused by Mr. A, her husband, setting fire to the family home. Mr. A died of burns he received from the fire on 26 January 2010.

Mr. A received care and treatment for his mental health issues from the Cornwall Partnership NHS Trust, which is now the Cornwall Partnership NHS Foundation Trust. It is the care and treatment that Mr. A received from the mental health services provided by the Cornwall Partnership NHS Trust that is the subject of this Investigation. This Report will use the current name of the Trust throughout, as this will be the organisation producing an Action Plan in response to the published Report.

Investigations of this sort aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help improve the reporting and investigation of similar serious events in the future.

This Independent Investigation is unusual in that not only did the Cornwall Partnership NHS Foundation Trust undertake an Internal Investigation into the Serious Untoward Incident, the Acting Chief Executive also commissioned a Second Internal Investigation to provide a more rigorous examination of the events leading to the death of Mr. And Mrs. A and their 10 year old son. It is understood that when a significant serious untoward incident has occurred the Cornwall Partnership NHS Foundation Trust does undertake an additional review, often involving a non-executive director.

1 DoH Guidance EL (94)27, LASSL (94) 27

This Independent Investigation examined the work of the two Internal Investigations and their findings, and undertook a review of all the relevant clinical and social care notes related to the care and treatment of Mr. A. The transcriptions created from the interviews with staff at the Internal Investigation were available and as a result only four members of staff were interviewed by the Independent Investigation Panel. Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. We are grateful to them, and to those who have supported them. We would also like to thank the Trust Senior Management Team which has granted access to facilities and individuals throughout this process. The Trust Senior Management Team has acted at all times in an exceptionally professional and open manner during the course of this Investigation and has engaged fully with the root cause analysis ethos of this Investigation.

This has allowed the Independent Investigation Panel to reach an informed position from which we have been able to formulate conclusions and set out some recommendations which complement those of the earlier Internal Investigations.

2. Condolences to the Family and Friends of Mr. And Mrs. A and their son

The Independent Investigation Panel would like to express its sincere condolences to the family and friends of Mr. And Mrs. A and their son.

The family members were involved in the Internal Investigation undertaken by the Cornwall Partnership NHS Foundation Trust and met the Chief Executive. They also assisted in the second Internal Investigation undertaken by two staff from the Plymouth Mental Health Services. This information was made available to the Independent Investigation Panel which provided extremely helpful and corroborative information about Mr. A and his mental health problems.

Family members were invited to meet the Panel Chair and the Commissioner of the Investigation from NHS South at the end of the Independent Investigation to learn the findings of the Panel at first hand.

3. Incident Description and Consequences

At 06.12 on 18 January 2010 a report was received by the Cornwall Fire and Rescue Services about a fire at the home of Mr. And Mrs. A in Newquay. Mr. A's 10-year old son and his wife died following this house fire, the son had been injured by a blow to his head prior to the fire. The Police Investigation suggested the fire was started deliberately in Mrs. A's bedroom, an accelerant was used and a murder inquiry was started. Mrs. A's niece, who was staying with her aunt in the flat below that of Mrs. A, heard a loud bang at 06.00 which had woken her up. She saw Mr. A leaving the house covered in blood, and then the fire had started.

Mr. A was found by Police Officers at 07.20 walking along the Coast Road, in Newquay. He had serious burns on his body. Mr. A was detained, and although seriously injured with burns on his body, he resisted arrest. Mr. A survived for a week and died seven days later of his injuries on 26 January 2010 at Frenchay Hospital in Bristol. The Police were not able to interview him as he was not well enough during that period.

4. Background and Context to the Investigation (Purpose of Report)

The Health and Social Care Advisory Service was commissioned by NHS South West, the Strategic Health Authority (SHA), to conduct this Investigation under the auspices of Department of Health Guidance *EL(94)27, LASSL(94) 4*, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced Care Programme Approach, of specialist mental health services in the six months prior to the event.

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

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

The purpose of an independent investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

The role of the Independent Investigation Panel is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Panel to form a view of what should have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been investigated fully by an impartial and independent investigation team.

5. Terms of Reference

The Terms of Reference for the Independent Investigation into the Care and Treatment of Mr. A were set by the NHS South West Strategic Health Authority and were as follows:

1. Overall Aims and Objectives

1.1 to evaluate the mental health care and treatment of Mr. A including risk assessment and risk management;

1.2 to identify key issues, lessons learnt, recommendations and actions by all directly involved health services;

1.3 assess progress made on the delivery of action plans following the internal investigation; and

1.4 identify lessons and recommendations that have wider implications so that they are disseminated to other agencies and services.

2. Terms of Reference

2.1 to review the quality of the health and where relevant social care provided by the Trust and establish if this was in line with Trust Policy and best practice/national guidance;

2.2 to identify whether any risk assessments were timely, appropriate and were followed by appropriate action;

2.3 to examine the adequacy of care plans, delivery and monitoring;

2.4 to review the understanding of the Mental Health Act (to include Community Treatment Orders) by doctors and whether the Mental Health Act was appropriately used and considered (to include on 28 September 2009, 21 October 2009, and 02 December 2009) and any training requirements that may arise;

2.5 to review the understanding of the Mental Health Act Managers with regards to the detention criteria and its application and training requirements to address these;

2.6 to consider the particular challenges facing the Trust and uncooperative patients moving between different areas and include issues concerning the transfer of information;

2.7 to review the quality of the documentation and the recording of key information;

2.8 to examine the adequacy of collaboration and effectiveness of communication between the Trust and any other agencies (to include the GP and the Police) that may have been involved;

2.9 to evaluate the Internal Investigation into the care of Mr. A already undertaken by the Trust against Trust processes and best practice and any recommendations and actions taken and/or required;

2.10 to consider any other matters that arise during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence that the public interest may require.

3. Outcomes

3.1 A comprehensive report of this Investigation which contains the lessons learnt and recommendations based on the evidence arising from the Investigation.

6. The Independent Investigation Panel

Selection of the Investigation Panel

The Independent Investigation Panel comprised individuals who worked independently of the Cornwall Partnership NHS Foundation Trust. All professional panel members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation and Inquiry work of this nature. The individuals who worked on this case are listed below.

Investigation Panel Leader and Chair

Mr. I. Allured	Director of Adult Mental Health, HASCAS Health and Social Care Advisory Service. Social Worker Member

Investigation Panel Members

Dr. L.A. Rowland	Director of Research, HASCAS Health and Social Care advisory Service. Clinical Psychologist Member
Dr. S. Britton	Consultant Psychiatrist (recently retired)

Support to the Investigation Panel

Mr. Christopher Welton	Investigations Manager, HASCAS Health and Social Care Advisory Service
Fiona Shipley Transcriptions Ltd	Stenography Services
Independent Legal Advice	Kennedy's Solicitors

7. Investigation Methodology

Classification of Independent Investigations

Three types of Independent Investigation are commonly commissioned, these are:

- **Type A** – a wide-ranging investigation carried out by a team examining a single case;
- **Type B** – a narrowly focused investigation by a team examining a single case or a group of themed cases;
- **Type C** – a single investigator with a peer reviewer examining a single case.

Each of these categories has its own strengths which make it best suited to examining certain cases. This Investigation was commissioned by NHS South West Strategic Health Authority as a Type C Independent Investigation.

A Type C review is principally a documentary analysis review which utilises:

- clinical records;
- Trust Policies and Procedures;
- the Trust Internal Investigation report;
- the Trust Internal Investigation archive.

A Type C Review does not seek to reinvestigate a case from the beginning if it can be ascertained that the Internal Investigation was robust. In a Type C review the Independent Investigation is charged with building upon any investigative work that has already taken place.

7.1 Consent

As Mr. A died soon after the incident in which his wife and son died there was no requirement to seek consent, and the full clinical notes from the Cornwall Partnership NHS Foundation Trust were made available to the Independent Investigation.

7.2 Communication and Liaison

Communication with the Family of the Victims and of Mr. A

The Cornwall Partnership NHS Foundation Trust had written to the families of Mr. And Mrs. A prior to the first Internal Investigation and again when the second Internal Review was commissioned. Family members met the Chief Executive of the Trust and the authors of the Second Internal Investigation also contacted the families by telephone and by letter.

The Cornwall Partnership NHS Foundation Trust wrote to the families again when the Independent Investigation Panel commenced its work, and the previous information they had provided was made available to the Independent Investigation. The Independent Investigation Panel offered to meet the family members during the Investigation but it was agreed that this should be when the Investigation was complete prior to publication by the NHS South West, now NHS South of England.

Communication with the Cornwall Partnership NHS Foundation Trust

The NHS South West Strategic Health Authority wrote to the Cornwall Partnership NHS Foundation Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. A.

The Independent Investigation Panel worked with the Trust liaison person to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished.

On 02 March 2011 the Chair of the Independent Investigation Panel met with representatives from the Cornwall Partnership NHS Foundation Trust, the Primary Care Trust and the South

West Strategic Health Authority to agree the Terms of Reference and to discuss how the Independent Investigation would undertake its work.

Four members of staff were interviewed on 29 June 2011 at the Cornwall Partnership NHS Foundation Trust Headquarters in St Austell, Cornwall. On 15 May 2012 the Chair of the Independent Investigation Panel met with the Chief Executive of the Trust, the Medical Director and the Director of Corporate Governance to discuss the findings of the Investigation and to discuss the appropriate recommendations to be made taking into account the actions the Trust has taken since January 2010.

Witnesses called by the Independent Investigation

Each witness also received a letter which explained the details of the Independent Investigation and the process to be followed. The Chair of the Independent Investigation Panel gave the witnesses the opportunity to telephone or e-mail him if they had any concerns or questions about the Investigation. The interviews were managed in line with Scott and Salmon processes.

Table 1: Witnesses Interviewed by the Independent Investigation Team

Date	**Witnesses**	**Interviewers**
29 June 2011	**<u>Trust</u>** • Chief Executive • Medical Director • Consultant Psychiatrist • Social Worker and Appropriate Mental Health Professional	**<u>Investigation Panel,</u>** • Investigation Panel Chair, Social Worker • Investigation Panel, Clinical Psychologist • In attendance: Stenographer

Salmon Compliant Procedures

The Independent Investigation Panel adopted Salmon compliant procedures during the course of their work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a colleague, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign;

(h) that they will be able to access copies of the clinical records both before and during their interviews to refresh their memory.

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Panel Meetings and Communication

The Independent Investigation Panel Members were recruited following an examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood, the Investigation Panel was recruited to provide the level of experience that was needed. During the Investigation the Panel worked both in a 'virtual manner' and together in face-to-face discussions.

Prior to the first meeting taking place each Panel Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It was possible for each Panel Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview of the general question areas about which they could expect to be asked.

The Independent Investigation Panel Met on the Following Occasions

The Independent Investigation Panel met on 01 June 2011 to examine the clinical records for Mr. A and the appropriate policies and procedures. It was at this meeting that the questions for the four witnesses were finally decided and the letters sent out giving them time to prepare. A further meeting took place on 13 September 2011 to identify the key issues which had not been covered by the two Internal Investigations. The quality and outcomes of both these earlier investigations were discussed and the actions plans arising from them were reviewed to check progress in implementation.

The Independent Investigation Report was completed by the Panel Members using e-mail and telephone communication to agree areas where recommendations were required.

Root Cause Analysis (RCA)

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root Causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

The ethos of Root Cause Analysis (RCA) is to provide a robust model that focuses on underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.

2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix 1). From this, causal factors or critical issues can be identified.

3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This investigation utilised the Fish Bone.

4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Independent Investigation Panel avoids generalisations and seeks to use findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

Anonymity

The staff of the Cornwall Partnership NHS Foundation Trust have been referred to by their role title, hence they become Doctor 1, Community Psychiatric Nurse 1, Social Worker 1 and similarly for other professions. The perpetrator has been referred to throughout this Report as Mr. A and his wife, one of the two victims, is called Mrs. A. The son of Mr. And Mrs. A is referred to as their son.

8. Information and Evidence Gathered (Documents)

During the course of this investigation the following documents were used by the Independent Investigation Panel to collect evidence and to formulate conclusions:

- Clinical Records for Mr. A
- The Internal Investigation into Serious Untoward Incident involving Mr. A dated 04 May 2010
- The Independent External Overview Investigation and Report into the Care and Treatment provided by Cornwall Partnership NHS Foundation Trust Mental Health Service to Mr. A dated 11 April 2011
- The Timeline (Chronology) from the External Overview Investigation dated April 2011
- Transcripts from the Interviews with the four staff seen by the Independent Investigation Panel
- The Cornwall and Isles of Scilly Local Safeguarding Children Board : Serious Case Review dated August 2010
- The Cornwall and Isles of Scilly Local Safeguarding Children Board : Serious Case Review Overview Report dated July 2010

Cornwall Partnership NHS Foundation Trust Policies and Operational Policies

- Serious Untoward Incident Reporting Policy and Procedure (28 May 2008)
- Serious Untoward Incident Reporting Policy and Procedure (16 March 2009)
- Community Mental Health Teams Operational Policy (20 April 2004)
- Community Mental Health Teams Operational Policy (09 September 2009)
- Care Coordination CPA Policy Document (15 December 2004)
- Guidance for the Care of Patients with a Dual Diagnosis of Mental Illness and Substance Misuse (19 February 2009)
- Risk Assessment Policy (16 March 2009)
- The role of the Inpatient Named Nurse in adult Mental Health Units (01 October 2007)
- Review Caseload Protocol (01 May 2007)

- Standards for Unified Health & Social Care Records (01 June 2007)
- Clinical and Community Psychology Operational Policy (01 October 2007)
- Safeguarding Children Training Strategy (03 November 2010)

9. Profile of Trust Service

In January 2010, the Trust was in its final approach to becoming a Foundation Trust. A transition from Networks to Service Lines was happening as part of this. The benefit of this was that the Community Service Line linked the east and west networks. Subsequently, the Assertive Outreach Team moved to a single team (instead of two). This has reduced fragmentation across community teams and enabled dispute resolution between teams based in the community by a single, over-arching manager.

In July 2010, the Trust introduced the RiO Electronic Patient Record. This has become the primary clinical record, with the significant contribution to safety of contemporaneous recording, accessible by any appropriate member of staff, 24 hours a day, seven days a week. RiO includes a risk checklist, a care planning function, a structured core assessment and progress notes. All entries are timed and dated and traceable to the author. Audits of the records have monitored and improved compliance with record keeping standards.

Another change, since April 2011, is that the Trust now also provides universal children's services, including health visitors and school nurses. This conforms to the aspirations of the Kennedy Report to pool expertise when working with children. It has also created new opportunities for information sharing within the same organisation between services treating parents or other adults and those with direct clinical access to children.

Communication with staff previously took the form of monthly Team Brief, where managers attended to be briefed following on from the Trust Board. Since the new Chief Executive commenced, a wider group of managers and clinicians have attended a more in depth briefing, including enhanced participation and engagement. Relevant topics covered in these sessions have included: information sharing, use of mobile telephones in clinical settings, 'Think child, think parent, think family' and learning from serious incidents (twice).

10. Chronology of Events

This Forms Part of the RCA First Stage

The Chronology of Events forms part of the Root Cause Analysis first stage. The purpose of the Chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. A and on his care and treatment from Mental Health Services.

Background Information

Early Years

Mr. A was 47-year old at the time of his death. He was born in Luton, moving to Winchester in Hampshire at the age of three. He was the second of five children, three brothers and one sister. He left school at aged 16 gaining seven qualifications. His employment included training as a mechanic followed by working for British Rail for four years. Mr. A then established his own decorating business for a number of years. He later included in the business buying furniture from China and later wood for making picture frames. Mr. A sold these items and services in the United Kingdom prior to his becoming unwell with mental health problems.

Mr. A moved to Cornwall with his wife and son in 2002. There is no known family history of mental illness. His mother continued to live in Hampshire. Shortly after his referral to mental health services Mr. A was separated from his wife and son due to his mental ill health. He had become delusional about having physical health problems and, despite tests proving negative, Mr. A became convinced he was the victim of an "*evil conspiracy*".

Once separated from his wife Mr. A went to live in a converted garage in the Redruth area. The garage was situated to the rear of a property owned by Mrs. A which was rented and occupied by tenants. Mrs. A and her son lived in the Newquay area on the top floor of a house shared with the mother of Mrs. A, who resided on the ground floor. Mrs. A worked in the Medical Records Department at Treliske Hospital.

Clinical History with the Cornwall Partnership NHS Foundation Trust Mental Health Services

Initial Referral to Mental Health Services

Mr. A was not known to Mental Health Services in Cornwall or in Hampshire prior to his GP referring him to the local Restormel Community Mental Health Team (CMHT) on **03 January 2008**. This CMHT covered the east of Cornwall and the Newquay area. The referral was because Mr. A had made many visits to his GP (GP1) complaining of ill health, and arguing when told there was no sign of illness. His visits to GP1 became more frequent and Mr. A remained convinced that he was ill and had been purposely infected with HIV by somebody. GP1 feared that Mr. A might become psychotic but Mr. A would not contemplate the possibility that he had a mental illness.

The GP records did indicate that Mr. A may have been mentally unwell in 2007, and the records indicate an increasing number of visits to the GP[2]. It appears that Mr. A had begun to behave oddly from **August 2007**. He made many telephone calls to his GP which were repetitive, and in which he stated that he thought he had HIV. Mr. A was paranoid, believing that people were trying to destroy his marriage.[3]

In **September 2007** Mr. A received a consignment of wood from China for his picture-framing business. This wood had arrived warped and Mr. A saw this as part of a conspiracy which really affected him badly.[4]

In an interview with Mrs. A's family in March 2011 as part of the Second Internal Investigation, family members shared the information that Mr. A was known to have been involved in a 'bikers' culture in his youth and was known to be impulsive. In the relationship with Mrs. A prior to their marriage, Mr. A was described as having been very possessive. Mrs. A at no time disclosed that the marriage involved physical violence, either before their

2 Clinical File 1 Page 567.
3 The External Review Timeline Page 2
4 As 3 above.

wedding or afterwards.[5] On **19 November 2007** Mr. A went to Redruth Police Station concerned about his having HIV and/or AIDS. He was upset and the Police advised him to go to Newquay Hospital for checks, but it is clear that he did not follow this advice.

On **04 December 2007** Mrs. A visited the Police and reported that she was frightened that her husband would either harm himself or her. Mrs. A stated that her husband had been verbally threatening over the previous three months. He refused medication when he visited the GP because he thought the doctor was trying to kill him. He had also been aggressive to his mother. Mr. A accused his wife of having given him cancer and of trying to kill him. The information was passed to the Domestic Violence Unit.[6]

Second Referral to Mental Health Services

On **17 January 2008** Mrs. A telephoned the Mental Health Out of Hours Service saying that her husband had walked out of the house stating that he was going to commit suicide. Mrs. A was advised to contact the Police. Mrs. A had done this before and they had been unable to help. The referral was faxed by the Out of Hours Service to the Restormel CMHT asking the duty worker to contact Mrs. A and arrange to see her for support and assessment. Mr. A refused to see a Community Psychiatric Nurse (CPN 1), but did agree to a meeting with him the next day.[7]

CPN 1 visited Mr. A with a colleague on **18 January 2008** and found him to be less anxious than had been described by his wife in her referral. A meeting was arranged to see Mr. A again the following week. Whilst with Mr. A the two staff undertook an assessment and talked about Mr. A and his life. He explained that he and his wife and their son live on the top floor of a house they share with Mrs. A's mother. They had moved to Cornwall from Winchester in the summer of 2002.[8] CPN 1 became the Care Coordinator for Mr. A.

Mr. A informed CPN 1 that about 17 years previously his father had died. Mr. A stated that he had had a violent relationship prior to this where he and his partner both hit each other. It was clear to CPN 1 that Mr. A strongly believed that he had HIV and was worried he would

6 Second Internal Investigation Timeline Page 2
7 Second Internal Investigation Report Page 3
8 Second Internal Investigation Report Pages 3-5

infect his wife and son. Mr. A was prescribed Quetiapine 25 mg which appeared to have a beneficial effect and he agreed to continue taking it.[9] Mr. A was placed on the caseload of CPN 1 and the plan was for him to be seen weekly.

On **07 February 2008** Mr. A attended an outpatient appointment with Doctor 1. Mr. A repeated the information he had given to CPN 1 and Doctor 1 decided to stop the prescription of Quetiapine and to replace this with Mirtazapine 15mg. He warned Mr. A that it would take two or three weeks for the medication to take effect, and warned him that it could increase his appetite and he could gain weight.[10]

Four days later on **11 February 2008** Mr. A presented at the Accident and Emergency Department at Newquay Hospital with chest pains. He talked about his physical ill health and the HIV issues. When the Senior House Office suggested that he should have a psychiatric assessment Mr. A ran away. The Police were called and it was discovered that Mr. A had gone to London to visit his sister.[11]

Two days later, **13 February 2008,** Mr. A was seen at his house by CPN 1 who described him as appearing calm. He said that he had stopped taking his medication. Mr. A agreed to see CPN 1 every Wednesday at 11.00 hours and promised to telephone him if he had any concerns.[12] The next week, on **23 February 2008**, Mr. A was not at home when CPN 1 visited. His wife had had contact but she thought he was at his workshop in Redruth. Mrs. A made no comment as to whether the Police should be involved in helping to facilitate a Mental Health Act Assessment. Mr. A remained out of contact and had his mobile telephone turned off for several days.[13]

Mrs. A telephoned CPN 1 on **28 February 2008** as she was concerned about the state of her husband's mental health. She described the level of his belief about his having a physical illnesses as being intense. A Mental Health Act Assessment was arranged for the next day. When Mr. A was seen he was examined and his mental state assessed under Section 135 of

9 Clinical File 1 Pages 76-89
10 Clinical File 1 Pages 348-349
11 Clinical File 1 Page 349
12 Clinical File 1 Page 350
13 Clinical File 1 Page 351

the Mental Health Act and he was deemed not to be detainable. It was agreed that CPN 1 should monitor his symptoms.[14]

As Mr. A was spending much of his time in Redruth, CPN 1 referred Mr. A to the Trengweath Community Mental Health Team (CMHT) which provided community mental health services to the Redruth area. The referral was not accepted by the Trengweath CMHT because it was clear that Mr. A would not engage with services. There was no care coordinator after 24 March 2008.

On 24 April 2008 GP 2, in Redruth, referred Mr. A to the Trengweath CMHT. GP 2 said that he was worried about Mr. A and his mental ill health and would welcome advice on how best to help him. There was no reply to this referral until Doctor 2 wrote to GP 2 on **03 September 2008.**[15]

During **September and October 2008** Mr. A's family became aware of his poor mental health as he was repeatedly telephoning his family discussing his physical health problems and his concerns. There were five main concerns according to his sister:

- there were people out to destroy his business (following warped wood from China being delivered to him for his picture framing);
- the doctors were lying about his negative HIV results;
- when he attended the market everyone there was talking behind his back;
- he overheard someone mention HIV and knew that he was talking about him;
- he was very worried that he had infected his wife and son.[16]

On **02 October 2008** GP 1 referred Mr. A to the Newquay Community Mental Health Team and CPN 2 saw Mr. A. He had agreed to see CPN 2 because his wife would not have anything to do with him unless he engaged with Mental Health Services. Mr. A was seen again the next week on **07 October 2008** when he attended Newquay Hospital for another appointment with CPN 2. He reported that he had been better during the week and his wife was glad that he had made contact with services. When Mr. A talked about medication he declared that he had not taken any and did not want any as it did not do him any good. He

14 Clinical File 1 Page 352
15 Clinical File 1 Page 545
16 Clinical File 1 ERT Page 21

accepted that he had to deal with his HIV issue and could see he might not have it. Mr. A also talked about an unhappy childhood which he blamed for his overall problems.[17] CPN 2 became his second Care Coordinator on **02 October 2008.**

The next day, **08 October 2008,** Mr. A visited the CMHT office in the hope of seeing CPN 2 as he wanted to apologise to her for his behaviour the previous day when he was strident about medication. Mr. A had started to send emails to his family which made paranoid references, but he did agree to take Diazepam 2mg *via* his GP. He failed to attend his next appointment with CPN 2 on **14 October 2008** and she sent him a letter asking if he was well. Mr. A tried to speak to her by telephone on **21 October 2008** but she did not answer and he left no message.[18]

Two days later, on **23 October 2008,** Mrs. A telephoned the Home Treatment Team stating that she thought she and her son were at risk from Mr. A. The following day Mr. A said he wanted to leave Cornwall.[19]

On **24 October 2008** Mr. A had an assessment by CPN 3 and CPN 4. He agreed to accept daily support from the Home Treatment Team and to take Olanzapine 10 mg at night. He also agreed to attend an outpatient appointment on 27 October 2008.[20]

In **October 2008** Mr. A was harassing his wife by sending her texts with threats. Mr. A had visited his wife's place of work. The Police were called and took Mr. A to the Police Station for interview. He subsequently agreed to an assessment of his mental health at Newquay Hospital where the Community Mental Health Team was based. He agreed to an informal admission to Bodmin Hospital on **28 October 2008,** but within two days wished to leave the ward.[21]

On **03 November 2008** Mr. A was prevented from leaving the ward through the use of Section 5(2) which was later replaced when he was made subject to Section 2 of the Mental Health Act. A nurse on the ward discussed the involvement of Social Care Services with a

17 Clinical File 1 Page 354
18 Clinical File 1 P357
19 Clinical File 1 Page 355-357
20 Clinical File 1 Page 359
21 Clinical File 1 Page 362-363 and Page 374

student social worker who was assessing Mr. A's son as a consequence of his father's mental health problems.[22]

An electrocardiogram (ECG) test was undertaken which demonstrated there were no concerning factors or abnormalities with Mr. A's heart. Mr. A then visited the Pool GP Surgery as he wanted to register as a patient there. He was complaining of stomach pains. Mrs. A had made it clear that she did not wish Mr. A to live with her in Newquay so he had obtained a property in Redruth. On **18 November 2008** Mr. A was discharged from Section 2 of the Mental Health Act and agreed to stay in hospital informally. The next day he was on leave and he did not return, and his wife discovered him at his workshop on **21 November 2008** and he returned to the ward the next day **22 November 2008**. During his time at his Redruth home Mr. A reported that he had used cannabis and magic mushrooms.[23]

Mr. A was assessed under the Mental Health Act on **26 November 2008** and was detained in hospital under Section 3 of the Act.[24] A week later, on **02 December 2008**, Mr. A was given Section 17 leave for 14 days until 16 December. The plan was that he would be driven to Winchester by his wife so that he could stay with his mother and she had agreed to monitor his medication and to register him with a local GP as a temporary resident.[25]

Whilst in Winchester Mr. A decided to buy a car. He then drove back to Redruth and contacted his wife on arrival there on **10 December 2008.**[26] Mr. A returned to hospital on **12 December 2008** and was given further Section 17 Leave until 16 December, which had already been agreed but for him to be residing in Winchester. On **12 December 2008** Mr. A returned to the Hospital for the Ward Round Meeting. There was a Section 117 Meeting to discuss the Care Plan for Mr. A when he was discharged from Hospital. It was decided that he would be made subject to a Supervised Community Treatment Order.[27]

Mr. A was discharged from hospital on **30 December 2009** and was placed on a Supervised Community Treatment Order. In addition to the statutory conditions Mr. A had to also accept assistance from the Community Mental Health Team and to accept depot injections of

22 Clinical File 1 Page 377
23 Clinical File 1 Pages 388-389 and Page 396
24 Clinical File 1 Page 401
25 Clinical File 1 Page 407
26 Clinical File 1 Page 409
27 Clinical File 1 Page 411

Risperidone 25mg every two weeks. It was noted that that the next injection was due on 13 January 2009.[28]

On **14 January 2009** CPN 4 telephoned Mr. A and arranged for his depot injection to be at 16.00 that day. Mr. A attended and appeared paranoid and to be expressing delusional beliefs that he was HIV positive. He spoke *about "a thing that burst in his leg giving him pins and needles".* At first he refused the depot but agreed when the conditions of the Supervised Community Treatment Order were explained to him again.[29] Mr. A contacted Care Coordinator 1 at her request so that his care could be discussed. She and CPN 4 thought the care would be better coordinated if he registered with a GP in Newquay as he appeared to be spending more time there than in Redruth. It was noted that Mr. A attended for his next depot at Newquay Hospital on **30 January 2009**, the delay of two days having been agreed.[30] CPN 4 became Care Coordinator from **14 January 2009.**

Mr. A telephoned the CMHT on **07 February 2009.** He said he had been physically unwell with painful kidneys. He also felt dizzy and was sleeping badly and was low in mood. He stated that he would like to be back in hospital.[31] Three days later Mr. A phoned CPN 4 from Winchester as he had been unable to get any work done in Cornwall. Mr. A said that he would return to Cornwall and CPN 4 said that the Duty CPN would talk to him on his return. Later that day his wife and then his mother telephoned the CMHT regarding the deterioration in his mental health.[32]

On **11 February 2009** Mr. A telephoned the Fletcher Ward. Doctor 1 was not keen to admit him as when he had met the Second Opinion Doctor for a review of the efficacy of the Supervised Community Treatment Order earlier in the week, Mr. A had presented well and the Supervised Community Treatment Order was assessed as being effective. Mr. A was seen at Newquay Hospital on an urgent basis on **12 February 2009.** His symptoms showed that his mental health had started to relapse. Mr. A was expressing delusional beliefs about his physical health and would not be distracted from this. He insisted that he needed to have various physical health checks. Mr. A stated that he felt he had been blamed for the death of

28 Clinical File 1 Page 413
29 Clinical File 1 Pages 414-415
30 Clinical File 1 Page 416
31 Clinical File 1 Page 417
32 Clinical File 1 Pages 417-419

his wife's sister. His symptoms were: delusional beliefs, being distressed and tearful, restlessness, having persecutory delusions and ideas of guilt. Mr. A was admitted as an informal patient. [33]

Mr. A was still expressing delusions, feeling distressed, tearful and restless the following day at the Ward Round Meeting. Mr. A stated that he wanted to go home and was asking to be forgiven and begging the staff not to kill him. He insisted on being allowed to go into town as he was an informal patient. This was agreed and Mr. A returned on time.[34]

On **15 February 2009** Mr. A asked to be allowed to go home and to take his son to a football match. As his wife did not know of his plans he was asked to telephone her and he went outside to speak to her. He did not return to the Ward and was missing for four hours. On his return he said he had visited his wife and his son.[35] The next day Mr. A again wanted to help look after his son. As he appeared to be settled he was allowed to leave the Ward but was asked to be back by 19.00. Mr. A returned on time and took his depot injection without comment. In view of the improvement in his mental state the plan was for him to be discharged the next day if he remained stable.[36] Mr. A was well the next morning and he was discharged on **17 February 2009**. He remained subject to the Supervised Community Treatment Order.

Mr. A's mother telephoned the CMHT from Winchester on **23 February 2009** to say that she was concerned that Mr. A had driven to see her and the next day was planning to return to Cornwall. He had complained of kidney and bowel problems. His wife thought that he had deteriorated following his transfer to the new intra-muscular medication. It was noted that Mr. A had registered with a GP in Newquay.[37] Mr. A did not keep his appointment with Care Coordinator 1 the next day. Later his wife telephoned the CMHT and reported that her husband had panicked and had gone to Exeter.

On **25 February 2009** in response to a question about Mr. A being admitted to hospital the Mental Health Administrator at Bodmin Hospital sent an email to Care Coordinator 1 saying *that "if Mr. A wanted to be admitted to hospital he could be admitted and this would not*

33 Clinical File 1 Pages 420-423
34 Clinical File 1 Pages 424-425
35 Clinical File 1 Page 427
36 Clinical File 1 Pages 428-429
37 Clinical File 1 Page 432

require him having to be recalled from his Community Treatment Order". The Administrator added that recall should only be used where the patient fails to comply with two statutory conditions of Section 17A of the Mental Health Act 1983 as amended 2007 (Community Treatment Orders) :

- failure to attend for a meeting with a Second Opinion Authorised Doctor; and
- failure to be available for examination by the Responsible Clinician for the purpose of the renewal of the Community Treatment Order.

Recall could also be considered where the patient failed to comply with the other conditions of the Supervised Community Treatment Order or if it was necessary to recall due to deterioration in the condition of the patient. Any deterioration should be reported to the Responsible Clinician and the team which is supporting the patient. The Administrator advised "*You should not wait until you see him on **02 March 2009.** Increased support or informal admission should be considered now".*[38]

Mr. A was next seen on **02 March 2009** when he attended for his depot appointment and took the Risperdal Consta 25mg given by CPN 2. Doctor 1 also saw Mr. A and decided to increase his depot to 37.5mg Risperdal Consta from 10 March 2009.[39]

The next day Mrs. A telephoned the CMHT as she was very concerned that her husband was worse. CPN 2 explained that the plan was for the Home Treatment Team to become involved. If he needed admission Mr. A would be required to stay in hospital for three weeks. Mr. A had visited the Accident and Emergency Department at Truro Hospital and had asked for a new pair of lungs. CPN 2 visited Mr. A's address in Redruth on **04 March 2009** but Mr. A did not answer or was not in. Later that day Mr. A telephoned from Winchester and said he was well but was unhappy that he was being harassed by everybody.[40]

On **05 March 2009** Mr. A informed the CMHT that he had decided to stay in Winchester and would find somewhere to live and register with a local GP there. The next day Mr. A had left Winchester and was returning to Cornwall. The Police were alerted as staff thought he might be driving erratically due to his medication and his state of mind.[41]

38 Clinical File 1 Page 432
39 Clinical File 1 Page 434
40 Clinical File 1 Page 435
41 Clinical File 1 Page 438

On **09 March 2009** the Police visited Redruth and found Mr. A at the converted garage there.[42] Mr. A attended his outpatient appointment with Doctor 1. A decision was made to recall Mr. A to Fletcher Ward. His next depot was due on **16 March 2009**. Mr. A attended for his depot. When CPN 2 told him that he was going to be recalled to Hospital he snatched the paper and threw it on the floor and then ran out of the building. The Police were informed that Mr. A had done this. The following day Mr. A was escorted to Fletcher Ward at Bodmin Hospital by the Police due to the recall of the Supervised Community Treatment Order. Soon after arriving he wanted to leave but was informed that he was not allowed to.[43]

The Supervised Community Treatment Order was revoked and Mr. A was detained under Section 3 of the 2005 Mental Health Act on **20 March 2009.** He was prescribed and given Fluoxetine 20mg. by Doctor 3, a locum consultant. Later Mr. A was seen regarding his discharge on another Supervised Community Treatment Order a condition of which was that he would be a patient with the Home Treatment Team.

The new conditions for the Supervised Community Treatment Order were to:

- take the Risperdal Consta as prescribed at 37.5mg every 14 days;
- stay resident in Redruth (not Newquay) and remain in contact with the Home Treatment Team for seven days;
- after that remain in contact with the Home Treatment Team so as not to miss any appointments;
- not drive outside the Redruth area for seven days and then to discuss this with his Responsible Clinician before travelling beyond Newquay.[44]

It was apparent that the staff at the Newquay CMHT were unaware of this discharge[45] plan as on **23 March 2009** Care Coordinator 1 had arranged to meet Mr. A. The next day he was visited by Student Social Worker 1 when he was amenable although he did mention his concerns about his physical health. Doctor 3 thought it would help engagement if the Team worked with the plans made by Mr. A rather than obstructing them. It was also decided that

42 Clinical File 1 Page 453
43 Clinical File 1 Pages 455-457
44 Clinical File 1 Page 464
45 The External Review Timeline Page 153 (from Newquay CMHT MDT Minutes) and Reference below.

staff should visit Mr. A in pairs due to his past verbal aggression.[46] The Home Treatment Team was following up Mr. A after his discharge.

On **25 March 2009,** Student Social Worker 1 visited Mr. A with the Home Treatment Team and he was described as having been warm and affable. His family was planning a weekend in Burnham on Sea and he was invited, so the Supervised Community Treatment Order was altered to allow this to take place. The relevant Home Treatment Team in Somerset was notified that Mr. A would be in Burnham for the weekend in case they were contacted.[47]

Mr. A attended for his depot on **30 March 2009.** He asked if having regular a depot would be on-going as he did not want to continue with it. He did, however, agree to return in two weeks for the next depot. Mr. A was offered the chance to speak to a Consultant Psychiatrist but he declined. Mr. A was sometimes hard to locate, but he did seem pleased to see the Home Treatment Team when they visited. Staff discussed with Mr. A his care being transferred to the Newquay CMHT.[48]

On **06 April 2009** Mr. A refused the arranged Home Treatment Team visit, and when they telephoned he said that he had had to go to Newquay to collect a prescription and was planning to spend rest of the day with his family. Care Coordinator 1 arranged a visit to transfer Mr. A to the Newquay CMHT for the next day.[49]

Care Coordinator 1 and the West Home Treatment Team visited Mr. A. His usual delusional beliefs were unchallengeable and he was sure he was going to die and that it was to do with the wrong medicine in the first depot he had received. He agreed to visit Newquay for his depot on 14 April 2009 "as he has no choice".[50]

On **13 April 2009** a telephone call from Mrs. A was received by the Newquay CMHT saying that her husband was convinced he would die. He had been informed by University College Hospital, London that he had cancer on a kidney and that he "*will die as will his wife and son*". CPN 5 agreed to visit him.[51]

46 Clinical File 1 Page 466
47 Clinical File 1 Page 468
48 Clinical File 1 Page 473
49 Clinical File 1 Page 473
50 Clinical File 1 Page 474
51 Clinical File 1 Page 476

Mr. A went for his depot on **14 April 2009** and appeared calm and resigned. He still believed that his depot was a lethal injection. Care Coordinator 1 was present and the GP had misunderstood the dosage having prescribed 50mg instead of 37.5mg. As a result the depot injection was rearranged for Friday. Mr. A saw this as a plan for him to go back home and die. Care Coordinator 1 discussed with Mr. A ways in which he might be able to prevent spiralling into panic. She told Mr. A that he could telephone the CMHT and they would help, as talking to people had seemed to assist him on previous occasions. Mr. A appeared to be in a confused state and wanted to be admitted to hospital and then quickly became against this course of action.[52]

Mr. A visited Fletcher Ward at Bodmin Hospital seeking admission for a "*good night's sleep*" on **15 April 2009**. He refused Home Treatment Team support and would not guarantee that he would stay for long on the Ward. He then left agreeing to come for his depot on Friday (**17 April)** which he did. On arrival he was in tears and was overwhelmed with thoughts of death and diseases. CPN 6 had received a telephone call from Mr. A's sister saying that he had told his wife he was leaving the country. Care Coordinator 1 worked with him and they agreed that Friday would be the best day for his depot injections. In view of his concerns GP 1 agreed to prescribe Lorazepam 1mg twice per day for two weeks only. Mr. A agreed for the CMHT to contact University College Hospital London, and informed staff that he had given his name as James Stott.[53]

On **24 April 2009** University College Hospital London responded to the enquiry from Doctor 1 about his diagnosis and stated that he had been diagnosed as having blocked bowels. Mr. A did not have a tumour but malignancy could not be ruled out without further tests.[54]

Mr. A was reviewed in the Outpatient Clinic by Doctor 1 and Care Coordinator 1on **27 April 2009**. Mr. A stated that he had benefitted from the Lorazepam. Doctor 1 was willing to reduce the depot and consider Citalopram which Mr. A agreed he was willing to try. He also agreed not to drive when he was distressed and when he was taking Lorazepam. The depot was reduced to 25 mg. Mr. A was therefore being prescribed the following medication:

- Risperdal Consta 25mg every two weeks with the next due on 01 May 2009;

52 Clinical File 1 Page 477
53 Clinical File 1 Pages 480-482
54 Clinical File 1 Page 483

- Citalopram 10mg in the morning after food;
- Lorazepam tablets 1mg twice per day for two weeks;
- Zopiclone 7.5mg at night.[55]

Mr. A missed an Out Patient Appointment on **30 April 2009** but did attend for his depot the following day.[56]

On **10 May 2009** Mrs. A rang CPN 6 saying that her husband had been telephoning her constantly saying they are all going to die. Mrs. A felt unsupported and also commented that little appeared to be done to help her husband.[57]

Mr. A was discussed at the Multidisciplinary Team Meeting on **11 May 2009.** It was planned for Doctor 1 to see him on 15 May with the intention of recalling him to hospital. CPN 4 arranged for Mr. A to visit her for depot that day and to see Doctor 1.

Mr. A attended for his depot injection on **15 May 2009** and having seen it drawn into the syringe he took it. He then saw Doctor 1. He presented well and said he had had some whisky the day before. As a result there were not grounds to recall him from the Supervised Community Treatment Order. It was noted that Mr. A was good at presenting well to Mental Health Staff but that in reality he was unwell and was causing great concern to his wife, son and wider family. He was neglecting himself and was not eating properly and the house was very dirty and unkempt. He was not eating, drinking or going out. Doctor 1 thought the crises would keep happening unless the Mental Health Service could work with him in the community.[58]

On **27 May 2009** a home visit to Mr. A was made by Doctor 1, an Appropriate Mental Health Professional and a Policeman. A warrant for a Section 135 was obtained from Bodmin Magistrates Court. This was used to enable the assessment by the Responsible Clinician and the Approved Mental Health Professional which enabled the Supervised Community

55 Clinical File 1 Pages 484-485
56 Clinical File 1 Pages 485-486
57 Clinical File 2 Page 258
58 Clinical File 2 Pages 259-263

Treatment Order to be recalled and revoked by them. Mr. A was admitted to hospital at 19.00 and was cooperative with the process.[59]

At the Ward Round Meeting on **29 May 2009** Mr. A stated that he felt better in hospital. The plan agreed was that the ward staff should continue their assessment of Mr. A. It was also agreed that Mr. A should continue to take medication and not be granted any leave and be encouraged to work with nursing staff on the Tidal Model. This is the first model of mental health nursing to be used as the basis for interdisciplinary mental health care and to focus at the beginning on the recovery journey when the person is at their lowest ebb. Mrs. A provided staff with information about her husband and informed them that he and she had separated.[60]

On **05 June 2009** Mr. A refused Citalopram and later refused all medication except for Lorazepam.[61] On **08 June 2009** the electronic health record Care Plan Review was completed and a legal Care Plan was produced to reflect the fact that the Community Treatment Order had been revoked on **29 May 2005.** It was evident that on the ward Mr. A was not engaging with staff on the ward despite them being proactive in trying to involve him in care planning. Mr. A refused to cooperate with the 1-1 sessions the staff were offering.[62] There was discussion about Electro Convulsive Therapy (ECT) being a possible treatment option.

Mrs. A visited her husband on **10 June 2009** and argued with Mr. A about him tormenting her with his fixed delusions which he presented in an aroused and angry manner whenever she visited. She threatened not to visit again. Mr. A felt that if he was on no medication and let out he would be better.

On **12 June 2009** Care Coordinator 1 talked to Mrs. A about obtaining housing for her husband, and reassured her about Mr. A not being discharged yet. Mrs. A would be re-letting the house in Redruth and the garage conversion was not appropriate accommodation for him as it was damp and Mr. A felt isolated and frightened when he was there. He was technically of No Fixed Abode. Mr. A was given his depot.[63]

59 Clinical File 1 Page 488
60 Clinical File 2 Page 272
61 Clinical File 2 Page 278
62 Clinical File 2 Pages 280-281
63 Clinical File 2 Pages 283 and 287

On **16 June 2009** at the Ward Round it was agreed that:

- the medication for Mr. A should be altered to Risperidone depot and he would be monitored for side effects;
- information on Mirtazapine would be given to Mr. A to read.

In addition the plan was to:

- contact Mrs. A about Mr. A having leave with her;
- contact Child and Family Services about the son of Mr. A being involved in his father's delusional belief system;
- adjust the depot to the equivalent of 4-6mg oral Risperidone;
- be vigilant to detect any illicit drug use by Mr. A.

Mrs. A rang the ward as Mr. A had worried her with his views of what had happened in the Ward Round Meeting. Following discussion with staff she was reassured. She did not feel her husband was a threat to her or her son.[64]

At the next ward round on **19 June 2009** it was noted that Mr. A was booked for an endoscopy the following week and that he should keep this appointment. His depot was increased to 50mg every 14 days and he could be given leave off the ward if his wife felt comfortable. It was also important for staff to continue to encourage Mr. A to engage. Mrs. A said she was happy for leave on Sunday overnight and for Mr. A to return on Monday morning.[65]

On **20 June 2009** Mr. A did not start his leave as expected. The plan was that if Mr. A's leave went well he would stay overnight and return on Monday morning. He actually returned at 18.30 on Sunday evening, when he said he had not wanted to stay longer in case he "*went on at her*". Next day Mr. A said he knew where a missing bottle of alcohol from another patient's drawer had gone.

At the Ward Round Meeting on **23 June 2009** there was discussion about where Mr. A would live. Mr. A said that he wanted to keep his Newquay GP and would look for accommodation in Newquay. The plan was that at discharge Mr. A would be referred to the Home Treatment Team West and have his depot at Newquay Hospital. However such contact would not

64 Clinical File 2 Pages 289-290
65 Clinical File 2 Pages 293-294

adequately monitor how he was coping in the community. Mr. A wanted to leave Hospital even though his wife was away but he would not agree to working with the Home Treatment Team.

On **25 June 2009** Doctor 1 prepared his Psychiatric Report for the Mental Health Managers Review Tribunal. His Responsible Clinician recommendation was:
"*that Mr. A was suffering from a psychotic disorder or possibly psychotic depression which is of the nature and degree which warrants continued detention in hospital for treatment so that he can receive the treatment. Detention is required for his own safety.*
If Mr. A was to be discharged the following care plan could be implemented:

- *treatment in hospital as an informal patient although he does not believe he has a mental illness;*
- *transferred to CMHT or Assertive Outreach Service and to his GP;*
- *his management plan would be carried out within the framework of a care plan".*

Mr. A refused leave on **27 June 2009** as it was 14.00 when the transport had arrived and he felt there was little point in going on leave. The referral to the Home Treatment Team had been dropped as Mr. A would not cooperate and would only agree to see them on the doorstep.[66]

On **30 June 2009** Mr. A lost his managers' appeal and was required to remain in hospital. There would be another sitting in two weeks and a Mental Health Act Tribunal on 28 July. There were concerns about housing for Mr. A and a danger of his being of no fixed abode. There was concern that the use of the Redruth garage could rule out any social housing option for Mr. A. Mr. A returned to Hospital a day early from his leave on **05 July 2009.** His wife reported later (07 July) that he had been the best she had seen him for some time during this leave.[67]

Care Coordinator 1 had been looking into the possibility of Mr. A being housed in Kernow Court (Council accommodation for homeless people). At the Ward Round Meeting on **14 July 2009** there was discussion about the potential for using a Supervised Community Treatment Order to facilitate discharge for Mr. A. The conditions would be for him to:

66 Clinical File 2 Page 306
67 Clinical File 2 Pages 307 and 309-313

- accept medication;
- engage with Community Psychiatric Nurses;
- allow and attend reviews.

There was no Approved Mental Health Professional available to discuss a Supervised Community Treatment Order with, so consideration was given to allowing Mr. A to have Section 17 Leave until a Supervised Community Treatment Order could be arranged.[68] The following day the result from Mr. A's sigmoidoscopy test was normal. The Assertive Outreach Service West reported that they would accept a referral for Mr. A but there were no available places at the current time.[69]

On **17 July 2009** Approved Mental Health Professional (AMHP) 1 visited Fletcher Ward to assess Mr. A for a Supervised Community Treatment Order (SCT). He was adamant that he would not comply with the three conditions. He did not accept that his medication had helped him to rationalise his thinking. Doctor 1 agreed that Mr. A's consent was not required, but if he was unwilling to cooperate then he would be recalled to hospital in a short time period. AMHP1 and Doctor 1 saw Mr. A together but Mr. A was still adamant that he would not comply and therefore AMHP 1 would not agree to the SCT Order as there was no evidence it would enable Doctor 1 and the CMHT to maintain his mental health in the community.[70] Later that day the Mental Health Act Managers Review discharged Mr. A from his Mental Health Section.[71]

Mr. A was granted leave over the weekend following his discharge from detention under the 1983 Mental Health Act amended in 2007. He returned from leave on 21 July 2009 and attended the Ward Round Meeting where it was agreed that:

- Mr. A would be discharged from the ward that day;
- 48-hour contact from Kerrier Team (Redruth) would be available;
- Assertive Outreach Team would assess Mr. A within 14 days;
- Mr. A would be kept on the case load as there was a clear risk of relapse.[72]

68 Clinical File 2 Pages 318-319 and Page 320
69 Clinical File 2 Page 320
70 Clinical File 2 Pages 321-322
71 Clinical File 2 Page 323
72 Clinical File 2 Pages 325-326

It was also noted that Mr. A was due to attend for his depot injection on Friday and he would be telephoned as a reminder. On **23 July 2009** Social Worker 1 went to visit Mr. A who reported that he had no medication and would not take any. He made it clear that he was happy to be contacted by telephone.[73] This visit was the required 48 hours after discharge visit.

Mr. A let the Community Mental Health Team know that he no longer wanted any contact with mental health services on **27 July 2009.** In response he was sent a letter discharging him from the service.[74] The third Care Coordinator (CPN 4) withdrew from **21 July 2009.**

Two days later the West Cornwall Assertive Outreach Service sent a letter to the Restormel CMHT stating that it could not accept the referral of Mr. A as although his address was in Redruth his GP was in Newquay and the Community Psychiatric Nurse cover was from the Restormel area.[75]

On **19 August 2009** Mrs. A telephoned CPN 3 saying that her husband had been distressed for a week. CPN 3 telephoned him but he said that his issues were regarding his physical health and he was advised to contact his GP.[76] Another Care Coordinator worked with Mr. A from **20 August 2009.**

The next day Mrs. A telephoned Social Worker 1 about her husband being in a dreadful state. Social Worker 1 then telephoned Mr. A who said he did not want a "*f****** injection*". Mr. A agreed to drive to Bodmin for an assessment. The end result was that he was admitted to Fletcher Ward informally. He had:

- been neglecting food and fluid intake and had been drinking alcohol;
- started having thoughts of harming others/those who, he believed had ruined his life;
- been worrying about his physical health;
- wanting something to calm him down.[77]

At the Ward Round Meeting with Doctor 3 on **21 August 2009**, Mr. A said that his mother was one person he would harm and the other was a male friend. The risk was deemed low as

73 Clinical File 2 Page 327
74 Clinical File 2 Page 326 and 395
75 ERT Page 271
76 Clinical File 2 Page 329
77 Clinical File 2 Page 268-269

they were 250 miles away; however he had driven long distances in the past. He seemed more rational and the diagnosis of a personality disorder was considered. The need to be alert to his mental state changes and the level of risk he presented when ill were emphasised. Mrs. A had agreed with her husband that he could stay with her provided he complied with the treatment plan suggested by the Mental Health Services. She was informed that she could return him to the Ward at any time. Leave was granted for two days.[78]

Mrs. A telephoned the Ward to say that Mr. A had left her house and had gone to Redruth. He had said to her that he would not hurt his mother. Mrs. A said she had never felt that he would hurt her. The Ward staff asked the Police to undertake a welfare check. They reported that he was safe and that they had told him the Home Treatment Team would visit him in the morning. Doctor 3 did not want Mr. A returned to the Ward unless he came of his own volition.[79]

At the Ward Round Meeting on **25 August 2009** it was decided that Mr. A would be discharged. The following day Social Worker 1 had a telephone call from Mr. A's mother. He had been with her on Monday evening and was "*thoroughly paranoid*". She was worried that her son was so anxious he might have a heart attack.[80]

The next day CPN 6 telephoned Mr. A's mother who reported he was calmer but having periods of acute anxiety. If a crisis should occur she said she would contact her GP or the Community Mental Health Team.

CPN 3 tried to telephone Mr. A on 28 August 2009 and again on 01 September 2009 but received no answer and heard a message saying that the person was temporarily unavailable.

CPN 6 telephoned Mr. A who said he felt well. When he was asked if he could attend a meeting with a Community Psychiatric Nurse at Newquay Hospital he had asked if it could be the following week. On 09 September 2009 Mr. A agreed to attend a meeting on 18 September 2009.[81]

78 ERT Page 282
79 ERT page 288
80 Clinical File 2 Pages 330-331
81 Clinical File 2 Page 332

CPN 3 wrote to GP 3 in Newquay saying that the CMHT contact with Mr. A had been compromised by Mr. A having a Newquay GP when he lives in Redruth. GP 3 had been treating Mr. A cream as he was worried about having a rectal tumour. He was due to see Mr. A that day and would tell him that he would now have to register with a GP in Redruth. GP 3 also said Mr. A had been requesting Zopiclone and Lorazepam regularly as he had misplaced them in his home.[82]

Mr. A visited Newquay CMHT and saw CPN 4 on **22 September 2009**. Mrs. A said that her husband had returned to his delusional state. He had visited the Newquay GP but was told he had been removed from their list. CPN 4 confirmed this with the GP. She also contacted the Out of Hours Team to alert them that they might hear from Mr. A as he was delusional again. [It appears that he did not attend his agreed appointment on **18 September**].[83]

Mr. A telephoned CPN 3 on **23 September 2009** and appeared to be much calmer. He said he had taken six Zopiclone tablets as he needed this amount to get some sleep. Mr. A was advised to only use the prescribed amount by CPN 3 who contacted the poisons unit and was advised that no treatment was needed for the overdose. He had seen GP 4 from the Poole Surgery, and CPN 3 contacted him and he had been happy to see Mr. A again.[84]

An appointment was arranged for **25 September 2009** and it was agreed that Mr. A would be reminded on **24 September.** When CPN 3 telephoned Mr. A on **24 September 2009** he had had car problems and had not been sure he would be able to keep the appointment. GP 4 was concerned about the medication of Olanzapine 2.5mg and Zopiclone 7.5mg and he had given Mr. A three Zopiclone pills.[85]

On **28 September 2009** at a CMHT Team Meeting discussion Doctor 1 advised GP 4 to prescribe Olanzapine 5mg after one week and then increase to 10 mg if he tolerated this dosage, plus one 7.5mg Zopiclone at night. Mrs. A had telephoned the CMHT saying that her husband had been sending her worrying texts. She was concerned he might take revenge on

82 Clinical File 2 Page 333
83 Clinical File 2 Page 335
84 Clinical File 2 Page 336
85 Clinical File 2 Page 336-337

some of his past friends who he blamed for his illnesses. Care Coordinator 1 agreed this was possible but that he had been better during that week as he had managed to sleep.[86]

On **29 September** the Community Mental Health Team felt that Mr. A needed to be seen for his situation to be assessed. Care Coordinator 1 and CPN 3 went to his home. He was in bed looking unkempt and unhappy but talked and stayed calm. He was still not prepared to have too much intervention but did agree to a telephone call on 02 October and for the two staff to see him the following week. The Kerrier CMHT had asked about a referral of Mr. A to them from Newquay. They agreed to the referral as Mr. A was registered with a Redruth GP.[87]

On **05 October 2009** the Housing Department invited Mr. A to visit Kernow Court to see if it was the sort of accommodation he was seeking. He was also offered an appointment for Psychology for **08 October 2009**. The next day CPN 3 spoke on the telephone to Mr. A who explained that he wanted no regular contact with Mental Health Services but he would attend the Psychology Appointment.[88]

Mr. A attended the Psychology Session and discussed how he came to believe that he had HIV. He refused to accept the offer of Cognitive Behavioural Therapy and left the meeting after an hour and said he did not want any more appointments. Mr. A rang Psychologist 1 the next day and said he could not attend weekly and when fortnightly was suggested he said that this was too long to wait. He was offered an appointment for **22 October 2009** and asked to let CPN 3 know if he could attend.[89]

On **12 October 2009** the Restormel CMHT was trying to hand over Mr. A to the Kerrier CMHT and the latter wanted to have a professionals meeting. The comment was made that if they then refuse to accept the referral it would have to be agreed between the two consultants.[90]

On **20 October 2009** CC1 and CPN 3 had a meeting with the Kerrier CMHT and agreed that they would visit Mr. A and see if he was prepared to engage with the Kerrier CMHT. When

86 Clinical File 2 Pages 338-341
87 Clinical File 2 Pages 341-343
88 Clinical File 2 Pages 343-345
89 Clinical File 2 Pages 345-347
90 ERT Page 314

staff from the Restormel CMHT visited Mr. A, he would only open the window and quickly began to shout at them. When they withdrew he followed them to their car and was yelling and so they left. He was threatening and intimidating so they telephoned the office where Approved Mental Health Practitioner (AMHP) 2 took the call and contacted the Police.

The same day Mr. A contacted the Restormel CMHT office by telephone and apologised for his outburst. It was agreed that he should be assessed the following day. Mr. A had calmed down and after talking to Mrs. A AMHP 2 decided that a Mental Health Act Assessment was not needed. The plan was to transfer care to the West Cornwall Assertive Outreach Service.[91]

On **27 October 2009** Mrs. A telephoned CPN 3 and said that Mr. A was screaming and shouting down the telephone to her that he needed help. He had stomach pain and was bleeding from his back passage.[92] The same day CPN 3 telephoned Kerrier CMHT and arranged a joint meeting for a Care Coordinator transfer on 05 November 2009.

Following the meeting on **05 November 2009 a** joint visit with Care Coordinator 1 and two staff from the Kerrier CMHT was made to Mr. A to bring him up to date on his care. Mr. A spoke to them through a window. When they explained that they wished to transfer his care from Newquay to Kerrier, Mr. A said he did not want a transfer but wished to be discharged from the service.[93]

On **26 November 2009** CPN 3 telephoned Mrs. A as she had contacted the duty CPN the day before reporting that her husband was distressed and expressing delusional beliefs. CPN 3 explained that she was visiting Mr. A that afternoon with the Assertive Outreach Team to transfer the care to Kerrier CMHT. Later there was another telephone call from Mrs. A saying Mr. A was in Bristol having paid for another HIV test. He was hitching back from Bristol. CPN 3 spoke to the Assertive Outreach Team and was advised to send them a referral and they would let her know the outcome. GP 4 was informed of the referral to the Assertive Outreach Service.[94]

91 Clinical File 2 Pages 348-349
92 Clinical File 2 Page 352
93 Clinical File 2 Page 352
94 Clinical File 2 Page 354

The next day Mrs. A telephoned the CMHT to report that Mr. A was back in Redruth. He had had two negative tests for HIV but was refusing to believe them. He was still "*ranting*" about conspiracies against him. Mr. A was accepted by the West Assertive Outreach Service but the handover to the North Kerrier CMHT was not possible as he would not engage and was requesting to be discharged from the Mental Health Services.[95]

On **30 November 2009** CPN 3 telephoned the Assertive Outreach Service Manager asking what was happening as she was still Mr. A's Care Coordinator. She was informed that Mr. A would be discussed at their Wednesday Team Meeting and a new care Coordinator would be allocated.[96]

On **02 December 2009** AMHP 2 spoke to Mrs. A as she was requesting an urgent Mental Health Act Assessment as Mr. A had smashed up the garage during the past week. He had been home with his wife since this had occurred. His son was off school with an infection and was being badly affected by his father's HIV claims. Mr. A telephoned his wife from Truro Station begging her to have him back but she refused. The Police were asked to consider detention under Section 136 of the 1983 Mental Health Act amended 2007 and went to Truro Station. The train had left and he was not at Redruth so he was logged as a missing person.[97]

The Assertive Outreach Service Manager spoke to Mrs. A eventually although her mobile telephone rang six times from her husband during the call. It was arranged that AMHP 2 would deal with the Mental Health Act Assessment and the Home Treatment Team would be on standby over the weekend.

CPN 3 discovered that the Assertive Outreach Service had not accepted Mr. A as he remained the responsibility of the Community Mental Health Team. Doctor 2 refused to accept Mr. A as a patient while a Mental Health Act Assessment was still pending. The Police visited Mr. A at his Redruth address where he appeared to be well. He was constantly telephoning his wife and the potential for a domestic violence risk was rated as high.[98]

95 Clinical File 2 Page 355
96 Clinical File 2 Page 355
97 Clinical File 2 Page 359-360
98 Clinical File 2 Page 364

Mr. A Investigation Report

On **07 December 2009** the Police were requested to be at Mr. A's Redruth address as the Community Mental Health Team were preparing to undertake a Mental Health Act Assessment. This was cancelled when it was discovered that he was back with his wife in Newquay. On **09 December 2009** AMHP 2 saw Mr. A in the office. Mr. A explained that he had been afraid of seeing AMHP 2 as he thought he would be placed back in Bodmin Hospital.[99]

AMHP 2 agreed with Restormel CMHT that he would be Care Coordinator. He dealt with Mr. A's finances and contacted the Citizens' Advice Bureau and Capital One to see if lower payments could be arranged for Mr. A. Mr. A's sister had told the Police that he had slept with a hammer or a knife under his bed in case people came to kill him.[100] AMHP 2 became Mr. A's fifth Care Coordinator.

On **16 December 2009** the Assertive Outreach Service Manager clarified that his team was not involved and that Care Coordination was the responsibility of the Restormel Community Mental Health Team as Mr. A was back living with his wife in Newquay.[101] When AMHP 2 saw Mr. A he did not consider him to be detainable under the 1983 Mental Health Act amended 2007.[102]

AMHP 2 telephoned Mrs. A on **21 December 2009** to update her about how he was trying to help her husband with his finances and to find accommodation. The Police information gathered from an interview with Mr. A's mother-in-law stated that Mrs. A had told Mr. A that the marriage was over and that she had a new man. Mrs. A saw him at weekends and since her husband had known this Mr. A constantly telephoned his wife and would not stop.[103] This information was not made available to the Mental Health Services.

On **29 December 2009** Mr. A was removed from his wife's home by the Police. Mrs. A had telephoned AMHP 2 with this information. Two days later on New Year's Eve Mr. A had claimed in a telephone call to AMHP 2 that the Christmas period had gone well. AMHP 2 agreed to meet with Mr. A on at 08.30 on **13 January 2010** at Newquay Hospital.

99 Clinical File 2 Page 362
100 Clinical File 2 Page 362
101 Clinical File 2 Page 364
102 Clinical File 2 Page 364
103 Clinical File 2 Page 365 and ERT Page 347

Mr. A Investigation Report

When AMHP 2 telephoned Mr. A on **05 January 2010** he was abrupt but reported that things were going well. Mr. A asked about accommodation and mentioned that his stomach was bloated again and he was unable to return to work. Mr. A agreed to contact the Council about his need for accommodation by 31 January 2010.[104]

On **12 January 2010** AMHP 2 had a message from Mrs. A saying that her husband was becoming a problem again. Mr. A had been saying that AMHP 2 had told him that his wife and son were terrified of him. Mr. A was going to go away for a few days and would miss his appointment with AMHP 2 the next day.[105]

On **14 January 2010** AMHP 2 received a telephone message from Mrs. A saying that she had had many frantic telephone calls from Mr. A who was very tearful. She felt someone should know.[106]

Account of the Incident

On **18 January 2010** there was a report of a fire at Mrs. A's address. A niece had been staying and had reported to the Emergency Services that she had heard a loud bang at 06.00 which had woken her up. She then saw Mr. A leaving the house covered in blood and then the fire had started. When the Emergency Services arrived at the house they found Mrs. A dead. Her son was taken to hospital where he died of his injuries.[107]

The Police found Mr. A walking down a road and he was clearly badly burned. He was taken to hospital and transferred to a specialist Burns Unit where he died of his injuries on **26 January 2010**. Mr. A had been too ill to speak to the Police while he was in hospital.

[104] Clinical File 2 Page 366
[105] Clinical File 2 page 367
[106] Clinical File 2 Page 367
[107] ERT Page 356

11. Identification of the Thematic Issues

11.1. Thematic Issues

The Independent Investigation Panel identified 10 thematic issues that arose directly from analysing the care and treatment that Mr. A received from the Cornwall Partnership NHS Foundation Trust Mental Health Service. These thematic issues are set out below.

1. **Diagnosis.**

   Mr. A developed a persistent psychotic illness from approximately the age of 40 onwards. It seems that the most likely diagnosis is that Mr. A suffered from a depressive illness possibly related to failure at work. The depressive symptoms seem closely associated with ideas of reference (the belief that things in the environment and events refer to the individual, for example issues being discussed on the television or radio are pertinent and directly aimed at the person). He later had paranoid delusions concerning people he knew who, Mr. A claimed, wished him harm. He also had strongly held delusional beliefs that he had contracted HIV and cancer.

   First Internal Investigation

   The first Internal Investigation did not comment much on the diagnosis made by the staff working with Mr. A. It generally concurred with the clinical opinion that Mr. A had a psychosis, probably schizophrenia, with depression.

   Second Internal Investigation

   The second Internal Investigation considered that the care and treatment provided to Mr. A by the Restormel Community Mental Health Team (CMHT) and the Home Treatment Team (HTT) was appropriate and suitable for his assessed need for medication and support, whilst recognising that Mr. A did not engage with the services and was non compliant with his Care Plan and the taking of medication.

   The diagnosis of Psychotic Depression and Psychotic Illness/Depression with Psychosis were considered accurate, and that the medication prescribed was appropriate and the effect it was having was monitored by the CMHT and the HTT. Depot injections were attempted but Mr. A would usually refuse to have them. During

the four months he was on the Supervised Community Treatment Order the fortnightly Depot injections were accepted, albeit unwillingly. The second Internal Investigation report concluded that the *"treatment of [Mr. A's] mental health was appropriate although not easily delivered… It was shared care between GP and Secondary Mental Health Services".*

Independent Investigation Panel

The Independent Investigation Panel concluded that the diagnosis given to Mr. A was correct and that the medication prescribed was appropriate. The gathering of information about Mr. A and his life up until his time in Cornwall from Mr. A and his relatives could have been more rigorous. Such questioning could have provided additional information leading to a better understanding of his condition.

It was known that Mr. A was drinking alcohol and took 'magic mushrooms' and cannabis but no full consideration of his having a Dual Diagnosis was formally considered. His presentation of being admitted to hospital in crisis and then becoming calm in a relatively short time further suggested the possibility that his psychosis was due to the illicit substances. The agreed consensus diagnosis was that Mr. A had a psychosis, probably schizophrenia, and also depression. There was evidence that his mental ill health was exacerbated by alcohol and illicit drugs.

Doctor 1 did not discuss Mr. A and his needs in any multidisciplinary forum other than the Ward Round which appeared to have a limited membership from the records of those attending. He did discuss Mr. A with his 'cross-over' consultant, but there appeared not to be a forum where difficult and complex 'cases' could be discussed with other clinicians across the Trust in order to gain fresh suggestions for treatment.

2. Medication and Treatment.

First Internal Investigation

The first Internal Investigation considered that the medication and treatment of Mr. A was appropriate. The main approach was pharmacotherapy with the use of Depot antipsychotic injections for his paranoid delusions. Mr. A was prescribed antidepressants by his GP initially and it was later also prescribed by the Mental Health Service.

Mr. A made it quite clear that he did not wish to accept medication as he remained steadfast in his belief that he did not have a mental illness and that his problems were due to serious physical conditions.

The Second Internal Investigation

The second Internal Investigation considered that the Discharge Guidance HSG (94)27 was applied in Mr. A's care. The Supervised Community Treatment Order allowed under the Mental Health Act 2007 was applied correctly and worked well for a four month period. The Report stated that *"the care provided to [Mr. A] was delivered appropriately using the Care Programme Approach framework. [Mr. A] was assessed, treatment was planned, the Care Plan was written, care was attempted to be delivered within the restrictions of [Mr. A's] resistance to services…There were barriers to the delivery of aftercare and follow up by services due to [Mr. A's] lack of insight and continued refusal to work with Mental Health Services and the issue of geographical distance and service boundaries".*

Independent Investigation Panel

The Independent Investigation Panel noted that Mr. A was not offered psychological therapies during his first admission to Fletcher Ward at Bodmin Hospital which started on 28 October 2008. Following his discharge to the community there was no psychological therapy input. His Care Coordinator in April 2009 tried to help Mr. A manage his anxiety by using a Cognitive Behavioural Approach which helped slightly for a short period, but as it was not delivered face to face but *via* telephone it stalled, but had been attempted. Mr. A had one session with a Clinical Psychologist but left half way through, although during the hour he had expressed some views and history which he had not mentioned previously.

Whilst on Fletcher Ward Mr. A did attend some art groups but generally did not engage and played scant lip service to the Tidal Model of Nursing Care, refusing to answer the questions and to discuss his situation with the nursing staff.

One can only conjecture whether the provision of a psychological therapeutic approach on his first admission to Fletcher Ward would have made a difference, but it

should have been tried in line with advice from the National Institute for Health and Clinical Excellence.

3. Use of the Mental Health Act 2007

First Internal Investigation

The first Internal Investigation considered that the discharge of Mr. A by the Mental Health Managers Tribunal to have been unwise as it confirmed to Mr. A that he did not have to stay in hospital because he was not suffering from a mental illness. It questioned whether the Managers may have overstepped their authority.

The First Internal Investigation Report recommended that *"The Cornwall Partnership NHS Foundation Trust should review the robustness of the current Mental Health Act Managers' Review process, and the level of organisational support provided to it:*

- *Training for the role of Mental Health Act Manager should continue to include legal aspects of the MHA, but be augmented by training to raise awareness of complex clinical presentations;*
- *Advice on clinical issues from an appropriately qualified and experienced clinician who is independent of the MHA Review process".*

Second Internal Investigation

The second Internal Investigation did not concur with this finding and considered that the use of the Mental Health Act had been appropriate, and that the Mental Health Act Managers were within their rights to discharge Mr. A. It took a more sanguine view of the discharge by the Hospital Managers and did not conclude that it was significant when viewed in the totality of the case.

The Independent Investigation Panel

The Independent Investigation Panel does not support the finding of the first Internal Investigation but agrees with the second Internal Investigation as although Mr. A initially may have viewed the decision as a triumph for his point of view, the course of events following this discharge does not support the view that this was a significant turning point in the management of Mr. A and his mental ill health.

As requested in the Terms of Reference of the Independent Investigation the Panel examined the specific use of the Mental Health Act 2007 on 28 September 2009, 21 October 2009, and 02 December 2009. The Independent Investigation Panel concluded that the Mental Health Act was used appropriately on all three occasions given the information available in the clinical records and the description of how Mr. A presented at the time of the assessment. The use of the Supervised Community Treatment Order was also considered appropriate throughout the period it was used from 30 December 2008 to 27 May 2009 when it was revoked. Throughout this period Mr. A was more compliant than at any other time he had been with the Cornwall Partnership NHS Foundation Trust Mental Health Service.

4. The Care Programme Approach

First Internal Investigation

The first Internal Investigation did not specifically examine the working of the Care Programme Approach other than commenting that Mr. A's care and treatment was appropriate for his assessed needs and that the services had worked hard to remain in contact with him despite his reluctance to work with Mental Health Staff.

The Cornwall Partnership NHS Foundation Trust Care Programme Approach Policy includes a section on Children's Issues which clearly describes the importance of Safeguarding Children and states "*All clinical and support staff must place the needs of any dependent children above those of the service user and their carer"*. The Policy then explains the importance of reporting any concerns to *"a specialist children and family team"*.

The First Internal Investigation did highlight an apparent lack of knowledge about the need to contact the Local Authority when there were concerns about the Safeguarding of a child, and where the effect of a parent's mental ill health could be having an adverse effect upon the child's welfare. Their recommendation was that:
"The SCIE report 'Think child, think parent, think family; a guide to parental mental ill health and child welfare' (July 2009) should:

- *be incorporated into all Safeguarding Children mandatory training in order to increase awareness of the issues it raises for service delivery;*

- *CPFT Safeguarding Children Group develops an action plan for implementation of the recommendations of the SCIE Report".*

The Second Internal Investigation

The second Internal Investigation also concluded that the training of Mental Health Staff regarding the Safeguarding of Children required urgent attention and made some comprehensive recommendations linking the Safeguarding Issues with Domestic Violence and the related Multi Agency Risk Assessment Conference (MARAC). It also recommended the National Patient Safety Agency (NPSA) Rapid Report *Preventing Harm to Children from Parents with Mental Health Needs* published in May 2009. It also highlighted the need to include the date of birth of all children present in the family of a mental health service user, and to be aware of any adverse effect the service user may pose to a child.

The Independent Investigation Panel

The Independent Investigation Panel agreed with the action proposed by the second Internal Investigation Report and endorses their recommendations. An initial issue was the number of Care Coordinators Mr. A had during his two years with the Cornwall Mental Health Service. From 18 January 2008 to 18 January 2010 Mr. A had five Care Coordinators, which considering his difficulties in engaging with services, appeared unhelpful in allowing good relationships to develop. This said, the Panel did accept that the services did follow him up and did not discharge him, and remained in touch when he was not formally a client, having said he wanted no more contact.

5. Risk Assessment and Management

First Internal Investigation

The first Internal Investigation concluded that there was a need for greater knowledge and training about Clinical Risk Assessment and Risk Management as the number of staff attending organised training sessions for clinicians was low. It therefore recommended that:

"Clinical Risk Assessment Training is:

- *prioritised for clinical staff throughout the Trust;*

- *considered for being incorporated into the Mandatory Training process".*

Second Internal Investigation

The second Internal Investigation highlighted the deficiencies in the recording of risk on the Trust's Risk Assessment and Risk Management forms. Each separate completed form for different risk assessments looked like the others and old out of date information was not removed. Any new material added was difficult to locate which hindered the easy recognition of the current level of risk. The recommendation from the first Internal Investigation was endorsed. It also recommended that the local Protocol for Sharing Information between Agencies should be used as in the situation with Mr. A and the Police held relevant additional information. This concerned additional violent criminal activity in the past and also information from Mr. A's mother that his wife had formed a new relationship and had informed her husband.

Independent Investigation Panel

The Independent Investigation Panel endorses the findings and recommendations of both the Internal Investigations and also added that the recording of risk assessment and risk management plans was difficult to fully understand. This was because from the review of the clinical records, both written and electronic, it is evident that there was a lack of detail recorded of descriptions of issues and concerns raised by Mrs. A and other family members. On a number of occasions this lack of detail may have impeded appropriate assessment of risk. For example, the documentation of the harassing and threatening text messages Mr. A sent to his wife was poor, with no examples recorded to identify the actual content and scale of the harassment and the likely fear and concern this would cause the recipient.

6. Referral, Admission and Handover Processes.

First Internal Investigation

The first Internal Investigation considered that the difficulty of Mr. A having a GP in Newquay whilst living in Redruth caused difficulties in the Restormel Community Mental Health Team being able to offer him as full a service given the 37 mile round trip journey this entailed for home visits. As a result Mr. A was not seen as frequently as he might otherwise have been. It recommended that:

"Cornwall Partnership NHS Foundation Trust, in collaboration with Primary Care Services, to develop and implement a protocol governing the management of service users whose care and treatment regularly moves between geographical areas and teams".

Second Internal Investigation

The second Internal Investigation took a more positive approach to the method to be used to ensure that service users get the service they need as close to their home as possible. The recommendation was that the services should review their operational policies to ensure that all the teams were complementary and the care pathway within and between the services was clear and unobstructed. For situations where a service user was refused a local service due to the address of his GP it was recommended that Trust Policies should within three months:

- develop policy to manage professional differences;
- develop a policy for escalation of operational difficulties from team manager up through the organisation in order that risks are identified and shared appropriately;
- develop a policy to trigger staff response to concerns raised by others regarding service users.

Staff will be prompted to:

- review a service user's care;
- hold a multi-agency risk management meeting;
- review any contact with children and identify risk.

(Where concern relates to a child there must be a parallel process and need for staff to follow Child Protection procedures. The named nurse should be invited to risk meetings).

- request information from other agencies;
- action plan to respond to care needs/risks.

Independent Investigation Panel

The Independent Investigation Panel endorses the recommendations of the second Internal Investigation. The difficulties the Restormel Community Mental Health Team experienced in trying to transfer Mr. A to a Redruth based service was extraordinary given that the Teams are within the same overall service. The creation of a Senior

Operational Service Manager to whom decisions which could not be resolved can be escalated will ensure that the best interests of the service user are fully considered in future.

The Panel did not endorse the recommendation of the second Internal Investigation suggesting all the Cornwall Mental Health Teams should cover the whole of Cornwall as this was deemed to be impracticable given the size and rural nature of much of Cornwall.

7. Service User Involvement in Care Planning and Treatment.

First Internal Investigation Panel

The first Internal Investigation did not really cover this area as it considered that Mr. A and his family received a good service from the Cornwall Partnership NHS Foundation Trust.

Second Internal Investigation

The second Internal Investigation considered that whilst Mr. A appeared to receive an adequate service, when the clinical records were examined in more detail the service offered was thought to have been less proactive and dynamic than it could have been. One example cited was that Mr. A was not engaging with the Mental Health Services and yet he was expected to attend office-based appointments, which made it likely that he would not attend. The relative lack of home visits lessened the overall knowledge staff had about Mr. A, as they did not see him in his own environment.

Staff relied on what Mr. A told them and he may not have been the most direct and honest reporter of his situation. He told staff that his Christmas leave (2009) had gone well, but information from his wife showed this to have been anything but the case as he had been asked to leave her home. Often staff can discover so much about a service user when they see them in the context of their own home environment, and can observe whether they are coping and looking after themselves from the state of the home.

Independent Investigation Panel

The Independent Investigation Panel considered like the second Internal Investigation that the Mental Health Services could have been more proactive, and consider that he should

have been helped by the West Cornwall (Kerrier) Assertive Outreach Team which was set up to work with people who found it difficult to engage with services. As Mr. A did not believe he had a mental illness he was unlikely to cooperate with his Care Plan, especially as he had to visit Newquay for his regular Depot injections and for outpatient appointments.

8. Carer Involvement and Carer Assessment

First Internal Investigation

The first Internal Investigation did not consider this area as it had concluded that Mr. A and his family received a good service from the Inpatient and Community Mental Health Services.

Second Internal Investigation

The second Internal Investigation was unable to tell from the clinical records, both written and electronic, whether Mrs. A had ever been offered a Carer's Assessment. It listed that *"there were 66 telephone calls from Mrs. A, Mr. A's mother and his sister"*.

The **Independent Investigation Panel** concluded the same findings as the second Internal Investigation Panel and identified that the Mental Health Staff were not as helpful and proactive as they could have been. On occasions they advised Mrs. A to contact the Police when they could have done more to explain the situation and provide advice.

There were no occasions when Mental Health Staff telephoned Mrs. A to see if she was well and coping with the stress her husband could cause when he was agitated and unwell. Mrs. A certainly should have been offered a Carer's Assessment as she was caring for her son, holding down a job in the Medical Records Department of Treliske Hospital and also frequently helping her husband. Her individual needs should have been assessed.

Other family members were pleased with the contact they had from the Cornwall Partnership NHS Foundation Trust but were unable to speak directly to the care coordinators and other staff directly in contact with Mr. A.

9. Documentation and Professional Communication.

First Internal Investigation

The first Internal Investigation considered that the communication between the Mental Health Services and Primary Care was of a good standard and the second Investigation also acknowledged this. This Investigation is also in agreement.

As discussed below, the quality of the Risk Assessment and Risk Management documentation was variable with confusion about which forms related to which date. The issue was that all the risk information was on all the Risk Assessments with little obvious difference between them. Old information was not removed and new information was not clearly identified but placed somewhere in the long list of high risk behaviour.

Second Internal Investigation

The second Internal Investigation confirmed the issues raised by the previous one, but also identified the lack of detail in what was recorded when family members telephoned and provided information about Mr. A. This was particularly apparent when Mrs. A telephoned to inform staff that her husband was harassing her and sending her many bizarre emails and text messages. Staff did not ask for details of the content which would have provided them with a greater understanding of the danger this indicated Mr. A might pose to the recipients. The same was apparent when on 23 October 2008 when Mrs. A telephoned the Home Treatment Team Out of Hours service to report that she felt she and her son were in danger as her husband was including her in his conspiracy theory that people were out to kill him. There was no documented evidence as to why Mrs. A felt threatened, which was a missed opportunity for staff to understand her concern and the danger she thought Mr. A actually posed to both her and her son.

Independent Investigation Panel

The Independent Investigation Panel concurred with the view of the second Internal Investigation.

Interagency Liaison

All three Investigations identified, to different levels, the paucity of the interagency liaison and interaction between the Cornwall Partnership NHS Foundation Trust, the Police and the Local Authority Safeguarding Services and the Children's Social Care Services.

Throughout the time that Mr. A was receiving services from the Restormel Community Mental Health Team and the Home Treatment Team there was no liaison with the Police despite the availability of a Local Protocol for such sharing of information. Similarly, apart from one telephone call to the Safeguarding Services to alert them to the fact that Mr. A was mentally unwell and that his behaviour at home could be adversely affecting his 10-year old son, no other contact was made. There were other opportunities to discuss Mr. A's mental health with the Police, the son's school or to report other information to the Children's Social Care Services.

The Police had additional information about Mr. A's previous criminal record including two cases of violence which the Mental Health Staff did not know about and which would have altered the seriousness of his level of risk. The Serious Case Review commissioned by the Cornwall and the Isles of Scilly Local Safeguarding Children Board commented that:

"When Mental Health Staff and the Police were dealing with the behaviour of the father, arising from his mental illness, they paid insufficient attention to the potential effect on the subject [Mr. A's son]. They did not always communicate effectively with Children's Services. Agencies focused too much on the father's behaviour and needs and not enough on the family as a whole and the subject [Mr. A's son] in particular".

10. Adherence to Local and National Policy and Procedure and Clinical Governance Arrangements

Local and National Policy and Procedure

First Internal Investigation

The first Internal Investigation identified that clinical staff had not attended the training on Risk Assessment and Risk Management and that as a consequence these areas of the clinical records were not well completed and information on the forms

was often unclear. This was due to having a mix of old outdated information which should have been removed, and also new current information which was not easily noticeable on the requisite forms.

It also recognised that the staff within the Mental Health Services did not appear to understand their role in the Safeguarding Children Policy as they did not liaise with the Local Authority as they should have done in relation to Mr. A's role as a father and the possible effects of his mental ill health on his son, aged 10 in 2010.

The Internal Investigation also identified a service issue which concerned the use of work mobile telephones. It was noted that when staff were on leave, or ill, their mobile telephones were left in the office but no one was responsible for answering them and any messages left would not get seen, possibly for several days. It proposed that in future each Team should have a policy to ensure that such practice was avoided and that there were practical and effective systems in place for work mobile phones to be regularly checked for messages. The recommendation stated:

"CPFT should review the safety and appropriateness of the use of mobile phones as a means of contact with service users. Teams may wish to develop and implement their own processes in order to maximise benefits and minimise risks".

Second Internal Investigation

The second Internal Investigation identified that some policies did not complement those of other teams and that transferring cases was not being dealt with as a 'transfer' from one team to another, but more like a new referral which required another assessment by the new team. A recommendation was made to review all the Policies of community based Mental Health Teams to ensure that they were acting as one system and that care pathways within and between services were coherent and functioning.

Independent Investigation Panel

The Independent Investigation Panel agreed with the findings of the two Internal Investigations.

11. Clinical Governance

First Internal Investigation

The first Internal Investigation did not fully investigate the Clinical Governance arrangements but did identify the issues relating to the Trust Clinicians requiring training in Safeguarding Children responsibilities and in the process of Clinical Risk Assessment and its Management.

Second Internal Investigation

The second Internal Investigation identified that the first Internal Investigation had not been as thorough as it might have been and that there was a need for greater supervision and management oversight of the Serious Untoward Incident Process. The trainers required better preparation and training for the work, and also advice and support whilst conducting the investigation, and some recognition that this work was in addition to their normal workload. It recommended that the Clinical Governance Arrangements were reviewed and that in particular an external Review into the Trust's Clinical Governance arrangements be commissioned.

Independent Investigation Panel

The Independent Investigation Panel was working in the Cornwall Partnership NHS Foundation Trust while the external Governance Review was taking place. It was clear from the interviews held with the Chief Executive and the Medical Director that changes had already been made and that further work was on-going.

12. Further Exploration and Identification of Contributory Factors and Service Issues

RCA Third Stage

This section of the Report will examine all of the evidence collected by the Independent Investigation Panel. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. key causal, contributory and service issue factors.

In the interests of clarity each issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms 'causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

Causal Factor. In the realm of Mental Health Service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term 'causal factor' is used in this report to describe an act or omission that the Independent Investigation Panel could have concluded had a direct causal bearing upon the failure to manage Mr. A effectively and that this as a consequence impacted directly upon death of Mr. A and Mrs. A and their son. No causal factors were found by this Investigation.

Contributory Factor. The term is used in this Report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Panel to conclude that it made a direct contribution to the breakdown of Mr. A's mental health and/or the failure to manage it effectively. Contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party.

Service Issue. The term is used in this Report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this Report whilst having no direct bearing upon the death of Mr. A need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

12.1 Cornwall Partnership NHS Foundation Trust Findings Relating to the Care and Treatment of Mr. A

12.1.1. Diagnosis

12.1.1.1. Context

Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs, symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information from carers, family, GP, interested or involved others, Mental State Examination and observation.

The process of reaching a diagnosis can be assisted by a manual known as ICD 10. The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. In the United Kingdom psychiatry uses the ICD 10 (10^{th} revision - published in 1992) Classification of Mental and Behavioural Disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework to conceptualise and understand their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis is only part of the process of understanding and determining the treatment and management of a service user. It is critical to see the individual in their own context, and not only understand what they want from treatment and recovery but also support them in being central in decisions made about their care including risk management issues.

Severe Depressive Episode with Psychotic Symptoms ICD 10

"An episode of depression in which several symptoms are present and are marked and distressing. These are typically loss of self-esteem and ideas of worthlessness or guilt. Suicidal thoughts and acts are common and a number of "somatic" symptoms are usually present.

There is also the presence of hallucinations, delusions, psychomotor retardation, or stupor so severe that ordinary social activities are impossible; there may be danger to life from suicide, dehydration, or starvation. The hallucinations and delusions may or may not be mood-congruent.

There are single episodes of:

- *major depression with psychotic symptoms;*
- *psychogenic depressive psychosis;*
- *psychotic depression;*
- *reactive depressive psychosis".*

National Institute for Health and Clinical Excellence (NICE) Guidelines for the Treatment of Schizophrenia

NICE first published Schizophrenia Treatment guidelines in 2002. These guidelines were published in full in 2003, and updated in 2009. NICE guidance states that *"Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with*

the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering". [108]

The 2002/3 Guidelines included the following:

1. *"In primary care, all people with suspected or newly diagnosed schizophrenia should be referred urgently to secondary mental health services for assessment and development of a care plan. If there is a presumed diagnosis of schizophrenia then part of the urgent assessment should include an early assessment by a consultant psychiatrist. Where there are acute symptoms of schizophrenia, the GP should consider starting atypical antipsychotic drugs at the earliest opportunity – before the individual is seen by a psychiatrist, if necessary. Wherever possible, this should be following discussion with a psychiatrist and referral should be a matter of urgency".*[109]

2. *"It is recommended that the oral atypical antipsychotic drugs amisulpride, olanzapine, quetiapine, risperidone and zotepine are considered in the choice of first-line treatments for individuals with newly diagnosed schizophrenia".*[110]

3. *"The services most likely to help people who are acutely ill include crisis resolution and home treatment teams, early intervention teams, community mental health teams and acute day hospitals. If these services are unable to meet the needs of a service user, or if the Mental Health Act is used, inpatient treatment may prove necessary for a period of time. Whatever services are available, a broad range of social, group and physical activities are essential elements of the services provided".*[111]

4. *"The assessment of needs for health and social care for people with schizophrenia should, therefore, be comprehensive and address medical, social, psychological, occupational, economic, physical and cultural issues…Psychological treatments [to include]*

    - *Cognitive behavioural therapy (CBT) should be available as a treatment option for people with schizophrenia.*

    - *Family interventions should be available to the families of people with schizophrenia who are living with or who are in close contact with the service user.*

108. NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care Issue 82. (2009) P. 1
109. NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) P. 8
110. NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) P. 8
111. NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) P. 9

- *Counselling and supportive psychotherapy are not recommended as discrete interventions in the routine care of people with schizophrenia where other psychological interventions of proven efficacy are indicated and available. However, service user preferences should be taken into account, especially if other more efficacious psychological treatments are not locally available".*[112]

12.1.1.2. Findings

Mr. A was a 47-year old married man who had moved to Cornwall with his wife and son in 2002. The notes record that he had agreed to become a house husband whilst his wife worked in the Records Department of Treliske Hospital. He did not appear to have had any mental health problems until about seven years previously when he felt that a work colleague was "*stitching him up*".

Mr. A developed a persistent psychotic illness from approximately the age of 40 onwards. It seems that the most likely diagnosis is that Mr. A suffered from a depressive illness possibly related to failure at work. The depressive symptoms seem closely associated with ideas of reference (the belief that things in the environment and events refer to the individual, for example issues being discussed on the television or radio are pertinent and directly aimed at the person). He later had paranoid delusions concerning people he knew who, Mr. A claimed, wished him harm. He also had strongly held delusional beliefs that he had contracted HIV and cancer. These beliefs were also associated with a belief that he did something very wrong as a young man which involved a girl of 19. He has not, according to his records, ever discussed the details of this event. On 21 July 2009 the discharge letter from Fletcher Ward stated that Mr. A had a *"psychotic illness/depression with psychosis".* The Independent Investigation Panel concurs with this diagnosis. It was also apparent in 2009 that Mr. A had been smoking cannabis and had had some magic mushrooms as well as using alcohol which could have had an adverse and disinhibiting effect upon his mental health. This use of alcohol and illicit substances was not added to his diagnosis.

In August 2009 Mr. A had threatened to kill the person who had ruined his life and on admission to hospital he again made the same threat. Mr. A was well known to his psychiatric

112.NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) P. 12-13

team who had, over the previous two years, worked persistently with him both as an inpatient and in the community. He presented as a highly anxious and deluded man who did not have high indicators of risk. He was very difficult to engage completely but also never completely eschewed the team. He remained more distant from his Responsible Clinician whom he knew would ask him to take medication, and if formally detained under the Mental Health Act (2007), require him to accept medication. Yet he would contact the Team when required and even of his own volition when particularly distressed.

As this episode of psychosis continued Mr. A became increasingly distressed and also more dependent on his wife. His behaviour towards her and his son caused her to ask him to leave the family home in Newquay and to live in Redruth, 18 miles (a 37 mile round trip) away in a small building at the back of a property owned and let to tenants by her. As she became more concerned she tended to telephone the Team for help and advice. In the two weeks leading up to the incident in January 2010 there appears to have been a lull in contact from the family.

In the months leading up to the incident Mr. A was recorded to have started drinking heavily, a half bottle of strong alcohol a day for an undefined period. He also was noted to have smoked cannabis and taken magic mushrooms. This was not added to the risk assessment and did not lead to a discussion concerning a possible diagnosis of Dual Diagnosis. Table 1 below shows the various diagnoses made during the two years Mr. A was in contact with the Cornwall Partnership NHS Foundation Trust Mental Health Services.

Table 1: Diagnoses for Mr. A

Date	**Diagnosis**
18/01/2008	No diagnosis made at this first assessment
07/02/2008	Moderate to Severe Depression
12/01/2009	Psychotic Illness
20/03/2009	Psychotic Disorder/? schizophrenia
27/04/2009	Psychotic Disorder/? schizophrenia
21/07/2009	Psychotic Illness/Depression with Psychosis

12.1.1.3. Conclusion

As Table 1 shows there were two main diagnoses which were consistently considered when

Mr. A was formally assessed by Doctor 1 or another psychiatrist. He was considered to have a depressive disorder but also on occasions displayed distinct psychotic symptoms. There were also periods where Mr. A appeared to be paranoid about people around him and to have thought people were talking about him and wanted to harm him. The conspiracy about his being pursued by people wishing to kill him and who had given him HIV, and the people he had known earlier in his life prior to moving to Cornwall who he believed had deliberately sabotaged his painting and decorating business.

Mr. A never believed that he was mentally ill and therefore did not see the need to engage or cooperate with the Community Mental Health Team or the Home Treatment Team. He displayed secretiveness when being interviewed by mental health staff, and was successful in hiding his fears and thoughts. Mr. A also declined to disclose key past life events and allowed the treatment teams to proceed with the most positive therapeutic assumption that he was a distressed, ill, but well meaning man with whom they must continue to attempt to engage.

This appears to have become an over optimistic view of Mr. A which allowed the teams to continue in a relationship with him without confronting the difficulties on both his side and theirs. The two Internal Investigations by the Cornwall Partnership NHS Foundation Trust provide considerable amounts of information, analysis and recommendations. The agreed consensus diagnosis was that Mr. A had a psychosis, probably schizophrenia, and also depression. There was evidence that his mental ill health was exacerbated by alcohol and illicit drugs.

The first Internal Investigation did not comment about the diagnosis and in fact congratulated the Mental Health Services for managing to have as much contact with Mr. A as they did, and that they were assertive in trying to engage with him. The second Internal Investigation considered that the *"treatment and care planned by Dr 1, the clinical team, community and inpatient services was appropriate to assessed needs. The care was implemented by inpatient services as required, and community mental health teams both the Home Treatment Team and the Community Mental Health Team. The GP was the consistent 'lynch pin'"*.

The Independent Investigation Panel concluded that the Diagnosis was correct and that the medication used was appropriate. The gathering of information about Mr. A could have been more rigorous as there was no evidence in the clinical records that his wife or other members

of his family who had contact with the Mental Health Staff were formally asked about Mr. A and his life prior to his first contact with the Community Mental Health Team in January 2008. Such questioning could have helped develop further understanding about Mr. A and therefore have contributed to a fuller diagnosis. Indeed there was no detailed case history taken by either a consultant or a junior doctor within the clinical records. Such a history would have presented the historical facts in a conventional manner assisting in the process of formulating a diagnosis, differential diagnosis, aetiological factors including dynamic and family factors, which leads to clear diagnosis and informs a definite treatment plan.

The picture of Mr. A painted by the various Team Members is very consistent. Despite his resistance to their requests of him for compliance, they remained sympathetic, validating his wish to return to the family home, to be a family man, and recording that he appeared to pose no risk of violence. They described a large and powerful man who could get angry and frustrated but would usually return peaceably to a ward round or meeting that he had walked out of. He was noted to have espoused the biker culture in earlier years. The Team did not know that he had a number of previous convictions. They recorded that he had been convicted of burglary at the age of 16 in the clinical record; but the Police Record showed that he had two further previous convictions for Actual Bodily Harm (ABH) and a warning for road rage. It was unfortunate that the Team never found out that violence was in Mr. A's repertoire of behaviours. This was probably not frequently manifested but was clearly there.

- ***Service Issue 1***

  The practice of not formally interviewing Mr. A and collecting information for a detailed case history reduced the level of knowledge there was about Mr. A. Mr. A was the sole informant and may not have been the most reliable witness. Mental health staff did not formally interview his wife or other family members to corroborate the information they had been given by Mr. A. The Service needs to ensure that full psychiatric histories are taken for all service users.

12.1.2. Medication and Treatment

12.1.2.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers.

Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and / or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders.

In prescribing medication there are a number of factors that the doctor must bear in mind. They include consent to treatment, compliance and monitoring, and side effects.

Consent is defined as '*the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent'* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practice to seek the patient's consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

When a patient is detained under the Mental Health Act under a Treatment Order (Section 3 or 37), medication may be administered without the patient's consent for a period of up to three months. Thereafter the patient must either give valid consent to treatment or must be reviewed by a Second Opinion Appointed Doctor (SOAD). The SOAD Service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration

has been given to the views and rights of the patient. The SOAD is an independent consultant psychiatrist appointed by the Care Quality Commission.

The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly/monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and / or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

All medication prescribed and administered should be monitored for effectiveness and also side effects. The most common side effects described for antipsychotic medications are called 'extra pyramidal' side effects i.e. tremor, slurred speech, akathisia and dystonia. Other side effects include weight gain and Electrocardiography (ECG) changes. Side effects can be managed by either reducing the dose of medication, changing to a different type of antipsychotic medication or by prescribing specific medication to treat the side effects.

12.1.2.2. Findings

The Medication in the Cornwall Partnership NHS Foundation Trust

The clinical team's main thrust of pharmacotherapy was centred on the use of Depot antipsychotics for his paranoid delusions. He was tried on antidepressants by his GP initially and subsequently it was offered by the Mental Health Team. It is unclear whether he completed a full six week trial of antidepressants at full dosage. It is noted in the record that Mr. A was more agreeable to taking depot antipsychotics because he could virtually stop treatment by refusing one single injection whereas with tablets that argument had to take place each day. Mr. A was consistently non-compliant with most of his medication and did not think he was mentally ill.

Table 2: Medication Prescribed to Mr. A

Date	Medication	Dose
18/012008	Quetiapine	25mg nocte
07/02/2008	Cease Quetiapine	75mg OD 15mg nocte

	Start Mirtazapine	
12/01/2009	Clopidogel Ramipril Simvastatin Omeprazole Aspirin enteric coated Nicotine patch Diazepam Risperdal Consta Risperidone (oral	75mg p.o.mane 2.5mg p.o.mane 40mg p.o. nocte 20mg p.o. b.d. 75mg p.o. mane 15mg topical 2mg p.o. tds 25mg im per 14 days 4 mg p.o. nocte (reduce by 1mg per week)
20/03/2009	Clopidogel Ramipril Simvastatin Omeprazole Aspirin enteric coated Risperdal Consta Risperidone (oral)	75mg once daily 2.5mg once daily 40mg at night 20mg b.d. 75mg once daily 37.5mg per 14 days 2 mg once daily
27/04/2009	Risperidol Consta Tablet Lorazepam Tablet Citalopram Tablet Zopiclone	Reduce 25mg im per 14 days 1mg half b.d. 10mg mane Start 7.5mg nocte
21/07/2009	Clopidogel Ramipril Simvastatin Aspirin enteric coated Risperdal Consta	75mg once daily 2.5mg once daily 40mg at night 75mg once daily 37.5mg per 14 days

The medication used by the Mental Health Services was appropriate to treat his presenting mental health symptoms and also his heart condition and high blood pressure plus excess acidity in his stomach. This has to be understood within the context that frequently Mr. A did not take his prescribed medication, apart from the period where he was subject to a Supervised Community Treatment Order.

Other Effective Evidence-Based Treatments

Mr. A was not offered psychological therapies during his first admission to Fletcher Ward at Bodmin Hospital on 28 October 2008 or whilst in the community, until 08 October 2009 when he had one session with a Clinical Psychologist which he left early. His Care Coordinator in April 2009 tried to help Mr. A manage his anxiety by using a Cognitive Behavioural Therapy problem solving approach. The delivery of the therapy was largely

carried out on the telephone and therefore lacked the direct personal element. No other approaches were attempted, except when Mr. A was in Hospital when he attended a few of the activities on the Ward. It was recorded that he did attend Art Therapy whilst on Fletcher Ward but this was not consistent. He refused to participate with the Tidal Model of Nursing Care in May 2009 and only loosely complied on other occasions when he declined to provide much information about himself.

Multidisciplinary Inputs

Clinical records detail sparsely attended ward rounds comprising the Consultant Psychiatrist, and ST3 (Senior House Officer), a medical student and the Ward Nurse for the Ward Round Day. There was therefore limited opportunity for a multidisciplinary discussion. Mr. A's Consultant Psychiatrist claimed he did not have access to Psychology on the ward.

Doctor 1 did not use any Clinical Forum to discuss Mr. A, even though he was a complex case. He did discuss the situation with his 'cross-over' Consultant Psychiatrist, who covered for him when he was unavailable, but not with his peer group. Additional ideas could have been forthcoming but the available forum was not used. Mr. A was discussed in the regular Ward Meetings and his Care Plan was frequently reviewed. The input from other consultant colleagues could have proved helpful. Discussion with the wider multidisciplinary team could also have been useful.

The Staff tended to take what Mr. A told them at face value. They did not try to get behind what he said by challenging some of his assertions as a more forensic approach would have done. He did respond and disclose more occasionally, for example when the Care Coordinator and CPN 3 worked together in September 2009. On relatively rare occasions Mr. A spoke openly on Fletcher Ward and he did answer the questions Doctor 1 posed when he was making an assessment. Although Mr. A attended only one session with Psychologist 1 on 08 October 2009, he did open up about his belief that he had HIV and gave some detailed information about some events in his earlier life.

During the two longer admissions to Fletcher Ward at Bodmin Hospital from 29 October 2008 until 30 December 2008, when he was placed on a Supervised Community Treatment Order, and again from 27 May 2009 to 21 July 2009, Mr. A did not have access to any psychological therapies. This is recommended by The National Institute for Health and

Clinical Excellence (NICE) but there is no evidence that Mr. A would have engaged with this. It would, however, have been another way of seeking to engage him and perhaps providing some techniques for him to better manage his stress.

Mr. A did attend one session with a Psychologist on 08 October 2009 but left before the end of the session saying he did not want any more involvement. Although Mr. A seemed unsure about whether to have another session he did not engage and no further opportunities were offered.[113] Psychologist 1 managed to discuss situations with Mr. A because she was assertive and did not accept everything she was told without making comments or asking follow-up questions. Although Mr. A refused the opportunity to have regular Cognitive Behavioural Therapy sessions he did, from the clinical notes, appear to be unsure in making that decision.

Mr. A also worked quite constructively with AMHP 2 in December 2009 when the emphasis was on practical help with budgeting and accommodation. These examples illustrate that there were opportunities to engage Mr. A to a small extent, although he remained in control of the situation and would discontinue as he saw fit.

12.1.2.3. Conclusion

The Second Internal Investigation commented on the fact that apart from *"the monitoring [of Mr. A's} mental health and administration of depot medication there was no clear direction to the care plan or treatment regime. Mr. A controlled his contact with mental health services"*.

The Independent Investigation Panel concluded that the observations of the Second Internal Investigation were correct and that Mr. A was in control of his treatment which was accepted or rejected on his terms. When Mr. A was in the community the Mental Health Services were hampered in their efforts to provide a treatment plan for him due to the geographical issue of his having a GP in Newquay which served to bar his being accepted by the Redruth Community Mental Health Services. The majority of contacts were in Newquay and therefore Mr. A was often seen without there being any other family members present, and also without the staff being able to review his progress within his home. This meant that it was

113 Clinical Records Volume 2 Pages 345-347

difficult for them to assess how he was managing as they rarely entered his Redruth home to see whether it was clean, looked after and if he had sufficient food.

- ***Service Issue 2***

  The lack of a forum where complex or difficult to diagnose and treat service users could be discussed with a multidisciplinary group of clinicians from across the Trust prevented possible alternative suggestions from other clinicians being considered. Such a group should be developed in order to make the best use of all the relevant knowledge available within the Trust as a whole.

- ***Service Issue 3***

  The National Institute for Health and Clinical Excellence advice for people with schizophrenia to be given a psychological therapeutic approach treatment during their first hospital admission was not followed with Mr. A when he was first admitted to Fletcher Ward on 28 October 2008. This should have been introduced although it is accepted that Mr. A would probably not have engaged with the therapist and would not have continued this treatment in the community. New service users with schizophrenia must be offered psychological therapy during their first admission.

- ***Service Issue 4***

  Mental Health Staff tended to accept what Mr. A told them at face value without asking any follow up questions or probing more deeply and challenging some of his statements. This could have provided more information or a clearer understanding of his overall situation and perhaps have broken through some of his guarded attitude to Mental Health Staff. The Service needs to ensure that where appropriate staff do challenge and question service users when they consider information is being withheld.

12.1.3. Use of the Mental Health Act (1983 and 2007)

12.1.3.1. Context

The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007.

At any one time there are up to 15,000 people detained by the Mental Health Act in England. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.[114]

Use of the Supervised Community Treatment Order

Context

Chapter 25 of the Code of Practice for the Mental Health Act 1983 amended in 2007 states that:

"The purpose of a Supervised Community Treatment Order (SCT) is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm- to the patient or others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery.

Only patients who are detained under Section 3 of the Act, or are unrestricted Part 3 patients, can be considered for SCT. SCT provides a framework for the management of

114 Mental Health Act Commission 12th Biennial Report 2005-2007

patient care in the community and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary".

The Act specifies the following criteria that a patient must meet if the option of Supervised Community Treatment is to be considered:

- *"the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;*
- *it is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment;*
- *subject to the patient being liable to be recalled…..such treatment can be provided without the patient continuing to be detained in a hospital;*
- *it is necessary that the responsible clinician should be able to exercise the power in Section 17E(1) of the Act to recall the patient to hospital; and*
- *appropriate medical treatment is available for the patient".*

A further condition is that the patient must be "*prepared to cooperate with the proposed treatment".* The patient may be recalled if *"the patient needs treatment for mental health in hospital or poses a risk of harm to self or others".*

12.1.3.2. Findings

Mr. A disliked the imposition of the Supervised Community Treatment Order, but during the period from 30 December 2008 until the Order was revoked on 08 June 2009 when he was readmitted to hospital, it had had a positive effect as Mr. A had complied, albeit unwillingly, to a greater extent than hitherto.

The Terms of Reference for this Independent Investigation required the Panel to examine specifically the use of the Mental Health Act 2007. In particular the Panel was asked *"to review the understanding of the Mental Health Act (to include Community Treatment Orders) by doctors and whether the Mental Health Act was appropriately used and considered (to include on 28 September 2009, 21 October 2009, and 02 December 2009) and any training requirements that may arise".*

Use of Mental Health Act 2007 on 28 September 2009

The context for the consideration of using the Mental Health Act on 28 September 2009 was that Mr. A had not attended his meeting with CPN 3 on 25 September 2009 due to his having difficulties with his car. CPN 3 had agreed that if he could not attend she would telephone him on 28 September 2009. In the meantime GP 2 had spoken with CPN 3 about Mr. A's misuse of his medication, and it was agreed that this would be discussed with Doctor 1 at the Team Meeting on 28 September 2009.

At the team meeting on 28 September 2009 Doctor 1 agreed to increase Mr. A's Olanzapine to 5mg and after one week it could be raised further to 10 mg if well tolerated by him. That day CPN 3 received a telephone call from Mrs. A (wife) who reported that Mr. A was very distressed and was sending her worrying text messages saying that he needed help for physical illnesses and that he had cancer. CPN 3 telephoned Mr. A who reiterated his belief that he had physical ill health problems but did admit that he had not been told by a doctor that he had cancer.[115] He agreed with the increase in Olanzapine and also requested some Zopiclone to help him sleep. CPN 3 said she would arrange this with his GP.

Later the same day Mrs. A (wife) visited the Community Mental Health Team to show Care Coordinator 1 text messages on her mobile telephone which she had received from her husband. It was agreed that recent events surrounding Mr. A tended to show that if he had a good night's sleep he "*remained calm, rational and insightful the next day*". Care Coordinator 1 agreed with Mr. A on the telephone that he should only use his medication as prescribed, and that she and CPN 3 would visit him the next day (29 September 2009).

On 29 September 2009 Mr. A telephoned Care Coordinator 1 and refused to have a visit from her that day as he did not want to see anyone. He was distressed and said he would wait to see if he died from his physical illness. As Mr. A was clearly distressed from the evidence of the content of his telephone calls the Team decided that he did need to be seen and Care Coordinator 1 and CPN 3 visited him at 13.30 that day. When they arrived that day Mr. A was in bed and appeared unhappy and unkempt, although he did manage to talk to the staff and remained calm except when he talked about people talking about him having HIV. He

115 Clinical Records Volume 2 Pages 337-339

was more accepting of having these thoughts challenged. When asked about his mental state Mr. A denied any suicidal thoughts.

On the evidence from the home visit Care Coordinator 1 and CPN 3 concluded that they did not have grounds to consider requesting a Mental Health Act Assessment with a view to admission to hospital.

12.1.3.3. Conclusions

Mr. A certainly had been distressed and did not want to be visited. Over time however he was able to alter his firm views and agree that he did sleep better with the Zopiclone or Olanzapine taken at night. He had agreed to the two staff visiting and also accepted that they would visit again the next week and telephone him in between. Given his poor level of engagement and the suggestion that he was deteriorating there might have been grounds for considering using the Mental Health Act. It was however decided that it was not appropriate as there were no grounds for undertaking a formal Mental Health Act Assessment at this time.

Use of Mental Health Act 2007 on 21 October 2009

The context for consideration of using the Mental Health Act on this occasion was that when CPN 3 and Care Coordinator 1 visited Mr. A on 20 October 2009 he had refused them entrance and had spoken to them through an open window. Mr. A said that he wanted to be discharged from the Mental Health Service. He had become verbally aggressive and made references to HIV and e-mails and telling the two staff to "*go away*!!" CPN 3 and Care Coordinator 1 returned to their car to depart when Mr. A followed them and was verbally aggressive whilst making statements about his physical health and saying that "*it was us bastards' fault".*

The staff contacted AMHP 2 who contacted the Police who telephoned the two staff to enquire if they needed assistance. When they arrived back at their office CPN 3 and Care Coordinator 1 were informed that Mr. A had telephoned several times apologising for his behaviour. AMHP 2 spoke to Mr. A's GP and learned that he had made an appointment to see the GP at 16.00. AMHP 1 had spoken to Doctor 1 and had prepared a letter for Mr. A to be given by him to the GP providing some medication advice (10 mg Diazepam that night)

and the offer of an appointment with AMHP 1 at Newquay the following day. Mr. A later cancelled his 16.00 appointment with the GP.

On 21 October 2009 Mr. A made another appointment with his GP which he attended. He had been well dressed and his behaviour was appropriate and he was complaining of an abdominal problem which was not specific. The Mental Health Team decided that in view of Mr. A's subsequent behaviour it was not appropriate for them to undertake a Mental Health Assessment.[116]

Conclusion

Mr. A appears to have been behaving as he had in the past by refusing help from services and losing his temper. He very quickly apologised for his behaviour and was appropriate with the GP the following morning. Throughout his contact with the Mental Health Services he had insisted that his problems were due to physical health issues and were nothing to do with his mental health. On the other hand his rapidly changing behaviour from being reasonably calm and then being distressed and appearing to be irrational, and then to revert to being more amenable was part of the nature of his 'problems'.

It would appear that the grounds for a Section under the Mental Health Act would have been hard to substantiate with Mr. A behaving well and not exhibiting the aggressive and frightening behaviour he had displayed the day before when the staff visited him at his home.

Use of Mental Health Act 2007 on 02 December 2009

The context was that at this time the Restormel Community Mental Health Team was trying to effect a transfer of care to the Assertive Outreach Team.

On 02 December 2009 at 09.00 Mrs. A (wife and nearest relative) contacted AMHP 2 asking for an urgent Mental Health Act Assessment for her husband. Mr. A had moved as he had seriously damaged the garage conversion he was living in at Redruth. He had not paid the utility bills so there was no electricity and no power as the generator had burnt out. The garage was not fit for human habitation and Mrs. A was worried for the family with a young son who rented the main house attached to the garage.

116 Clinical Records Volume 2 Pages 348-351

Mr. A Investigation Report

Mr. A had been with Mrs. A for the weekend but her son was off school with an illness and his father had been constantly referring to his fixed delusions regarding his being riddled with cancer, his having AIDS or HIV. The son was finding this very stressful. Mrs. A had taken her husband to Treliske Hospital for an arranged CT scan to check for cancer. He had previously had other tests which proved negative, but Mr. A did not accept that he did not have cancer. Because of the effect on her son Mrs. A wanted Mr. A to be assessed under the Mental Health Act.

Later that day at noon Mr. A had telephoned his wife from Truro Station begging her to have him back at her house but she had refused. AMHP 2 contacted the Police and asked if they could go to the Station and assess whether Mr. A could be brought to hospital on a Section 136 of the Mental Health Act (Police powers for people with mental health issues in a public place). By the time the Police reached the Station the train to Redruth had left. The Police were also asked to do a welfare check to see if Mr. A was safe, but he was not at his home address so he had been listed as a missing person.

Conclusion

The situation appears very confused. The Restormel CMHT was trying to refer Mr. A to the West Assertive Outreach Team covering Redruth, or to the Home Treatment Team due to the lack of a response to Mrs. A's request for an urgent Mental Health Act Assessment. Mr. A went missing but was known to have been in Redruth on 04 December 2009. There is no clear explanation why a Mental Health Act Assessment was not arranged. By 07 December 2009 Mr. A was back at his wife's address and was reported to have been much better having visited the Terence Higgins Trust where he had a blood test which confirmed he did not have AIDS. Mr. A said he did not want any contact with the Mental Health Services. Mrs. A is reported to have said that she no longer thought a Mental Health Act Assessment was necessary.

It has to be assumed that as Mr. A 'went missing' a Mental Health Act Assessment could not be effected. The rapid transformation in his presentation between 02 December 2009 when he was at Truro Station and his calm demeanour on 04 December 2009 when at his wife's address could be seen as an indicator that Mr. A would not have been able to have been made subject to a Mental Health Act Section at that time.

The Use of the Supervised Community Treatment Order

Mr. A had been detained in hospital under Section 3 of the Mental Health Act 1983 on 26 November 2008.[117] On 30 December 2008 he was placed on a Supervised Community Treatment Order with the conditions that he must:

- Accept input from the Community Mental Health Team (Restormel);
- Accept depot Risperidone 25mg every 2 weeks.[118]

On 25 February 2009 Care Coordinator 1 was concerned that Mr. A needed to be admitted to hospital and sought advice from the Mental Health Act Administrator at Bodmin Hospital. The advice received stated that:

"*If Mr. A wanted to be admitted then he could be and did not have to be recalled from his SCT Order. Recall is only used where:*

- *Patient fails to comply with two statutory conditions of Section 17A SCT – failure to attend for a meeting with Second Opinion Advice Doctor and failure to be available for examination by the Responsible Clinician for the purpose of the renewal of the SCT Order;*
- *Recall can also be considered where a patient fails to comply with the other conditions of the SCT Order if it is necessary to recall due to deterioration in the patient's condition.*

Any deterioration needed to be reported to the Responsible Clinician and the team which is supporting him and this should not wait until you see him on 02 March 2009. Increased support or informal admission should be considered now".

Mr. A was admitted to Bodmin Hospital on 17 March 2009 and was placed on a revised Supervised Community Treatment Order on 20 March which would be supervised by the Home Treatment Team. The new conditions were to:

- take the Risperdal Consta as prescribed – 37.5mg every 14 days;
- stay resident in Redruth (not Newquay) and to remain in contact with the Home Treatment Team (HTT) for seven days;
- remain in contact with HTT so as not to miss any appointments;
- not drive outside the Redruth area for seven days and then to discuss this with his Responsible Clinician before travelling beyond Newquay.

117 Clinical Records Volume 1 Page 401
118 Clinical Records Volume 1 Page 413

Mr. A Investigation Report

Mr. A continued in the community but was becoming less compliant with the Supervised Community Treatment Order and on 27 May 2009 it was revoked and he was admitted to Bodmin Hospital.[119] On 14 July 2009 at the Ward Round there was discussion about Mr. A being discharged with a new Supervised Community Treatment Order being put in place. The conditions would be to:

- accept medication;
- engage with Community Psychiatric Nurses;
- allow/attend reviews.

There was no Appropriate Mental Health Professional (AMHP) available to meet Mr. A and Doctor 1 to discuss the Supervised Community Treatment Order.[120] On 17 July AMHP 1 visited Mr. A at Bodmin Hospital and saw him with Doctor 1. Mr. A was still adamant that he would not comply with the three conditions and therefore AMHP 1 would not agree to the Supervised Community Treatment Order as there was no evidence it would enable Doctor 1 and the CMHT to maintain his mental health in the community.[121]

That same afternoon the Hospital Managers Tribunal discharged Mr. A from his Mental Health Act Section as they considered that he did not have to remain in hospital to secure effective treatment.

Conclusion

It is clear that the Supervised Community Treatment Order would not have been effective as Mr. A was refusing to comply with any of the three conditions. The Code of Practice is clear in this situation that the patient must agree, and AMHP 1 was correct to refuse to agree to the making of the SCT Order. It was coincidental that the Mental Health Managers Review Tribunal was meeting that same afternoon.

The Mental Health Managers Review Tribunal

Context

Section 23 in Chapter 30 ‘Functions of Hospital Managers’ of the Mental Health Act gives Hospital Managers the power to discharge most detained patients and all patients subject to a

119 Clinical Records Volume 1 Page 488
120 Clinical Records Volume 2 Pages 318-320
121 Clinical Records Volume 2 Pages 321-322

Supervised Community Treatment Order. (They are excluded from discharging those patients under Sections 35 or 36 of the Act or those subject to Interim Hospital Orders under Section 38. They may not discharge restricted patients without the consent of the Secretary of State for Justice).

The Hospital Managers were working within the Mental Health Act 2007. The report to the Managers Tribunal from Doctor 1 did provide an alternative community option for Mr. A which stated that if he was discharged this Care Plan could be activated and put in place. The arguments for Mr. A to be further detained were to some extent undermined by the amount of time he was allowed Section 17 Leave and the discussion with the AMHP about arranging another Supervised Community Treatment Order. The Mental Health Act Managers decided to discharge Mr. A from formal admission in hospital. Mr. A's consultant wrote a report which was slightly vague in its diagnosis ("psychotic disorder or possibly psychotic depression"). There was also, as required, an alternative plan for Mr. A to be discharged and to be placed under a Supervised Community Treatment Order so it was perhaps unsurprising that the decision of the Managers Tribunal was to discharge Mr. A given his refusal to accept the conditions.

Although the use of Supervised Community Treatment Orders was relatively new, AMHP 1 demonstrated that she had a good grasp of the law regarding it and she confirmed that Doctor 1 was also in agreement as Mr. A had failed to engage with the Home Treatment Team when he had recently been on leave, and was adamant that he would not comply with the three conditions attached to the proposed Supervised Community Treatment Order.

Conclusion Summary

The First Internal Investigation

The First Internal Review made considerable comment about how the Hospital Managers may have overstepped their authority and how this action gave a wrong message to Mr. A by confirming that he did not have a mental illness. It made a recommendation which stated:

"The Cornwall Partnership NHS Foundation Trust should review the robustness of the current Mental Health Act Managers' Review process, and the level of organisational support provided to it. We recommend that:

- *training for the role of Mental Health Act Manager should continue to include legal aspects of the Mental Health Act, but be augmented by training to raise awareness of complex clinical presentations;*
- *Mental Health Act Managers already have recourse to advice on legal aspects of the Mental Health Act via the Trust's Mental Health Act Advisor. Consideration should be given to matching this with provision of advice on clinical issues from an appropriately qualified and experienced clinician who is independent of the Review process. The purpose of this would be to assist the Mental Health Act Managers in reaching a fuller understanding of the clinical information before them in the panel, both in terms of the content and interpretation of professional reports, and the presentation of the service user on the day. Independence of decision-making by the Mental Health Act Managers is obviously and appropriately enshrined in the legislation, but it does seem important that such decisions are based on the best evidence available".*

The Second Internal Investigation

The Second Internal Investigation did not support this finding. It concluded that whilst it had confirmed the belief of Mr. A that he did not have a mental illness which warranted his detention in hospital, there was little evidence that it had significantly altered his relationship with the Mental Health Services. In the overall context of the totality of the involvement the Cornwall Partnership NHS Foundation Trust Mental Health Services had with Mr. A the discharge by the Hospital Managers did not affect the outcome of his care.

The Independent Investigation Panel

The Independent Investigation Panel supports the finding of the Second Internal Investigation. Although Mr. A may have viewed the decision as a triumph for his point of view, the course of events following his discharge does not support the view that this was a significant turning point in the management of Mr. A. He continued to act as he had prior to his discharge and remained reluctant to fully engage with services except when he felt he needed some assistance. He maintained his belief that he did not have a mental illness and therefore did not require treatment or contact with Mental Health Services.

12.1.4. The Care Programme Approach

12.1.4.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.[122] Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach.*[123]

"*The Care Programme Approach is the cornerstone of the Government's Mental Health Policy. It applies to all mentally ill patients who are accepted by specialist mental health services".*[124] (Building Bridges; DoH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist Mental Health Services and its primary function is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

122 The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990
123 Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008
124 Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH; 1995

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
  - to keep in close contact with the patient
  - to monitor that the agreed programme of care remains relevant and
  - to take immediate action if it is not
- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need.

The Cornwall Partnership NHS Foundation Trust CPA Policy

The 2004 Policy of the Cornwall Partnership NHS Trust states that the "*Guiding Principles"* of the Care Programme Approach are that:

"*The Care Programme Approach is the care process for all those in contact with specialist mental health services. It provides a framework and pathway for best practice to take place and its aim is to keep the service user and their wider network as central to the process rather than the service".* The Care Programme is:

- " *Service user focused in its approach, appropriate to the needs of the individual and fully involves them in the process of assessment, care planning and review;*
- *Recognises the role of carers and the support they need;*
- *Provides a framework to stop users falling through the net;*
- *Works as a process regardless of setting;*
- *Pays attention to confidentiality and privacy with regard to information sharing;*
- *Provides regular training and support for clinical staff including the Care Co-ordinator role or work in support of that role;*
- *Audits the process on a regular basis and provides feedback to service users that carers and staff are involved in the Care Programme Approach process.*

Children's Issues

Cornwall Partnership Trust places the highest importance on the welfare of children in need and at risk. All clinical and support staff must place the needs of any dependent children above those of the service user and their carer. The needs of children may be in one or more separate areas:

- *child protection – for protection to avoid abuse;*
- *children in need – to improve the life experience of children in need;*
- *children as carers – to provide help to children who undertake the role of carer in relation to adults who are experiencing mental health difficulties.*

If, during the course of an assessment, it becomes apparent that children are being cared for or living with the person in receipt of care, consideration should be given to the children's needs. Areas for consideration are:

- *children's developmental needs, physical and emotional well-being;*
- *the capacity of the parent(s) to provide care;*
- *environmental factors potentially affecting children.*

Identifying an area of need or concern affecting children may warrant a referral to a specialist children and family team".

12.1.4.2. Findings

Mr. A was treated under the Care Programme Approach (CPA) throughout the period that he was in contact with the Mental Health Services in Cornwall, from 17 January 2008 to 18 January 2010. During this time he had five care coordinators. The periods each of the Care Coordinators was working with Mr. A were:

Care Coordinator 1: 18 January to 24 March 2008;
Care Coordinator 2: 02 October 2008 to 07 February 2009;
Care Coordinator 3: 14 January to 21 July 2009;
Care Coordinator 4: 20 August to 09 December 2009;
Care Coordinator 5: 09 December 2009 to 18 January 2010.

The longest period during which Mr. A received support from a Care Coordinator was with Care Coordinator 3 who worked with him for six months. The work with Mr. A was difficult for Care Coordinators as he did not wish to engage with services and did not want to assist in the development of a Care Plan. The number of Care Coordinators did not assist in

developing a consistent approach with Mr. A although he was in contact with the same Restormel Community Mental Health Team and Dr 1 for most of his two years with the services.

As discussed in the next Section on Risk Assessment and Risk Management the recording of risks was poor as the forms all looked the same and there was no clear way of identification of the latest risk, nor the removal of old risks no longer applicable. It was also evident that the risk management plans did not really reflect the assessed risks. In the clinical records there are 11 Risk Assessment and Risk Identification Forms between 06 February 2008 and 27 August 2009. These all appear similar and have largely the same risks identified with the Care Plan being for Mr. A to have regular depot and to have contact with the Restormel Community Mental Health Team. This was the main purpose for the Restormel Community Mental Health Team to remain working with Mr. A so that they could at least monitor his mental health condition, albeit without very much contact with him inside his own home.

Whilst an inpatient Mr. A had many agreed periods of Section 17 Leave and also several instances where he absconded from hospital or failed to return as required under the conditions of his Leave. The Care Coordinators were largely unable to forge a working relationship with Mr. A and they were also to some extent distracted by trying to transfer Mr. A to the West Assertive Outreach Team. When discharged from Hospital the Home Treatment Team worked with Mr. A until he was deemed to be more settled and able to return to the Restormel Community Mental Health Team.

Towards the end of 2009 it was clear that Mr. A was homeless as the converted garage was unsuitable for winter use due to damp and the need for repair. Mr. A had also caused considerable damage to this property on 02 December as well as having failed to pay the utility bills leading to the power being discontinued. AMHP 2 had taken steps to help Mr. A gain accommodation early in 2010.

The Mental Health Services worked in isolation from the other agencies working with Mr. And Mrs. A and their son. The Secondary Mental Health Services sometimes tended to use the Police to undertake work that would usually be undertaken by Mental Health Staff. The main examples of this were:

- On 02 December 2009 Mr. A was distressed and was begging his wife to let him return to her home after having rendered his Redruth 'garage home' uninhabitable through smashing things and not paying the utility bills. The AMHP asked the Police to undertake a welfare visit. It would have been more appropriate to assess whether Mr. A required a Mental Health Act Assessment rather than see if the Police could effect a Section 136 admission. The Police could legitimately have been asked to be in attendance to assist with this;

- On 17 January 2008, soon after Mr. A had been referred to the Mental Health Service by his GP, his wife had telephoned the Out of Hours Service as her husband had left the house saying he was going to commit suicide. The advice given was to call the Police, but she had tried this and had been told there was nothing they could do. There was no immediate response, but a referral was faxed to the Restormal Community Mental Health Team asking the Duty Worker to contact Mrs. A and to arrange support and assessment of the situation.

It is also clear from the clinical records that the Mental Health Services and the Police worked in relative isolation from each other and did not share information which would have been helpful to both. The Independent Investigation Panel agrees with the comments of the Second Internal Investigation when it states that the information held by the Police *"would have assisted in risk assessment, the authors wish to note that we do not believe this information would have led Mental Health Services to conclude that [Mr. A] was at risk of harming his wife, son and himself as occurred in this case. We also note that [Mr. A] prevented mental health staff from exploring his thoughts, feelings in any depth by refusing to engage in one to one time when an inpatient, and by being guarded and closed in his interviews with staff at other times".*

There is an Information Sharing Protocol which allows information to be shared between Mental Health Services and the Police, and other statutory services. This Protocol could have been used in Mr. A's case. This would have enabled mental health staff to be aware of all Mr. A's offending history and also about the Police Intelligence about domestic abuse concerns. It is not clear why the Clinical Team did not use this Protocol as there were a number of occasions where staff had contact with the Police but did not think about what information might be held by the Police that would assist with risk assessment.

Safeguarding Children

The Cornwall Partnership NHS Foundation Trust Care Programme Approach Policy quoted at the start of this Section clearly states the expectation that staff working with families with children should be aware of the effect the mental health service user may be having on children in his/her care. The only documented contact between the Mental Health Services and the Cornwall Children's Social Care Services was on 16 June 2009 following a Ward Round when the fact that Mr. A was being treated for a mental illness was shared. Mrs. A telephoned Fletcher Ward later in the day to ask what had been discussed at the Ward Round as her husband had been worried about the mention of his son during the discussion. Mrs. A did state that she did not think her husband would harm their son.

The national requirement for services to work together was provided in Working Together to Safeguard Children published in 2006. There is a clear expectation that "*all practitioners working with children and families should be familiar with and follow your organisation's procedures and protocols for promoting and safeguarding the welfare of children in your area, and know who to contact in your organisation to express concerns about a child's welfare"*. It is clear that with the exception of the contact made by Fletcher Ward described above no other contact was made.

The Mental Health Services had limited contact with Mr. And Mrs. A's son but there were two occasions which should have prompted a referral to the Children's Social Care Services. The first was on 23 October 2008 when Mrs. A had telephoned the Home Treatment Team (West) as she was distressed because she felt that:

> *"she and her nine year old son were at risk from [Mr. A]"* as he had been "*regularly in contact with her by telephone and by text and in the last week had started accusing her of being part of the conspiracy to kill him, hence her increased worry for her and her son's safety. Staff advised her to contact the Police if she felt she was in danger".*

The second occasion was on 02 December 2009 when Mrs. A explained to AMHP 2 that Mr. A had stayed with her and their son for the weekend. Her son had been away from school with an illness and his father had been constantly referring to his fixed delusions regarding his being riddled with cancer, his having AIDS or HIV. The son was finding this very stressful. Both these situations should have alerted Mental Health Staff to make contact with the Children's Social Care Services.

12.1.4.3. Conclusion

The First Internal Investigation considered that the Risk Assessment and Risk Management was poor, and that the way the Risk Assessment Forms were completed was confusing in that the latest risks were not easily identifiable. The Care Plans did not reflect the Risk Assessment, partly because Mr. A did not engage but also because his presentation could rapidly alter.

The Second Internal Investigation concluded that *"there was no early history taking from Mr. A or family members, and although this was planned by Care Coordinator 3 in April 2009, 17 months after his first referral to services, this did not take place. The core assessments after the first admission refer back to the first contact with services and previous hospital admissions as previous mental health history; it could be argued that this was actually one episode of care and not previous history".* The Independent Investigation panel would endorse this view.

The Second Internal Investigation continued by commenting that "*the information recorded when reflecting on the content of the timeline does not show any significant change in the presentation.* [of Mr. A]. *The on-going delusional presentation with fixed beliefs and resistance to engaging with services could have prompted a multidisciplinary/agency case conference to review the care and identify the way forward. The care and treatment of Mr. A lacked ownership and direction, however a significant feature of this was Mr. A's continued refusal to engage, refusal to take medication, accusing services of harassment and his lack of insight. Staff were trying to work with the balance of least restrictive involvement and the cooperation of Mr. A, whilst respecting his wishes and not intruding disproportionately into this man's life".*

The Independent Investigation concurs with the difficulties the Mental Health Services faced. It also notes that if they had called a case conference with all the relevant agencies, or contacted the Police, much more information about Mr. A would have been available, and the safeguarding of his son would also have been better highlighted.

The lack of contact with the Cornwall Children's Social Care Services did not conform to either local or national policy expectations. The Second Internal Investigation considered that several opportunities to contact the Children's Social Care Services were missed and like the

First Internal Investigation identified the need for training for all staff regarding Safeguarding Children. The telephone conversation AMHP 2 had with Mrs. A on 02 December 2009 regarding the effect Mr. A's behaviour was having on their son should at the very least have prompted contact with the Children's Social Care Services to ask them to assess the home situation, or preferably to have requested a Strategy Meeting to examine the situation within the family and its effect on the son. This latter course of action would have triggered the sharing of information by all agencies working with the family, the Police, Education, Primary Care and Mental Health Services.

The Independent Investigation Panel has also recommended that a Multi-Agency Conference on Safeguarding is organised by the Cornwall Partnership NHS Foundation Trust to ensure that all staff are kept up to date and are sure of their respective responsibilities in this important area. It is acknowledged that work in this area has been undertaken following the untoward incident and the recommendations of both Internal Investigations have been fully implemented.

12.1.5. Risk Assessment and Risk Management

12.1.5.1. Context

Risk Assessment and Risk Management is an essential and on-going element of good mental health practice and a critical and integral part of the Care Programme Approach (CPA). Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The Management of Risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and/or others, and working positively with that.

The Management of Risk is a key responsibility of NHS Trusts and is an on-going process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their

health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in Risk Assessment and Risk Management Skills.

Clinical Risk Assessment supports the provision of high quality treatment and care to service users. It supports the provision of the CPA and is a proactive method of analysing the service user's past and current clinical presentation to allow an informed professional opinion about assisting the service user's recovery.

It is essential that Risk Assessment and Risk Management are supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

Best Practice in Managing Risk (DoH June 2007) states that *"positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed".*[125]

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

Effective and high quality Clinical Risk Assessment and Risk Management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared

125 Best Practice in Managing Risk; DoH; 2007

amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

Cornwall Partnership NHS Foundation Trust Policy

The Clinical Risk Assessment and Risk Management Policy for Specialist Mental Health Services within Cornwall Partnership Trust was ratified on 18 September 2005. The Policy states that:

"All persons in the care of Cornwall Partnership Trust Specialist Mental Health Services will have a risk assessment completed by a trained member of staff. All staff involved, in the care of the person, will be required to input to the assessment and management plan. The risk assessment is commenced and recorded at first contact with the service and updated:

- *at CPA review;*
- *when there is a change in presentation or new information available;*
- *on admission to the in-patient unit;*
- *prior to leave or discharge from the in-patient unit;*
- *prior to discharge from the service".*

Core areas for Risk Assessment are identified as being *"harm to others, harm to self, self-neglect and hazards in the delivery of care. Risk is seen as a product of person and environment and its assessment should cover the:*

- *nature/severity of the risk behaviour and consequences*
- *probability of the risk behaviour (lifetime, imminently, critical timings and triggers)*
- *management of the risk*
- *consideration of plans, costs and benefits".*

12.1.5.2. Findings

The Mental Health Services did regularly undertake risk assessments of Mr. A and also developed Care Plans to try to manage the risks identified. Mr. A was regularly assessed and his identified likely harm to himself was described as being:

- risk of self harm;
- risk of self neglect;
- risk of relapse;
- risk to self when driving when agitated.

The identified potential harm to others was recorded as being:

- risk of harm to others when driving while agitated;
- his threats to harm his mother (and also verbal threats to harm his wife which she recorded);
- threats of harm to unknown individuals who Mr. A blamed for the failure of his business;
- threats to staff.

The Risk Assessment Forms were hard to follow as it was not clear where the latest risks were being identified, so all the Risk Assessments appeared the same and it was often time consuming and tedious to identify the date of the assessment and what were previous entries and which were the latest version. Out of date risk data was also still being recorded when additional risks were added. It is accepted that RiO has helped to overcome these issues.

The recording of Risk Assessment and Risk Management plans was difficult to fully understand as from the review of the clinical records, both written and electronic, it is evident that there was a lack of detail recorded of descriptions of issues and concerns raised by Mrs. A and other family members. On a number of occasions this lack of detail may have impeded appropriate assessment of risk. For example the documentation of the harassing and threatening text messages Mr. A sent to his wife was poor, with no examples recorded to identify the actual content and scale of the harassment and the likely fear and concern this would cause the recipient.

Another example was the telephone call made by Mrs. A (wife) to the Home Treatment Team Out of Hours Service on 23 October 2008 where she shared her concern that she and her son were at risk from Mr. A. Mrs. A explained that in the last week her husband had started accusing her of being part of the conspiracy to kill him, hence her increased worry for her and her son's safety. There was no documented further exploration of what Mrs. A feared her husband might do, and it was not recorded if this was subsequently discussed in more detail with Mr. A or Mrs. A. There is no documentation of any action plan from services in response to this concern.

It is accepted that the level of concern caused by Mr. A fluctuated very rapidly as on occasions he was described as being in a terrible state and to be telephoning relatives with bizarre concerns and paranoid ideas, and then appearing a few hours later being calm and contrite. This also occurred with Mental Health Staff when he stormed out of clinical meetings only to return a few minutes later to re-join the same group of staff.

There was another example on 20 October 2009 when CC 1 and CPN 3 visited Mr. A to see if he was prepared to engage with the CMHT. On arrival at his Redruth home Mr. A would only open the window and quickly began to shout at them. When they withdrew he followed them to their car and was yelling and almost spitting so they left as they considered that he was threatening and intimidating. CC 1 and CPN 3 telephoned their office where AMHP 2 contacted the Police. Before the two staff had returned to their office Mr. A had telephoned the office and had apologised for his outburst, and appeared calm.

The Risk Management Care Plans were generally concerned with ensuring that Mr. A took his Depot and that he was seen so that his mental state could be monitored. Staff tried to engage Mr. A but he did not respond positively for long.

There was no mention in the Risk Management Plans about the threat Mr. A posed to his son, despite his wife having raised concerns, although she had also stated on several occasions that she did not think that her husband would harm her or their son. This was examined in the previous Section about the Care Programme Approach.

12.1.5.3. Conclusion

The first Internal Investigation concluded that there was a need for greater knowledge and training about Clinical Risk Assessment and Risk Management as the *"the up-take of the Trust's formal Clinical Risk Assessment training has been low, and we therefore recommend that Clinical Risk Assessment training is prioritised for clinical staff throughout the Trust [and] consideration is given to this training being incorporated into the Mandatory Training process"*.

The second Internal Investigation concluded that there were issues surrounding the Risk Assessment and Risk Management process and provided recommendations within the context of the sharing of information with other agencies. This was so that all involved in the care of

service users would have access to the same information when and where appropriate and service users were known to two or more agencies, as was the situation with Mr. A.

The Independent Investigation Panel concluded that the completion of Risk Assessment and Risk Management Documentation was poor and that not all potential areas of risk had been given sufficient attention. The risk Mr. A posed to his wife and son was not fully understood by the Mental Health Services and this was compounded by them not contacting the Police or the Children's Social Care Services to raise concerns when Mr. A appeared to be threatening his wife and son, and to explain the nature of his mental ill health.

- ***Service Issue 5***

  This is another example where the Mental Health Staff did not seek clarification of what Mrs. A was telling them. The Staff Member should have asked why she thought she and her son might be vulnerable and what action her husband might take. Fuller recording of these types of contact would help to inform the Risk Assessment and Risk Management process and improve the resultant Care Plan and Risk Management Plan. The Service must ensure that staff fully record information given to them by relatives and friends of service users to inform the current level of risk the service user presents.

12.1.6. Referral, Admission and Handover Processes

12.1.6.1. Context

Referral, transfer and handover all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been completed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies are communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

The Cornwall Partnership NHS Foundation Trust Discharge Planning and Transfer Policy dated 10 August 2005 and updated in March 2009 states that "*Everyone who is discharged or*

sent on leave must have an enhanced care plan unless the Consultant Psychiatrist states otherwise in writing within the patient's health record. Risk assessments must be completed prior to the service user commencing leave or being discharged or being transferred.

The Care Coordinator should maintain contact with user and ward staff throughout their stay. When considering the timing of hospital discharge, there should be community support available as defined in individuals' care plans. This must be within seven days as per the National Service Framework or sooner as indicated by client need. Discharge and leave care plans, in consultation with Community Mental Health Teams and carers must include crisis and contingency planning".

12.1.6.2. Findings

The ability of the Mental Health Services to deliver good quality continuous care was compromised by the refusal of Mr. A to engage with services, but also by the discontinuity of care due to his having both a Newquay and a Redruth address where he could reside, and a GP in Newquay. As a direct result of this there were six Cornwall Partnership NHS Foundation Trust Services involved in the care of Mr. A, or asked to become involved in his care. These were:

- Restormel Community Mental Health Team (St Austell and Newquay, both in the east of Cornwall);
- Fletcher Ward Bodmin Hospital (the acute inpatient ward for the east of Cornwall);
- Home Treatment Team West (provides a service for the west of Cornwall and is based in Redruth);
- Home Treatment East (provides a service to St Austell and Newquay and the east of Cornwall. The service functions as a single Home Treatment Team covering all Cornwall at night);
- Assertive Outreach Team West (provides a service to the west of Cornwall including Redruth where it is based);
- Kerrier Community Mental Health Team (provides a service to Redruth, Helston and Camborne).

The difficulties involved in providing consistent and continuous care in these circumstances were well described at the Ward Round held on Fletcher Ward on **27 June 2009** when Mr. A

confirmed that he wished to retain his Newquay GP. Discharge from the Ward was being discussed and it was noted that Mr. A would "*be referred to the Home Treatment Team West and have his depot injections at Newquay Hospital. Such contact does not really see how he is coping in the community".* This was because the Restormel Community Mental Health Team tended to see Mr. A at their premises rather than at his Redruth home. Mr. A was therefore not seen within the context of where and how he was living.

A further difficulty was the distance between Newquay and Redruth, a 37 mile round trip, which was relatively easy in the winter but during the summer could take a considerable time due to the tourist traffic. It is clear from the Chronology that Mr. A did not engage with services and was often not at home when visited, and was also prone to miss appointments. This made it difficult for the services to maintain regular contact with him, and was the main reason he was asked to visit staff for interviews, reviews and Depot injections. This made it difficult for staff to monitor how he was managing in the community as highlighted in the quotation above from the Ward Round.

The Restormel Community Mental Health Team tried to 'transfer' the care and treatment for Mr. A to the Kerrier Community Mental Health Team as he was spending more time in Redruth than Newquay. The way the 'transfer' was described in the clinical notes made it seem like a referral to another service, rather than it being another service within the Cornwall Partnership NHS Foundation Trust. The attempts to transfer the care and treatment of Mr. A to a West Cornwall Team are shown in Table 4 below.

Table 4: Attempts to Transfer the Care and Treatment of Mr. A by Restormel CMHT

Date	Outcome
24/03/2008	Referral to Kerrier CMHT at Trengweath (Redruth). Not accepted as Mr. A would not engage with services; it was a third party referral, and there was little information.
26/06/2009	On discharge Mr. A insisted on keeping his Newquay GP so the services involved were the West Home Treatment Team and the Restormel CMHT for Depot and support.
29/07/2009	West Cornwall Assertive Outreach Team did not accept referral as Mr. A had a Newquay GP and his consultant and CPN were from the Restormel CMHT although he had a Redruth address.
29/09/2009	Kerrier CMHT accepted referral as Mr. A was registered with a Redruth GP. However by 12 October 2009 Kerrier CMHT wanted a professionals meeting.

27/10/2009	Care Coordinator transfer agreed for 05 November 2009. Joint visit to Mr. A was undertaken when he said he wanted to be discharged from the service, so the transfer did not take place.
26/11/2009	West Assertive Outreach Team asked to accept Mr. A. It was at first accepted but then refused as a Mental Health Act Assessment was pending.
11/12/2009	Assertive Outreach Manager confirms that Restormel CMHT is involved and has the Care Coordinator.

12.1.6.3. Conclusion

The Independent Investigation Panel concluded that the community care for Mr. A should have been provided by either the Kerrier Community Mental Health Team or, given his difficulties in engaging with mental health services, preferably the Assertive Outreach Team West.

The Chronology demonstrates that Mr. A used the fact that the local services could not agree which service should provide his care and treatment in Redruth to not engage and to travel repeatedly between Newquay and Redruth, and to avoid contact with the Restormel Community Mental Health Team staff. The lack of a clear Operational Policy for all teams which clearly identified their role and function, and the lack of a process to escalate situations where the services could not reach a mutually agreeable decision to a more senior level of Trust Management was the cause of Mr. A never being transferred to the Redruth Services. He did when discharged from hospital, and when his mental state warranted, receive services from the Home Treatment Team West, but his Care Coordination remained with the Restormel Community Mental Health Team.

The second Internal Investigation considered that *"Mr. A's supervision of care was not appropriate as the time line identifies that he moved to the Redruth area in February 2008, therefore his care could have transferred to the Kerrier CMHT (Redruth, Helston and Camborne area).*

Mr. A's registration with a Newquay GP has been cited as the major impediment to his transfer of care to a Redruth team. However, when the GP was written to in September 2009 requesting that he be removed from the list, this was enacted immediately. This suggests that this factor could have been overcome at an earlier stage potentially overcoming a significant

barrier. It was clearly communicated to mental health services by Mrs. A (wife) on a number of occasions that when Mr. A stayed with her and their son at weekends it was temporary. The authors are of the view that the care should have been transferred to the Redruth area, and shared care arrangements could have been agreed to cover periods of time when he was staying with this wife and son and when staying with his mother in Hampshire.

The different teams working to their own operational criteria and geographical boundaries were not supportive of Mr. A or of colleagues. The authors were of the impression that the Restormel CMHT staff had accepted by default that they were the Care Coordinators of Mr. A's care, even when they were the least appropriately placed to do so".

The Independent Investigation Panel fully endorses the above findings by the second Internal Investigation but did not agree that its recommendation to make all the Cornwall Community Mental Health Services cover the whole County was viable due to the distances to be travelled and the extreme rural nature of much of Cornwall. The Cornwall Partnership NHS Foundation Trust has implemented this recommendation in an alternative way by having a Senior Operational Manager responsible for all the community services. This post enables any difficulties concerning the provision of services to service users like Mr. A to be 'escalated' up the management structure so that a quick and service user friendly solution can be made and be kept under review.

Having examined the difficulties the Mental Health Services had with providing care and treatment for Mr. A from the most accessible and appropriate service, the Independent Investigation Panel concluded that the preferred service would have been the Assertive Outreach Team West. The Department of Health Policy Implementation Guidance[126] which stated that Assertive Outreach Teams would provide a service for adults aged between 18 and approximately 65. It continued to specify the types of mental illness the teams were designed to assist:

"*A severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a high level of disability*

1. *A history of high use of inpatient or intensive home based care (for example, more than two admissions or more than six months inpatient care in the past two years)*

126 The Mental Health Policy Implementation Guide, DoH 2001 Pages 26-42

2. *Difficulty in maintaining lasting and consenting contact with services*
3. *Multiple, complex needs including a number of the following:*
    - *History of violence or persisting offending;*
    - *Significant risk of persistent self harm or neglect;*
    - *Poor response to previous treatment;*
    - *Dual diagnosis of substance misuse and mental illness;*
    - *Detained under the Mental Health Act (1983) on at least one occasion in the past two years;*
    - *Unstable accommodation or homelessness".*[127]

The Guidance went on to state that "*using an assertive outreach approach can:*

- *Improve engagement;*
- *Reduce hospital admissions;*
- *Reduce length of stay when hospitalisation is required;*
- *Increase stability in the lives of service users and their carers/family;*
- *Improve social functioning;*
- *Be cost effective".*

Other highlighted qualities of the Assertive Outreach Approach included the need for regular review in the form of brief Daily Review Meetings to ensure those with the greatest risk and/or needs were identified. Weekly Review Meetings of the Team with the consultant psychiatrist should be held, where action and any necessary changes in treatment would be agreed. Progress and outcomes were to be regularly monitored with a Care Plan formally reviewed at least six monthly. The composition of an Assertive Outreach Team was also specified but with some allowance for local circumstances. A team was designed to cover a population of approximately 250,000 and its make up was to reflect the local demography.

The Assertive Outreach Team would have been better resourced to meet the needs of Mr. A and to follow him up in the community rather than him having to attend the majority of meetings, reviews and Depots at Newquay Hospital. With the Team geared to work more intensively with service users it would have been better placed to meet his individual needs, and had more ability to cross the geographical boundary between East and West Cornwall

127 The Mental Health Policy Implementation Guide, DoH 2001 Page 26

Services. This should have been considered by the Cornwall Partnership NHS Foundation Trust.

There is no guarantee that this approach would have worked, but a more proactive approach could have been attempted as the resources of the Assertive Outreach Team were geared to providing this type of intervention unlike the Community Mental Health Team which, despite failing to successfully transfer Mr. A to another service, did seek to maintain contact and to respond when required.

It was evident that Mr. A did not wish to engage with services as throughout his time with the Mental Health Services of the Cornwall Partnership NHS Foundation Trust he refused to accept that he had a mental illness and remained determined not to accept medication. The Independent Investigation Panel concluded that the Assertive Outreach Team was the correct service for him. Its ethos was to work with people who found it hard to engage, it was established with the remit to try to engage with people like Mr. A, and it had a staffing level to enable frequent contact in order to attempt to retain contact even when the service user did not wish to cooperate. The difficulties in managing Mr. A between Newquay and Redruth should have been addressed as both previous Internal Investigations had highlighted.

12.1.7. Service User Involvement in Care Planning

12.1.7.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:

"the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes".

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *"people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care"*. It also stated that it would *"offer choices which promote independence".*

12.1.7.2. Findings

The Second Internal Investigation

The second Internal Investigation stated that: *"On the surface the mental health care [received by Mr. A} was adequate, but when the details are examined, some of the responses could have been more pro-active and dynamic. For example there was a frequent reliance on Mr. A attending office based services"* which was unlikely to be effective as he did not wish to engage with mental health services.

"One male worker [CPN 1] who was part of his [Mr. A's] early care achieved small things with Mr. A by simply being present at his home address and trying to engage him in services". This was also the case when Care Coordinator 1 and CPN 3 were working with him and successfully challenged some of his delusions in September and October 2009 when he also accepted a session with a psychologist.

Mr. A was difficult to engage, but this was because as he did not accept he had mental health issues it was likely that he would not wish to meet those who refused to accept he was physically ill. There were times where Mr. A became so anxious and distressed that he sought admission to Bodmin Psychiatric Hospital and accepted visits from the Mental Health Staff. The second Internal Investigation examined what level of involvement Mental Health Services provided to Mr. A. This was difficult as "*Mr. A remained without insight into his need for the support of mental health services thus making it very hard to deliver the prescribed treatment and care plans in partnership with him as would be good practice in person centred care planning. Mr. A was of the view that his problems were of a physical nature. He was not in agreement with medication for a psychotic disorder, did not believe he was depressed and did not want contact from mental health services".*

"The care records for Mr. A when covering the care reviews state 'YES' recorded on a number of them to the question of whether the 'carer/patient' had been offered or given a copy of the care plan. These care reviews did not specify if this was Mr. A and or one of his family. There is no outcome recorded as to whether the offer of a copy of the plan had been accepted, and therefore no evidence to say if this happened or not".

"The authors (and the Independent Investigation Panel) *have formed the view that it is unlikely Mr. A would have participated in discussions about his care needs. It is unlikely Mr. A would have wanted a Care Plan or agreed or declined to sign one saying he disagreed.*

There is no record of any of discussions specifically related to whether Mr. A was in agreement or not. Only one record could be found dated 09 June 2009 where staff had recorded that Mr. A had declined a copy of the care plan and declined to sign the care plan. On 25 March 2009 his care coordinator recorded that a copy of his Care Plan was posted to Mr. A. There are two Care Plans dated 02 December 2008 and 28 May 2009 where Mr. A had signed a copy held in the notes, although these care plans record that 'carer / patient was not offered' a copy of the Care Plan. The Care Plans and the risk assessments were not always written as a person centred plan".

12.1.7.3. Conclusion

The overall presentation of Mr. A did not alter significantly in terms of his attitude towards the attempts by Mental Health Staff to provide him with therapy. Staff noted in the Clinical Records, when describing their direct contacts with Mr. A, that he was guarded, suspicious and reluctant to engage and discuss his thoughts. He generally tried to keep the Mental Health Services at arms length unless he had a specific problem or was very anxious about something he thought they might be able to help him with.

It is safe to conclude that given Mr. A's belief that he did not have a mental illness he would be unlikely to be involved in his care and treatment. Staff would quickly have realised this but would still, as shown above, have followed their usual policy and procedure by continuing to try and engage him as best they could.

12.1.8 Carer Involvement and Carer Assessment

12.1.8.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that '*the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes*'. In particular the National Service Framework for Mental Health (DH 1999) states in its guiding principles that '*People with mental health problems can expect that services will involve service users and their carers in planning and delivery of care*'. Also that it will '*deliver continuity of care for as long as this is needed'*, '*offer choices which*

promote independence' and '*be accessible so that help can be obtained when and where it is needed*'.

Carer Involvement

The recognition that all carers, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensures that services take into account information from a carer assessment when making decisions about the type and level of service provision the service user requires.

Further to this, The Carers and Disabled Children Act 2000 gave Local Councils mandatory duties to support carers by providing services directly to them. It also gave carers the right to an assessment independent of the person they care for. Then The Carers (Equal Opportunities) Act 2004 placed a duty on Local Authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. This Act also helped to facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

For Mental Health Services in particular Standard Six of the NHS National Service Framework for Mental Health stated that all individuals who provide regular and substantial care for a person on CPA should have:

- an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;
- their own written care plan which is given to them and implemented in discussion with them.

12.8.1.2 Findings

It is unclear from the clinical records if Mrs. A (wife) was ever offered a Carer's Assessment. Given the level of support she was providing for her husband, despite being estranged from him, this should have been offered. There was also little evidence from the written documentation that when Mrs. A did raise concerns about her husband staff arranged to meet her and explain the situation to her, or to offer her advice. Staff did not telephone Mrs. A to enquire how she was but more to discuss how her husband was. When she expressed concern

about her husband being aggressive or harassing her with threatening text messages she was told to contact the Police. Mrs. A was concerned about the effect Mr. A was having on his son, and she had to bear the brunt of his delusional concerns about his health and help him when he became excessively distressed or anxious and made threats to kill himself.

On 23 October 2008 Mrs. A telephoned the Home Treatment Team (West) as she was distressed because she felt that:
"she and her nine year old son were at risk from [Mr. A]" as he had been "*regularly in contact with her by telephone and by text and in the last week had started accusing her of being part of the conspiracy to kill him, hence her increased worry for her and her son's safety. Staff advised her to contact the Police if she felt she was in danger".*

12.8.1.3 Conclusion

The Independent Investigation Panel concluded that services were not proactive enough to support Mrs. A but suggested she contact the Police. They should have treated her as a carer and have offered her support in her own right, as she carried the strain of coping with Mr. A when he was distressed or excessively agitated. The data collected by the second Internal Investigation supports this conclusion: *"during Mr. A's involvement with the Mental Health Services there were 66 telephone calls expressing concern about Mr. A from his wife, his mother and his sister".*

Mrs. A had a job in the Records Department at Treliske Hospital and also had the main caring role for her son. It is evident from the Chronology of the Care and Treatment provided to Mr. A that his wife, despite being estranged from him, continued to offer him considerable practical and emotional help and support. It is, as stated above, unclear whether Mrs. A was ever offered a Carer's Assessment, but from the findings of the two Internal Investigations and the Independent Investigation there is no doubt that she should have been given more support in her own right and to have been offered a Carer's Assessment.

- ***Service Issue 6***

  National and Local Policy was not followed in this instance as there is no evidence that any member of staff offered a Carer's Assessment to Mrs. A. Mrs. A was under almost constant pressure and could have benefitted from a more proactive approach to her situation from

Mental Health Services. The Service must ensure that all carers are offered a Carer's Assessment.

12.1.9 Documentation and Professional Communication

12.1.9.1 Context

Documentation

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professionals have adopted similar guidance.

The GMC states that:

'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off [128] *'*

Pullen and Loudon writing for the Royal College of Psychiatry state that:

"Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised."[129]

Professional Communication

"'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion".[130]

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between Secondary and Primary Care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.

128 http://www.medicalprotection.org/uk/factsheets/records
129Pullen and Loudon, *Advances in Psychiatric Treatment*, Improving standards in clinical record keeping, 12 (4): (2006) PP 280-286
130 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) P121

Mr. A Investigation Report

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone[131]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively[132]. The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

12.1.9.2. Findings

The documentation and written communication between secondary Mental Health Services and Primary Care was of a good standard, as were the notes kept by the inpatient staff when Mr. A was in hospital. Some of the Community Team documentation in relation to describing interviews and meetings with Mr. A and members of his family were well recorded and very clear. It was noticeable that there was less information recorded where family members telephoned to report issues they were concerned with. Mental Health Staff did not collect sufficient information to be useful in deciding whether the behaviour being described had a direct bearing on the level of risk Mr. A posed to himself and/or to others.

The Second Internal Investigation described that *"prescribed treatment and care plans were documented both in written records, ward rounds, outpatient appointments, Mental Health Act Assessments and the Electronic Health Record. The care was provided under the Care Programme Approach...There was a good standard of documentation available about the care and treatment and the electronic care reviews were contemporaneous and up to date. Within the notes there were a number of entries which were out of sequence. This appears to be due to the fact that a number of teams in contact with Mr. A (the Home Treatment Team Redruth Area, the Community Mental Health Team Newquay Area, the inpatient services, Consultant Psychiatrists at outpatient clinics, referrals to other services and family contact with Out of Hours Services.) It is likely that some unavoidable delay occurred before the documentation was filed in the main set of notes".*

The poor quality of the risk assessment and risk management documentation was discussed in Section 12.5.

131 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing,* Institute of Health Services, (1999) P144.
132 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

Professional Communication

There was good communication between the Secondary Mental Health Services and the Primary Care staff involved with Mr. A. One of the junior doctors at Bodmin Hospital had telephoned Mr. A's GP in order to discover whether there was any pertinent information contained within his GP records. This was good practice.

Primary Care

Throughout the period from the first referral of Mr. A to the Restormel Community Mental Health Team until 18 January 2010 the Mental Health Services and Primary Care worked well together. The Secondary Mental Health Services provided written accounts of any outpatient appointments Mr. A had, and the Community Mental Health Staff provided support to Primary Care and kept their colleagues there informed and up to date about how Mr. A was and their plans for his continued treatment.

The second Internal Investigation covered this area well when it described the GP as being the lynch pin in terms of knowing how Mr. A was at any given time. Mr. A attended his GP regularly but never engaged as well with the Community Mental Health Services. This Investigation stated *"The GP appropriately made referrals into Mental Health for further assessment, advice and supervision of medication. The GP was key to the on-going awareness of Mr. A's presentation as he remained resistant to contact with Mental Health Services from the outset of his care believing that his difficulties were as a result of serious physical ill heath. Mr. A frequently visited his GP in order to obtain physical assessment and reassurance. Mr. A included Mental Health Services in his delusional and fixed beliefs making interventions with him difficult and limited in progress".*

"*Mr. A's care and treatment planned by the Consultant Psychiatrist, the clinical team, community and inpatient services was appropriate to assessed needs. The care was implemented by inpatient services as required, and Community Mental Health Teams both the Home Treatment Team and the Restormel CMHT. The GP was the consistent 'lynch pin".*

It was noted by the second Internal Investigation and the Independent Investigation that the Mental Health Services had tended to work alone without sharing information with the other

agencies involved with Mr. A and other members of his family. This lack of sharing, and seeking information from, other local agencies is considered in the next Section.

Interagency Liaison

There is an Information Sharing Protocol which allows information to be shared between Mental Health Services, the Police, and other statutory services. This Protocol could have been used in Mr. A's case. This would have enabled Mental Health Staff to be aware of Mr. A's offending history and the intelligence about domestic abuse concerns which were held by the Police. It is not clear why the Clinical Team did not use this protocol as there were a number of occasions with prompts to staff to think about what information might be held by the Police that would assist with risk assessment, in particular risk to self and members of the public while driving when feeling distressed and behaving erratically.

The two Internal Investigations had identified the risk to Mr. A and others from his driving and the Independent Investigation Panel endorses this recommendation. Mr. A became extremely volatile on occasions and posed a real danger to other road users and pedestrians when he drove erratically, as described in the clinical records. The onus of responsibility is on the clinician to alert Driver and Vehicle and Licensing Agency (DVLA) when such a situation arises and not to do this via the Police.

The current advice is given below and is almost identical to that extant in 2008 and 2009 and states:

Confidentiality and Duty to Inform the DVLA regarding an Individual's Fitness to drive.

The General Medical Council in its guidance on confidentiality[133] notes that while there is a clear public good in having confidential medical services there can be instances where it is in the public interest to disclose confidential information. The guidance states: "*Disclosure of personal information about a patient without consent may be justified in the public interest if failure to disclose may expose others to a risk of death or serious harm"*.

133 GMC (2009) *Confidentiality*

It is the responsibility of the DVLA and Driver and Vehicle Agency (DVA) to decide if a person is medically unfit to drive. However to exercise this responsibility they have to have relevant information.

The DVLA guidance notes state that it is the legal responsibility of the licence holder to inform the DVLA if s/he has a condition that may impair his/her driving. However, it advises that the doctor caring for a patient should explain to the patient:
*"**(a)** that the condition may affect their ability to drive (if the patient is incapable of understanding this advice, for example, because of dementia, you should inform the DVLA or DVA immediately), and **(b)** that they have a legal duty to inform the DVLA or DVA about the condition…If you do not manage to persuade the patient to stop driving, or you discover that they are continuing to drive against your advice, you should contact the DVLA or DVA immediately and disclose any relevant medical information, in confidence, to the medical adviser. Before contacting the DVLA or DVA you should try to inform the patient of your decision to disclose personal information. You should then also inform the patient in writing once you have done so".*[134]

Table 5 below is adapted from the DVLA Guidance and indicates the behaviour the individual may be displaying, whether the DVLA should be notified and their likely action.

Table 5: Current Medical Standards of Fitness to Drive

ALCOHOL/DRUG-RELATED CONDITIONS		
Alcohol/drug misuse or dependency	Licence withheld until patient has been free of problems for: – ≥6 months (persistent alcohol misuse; misuse of cannabis, amphetamines other than methamphetamine, ecstasy, psychoactive drugs) or – ≥1 year (alcohol dependency; misuse of heroin, morphine, methadone, cocaine, methamphetamine, benzodiazepines)	Yes
PSYCHIATRIC DISORDERS		
Dementia	If patient has poor short-term memory, disorientation, lack of insight and judgement, he/she is unlikely to be fit to drive.	Yes
Mania or hypomania	Cease driving during acute illness. Following an isolated episode, patient can be licensed when he/she has remained stable for ≥3 months (6 months if ≥4 episodes of mood swing during previous	Yes

134 DVLA (2011) *For medical Practitioners; At a glance Guide to the current Medical Standards of Fitness to Drive.*

	year), if necessary criteria met.	
Psychotic disorders (acute)	Cease driving during acute illness. Patient can be licensed if he/she has remained well and stable for ≥3 months, if necessary criteria met.	Yes
Schizophrenia (chronic)	Cease driving unless patient has had stable behaviour for ≥3 months, adequate treatment adherence and no adverse effects of medication (subject to favourable specialist report).	Yes

There were several occasions where the Mental Health Services contacted the Police to seek their help in checking if Mr. A was well, as well as when they were preparing to undertake a formal Mental Health Act Assessment. There was also contact when Mr. A was driving when taking Lorazepam, which made him drowsy, and when he was in an extremely agitated state which would have seriously impaired his driving ability. Doctor 1 had advised Mr. A not to drive when he had taken Lorazepam or when he was distressed which he agreed to do, having denied that he did drive in such circumstances.

The lack of contact with Children's Social Care Services about Mr. A and his mental illness and its possible effect on his son was discussed in the Section 12.6.1 under the Care Programme Approach. Suffice to comment here that had further information been provided following the telephone conversation AMHP 2 had with Mrs. A on 02 December 2009 regarding the effect Mr. A's behaviour was having on their son it should have prompted contact with the Children's Social Care Services to ask them to assess the home situation, or preferably to have requested a Strategy Meeting to examine the situation within the family and its effect on the son. This latter course of action would have triggered the sharing of information by all agencies working with the family, the Police, Education, Primary Care and Mental Health Services.

The Cornwall Partnership NHS Foundation Trust Mental Health Services were unaware of several important facts regarding Mr. A which were known to the Police. These facts were that Mr. A had further convictions to the ones recorded in his clinical records. There had been two convictions for Actual Bodily Harm, some Road Traffic Act offences and a conviction for an episode of road rage. It was also known by the Police that Mrs. A had told her husband that she had commenced a new relationship in December 2009.

The knowledge of additional violent incidents involving Mr. A would have increased the risk of him posing a threat to other people and would have significantly raised the risk profile of Mr. A considerably had the mental health services known this.

12.1.9.3. Conclusion

Documentation and Professional Communication

The findings of the first and second Internal Investigations were that the level of Risk Assessment and Management was not well documented and also not as well understood by clinicians as it should have been. The low take up of training about risk issues by clinicians was highlighted as a serious problem as was the unclear completion of the prescribed Risk Assessment and Risk Management Forms.

The Independent Investigation Panel considered that whilst the documentation was sometimes poor, especially in respect of Risk Assessment and Risk Management Forms, there was good recording of the inpatient admissions, and the Community Mental Health Services involvement with Mr. A. There was less completeness about telephone messages and conversations with members of Mr. A's family which should have been recorded in more detail so that the level and extent of the concerns or anxieties raised could be better understood. There was a lack of asking for further information which served to diminish the value of some of the information in relation to potential risks Mr. A posed for his family.

Interagency Liaison

The lack of interagency liaison and discussion had the effect of reducing the common pool of information held about Mr. A and also the possible adverse effects his behaviour could be having on his son. The Mental Health Services did not contact his school, and there was only one reference within the clinical records of a nurse contacting the Children's Social Care Services to inform them of Mr. A's mental ill health.

The Cornwall and Isles of Scilly Local Safeguarding Children Board Serious Case Review Report (SCR) discussed the lack of interagency liaison and discussion and concluded that *"whilst practice within Mental Health Services and communication within and between agencies had many weaknesses, the violent death of the subject [the son] and his mother at the hands of his father could not have been foreseen. Family members did not foresee such a tragic event and did not think the mother had either. No agency had considered the subject*

[the son] to be at risk of serious harm from his father and they thought the mother to be competent and willing to protect him from the excesses of the father's behaviour. As a result, the SCR process has been the vehicle for agencies to share information in order to learn and improve future multiagency safeguarding children arrangements".

The Independent Investigation Panel concurred with the findings of the Serious Case Review that the interagency liaison had been poor and that as a result some important information held by other agencies was not known to all those involved with Mr. A and Mrs. A and their family members.

- ***Contributory Factor 1***

  The lack of information sharing between the agencies involved with Mr. A and the other members of his family when there were mechanisms in place through the Joint Information Sharing Protocol and through the Safeguarding Children Legislation was a contributory factor to the deterioration in Mr. A's mental health.
  It is clear from staff that had they known about the additional violent offences in Mr. A's criminal record and the fact that his wife had told him she had started a new relationship these new factors would have considerably increased his level of assessed risk and would almost certainly have prompted action by the Mental Health Services.

  As with the first and second Internal Investigations and the Local Safeguarding Children Board Serious Case Review into the death of Mr. A and Mrs. A's son the Independent Investigation Panel concluded that the events of 18 January 2010 could not have been foreseen or prevented.

12.1.10. Adherence to Local and National Policy and Procedure and Clinical Governance Arrangements

12.1.10.1 Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients"*.[135] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility.

Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance.

Team Responsibility.

Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility.

All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said policies or procedures or to raise any implementation issues as they arise with immediate effect.

135 Callaghan and Waldock, *Oxford handbook of Mental Health Nursing*, (2006) P 328

Clinical Governance

"*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish*".[136]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

During the time that Mr. A was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation. The reader is asked to look at the Care Quality Commission website for more information as to how the national performance framework is managed.

12.1.10.2 Findings

Adherence to Local and National Policies

Non-optimal Service for Mr. A

The Independent Investigation Panel found that the Cornwall Partnership NHS Foundation Trust did not meet all the Local Policies in relationship to the Transfer of Cases in that Mr. A did not receive a local service due to the fact that he lived in Redruth but had a GP in Newquay. Mr. A, after he had separated from his wife, lived in Redruth but often spent time with his wife on a temporary basis. Mr. A was registered with a Newquay GP and therefore the Mental Health Services considered that he had to have support from the Restormel Community Mental Health Team rather than the Kerrier Community Mental Health Team which served Redruth. The Discharge arrangements for Mr. A were not optimal for him as his main support would be from the Restormel CMHT which was a 37 mile round trip from his Redruth Home. Many of his appointments were at the annex at Newquay Hospital so Mr. A had to make the journey, and staff there missed the opportunity to assess his mental health and his coping skills within the context of his home.

[136] Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

As Mr. A did not think that he had mental health issues he did not wish to engage with services and if services were to have a chance of forging a relationship with him they needed to be local. Mr. A was not accepted by the West Assertive Outreach Team which would have been better placed to meet his needs and to attempt to engage him. Mr. A was therefore not provided with as proactive a service as he required. In the circumstances the Restormel CMHT offered as good a service as they could and realised that if they discharged Mr. A he would not receive a service. The lack of a method to escalate situations where local mental health teams could not agree which service should accept a service user prevented Mr. A being transferred to the Kerrier (Redruth) Mental Health Services.

The second Internal Investigation commented that the Operational Policies of the various Mental Health Teams needed to be reviewed to ensure that they all complemented each other and that together they accurately reflected the various pathways of care for service users within and between the specific services available. The following recommendation was developed to address these issues and the Trust was strongly advised to review policies and to make additional policies where necessary. This work was to be completed within three months. The Trust should:

- *"develop policy to manage professional differences;*
- *develop policy for escalation of operational difficulties from team manager up through the organisation in order that risks are identified and shared appropriately;*
- *develop a policy to trigger staff response to concerns raised by others regarding service users.*

Staff will be prompted to:

- *review a service user's care;*
- *hold a multi-agency risk management meeting;*
- *review any contact with children and identify risk;*

(Where concern relates to a child there must be a parallel process and need for staff to follow child protection procedures. The named nurse should be invited to risk meetings).

- *request information from other agencies;*
- *develop an action plan to respond to care needs/risks".*

Safeguarding Issues and Services Working in Isolation

It was also evident from the clinical records that the Mental Health Services did not liaise with the Children's Social Care Services as closely as was required by the Local Safeguarding Policy nor with the National Policy as detailed in the 2006 Working Together to Safeguard Children. As the introduction to 'What to do if you're worried a child is being abused' states *"achieving good outcomes for children requires all those with responsibility for assessment and the provision of services to work together according to an agreed plan of action. Effective collaborative working requires professionals and agencies to be clear about their roles and responsibilities for safeguarding and promoting the welfare of children…".*

There were opportunities for Mental Health Staff to report that Mr. A had a mental illness and that he was disturbed and paranoid and was convinced that he had a serious physical life-threatening illness which made him agitated and irrational. Mrs. A reported that she was concerned that their 10 year old son was being affected by his father's strange behaviour and bizarre thoughts. Such information should have been passed to the Children's Social Care Services as a referral or a request for a Strategy Conference, but this was not done. By not sharing information about the father's mental health the local and national requirements for Safeguarding Children were not being followed.

Clinical Governance

The second Internal Investigation recommended that there should be a Review of the Trust Governance arrangements and that it should include examination of four key processes surrounding the management of serious untoward incidents, which were identified as the:

- :process for identification, management and review of serious incidents;
- process for Corporate notification and sharing of risk;
- process for sharing learning and seeking assurance from services;
- process for review of action plans and communication to Trust Board.

The Acting Chief Executive was concerned that the Trust Board was not receiving all the information it required to satisfy itself that the services were operating as well as they might. In response to these concerns an External Review of the Governance Arrangements in the Trust was commissioned and various recommendations were made covering the areas of the quality audit of serious incident investigations, the Governance Department's management of

and input to the action planning process which needed to be owned by an executive director to whom the investigator would report. A skills audit of the investigators should be undertaken and the suggestion made to have some investigators external to the Trust.

The Trust has reviewed and reorganised its Governance Arrangements so that serious untoward incidents and complaints and organisational risks are managed by the same group of managers. This was to make sure that lessons which needed to be learned did not get fragmented or lost due to there being different sections of the organisation involved. The Chief Executive and the Board keep a close scrutiny of how all work to rectify previous recommendations from other untoward incidents is progressing, and order additional measures should it be required. A good example was the rapid commissioning of the second Internal Investigation when it became known that there were additional issues which would require attention following the production of the original Internal Investigation.

One of the authors of the second Internal Investigation Report was appointed to help train the internal investigators and continues to provide advice and to act as a consultant to anyone undertaking an internal serious untoward incident investigation.

12.1.10.3. Conclusion

Local Policies and Procedures

It was clear that there were some policies which did not reflect national policy and the local policies themselves were not being followed by staff. This was the case with Safeguarding Children where the Mental Health Staff were not aware of the latest national guidance and therefore did not report the presence of a mentally ill father, Mr. A, to the Local Authority in a situation where his mental ill health could have adverse effects upon his son. This was done once after a Ward Round but other opportunities were not utilised.

The Local Operational Policies of the various Mental Health Teams working in the community did not provide a clear and easy to follow pathway as they had been written for the individual service and not in conjunction with the other services. The difficulties in transferring Mr. A to the Kerrier Community Mental Health Team when he was living in Redruth continued for the two years Mr. A was known to the Cornwall Partnership NHS Foundation Trust and had not been resolved by the date of the incident.

Clinical Governance

The Clinical Governance arrangements have been reviewed and appear to be much stronger with additional training for the internal investigators of serious untoward incidents and a source of advice when they are undertaking the investigation. The Board now ensure that it 'owns' the issues which emerge and provide support for those who are dealing with them and help identify practical and positive solutions. The Trust held a workshop in February 2012 to disseminate the lessons from two Independent Investigations into the care and treatment of two service users who had committed a homicide. This was a formal demonstration that the Trust had heeded the advice it received and had improved its handling of Internal Investigations and also the complete process to ensure the lessons learnt were disseminated across the Trust.

13. Findings and Conclusions Regarding the Care and Treatment Mr A Received

13.1. Findings

The 10 findings have been identified following a full review of the care and treatment that Mr. A received from the Cornwall Partnership NHS Foundation Trust. These have been set out below together with their accompanying relevant causal, contributory and service issues.

The Independent Investigation Panel considered the six factors where it was making additional recommendations using the Fishbone Root Cause Analysis Tool which groups factors under one of nine headings which are:

a) Team and Social Factors;
b) Communication Factors;
c) Task Factors;
d) Education and Training Factors;
e) Patient Factors;
f) Organisational and Strategic Factors;
g) Working Conditions Factors;
h) Equipment and Resources Factors;
i) Individual Factors (which stand alone and are not embraced by the other items).

1. **Diagnosis.**

First Internal Investigation

The first Internal Investigation did not comment much on the diagnosis made by the staff working with Mr. A. It generally concurred with the clinical opinion that Mr. A had a Psychosis, probably Schizophrenia, with Depression.

Second Internal Investigation

The diagnoses of Psychotic Depression and Psychotic Illness/Depression with Psychosis were considered accurate, and that the medication prescribed was appropriate and the effect it was having was monitored by the Community Mental Health Team and the Home Treatment Team. Depot injections were attempted but

Mr. A would usually refuse to have them. During the four months he was on the Supervised Community Treatment Order the fortnightly Depot Injections were accepted, albeit unwillingly. The second Internal Investigation report concluded that the *"treatment of [Mr. A's] mental health was appropriate although not easily delivered… It was shared care between GP and Secondary Mental Health Services.*

Independent Investigation Panel

The Independent Investigation Panel concluded that the Diagnosis was correct and that the medication used was appropriate. The gathering of information about Mr. A could have been more rigorous as there was no evidence in the clinical records that his wife or other members of his family who had contact with the mental health staff were formally asked about Mr. A and his life prior to his first contact with the Community Mental Health Team in January 2008. Such questioning could have helped develop further understanding about Mr. A and therefore have contributed to a fuller diagnosis. Indeed there was no detailed case history taken by either a consultant or a junior doctor within the clinical records. Such a history would have presented the historical facts in a conventional manner assisting in the process of formulating a diagnosis, differential diagnosis, aetiological factors including dynamic and family factors, which leads to clear diagnosis and informs a definite treatment plan.

This was considered to be a Task Factor in that the collection of information about a previously unknown service user presenting with a possible psychotic or depressive illness should have had a formal interview. His wife was his main carer and would have been able to confirm or disprove the history her husband had reported. This was a Task Factor in terms of finding out as much about Mr. A as possible. This would include looking at Primary Care Records, which was done later, and speaking to other members of Mr. A's family.

- ***Service Issue 1***

  The practice of not formally interviewing Mr. A and collecting information for a detailed case history reduced the level of knowledge there was about Mr. A. Mr. A was the sole informant and may not have been the most reliable witness. Mental Health Staff did not formally interview his wife or other family members to corroborate the information they had been given by Mr. A. The Service needs to

ensure that full psychiatric histories are taken for all service users.

It was known that Mr. A was drinking alcohol and took magic mushrooms and cannabis but no full consideration of his having a Dual Diagnosis was formally considered. His presentation of being admitted to hospital in crisis and then becoming calm in a relatively short time further suggested the possibility that his psychosis was due to the illicit substances.

Dr 1 did not discuss Mr. A and his needs in any multidisciplinary forum other than the Ward Round which appeared to have a limited membership from the records of those attending. He did discuss Mr. A with his 'cross-over consultant' (who covered his work when he was away and he hers when she was away), but there appeared not to be a forum where difficult and complex 'cases' could be discussed with other clinicians across the Trust in order to gain fresh suggestions for treatment. There was the opportunity for Dr 1 to discuss with his peer group how best to manage the care and treatment of Mr. A but this was not used.

The Independent Investigation Panel concluded that this was a Communication Factor as an opportunity to gain more information and suggestions as to how best to care and treat Mr. A had been missed.

- ***Service Issue 2***
  The lack of a forum where complex or difficult to diagnose and treat service users could be discussed with a multidisciplinary group of clinicians from across the Trust prevented possible alternative suggestions from other clinicians being considered. Such a group should be developed in order to make the best use of all the relevant knowledge available within the Trust as a whole.

  Mr. A did not believe he was mentally ill and did not see the need to work with the CMHT or the HTT. He displayed secretiveness when being interviewed by mental health staff, and was successful in hiding his fears and thoughts. Mr. A also declined to disclose key past life events and allowed the treatment teams to proceed with the most positive therapeutic assumption that he was a distressed, ill, but well meaning man with whom they must continue to attempt to engage.

This appears to have become an over optimistic view of Mr. A which allowed the teams to continue in a relationship with him without confronting the difficulties on both his side and theirs. The two Internal Investigations by the Cornwall Partnership NHS Foundation Trust provide considerable amounts of information, analysis and recommendations. The agreed consensus diagnosis was that Mr. A had a psychosis, probably schizophrenia, and also depression. There was evidence that his mental ill health was exacerbated by alcohol and illicit drugs but this was not fully explored.

2. **Medication and Treatment.**

Mr. A was not offered psychological therapies during his first admission to Fletcher Ward at Bodmin Hospital on 28 October 2008 or whilst in the community, until 08 October 2009 when he had one session with a clinical psychologist which he left early. His Care Coordinator in April 2009 tried to help Mr. A manage his anxiety by using a Cognitive Behavioural Therapy problem solving approach. The delivery of the therapy was largely carried out on the telephone and therefore lacked the direct personal element. No other approaches were attempted, except when Mr. A was in hospital when he attended a few of the activities on the ward. It was recorded that he did attend Art Therapy whilst on Fletcher Ward but this was not consistent. He refused to participate with the Tidal Model of Nursing Care in May 2009 and only loosely complied on other occasions when he declined to provide much information about himself.

The Independent Investigation Panel concluded that this was a Task Factor as the failure to provide psychological therapy to a service user with first onset of possible schizophrenia was against the national guidance from the National Institute for Health and Clinical Excellence.

- ***Service Issue 3***

The National Institute for Health and Clinical Excellence advice for people with schizophrenia to be given a psychological therapeutic approach treatment during their first hospital admission was not followed with Mr. A when he was first admitted to Fletcher Ward on 28 October 2008. This should have been introduced although it is accepted that Mr. A would probably not have engaged with the therapist and would not have continued this in the community. New service users

with schizophrenia must be offered psychological therapy during their first admission.

Clinical records detail sparsely attended ward rounds, the consultant, and ST3 (Senior House Officer), a medical student and the ward nurse for the ward round day. There was therefore limited opportunity for a multidisciplinary discussion. Mr. A's consultant claimed he did not have access to psychology on the ward.

Doctor 1 did not use any clinical forum to discuss Mr. A, even though he was a complex case. He did discuss the situation with his 'cross-over' consultant, the one who covered for him when he was unavailable, but not with his peer group. Additional ideas could have been forthcoming but the available forum was not used. Mr. A was discussed in the regular ward meetings and his care plan was frequently reviewed. The input from other consultant colleagues could have proved helpful. Discussion with the wider multidisciplinary team could also have been useful.

The Staff tended to take what Mr. A told them at face value. They did not try to get behind what he said by challenging some of his assertions as a more forensic approach would have done. He did respond and disclose more occasionally, for example when the Care Coordinator and CPN 3 worked together in September 2009. On relatively rare occasions Mr. A spoke openly on Fletcher Ward and he did answer the questions Dr 1 posed when he was making an assessment. Although Mr. A attended only one session with Psychologist 1 on 08 October 2009, he did open up about his belief that he had HIV and gave some detailed information about some events in his earlier life.

The Independent Investigation Panel concluded that staff not asking questions to try to gain more information from Mr. A or to gather some additional evidence or corroboration through gently challenging his answers was a Task Factor. This should have been recognised as part of the necessary collection of evidence when seeking to establish a diagnosis or an appropriate treatment plan.

- ***Service Issue 4***

  Mental Health Staff tended to accept what Mr. A told them at face value without asking any follow up questions or probing more deeply and challenging some of his statements. This could have provided more information or a clearer understanding of his overall situation and perhaps have broken through some of his guarded and suspicious attitude to Mental Health Staff. The Service needs to ensure that, where appropriate, staff do challenge and question service users when they consider information is being withheld.

The Independent Investigation Panel concluded that the observations of the Second Internal Investigation were correct and that Mr. A was in control of his treatment which was accepted or rejected on his terms. When Mr. A was in the community the Mental Health Services were hampered in their efforts to provide a treatment plan for him due to the geographical issue of his having a GP in Newquay which served to bar his being accepted by the Redruth Community Mental Health Services. The majority of contacts were in Newquay and therefore Mr. A was often seen without there being any other family members present, and also without the staff being able to review his progress within his home. This meant that it was difficult for them to assess how he was managing as they rarely entered his Redruth home to see whether it was clean, looked after and if he had sufficient food.

3. Use of the Mental Health Act (1983 and 2007).

The Independent Investigation Panel was asked specifically to examine the use of the Mental Health Act on three occasions it was used to arrange a formal Mental Health Act Assessment with Mr. A and on each occasion no admission to hospital occurred. It was also asked to examine the use of the Supervised Community Treatment Order and the decision taken by the Mental Health Act Managers Hearing. The conclusions in these five situations are reproduced as the detail is in Section 12.3.

Use of Mental Health Act 2007 on 28 September 2009

Mr. A certainly had been distressed and did not want to be visited. Over time however he was able to alter his firm views and agree that he did sleep better with the Zopiclone or Olanzapine taken at night. He had agreed to the two staff visiting and also accepted that they would visit again the next week and telephone him in between.

Given his poor level of engagement and the suggestion that he was deteriorating there might have been grounds for considering using the Mental Health Act. It was however decided that it was not appropriate as there were no grounds for undertaking a formal Mental Health Act Assessment at this time.

Use of Mental Health Act 2007 on 21 October 2009

Mr. A appears to have been behaving as he had in the past by refusing help from services and losing his temper. He very quickly apologised for his behaviour and was appropriate with the GP the following morning. Throughout his contact with the Mental Health Services he had insisted that his problems were due to physical health issues and were nothing to do with his mental health. On the other hand his rapidly changing behaviour from being reasonably calm and then being distressed and appearing to be irrational, and then to revert to being more amenable was part of the nature of his 'problems'.

Use of Mental Health Act 2007 on 02 December 2009

The situation appears very confused. The Restormel CMHT was trying to refer Mr. A to the Assertive Outreach Team covering Redruth, or to the Home Treatment Team due to the lack of a response to Mrs. A's request for an urgent Mental Health Act Assessment. Mr. A went missing but was known to have been in Redruth on 04 December 2009. There is no clear explanation why a Mental Health Act Assessment was not arranged. By 07 December 2009 Mr. A was back at his wife's address and was reported to have been much better having visited the Terence Higgins Trust where he had had a blood test which confirmed he did not have AIDS. Mr. A said he did not want any contact with the Mental Health Services. Mrs. A is reported to have said that she no longer thought a Mental Health Act Assessment was necessary.

It has to be assumed that as Mr. A 'went missing' a Mental Health Act Assessment could not be effected. The rapid transformation in his presentation between 02 December 2009 when he was at Truro station and his calm demeanour on 04 December 2009 when at his wife's address could be seen as an indicator that Mr. A would not have been able to have been made subject to a Mental Health Act Section at that time.

The Use of the Supervised Community Treatment Order

Context

Mr. A had been subject to a Supervised Community Treatment Order from 30 December 2008 until July 2009 which had worked well as although reluctant he had agreed to comply with the conditions. That Order was revoked when Mr. A was recalled to hospital.

Use of the Order

It is clear that the Supervised Community Treatment Order would not have been effective as Mr. A was refusing to comply with any of the three conditions. The Code of Practice is clear in this situation that the patient must agree, and AMHP 1 was correct to refuse to agree to the making of the SCT Order. It was coincidental that the Mental Health Managers Review Tribunal was meeting that same afternoon.

The Mental Health Managers Review Tribunal

Context

The Mental Health Managers Review Tribunal had upheld Mr. A's appeal against his Mental Health Detention.

The First Internal Investigation

The First Internal Review made considerable comment about how the Managers may have overstepped their authority and how this action gave a wrong message to Mr. A by confirming that he did not have a mental illness.

The Second Internal Investigation

The Second Internal Investigation did not support this finding. It concluded that whilst it had confirmed the belief of Mr. A that he did not have a mental illness which warranted his detention in hospital, there was little evidence that it had significantly altered his relationship with the Mental Health Services. In the overall context of the totality of the involvement the Cornwall Partnership NHS Foundation Trust Mental Health Services had with Mr. A the discharge by the Hospital Managers did not affect the outcome of his care.

The Independent Investigation Panel

The Independent Investigation Panel supports the finding of the Second Internal Investigation. Although Mr. A may have viewed the decision as a triumph for his point of view, the course of events following his discharge does not support the view that this was a significant turning point in the management of Mr. A. He continued to act as he had prior to his discharge and remained reluctant to fully engage with services except when he felt he needed some assistance. He maintained his belief that he did not have a mental illness and therefore did not require treatment or contact with Mental Health Services.

4. Care Programme Approach (CPA).

Mr. A was treated under the Care Programme Approach throughout the period that he was in contact with the Mental Health Services in Cornwall, from 17 January 2008 to 18 January 2010. During this time he had five care coordinators.

The longest period during which Mr. A received support from a Care Coordinator was with Care Coordinator 3 who worked with him for six months. The work with Mr. A was difficult for Care Coordinators as he did not wish to engage with services and did not want to assist in the development of a care plan. The number of Care Coordinators did not assist in developing a consistent approach with Mr. A although he was in contact with the same Restormel Community Mental Health Team and Doctor 1 for most of his two years with the services.

Whilst an inpatient Mr. A had many agreed periods of Section 17 Leave and also several instances where he absconded from hospital or failed to return as required under the conditions of his Leave. The Care Coordinators were largely unable to forge a working relationship with Mr. A and they were also to some extent distracted by trying to transfer Mr. A to the West Assertive Outreach Team. When discharged from hospital the Home Treatment Team worked with Mr. A until he was deemed to be more settled and able to return to the Restormel Community Mental Health Team.

It is clear from the clinical records that the Mental Health Services and the Police worked in relative isolation from each other and did not share information which would have been helpful to both. The Independent Investigation Panel agrees with the

comments of the Second Internal Investigation when it states that the information held by the Police "*would have assisted in risk assessment, the authors wish to note that we do not believe this information would have led mental health services to conclude that [Mr. A] was at risk of harming his wife, son and himself as occurred in this case. We also note that [Mr. A] prevented mental health staff from exploring his thoughts, feelings in any depth by refusing to engage in one to one time when an inpatient, and by being guarded and closed in his interviews with staff at other times".*

There is an Information Sharing Protocol which allows information to be shared between Mental Health Services and the Police, and other statutory services. This protocol could have been used in Mr. A's case. This would have enabled Mental Health Staff to be aware of all Mr. A's offending history and also about the Police intelligence about domestic abuse concerns. It is not clear why the Clinical Team did not use this protocol as there were a number of occasions where staff had contact with the Police but did not think about what information might be held by the Police that would assist with risk assessment.

The national requirement for services to work together was provided in Working Together to Safeguard Children published in 2006. There is a clear expectation that *"all practitioners working with children and families should be familiar with and follow your organisation's procedures and protocols for promoting and safeguarding the welfare of children in your area, and know who to contact in your organisation to express concerns about a child's welfare"*. It is clear that with the exception of the contact made by a Fletcher Ward nurse after a Ward Round to explain that Mr. A's mental ill health could be affecting his son no other contact was made.

The Mental Health Services had limited contact with Mr. A and Mrs. A's son but there were two occasions which should have prompted a referral to the Children's Social Care Services. The first was on 23 October 2008 when Mrs. A had telephoned the Home Treatment Team (West) as she was distressed because she felt that:
"she and her nine year old son were at risk from [Mr. A]" as he had been "*regularly in contact with her by telephone and by text and in the last week had started accusing her of being part of the conspiracy to kill him, hence her increased worry for her and her son's safety. Staff advised her to contact the Police if she felt she was in danger".*

The second occasion was the telephone conversation AMHP 2 had with Mrs. A on 02 December 2009 regarding the effect Mr. A's behaviour was having on their son should at the very least have prompted contact with the Children's Social Care Services to ask them to assess the home situation, or preferably to have requested a Strategy Meeting to examine the situation within the family and its effect on the son. This latter course of action would have triggered the sharing of information by all agencies working with the family, the Police, Education, Primary Care and Mental Health Services.

The Serious Case Review commissioned by the Local Safeguarding Children Board highlighted the lack of contact between the agencies but did not identify any individual staff failings and concluded that the events of 18 January 2010 could not have been predicted.

5. Risk Assessment and Management.

The Risk Assessment Forms were hard to follow as it was not clear where the latest risks were being identified, so all the risk assessments appeared the same and it was often time consuming and tedious to identify the date of the assessment and what were previous entries and which were the latest version. Out of date risk data was also still being recorded when additional risks were added. It is accepted that RIO has helped to overcome these issues.

The recording of Risk Assessment and Risk Management Plans was difficult to fully understand from the review of the clinical records, both written and electronic, because it is evident that there was a lack of detail recorded of descriptions of issues and concerns raised by Mrs. A and other family members. On a number of occasions this lack of detail may have impeded appropriate assessment of risk. For example the documentation of the harassing and threatening text messages Mr. A sent to his wife was poor, with no examples recorded to identify the actual content and scale of the harassment and the likely fear and concern this would cause the recipient.

The Independent Investigation Panel concluded that this was a Task Factor as Mental Health Staff were not asking questions to discover more details of important

information connected to allegations of risk from Mrs. A, and on occasions other members of the family.

- ***Service Issue 5***

  This is another example where the Mental Health Staff did not seek clarification of what Mrs. A was telling them. The Staff Member should have asked why she thought she and her son might be vulnerable and what action her husband might take. Fuller recording of these types of contact would help to inform the Risk Assessment and Risk Management process and improve the resultant Care Plan and Risk Management Plan. The Service must ensure that staff fully record information given to them by relatives and friends of service users to inform the current level of risk the service user presents.

6. Referral, Admission and Handover Processes.

The key issue for Mr. A was the lack of an effective handover (transfer) procedure so that as he lived in Redruth his care and treatment could be delivered from Redruth/West Cornwall Services. The fact that Mr. A was registered with a GP in Newquay, where he used to live prior to his partial separation from his wife, prevented the Restormal Community Mental Health Team transferring him to another service in West Cornwall, the Kerrier Community Mental Health Team or the West Cornwall Assertive Outreach Team. This issue had not been dealt with by the date of the incident.

The First and Second Internal Investigations

Both Internal Investigations highlighted this inability to provide Mr. A with a local service as a significant issue. Had he been able to receive his care and treatment from West Cornwall Mr. A could have been visited at home relatively easily and would therefore have been seen in his domestic context which would have provided better opportunities to assess his mental state and to identify how he was managing within the home.

The Independent Investigation Panel

The Independent Investigation Panel considered the recommendation made by the second Internal Investigation to be sound as it recommended the rapid development of

an escalation policy whereby issues between teams which could not be settled at team manager level could be referred up to a senior manager who could arbitrate and decide what was in the best interests of the service user.

7. Service User Involvement in Care Planning.

The Independent Investigation Panel agrees with the second Internal Investigation about Mr. A not really being difficult to engage, but that as he did not accept he had mental health issues it was likely that he would not wish to meet those who refused to accept he was physically ill. There were times where Mr. A became so anxious and distressed that he sought admission to Bodmin Psychiatric Hospital and accepted visits from the Mental Health Staff.

The second Internal Investigation examined what level of involvement Mental Health Services provided to Mr. A. This was difficult as "*Mr. A remained without insight into his need for the support of mental health services thus making it very hard to deliver the prescribed treatment and care plans in partnership with him as would be good practice in person centred care planning. Mr. A was of the view that his problems were of a physical nature. He was not in agreement with medication for a psychotic disorder, did not believe he was depressed and did not want contact from mental health services".*

The Mental Health Services attempted to engage Mr. A in making decisions about his care and treatment, but as he did not believe he had any mental health issues he did not wish to receive medication nor to be actively involved with Mental Health Services except when he was feeling agitated and sought admission to hospital or phoned the Restormel Community Mental Health for advice.

8. Carer Involvement and Carer Assessment

It is unclear from the clinical records if Mrs. A (wife) was ever offered a Carer's Assessment. Given the level of support she was providing for her husband, despite being estranged from him, this should have been offered. There was also little evidence from the written documentation that when Mrs. A did raise concerns about her husband staff arranged to meet her and explain the situation to her, or to offer her advice. Staff did not telephone Mrs. A to enquire how she was but more to discuss

how her husband was. When she expressed concern about her husband being aggressive or harassing her with threatening text messages she was told to contact the Police. Mrs. A was concerned about the effect Mr. A was having on his son, and she had to bear the brunt of his delusional concerns about his health and help him when he became excessively distressed or anxious and made threats to kill himself.

The Independent Investigation concluded that this was a Task Factor in that national and local policy was for the carers of people with mental health problems to be offered an assessment in their own right as carers.

- ***Service Issue 6***

  National and Local Policy was not followed in this instance as there is no evidence that any member of staff offered a Carer's Assessment to Mrs. A. Mrs. A was under almost constant pressure and could have benefitted from a more proactive approach to her situation from Mental Health Services. The Service must ensure that all carers are offered a Carer's Assessment.

9. Documentation and Professional Communication.

Documentation

The documentation and written communication between secondary Mental Health Services and Primary Care was of a good standard, as were the notes kept by the inpatient staff when Mr. A was in hospital. Some of the Community Team documentation in relation to describing interviews and meetings with Mr. A and members of his family were well recorded and very clear.

It was noticeable that there was less information recorded where family members telephoned to report issues they were concerned with. Mental Health Staff did not collect sufficient information to be useful in deciding whether the behaviour being described had a direct bearing on the level of risk Mr. A posed to himself and/or to others.

Professional Communication

There was good communication between the Secondary Mental Health Services and the Primary Care staff involved with Mr. A. One of the junior doctors at Bodmin

Hospital had telephoned Mr. A's GP in order to discover whether there was any pertinent information contained within his GP records.

It was noted by the second Internal Investigation and the Independent Investigation that the Mental Health Services had tended to work alone without sharing information with the other agencies involved with Mr. A and other members of his family. The lack of interagency liaison and discussion had the effect of reducing the common pool of information held about Mr. A and also the possible adverse effects his behaviour could be having on his son. The Mental Health Services did not contact his school, and there was only one reference within the clinical records of a nurse contacting the Children's Social Care Services to inform them of Mr. A's mental ill health following a Ward Round on Fletcher Ward on 28 October 2008.

The Independent Investigation Panel concurred with the findings of the Serious Case Review that the interagency liaison had been poor and that as a result some important information held by other agencies was not known to all those involved with Mr. A and Mrs. A and their family members. Had Dr 1 or AMHP 2 been aware of the additional violent incidents in Mr. A's previous convictions, and the fact that his wife had told him over Christmas that she had started a new relationship, action would almost certainly have been taken as these facts significantly raised the risk assessment profile for Mr. A. As stated in the Section on the Care Programme Approach this was seen as a contributory factor to Mr. A's mental health deteriorating through a lack of knowledge by all agencies prevented them acting to assess the situation.

The Independent Investigation Panel concluded that this was a Communication Factor as the Mental Health Service did not share information with the other agencies working with Mr. A and his family. It was also a contributory factor as it precluded information relevant to Mr. A's mental health being made known to the Mental Health Services.

- ***Contributory Factor 1***

  The lack of information sharing between the agencies involved with Mr. A and the other members of his family when there were mechanisms in place through the

Joint Information Sharing Protocol and through the Safeguarding Children Legislation was a contributory factor to the deterioration in Mr. A's mental health. It is clear from staff that had they known about the additional violent offences in Mr. A's criminal record and the fact that his wife had told him she had started a new relationship these new factors would have considerably increased his level of assessed risk and could have prompted action by the Mental Health Services.

As with the first and second Internal Investigations and the Local Safeguarding Children Board Serious Case Review into the death of Mr. A and Mrs. A's son the Independent Investigation Panel concluded that the events of 18 January 2010 could not have been foreseen or prevented.

10. Adherence to Local and National Policy and Procedure, and Clinical Governance Arrangements.

Local and National Policy and Procedure

The difficulties in transferring Mr. A from the Restormel Community Mental Health Team to the Kerrier Community Mental Health Team of the West Cornwall Assertive Outreach Team have been covered in detail in Section 12.1.6. The Cornwall Partnership NHS Foundation Trust Discharge Planning and Transfer Policy dated 10 August 2005 and updated in March 2009 detailing arrangements for handover was not adhered to, despite the efforts of the Restormel Community Mental Health Team to transfer Mr. A to a more local (for him) Redruth Mental Health Service.

The local operational policies of the various mental health teams working in the community did not provide a clear and easy to follow pathway as they had been written for the individual service and not in conjunction with the other services. The difficulties in transferring Mr. A to the Kerrier Community Mental Health Team when he was living in Redruth continued for the two years Mr. A was known to the Cornwall Partnership NHS Foundation Trust and had not been resolved by the date of the incident.

The issues surrounding the lack of adherence to the Safeguarding Children Policies in Cornwall were not followed as Mental Health Staff appeared to be unaware of

relevant local and national policies. This issue has been covered in detail in Section 12.1.4 and in the previous Section immediately above.

These issues were identified by both the Internal Investigations and their recommendations were endorsed by the Independent Investigation Panel. The Second Internal Investigation considered that several opportunities to contact the Children's Social Care Services were missed and like the First Internal Investigation identified the need for training for all staff regarding Safeguarding Children.

Clinical Governance Arrangements

The second Internal Investigation recommended that there should be a review of the Trust Governance arrangements and that it should include examination of four key processes surrounding the management of serious untoward incidents, which were identified as the:

- :process for identification, management and review of serious incidents;
- process for Corporate notification and sharing of risk;
- process for sharing learning and seeking assurance from services;
- process for review of action plans and communication to Trust Board.

The Acting Chief Executive was concerned that the Trust Board was not receiving all the information it required to satisfy itself that the services were operating as well as they might. In response to these concerns an external review of the Governance Arrangements in the Trust was commissioned and various recommendations were made covering the areas of the quality audit of serious incident investigations, the Governance Department's management of and input to the action planning process which needed to be owned by an executive director to whom the investigator would report. A skills audit of the investigators should be undertaken and the suggestion made to involve some investigators external to the Trust.

The Trust has reviewed and reorganised its Governance Arrangements so that serious untoward incidents and complaints and organisational risks are managed by the same group of managers. This was to make sure that lessons which needed to be learned did not get fragmented or lost due to there being different sections of the organisation involved. The Chief Executive and the Board keep a close scrutiny of how all work to

rectify previous recommendations from other untoward incidents is progressing, and order additional measures should it be required.

13.2. Conclusions

13.2.1 First and Second Internal Investigation Teams

Obtaining Optimal Care and Treatment

Mr. A was referred to the Restormel Community Mental Health Team based in Newquay because that was where he was registered with a GP. Despite lengthy discussions and attempts to transfer Mr. A to a West Cornwall (Kerrier Community Mental Health Team) and the West Cornwall Assertive Outreach Team Mr. A remained with the Newquay service. This directly caused him to have more office appointments than home visits and was inconvenient for the staff and for Mr. A due to the 37 mile round trip involved. This situation was also discussed as part of the Local Safeguarding Children Board Serious Case Review.

Use of Staff Mobile Phones

The first Internal Investigation identified that when staff were on leave or attending training events their mobile phones were left in their offices with no method of any messages left by clients being recorded and acted upon.

Safeguarding Children and the Sharing of Information

The Mental Health Staff were not fully aware of all their responsibilities under the Safeguarding Legislation and therefore important information about Mr. A's mental health was not shared with the Local Authority Social Services or the Education Authorities. Mental Health Staff had limited contact with Mr. A and Mrs. A's son but they were made aware that on at least two occasions Mrs. A thought her husband was having an adverse effect upon both she and her son and she felt frightened, but this information was not shared with the Police nor the Local Authority.

The Mental Health Services had on occasions during the time Mr. A was a service user asked the Police to carry out a 'welfare check' when it could have been better practice for mental health staff to visit to assess his mental state, with Police support should this have been

deemed necessary. The second Internal Investigation recommended that the Trust should review the process for requesting the Police to undertake 'welfare checks', and ensure that there are clear parameters dictating when it is a Mental Health Service responsibility to assess and when a 'welfare check' is required from the Police.

Both Internal Investigations made recommendations for urgent staff training about Safeguarding Children and Domestic Violence and their inclusion in the MARAC procedures. Sharing of information using the existing Protocol was highlighted and again recommendations for its use were made. Of particular value was the recommendation that the Mental Health Services should use the local Neighbourhood Police Sergeants as their point of contact.

Mental Health Act and the Mental Health Act Managers' Review Process

The first Internal Investigation considered that the Mental Health Act Managers had possibly exceeded their powers when they discharged Mr. A against the advice of his consultant psychiatrist. The second Internal Investigation concluded that when the discharge was examined in the totality of the care and treatment of Mr. A it did not make a significant difference to the way he behaved. Training for the Hospital Managers and the Mental Health Act Manager was recommended, as well as the provision of independent clinical advice to complement the legal advice already provided.

Governance Arrangements

The second Internal Investigation made recommendations for the review of the Trust's Governance Arrangements as it was considered that the process for investigating untoward incidents was not sufficiently robust and that training was required. There were also issues about the learning arising from untoward incident investigations and the subsequent dissemination of these across the Trust, including the Trust Board.

Trust Policies

The second Internal Investigation highlighted the fact that the operational policies for all the various Mental Health Community Teams did not necessarily match each other leaving potential gaps in the various care pathways. The issues over transferring Mr. A from one team to another highlighted the problem.

In addition it was noted that there was a need for additional policies to:

- manage professional differences;
- develop policy for escalation of operational difficulties from team manager up through the organisation in order that risks are identified and shared appropriately;
- develop a policy to trigger staff to respond to concerns raised by others regarding service users which would include prompts for staff to review a service user's care, hold multi-agency risk management meetings and to review any contact with children and identify the risk from parents with mental ill health.

Communication and Information Sharing

Lack of communication with the other agencies involved with Mr. A and other members of his family was highlighted as an issue which urgently needed to be addressed. All staff were sent a reminder of their responsibility to share information and a copy of the 'Information Sharing Pocket Guide (*HM Government Information Sharing: Pocket Guide*). This document was circulated as a controlled document, as was the guidance for notifying DVLA of a service user considered to be a potential danger to themselves or other road users and pedestrians.

Mental Health Service Configuration

The second Internal Investigation considered that the issue of service users being treated by their local Mental Health Services required the Trust to review the structure of their Mental Health Services and for them all to be Cornwall-wide with local office bases. The Independent Investigation Panel did not agree as the services would be stretched given the high rural nature of much of Cornwall. The key issues were to ensure that service users would have 'Patient Centred Care Plans' which must reflect the:

:

- location of the delivery of care, and include the reason for office based appointments, for example patient choice, risk to staff or others and consideration of the wishes of any carer;
- information to relatives and carers about treatment, progress and future plans;
- Child Protection *[Safeguarding]* information sharing and processes.

Documentation and Record Keeping

Both Internal Investigations concluded that some record keeping was poor, particularly in relation to the Risk Assessment and Risk Management Forms, the keeping of detailed notes when family contacted services with concerns about Mr. A, and the taking of minutes at meetings. It was recommended that the use of an agreed Trust-wide template based on a format used by MAPPA should be used for a comprehensive record of any risk meetings with the relevant data protection exemptions noted to enable sharing of patient information. It was also recommended that a Trust-wide template for recording Multidisciplinary Team Meetings should be developed to include listing those present, the actions agreed and the staff responsible for implementing the decisions taken.

Staff would be provided with training on record keeping and the need to keep detailed notes from third parties who provided information about service users, or who were raising concerns about them.

The Independent Investigation Panel

The Independent Investigation Panel concluded that the events of 18 January 2010 could not have been predicted nor avoided given the knowledge available to the Mental Health Services at the time. The provision of care and treatment to Mr. A could have been improved but it did not of itself lead directly to the death of Mr. A and Mrs. A and their son.

The Independent Investigation Panel agreed with the findings and recommendations of both the Internal Investigations. The first Internal Investigation highlighted the need for further training for staff asked to lead such Investigations. The second Internal Investigation was more probing and highlighted additional important issues. There were several areas which the Independent Investigation Panel highlighted where additional recommendations were needed. These are listed below:

Collecting a Formal Clinical History of Mr. A

Little was known about Mr. A as he was secretive and suspicious of Mental Health Staff and the clinical staff did not ask probing questions nor seek corroboration of what Mr. A told them from his wife or other relatives. One psychiatrist did make contact with Mr. A's GP and discussed the contents of his Primary Care Records which was good practice. Otherwise Mr. A was seldom challenged over his beliefs that he was physically ill and had HIV.

The Lack of a Trust-wide Multidisciplinary Forum where Complex Cases can be discussed

Doctor 1 did not use any clinical forum to discuss Mr. A, even though he was a complex case. He did discuss the situation with his 'cross-over' consultant, the one who covered for him when he was unavailable, but not with his peer group. Additional ideas could have been forthcoming but the available forum was not used. Mr. A was discussed in the regular Ward Meetings and his Care Plan was frequently reviewed. The input from other consultant colleagues could have proved helpful. Discussion with the wider multidisciplinary team could also have been useful.

Mr. A was not offered psychological therapies when he was first admitted to Fletcher Ward

Mr. A was not offered psychological therapies during his first admission to Fletcher Ward at Bodmin Hospital on 28 October 2008 or whilst in the community, until 08 October 2009 when he had one session with a clinical psychologist which he left early. His Care Coordinator in April 2009 tried to help Mr. A manage his anxiety by using a Cognitive Behavioural Therapy problem solving approach. He refused to participate with the Tidal Model of Nursing Care in May 2009 and only loosely complied on other occasions when he declined to provide much information about himself. This was contrary to the National Institute for Health and Clinical Excellence Guidance for People with Schizophrenia which recommended that they be given Cognitive Behavioural Therapy on their first admission.

Staff tended to take what Mr. A said at face value without probing further and challenging some of his statements

The Mental Health Staff tended to take what Mr. A told them at face value. They did not try to get behind what he said by challenging some of his assertions as a more forensic approach would have done. He did respond and disclose more occasionally, for example when the Care Coordinator and CPN 3 worked together in September 2009. On relatively rare occasions Mr. A spoke openly on Fletcher Ward and he did answer the questions Dr 1 posed when he was making an assessment. Although Mr. A attended only one session with Psychologist 1 on 08 October 2009, he did open up about his belief that he had HIV and gave some detailed information about some events in his earlier life.

Lack of Sharing Information between Agencies

The lack of contact with the Cornwall Children's Social Care Services did not conform to either local or national policy expectations. The Second Internal Investigation considered that

several opportunities to contact the Children's Social Care Services were missed and like the First Internal Investigation identified the need for training for all staff regarding Safeguarding Children. The telephone conversation AMHP 2 had with Mrs. A on 02 December 2009 regarding the effect Mr. A's behaviour was having on their son should at the very least have prompted contact with the Children's Social Care Services to ask them to assess the home situation, or preferably to have requested a Strategy Meeting to examine the situation within the family and its effect on the son. This latter course of action would almost certainly have triggered the sharing of information by all agencies working with the family, the Police, Education, Primary Care and Mental Health Services.

Staff did not clarify the information provided by Mrs. A and other relatives of Mr. A when they were asking for assistance or providing information about Mr. A

The documentation of the harassing and threatening text messages Mr. A sent to his wife was poor, with no examples recorded to identify the actual content and scale of the harassment and the likely fear and concern this would cause the recipient. Similarly the telephone call made by Mrs. A (wife) to the Home Treatment Team Out of Hours Service on 23 October 2008 where she shared her concern that she and her son were at risk from Mr. A. Mrs. A explained that in the last week her husband had started accusing her of being part of the conspiracy to kill him, hence her increased worry for her and her son's safety. There was no documented further exploration of what Mrs. A feared her husband might do, and it was not recorded if this was subsequently discussed in more detail with Mr. A or Mrs. A. There is no documentation of any action plan from services in response to this concern.

Mrs. A was not offered a Carer's Assessment

It is unclear from the clinical records if Mrs. A (wife) was ever offered a Carer's Assessment. Given the level of support she was providing for her husband, despite being estranged from him, this should have been offered. There was also little evidence from the written documentation that when Mrs. A did raise concerns about her husband staff arranged to meet her and explain the situation to her, or to offer her advice. Staff did not telephone Mrs. A to enquire how she was but more to discuss how her husband was. When she expressed concern about her husband being aggressive or harassing her with threatening text messages she was told to contact the Police. Mrs. A was concerned about the effect Mr. A was having on his son, and she had to bear the brunt of his delusional concerns about his health and help him when he became excessively distressed or anxious and made threats to kill himself.

Conclusion Summary

The above seven issues were identified by the Independent Investigation Panel and had not been fully addressed in the two Internal Investigations. The recommendations made by the Independent Investigation Panel cover these issues. These are listed in Section 17.

14. Cornwall Partnership NHS Foundation Trust Response to the Untoward Incident

The following information has been taken from the first Trust Internal Investigation Report and the second Internal Investigation Report commissioned from NHS Plymouth by the Acting Chief Executive of the Trust. At the time of the Incident the Trust had a Serious Untoward Incident Reporting Policy and Procedure which was ratified on 19 March 2009.

14.1. The Trust Serious Untoward Incident Process

The Serious Untoward Incident Reporting Policy and Procedure was followed and a 24-Hour Report and a Post Incident Report completed within seven days. As the incident was a homicide it was correctly graded as a Category A Serious Untoward Incident and Investigating officers were appointed to undertake a Full Investigation Report within 60 working days and the Report was produced in accordance with the Policy. The aim of the Policy was stated as being *"to ensure uniformity in the reporting and investigation of untoward incidents and to ensure that lessons are learned from these incidents to minimise the likelihood/prevent such incidents occurring in the future. The Trust is committed to promoting a culture where open honest and supportive incident investigation contributes to continuous improvements in quality and safety"*.

14.2. The Trust Internal Investigations

The First Internal Investigation

The Panel comprised three members of staff:

- The Professional Head of Nursing;
- Head of Psychology and Psychological Therapies;
- The Care Programme Approach Lead Officer (Support to the Panel).

The Terms of Reference for the first Internal Investigation were:

"*The aim of the investigation is to evaluate the mental health care and treatment given to [Mr. A] from the time of his first contact with mental health services to the time of the alleged homicide.*

1. *To apply the structure and process of a full root cause analysis at Level 2, as set out in the National Patient Safety Agency Guidance;*
2. *To complete a detailed chronology of the events from the first point of contact with mental health services to the time of the alleged homicide, to assist in the identification of care and service delivery problems;*
3. *To examine the extent and adequacy of the collaboration and communication between the agencies involved, or in the provision of services to him.*
4. *Review and consider any previously reported incidents involving [Mr. A] through the Trust's incident/accident/near miss reporting process.*
5. *To examine the adequacy with which [Mr. A's] risk was assessed and actions consequent upon the assessments were appropriate and within local and national guidelines.*
6. *To examine the appropriateness of the training and development of those involved in the care of [Mr. A].*
7. *To prepare a report on the findings with recommendations, to include an action plan to address the recommendations, appropriately time framed and with a clearly described monitoring process. The report should follow the National Patient Safety Agency Root Cause Analysis report template provided in the investigation toolkit.*
8. *To bring to the attention of the Executive Nurse/Medical Director any practice issues that need to be addressed immediately.*
9. *Through the process of the investigation the Trust will also seek to examine the extent to which [Mr. A's] prescribed treatment and care plans were:*
    a. *Documented;*
    b. *Agreed with him;*
    c. *Communicated with and between relevant agencies and his family*
    d. *Carried out, and*
    e. *Complied with by him.*

9.1 The quality and scope of his health, social care and risk assessments.

9.2 The appropriateness of his treatment, care and supervision in respect of any of the following which is relevant:

- *His assessed health and social care needs;*
- *His assessed risk of potential harm to himself/others and the associated risk management planning arrangements;*

- *Any previous psychiatric history, including drug and alcohol abuse;*
- *The number and nature of any previous court convictions (if appropriate);*
- *Statutory obligations, national guidance (including the Care Programme Approach HC(90)23/LASSL(90)11, and the discharge guidance HSG(94)27 and local operational policies for the provision of Mental Health Services;*
- *His assessed risk of and application of domestic violence;*
- *The assessed risk and application of safeguarding children procedures.*

10. *Documentation*
    - *All medical records relating to [Mr. A] including all hospital records whether as an inpatient or outpatient, GP records, all records prepared by any other doctor or nurse or professional involved in his care;*
    - *All documents in the possession of the Children Young People and Families Department;*
    - *Domestic Violence Department.*
11. *Timescale*

    It is anticipated the investigating (sic) report will be submitted to the Executive Team within 50 days of commissioning the investigation. The report will be sent to the Strategic Health Authority Homicide Review Group for consideration no later than 24 May 2010".

Methodology

The first Internal Investigation Report was examined by the Executive Team of the Cornwall Partnership NHS Foundation Trust and the Acting Chief Executive was not satisfied that the Internal Investigation had been as rigorous as it could have been. It was considered to have possibly under-estimated some of the issues identified during the care and treatment Mr. A received from the Trust.

To rectify this NHS Plymouth was commissioned to undertake a further Internal Investigation into the Care and Treatment of Mr. A. This was undertaken by a Consultant Psychiatrist and a Safeguarding Adults Manager. This second Internal Investigation was extremely thorough and identified a number of additional issues which needed to be considered and addressed.

Recommendations

The thematic issues identified by the first Internal Investigation by the Cornwall Partnership NHS Foundation Trust and those of the second Internal Investigation are examined below. The recommendations are not reproduced in this Section of the Report but can be found in Appendix 2 'Overview of Recommendations from the three Investigations' and it also includes the recommendations from the Serious Case Review commissioned by the Cornwall and Isles of Scilly Local Safeguarding Children Board.

The Second Internal Investigation

The second Internal Investigation was a very robust and rigorous Investigation which identified a number of areas where improvement was required as well as highlighting areas of good practice. It was realistic about the areas where the service had not followed best practice and made appropriate recommendations to ensure these were addressed. The Terms of Reference for the Second Internal Investigation were essentially the same as for the previous Internal Investigation with the additional remit to examine its findings. The recommendations were made in nine areas which as for the first Internal Investigation are contained in Appendix 2.

Overall Conclusion of the Second Internal Investigation

The Second Internal Investigation concluded that the "*actions of service user 'A' [Mr. A]"* were the root cause of the incident and the authors stated that they did "*not believe that this tragic incident could have been foreseen or predicted…No one specific root cause has been identified from the care and treatment delivered".*

The summary list of the contributory factors identified was:

"Care and Service Delivery Problems

Barriers to care

- *Team operational criteria*
- *Geographical boundaries*
- *No process in place to escalate risk issues / service delivery problems / professional differences through senior management and the organisation*

Safeguarding Children concerns

- *Statutory Safeguarding Children responsibilities were not fully recognised and polices and procedures in relation to child protection were not followed fully.*

Contributory Factors

- ***Patient Factors***
  Clinical Condition - Mental health, Psychological Factors, Interpersonal relationships, social factors
- ***Task Factors***
  Guidelines, Policies and Procedures
- ***Communication***
  Verbal communication, written communication, communication management
- ***Work Environment***
  Time, geographical boundaries, other work commitments balanced with required travel time from Newquay to Redruth
- ***Team Factors***
  Leadership Support and cultural factors".

Lessons Learnt

The following 'lessons learnt were identified:

- *"Mental Health Services worked in isolation internally and externally.*
- *Appropriate information sharing with partner agencies i.e. Police and Children's Services would have enabled more meaningful risk assessment of:*
  - *Potential harm to others*
  - *Risks from domestic abuse*
- *Mental Health Staff focused their attention on the behaviour of [Mr. A] and paid insufficient attention to the potential impact on the child*
- *Mental Health staff assessed [Mr. A] as a mental health service user in isolation of his role as a parent.*
- *Mental Health staff did not fully recognise and act on their statutory child protection responsibilities, when concerns were raised by 'A's wife and family members about:*
  - *Impact of 'A's behaviour / illness on the son;*
  - *Risks to wife and son.*
- *The following safeguarding children's processes are not embedded in practice in the mental health service:*
  - *Statutory child protection responsibilities and referral for strategy meetings;*

  - *Working Together to Safeguard Children 2006 (updated 2010);*
  - *Common Assessment Framework 'CAF';*
  - *Information sharing.*
- *The different teams involved in 'A's care did not support the family or assist 'A's care and treatment.*
- *The internal geographical boundaries imposed by service operational polices became a barrier to delivering care, making the service appear rigid and inflexible.*
- *The Mental Health service was not always pro active when concerns / risks were raised by 'A's wife, other family members and police. There was an over reliance on 'A's wife and family members to request MHA Assessments and action by police.*
- *Mental health services used the police as a first line of assessment and as an alternative to making contact at the home address when concerns were raised, limiting services ability to make comprehensive assessments".*

The First and Second Internal Investigations Positive Factors Identified

The following areas of good practice were identified by the First Internal Investigation:

- *"the mental health staff who worked with [Mr. A] over the two year period went to great lengths to offer and provide mental health care and treatment to him, despite the fact that for the main part he saw no grounds for their input and was non-compliant with it;*
- *Members of the Restormel Community Mental Health Team are to be particularly commended for their sustained efforts to provide care for [Mr. A] and [Mrs. A] and for their refusal to discharge him from their care…*
- *Mental health professionals provided timely and appropriate responses to calls from [Mrs. A and Mr. A's mother], and continued to offer [Mrs. A] support during periods when [Mr. A] was actively disengaged from services;*
- *…the Police were quick to assist with Mental Health Act Assessments when requested. They also responded promptly to mental health staff's requests for welfare checks to be undertaken at times of particular concern;*
- *…a referral to Social Care with respect to [Mr. A's son] during [Mr. A's] hospital admission in June 2009.*

The following areas of good practice were identified by the Second Internal Investigation:

- *the Restormel CMHT clinical team continued to attempt to work with 'A' despite their team being the least appropriately placed in terms of location to do so;*
- *Letter to 'A' to provide him contact numbers for out of hours and the local mental health team in his area;*
- *Ward staff introduced smoking cessation support;*
- *March 2009 - The Locum Consultant recording his rationale for agreeing 'A' to go on a family weekend away – that of trying to work with 'A' within the limitations 'A' presented;*
- *March 2009 - The Locum Consultant introduced more structured Community Treatment Order (CTO) conditions to enable 'A's engagement with services;*
- *March 2009 - The Locum Consultant recorded the rationale for not making notification to the DVLA;*
- *March 2009 - notification to Somerset HTT of 'A's weekend holiday arrangements in case of crisis;*
- *April 2009 - Care coordinator 3 tried to work creatively with 'A', looking for alternatives to medication by using a CBT problem solving and anxiety management approach;*
- *May 2009 - The Consultant Psychiatrist worked in negotiation with 'A' views about his depot medication, this was reviewed and reduced in response to 'A' concerns;*
- *June 2009 - The Consultant Psychiatrist negotiated with 'A' to try and find 'win win' gains to keep 'A' engaged in difficult circumstances;*
- *Care Coordinator 4 was a junior member of the CMHT and received support and guidance from previous care coordinator as 'A' was complex;*

Mr. A Investigation Report

- *Sept 2009 – Care Coordinator 3 and 4 reminding 'A' of his appointments by telephone;*

- *Sept 2009 - Care Coordinator 4 notifying GP of overdose of medication prescribed by GP.*

Independent Investigation Panel Feedback on the two Internal Investigation Reports

Findings

The Independent Investigation Panel concluded that the First Internal Investigation was not robust and did not highlight the areas where there had been lessons to learn. These were in the areas of:

- not sharing information with other agencies working with Mr. A and Mrs. A and their son, which led to important facts not being known by all those working with Mr. A;
- not solving the difficulties of Mr. A being provided care and treatment from the Restormel Community Mental Health Team rather than from the Kerrier Assertive Outreach Team due to his GP being in Newquay while he lived in Redruth;
- not following all the requirements for Safeguarding Children in relation to the effect Mr. A could be having on his son.

The Second Internal Investigation was more rigorous and did identify additional issues as the recommendations listed in Appendix 2 demonstrate. The issues were identified and understood and were addressed through some strong recommendations which have been accepted in full by the Cornwall Partnership NHS Foundation Trust.

The Independent Investigation Panel did notice that the Trust Serious Untoward Incident Reporting Policy and Procedure did not make mention of 'Being Open'. This was guidance issued by the National Patient Safety Agency in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by November 2005, and to have implemented the action plans in a Being Open policy by June 2006. The Being Open guidance ensures those patients and their families that they:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress caused;
- receive a factual explanation of what happened;

- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm.

It is clear that the relatives of Mr. A were informed about the First Internal Investigation as there was an Email chain showing that the Report had been shared with family members and that their questions had been responded to by the then Chief Executive. Similarly with the Second Internal Investigation family members were offered a meeting with the Panel, but they chose to have written contact with the opportunity to list their thoughts, comments and questions.

The Action Plan to implement all the recommendations made by the First and Second Internal Investigations is on the next page.

The Action Plan to Implement the Recommendations from the First and Second Internal Investigations

Action Plan and Recommendation	Lead	Target Date	Outcome	Completed
Safeguarding Children & Adults: meets the requirements from the NPSA/2009/RRR003 Rapid Response Report May 2009	EW	July 2011	Effective clear evidence based reports	√
Progress report to Trust Board on 'Think Child, think parent, think family: a guide to parental mental health and child welfare (July 2009) being included in mandatory safeguarding children training.	EW	Sept. 2011	Trust Board Report	√
Ensure the prompts identified in NPSA/2009/RRR003 are in place for: • CPA monitoring, review, discharge planning documentation and procedures • Conduct an audit of CPA, discharge, (Rio documentation) to ensure NPSA/2009/RRR003 requirements are met; • Audit document is circulated to all staff through Team Brief; • Review the contribution from Mental Health Services in reducing harm to victims and their families from domestic abuse.	Service Line Managers	Nov 2011	Improved data quality evidenced through RiO audits Audit of trust input into process	√
Review Mental Health's contribution to the MARAC process to establish: a) Information about mental health concerns are shared at this meeting; b) Mental Health Services are aware of all the families discussed at the MARAC in order that care coordinators are notified of the referral to MARAC; c) Introduce domestic abuse awareness into safeguarding adults training.	LB		Report to EMG Staff aware of MARAC	√
Consider the introduction of Routine Enquiry regarding Domestic Abuse – DoH 2005 into Mental Health Services.	LB		Improved staff awareness of domestic abuse issues	√
Within 12 months all mental health staff to have attended/have arranged training in domestic abuse awareness (not training linked to child protection)	Service Line Manager	May 2012	Improved staff awareness of domestic abuse issues	√
Mental Health staff receive targeted update training in; • Statutory child protection responsibilities and thresholds for referral into Children's Services and sharing of information; • Wider Cornwall's Working Training – Integrated Working Training – Common Assessment Framework (CAF) and sharing of information • TAC – model Team around the Child training.	LB AC Service Line Manager			

Action Plan and Recommendation	Lead	Target Date	Outcome	Completed
Review Governance arrangements for appropriate corporate risk sharing	DJ	July 2011	Assurance about Trust's Governance Structure and Processes	√
Develop Process/Policy to deal with professional differences. Develop a Process/Policy for escalation of operational difficulties from team manager up through the organisation in order that risks are identified and shared appropriately. Develop a Process/Policy which acts as a trigger for staff to: • review a service user's care; • review the contact service user has with any children; • hold a multiagency risk management meeting; • request information from other agencies following receipt of a number of concerns from various sources/families.	PLC Clinical Cabinets PLC	Sept 2011	A clear accessible arbitration process A clear route for managers to use to raise issues Improved care for service users and their carers.	√ √ √
Easy Read guidance sent out to Clinical Staff to support them to appropriately share and request information from other agencies i.e. *HM Government Information Sharing: Pocket Guide*	EW	July 2011	Staff clear on their duties on information sharing	√
CPFT to have reviewed current service configuration of the following: • formation of a single HTT, a single CMHT and a single AOT service with satellite bases for geographical coverage preventing geographical barriers to care • Patient centred care plans must reflect location and reason for office based appointments i.e. patient choice, risk to staff/others, carer consideration etc.	EMG Team Managers	Nov 2011	Clarity on service boundaries and how people cross these Clear care plans that evidence a person centred approach	√
Mental Health Services build closer working relationships with new Local Policing Teams (established May 2011) using the Neighbourhood Sergeant as a point of contact in order to enhance information sharing and interagency risk management strategies. The Trust review its processes for requests to Police for welfare checks to establish clear parameters when it is a mental health responsibility to assess and when a welfare check is required from the Police.	Service Line Managers JW		Improved joint working with the Police	√ √

Action Plan and Recommendation	Lead	Target Date	Outcome	Completed
Review of HTT, AOT and CMHT Team operational Policies to include: • Shared care requirements with teams in other areas, locally and out of county; • Transfers of care to other services without further assessment; • Receiving team has responsibility to review and discharge as appropriate; • Operational Policy to include the process for escalation of operational difficulties from team manager up through the organisation in order that risks are identified and shared appropriately as per recommendation under 'Governance Arrangements'; • Review of case load supervision to ensure that within case load supervision and line management there is a prompt to identify and discuss case load challenges, issues of dispute across services which can be escalated via line managers to senior operational managers for resolution; • The team's operational policies to include the use of a multiagency risk management meeting to facilitate the sharing of appropriate information across agencies. A template to be drawn up to record the meeting and the relevant data protection exemptions to enable sharing of patient information; • The Trust agrees a set template for recording MDT meetings which includes those present, actions and who is responsible for the action to be used corporately; • Guidance for notification to DVLA be circulated to medical staff; • Team operational policies to include a 'trigger' process which will prompt staff to review situation and gather information – i.e. following a number of concerns raised about service user this will trigger: a) Use of the information sharing protocol with Police for offending history/relevant Police intelligence; b) Case conference or multiagency risk management meeting to discuss concerns to agree way forward. • As part of routine health screening consider the wider use of illicit drug screening in patients with a history of drug use presenting with variable psychotic symptoms.	DS/JW	Nov 2011	Clear Operational Policies	√

Action Plan and Recommendation	Lead	Target Date	Outcome	Completed
All Mental Health staff to attend record keeping training annually with specific emphasis on the following: • When in receipt of third party information the documentation must reflect: a) Whom the information was received from; b) Specific details of what the information is about; c) Identify an action plan to address third party concerns; d) Details of the discussions should be fully recorded including rationale for decision making. • Review RiO risk documentation to establish if a prompt can be put in to remind staff to consider the information sharing protocol with the Police.	JD	May 2012	Improved quality of record keeping	√ √

15. Notable Practice

The Independent Investigation Panel identified the following examples of good practice:

The Independent Investigation Panel in examining the Internal Investigation and the External Investigation and in undertaking its work identified the following examples of good practice:

- the persistence of the Restormel Community Mental Health Team in responding to the needs of Mr. A when other services it considered more appropriate to help him were not able to accept the referral;

- the work of the AMHP who declined the making of the proposed second Supervised Community Treatment Order on 17 July 2009 when Mr. A was refusing to accept any of the three conditions. She made clear arguments for the refusal to agree that the Order could be made as in her opinion it would not be fit for purpose as Mr. A would be breached almost as soon as the order was made due to his stated intention not to comply;

- the commissioning of a further investigation, from NHS Plymouth, so that the Cornwall Partnership NHS Trust could learn more lessons in order to further improve services in the light of the death of Mrs. A, her son and Mr. A;

- the SHO at Bodmin Hospital did telephone GP 1 on 03 November 2008 and discussed Mr. A's medical history. This was good practice and enabled his physical health to be fully understood;

- continued attempts made by the Mental Health Services to remain engaged with Mr. A to see his problems in a psychological context.

16. Lessons Learned

The Internal Investigation which reported in May 2010 identified the difficulties the local Mental Health Services had had with Mr. A due to his not believing he had any mental health problems. The Report stated that *"Mr. A believed that he was suffering from a number of serious physical conditions but that mental health services were not only inappropriate to his needs, but were positively persecutory in their repeated attempts to engage him in treatment. He was avoidant of contact, believing that prescribed medication was part of a conspiracy to poison him. He was reluctant to work with Mental Health Services, apart from those times when he was obliged to do so under the terms of the Mental Health Act. There were occasions when Mr. A would instigate contact with mental health professionals, but this was usually at times of crisis or when seeking anti-anxiety medication. He consistently lacked insight into the delusional nature of his conviction that he was infected with HIV, despite several blood tests to the contrary. Given that he felt he was seriously ill and that no one was giving credence to his concerns about his physical health, it was logically consistent for him to show reluctance to engage with Mental Health Services and to regard their persistence as persecutory".*

The Mental Health Services added to their own difficulties by not being able to ensure that Mr. A had a service which was easy for him to contact, nor a Community Mental Health Team which was based close to where he was living. Because Mr. A's GP was in Newquay he was referred to the Restormel Community Mental Health Team but he lived in Redruth. He actually lived in both places and often moved between them. It was considered that the Redruth Assertive Outreach Team would be the best team to try and meet his needs, but because his GP was in Newquay this was not deemed possible. This issue was still unresolved at the time of the incident.

The Mental Health Services had no way of escalating difficult decisions to a higher level of management, hence the time spent trying to get a Redruth Team to accept Mr. A as a client. The good practice solution would have been to examine what was best for the service user and then to arrange services accordingly, especially as they were all part of the same Trust.

The second Internal Investigation by staff from NHS Plymouth also agreed this was an issue, but also highlighted several other issues which required action. The services did not work in partnership with one another and did not share information or pool resources. The Mental Health Services should have contacted the Police and used the Local Protocol for Information Sharing. This would have proved useful as Mr. A had two more entries on his criminal record than was known which highlighted more of his aggressive nature. Similarly as Mr. A was aggressive and often distressed and agitated the local Children's Services should have been informed that Mr. A was unwell and that his son could be adversely affected by his bizarre behaviour and possible ill temper at times.

The Mental Health Services started from where the service user was and tried to develop a treatment plan to provide flexible client-centred services. This was not easy with Mr. A as he would not engage or comply with help and advice. There were opportunities when he was in hospital and also whilst under the Supervised Community Treatment Order to pursue a more assertive approach to his care. There is no way of knowing if this would have worked, but it would have been worth trying.

17. Recommendations

The six recommendations made by the Independent Investigation need to be read alongside the recommendations from the two Internal Investigations which are all listed together alongside those relevant ones from the Serious Case Review commissioned by the Cornwall and Isles of Scilly Local Safeguarding Children Board in Appendix 2. The six recommendations are:

Recommendation 1

A conference including specific learning about Parental Mental Health, and referring to all guidance, should be held and should include all relevant agencies. This will be organised by the Cornwall Partnership NHS Foundation Trust.

Recommendation 2

Recognition of current risk profile: Mental health staff must obtain and record as much relevant information as possible about a new service user with complex issues or uncertainty with the formulation of diagnosis or appropriate treatment in order to understand their initial presentation and to put their situation within an appropriate context. Where there is little known staff should:

- talk to relatives or staff from other organisations involved;
- discuss with the GP the service user's Primary Care records which are likely to have the history from early childhood.

Recommendation 3

Where a service user has psychotic symptoms psychological interventions should be used as soon as practical. The service user should have access to a psychological therapist as an inpatient and a psychological approach tried whilst other variables may be more controlled. It is often too late if this approach is left until after discharge back to the community.

Recommendation 4

When a service user is known to have used violence in the past any additional risks should be identified and used to prepare an updated risk assessment and a management plan for that risk. Drinking alcohol and using illicit substances should always be recorded and included in

the risk assessment. Any change which increases risk should be recorded and where possible acted upon.

Recommendation 5

Senior clinical staff must be encouraged to seek the advice of their colleagues when they have a complex situation. Peer group and/or senior Multidisciplinary Team Meetings must be held to seek alternative approaches. Where cases are especially complex and/or risky and or intractable, senior clinical staff should engage in Multidisciplinary Team discussion and peer group consultation and ensure this is documented.

Recommendation 6

Where serious risks are identified as a result of non-engagement, staff should probe the reasons and not accept the rationalisations the service user presents. To help understand the issues more assertive and focused questioning is required and a pragmatic approach to optimise contact should be taken. The rationale for the approach to be taken must be documented with the preferred response identified.

18. Glossary

Care Coordinator	This person is usually a health or social care professional who coordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	A National systematic process to ensure assessment and Care Planning occur in a timely and user centred manner.
Community Mental Health Team (CMHT)	A CMHT provides Care Coordination and care and treatment to individuals with severe and enduring mental illness.
Crisis Resolution and Home Treatment Team (CRHTT)	A CRHTT provide care and treatment to people in crisis 24 hours day seven days a week in their own homes. A primary focus is in the prevention of unnecessary inpatient hospital admission.
Citalopram	An anti-depressant medication of the Selective Serotonin Re-uptake Inhibitor (SSRI) type. The normal dosage for treating depression is 20-30 mg daily with a maximum dosage of 60mg daily.
Clopidogel	A prescribed medication which is used to help prevent strokes and heart attacks.
Depot Injection	This is an injection into the muscle by which certain antipsychotic medication is administered, and which is then slowly released into the body over a number of weeks.
Dual Diagnosis	This term refers to a service user who has mental ill health and it is exacerbated by the use of illicit drugs and/or alcohol.
Lorazepam	This is a medication used for a short period to reduce anxiety and sleeplessness.

Mental Health Act (1983 and 2007)	The Mental Health Act 1983/2007 covers the assessments, treatment and rights of people with a mental health condition.
Mental Health Act Section 2 (1983 &2007)	Section 2 allows compulsory admission for assessment, or for assessment followed by medical treatment, for duration of up to 28 days.
Mental Health Act Section 3 (1983 and 2007)	Section 3 of the Mental Health Act (83 & 07) is a treatment order and can initially last up to six months; if renewed, the next order lasts up to six months and each subsequent order lasts up to one year.
Mental Health Act Supervised Community Treatment Order (1983 and 2007)	The 2007 Mental Health Act introduced this Community Order whereby the service user has to agree to terms and conditions of being allowed to reside in the community. The conditions are likely to comprise being compliant with the prescribed medication, maintaining contact with Mental Health Services and other specific conditions to reduce any risk relating to the person being in the community and not in hospital.
Mirtazapine	Mirtazapine works in the brain to increase the amount of noradrenaline and serotonin in order to lift mood and help relieve depression in adults.
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Omeprazole	A medication which helps to reduce the amount of acid produced in the stomach
Paranoid Delusions	These are when a service user has irrational thoughts about people being against them and that there is a conspiracy against them. They lose touch with reality and think television and radio programmes are talking about them.

PRN	The term "PRN" is a shortened form of the Latin phrase *pro re nata*, which translates roughly as "as the thing is needed". PRN, therefore, means a medication that should be taken only as needed.
Psychosis	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Quetiapine	Quetiapine is a prescription drug used to help control symptoms of schizophrenia and bipolar disorder.
Ramipril	A medication for high blood pressure and prevention of heart attack and stroke in people in danger of kidney problems.
Risperidone Consta	A medication used for the treatment of schizophrenia and for the longer-term treatment of Bipolar Affective Disorder.
Tidal Model of Nursing Care	The Tidal Mode of Nursing Care was the first model of mental health nursing to be used as the basis for interdisciplinary mental health care and to focus from the beginning on the service user's recovery journey.
Simvastatin	A medication for the lowering of Cholesterol in the blood.
Zopiclone	A medication for helping people to sleep.

APPENDIX 1: OVERVIEW OF RECOMMENDATIONS FROM THE THREE INVESTIGATIONS AND THE SERIOUS CASE REVIEW

1. **Internal Investigation**
2. **Second Internal Investigation**
3. **Cornwall and Isles of Scilly Safeguarding Children's Board Serious Case Review**
4. **Independent Investigation [HASCAS]**

This Table illustrates the various recommendations made by the four separate investigations which have examined the care and treatment of Mr. A or, in the case of the Serious Case Review the effects of this on his son.

Internal Investigation	Second Internal Investigation	Serious Case Review	Independent Investigation
CPFT, in collaboration with Primary Care Services, to develop and implement a protocol governing the management of service users whose care and treatment regularly moves between geographical areas and teams.		CPFT to develop with Primary Care Services a protocol governing the care and treatment of service users who regularly move between geographical areas and teams. By March 2011 with audit of practice to ensure arrangements are working.	
CPFT should review the safety and appropriateness of the use of mobile phones as a means of contact with service users. Teams may wish to develop and implement their own processes in order to maximise benefits and minimise risks.			

Internal Investigation	**Second Internal Investigation**	**Serious Case Review**	**Independent Investigation**
The SCIE report 'Think child, think parent, think family; a guide to parental mental ill health and child welfare' (July 2009) should: • be incorporated into all Safeguarding Children mandatory training in order to increase awareness of the issues it raises for service delivery; • CPFT Safeguarding Children Group develops an action plan for implementation of the recommendations of the SCIE Report. ***(also included in the Serious Case Review recommendations)***	***<u>Safeguarding Children</u>*** **Within 1 month** establish that the RIO electronic record and risk assessment: • meets the requirements from the NSPA/2009/RRR003 – Rapid Response Report (May 2009) • produce an action plan to address issues. **Within 3 months** provide: • a progress report to the Trust Board on the internal recommendation of incorporating 'Think child, think parent, think family; a guide to parental mental ill health and child welfare' (July 2009) into safeguarding children mandatory training; • this document is circulated to all staff as a controlled document. **Within 6 months** conduct an audit of CPA documentation to ensure the recommendations from NSPA RRR003 are met. • CPA, RIO documentation, discharge, 117 records; • CPA records should include the name/DOB of all children who are in household where patient has parental	CPFT to report to Health Executive Safeguarding Group on effectiveness of implementation on compliance with NPSA RRR003. Health managers are informed of progress on professionals' understanding of the needs of children in families where there is parental mental illness. CPFT Policy and guidance taken to Policy Development and Implementation sub-group. Single agency audit of staff awareness and understanding. LSCB endorses policy and guidance. CE for CPFT mental health services to ensure that Children's Social Care are consulted over arrangements for children visiting a psychiatric hospital (patients generally and parents in particular) in the County. Arrangements to	The Independent Investigation endorses the recommendations for mental health staff to better understand their roles and responsibilities for the safeguarding of children. **<u>Recommendation 1</u>** A conference including specific learning about Parental Mental Health, and referring to all guidance, should be held and should include all relevant agencies. This will be organised by the Cornwall Partnership NHS Foundation NHS Trust.

	responsibility for/significant contact with the child/children.	comply with DOH Guidance (HSC 1999/222 LAC (99)32).	
Internal Investigation	**Second Internal Investigation**	**Serious Case Review**	**Independent Investigation**
Clinical Risk Assessment Training is: • prioritised for clinical staff throughout the Trust • considered for being incorporated into the Mandatory Training process.	• NSPA/2009/RRR003 report is circulated to all staff as a controlled document; • Review the contribution from mental health services in reducing harm to victims and their families from domestic abuse; • Review mental health's contribution to the MARAC process to establish: ➢ Information about mental health concerns is shared at this meeting; ➢ Mental health services are aware of all families discussed at MARAC in order that care coordinators are notified of any referral to MARAC for service users; ➢ Introduce Domestic Abuse Awareness into Safeguarding Adults training; • Consider the introduction of Routine Enquiry regarding Domestic Abuse – DoH 2005 into Mental Health Services.		***<u>History Taking</u>*** Very little was known about Mr. A prior to his arriving in Cornwall. The GP records could have been searched to see more about his earlier life in the Midlands and his childhood. No detailed history taken. **<u>Recommendation 2</u>** **Recognition of current risk profile:** Mental health staff must obtain and record as much relevant information as possible about a new service user with complex issues or uncertainty with the formulation of diagnosis or appropriate treatment in order to understand their initial presentation and to put their situation within an appropriate context. Where there is little known staff should: • talk to relatives or staff from other organisations involved; • discuss with the GP the service user's Primary Care records which are likely to have the history from early childhood.

Internal Investigation	**Second Internal Investigation**	**Serious Case Review**	**Independent Investigation**
	Training : Within 12 months – • mental health staff receive update training focused on: ➢ statutory child protection responsibilities and referral for strategic meetings; ➢ sharing of information; ➢ Working Together to Safeguard ➢ Children (2010) Common Assessment Framework.	Cornwall and IOS PCT as commissioners should ensure that all health providers are aware of national guidance on HIV testing of children and young people. Audit December 2010 to ensure health professionals are aware of the needs of children and young people in relation to HIV testing.	
CPFT should review the robustness of the current Mental Health Act Managers' Review process, and the level of organisational support provided to it: Training for the role of Mental Health Act Manager should continue to include legal aspects of the MHA, but be augmented by training to raise awareness of complex clinical	• All mental health staff to have attended or have arranged training in domestic abuse awareness (specific awareness training not child protection training).	CPFT should review the robustness of the current Mental Health Act Managers' Review process, and the level of organisational support provided to it: • Training for the role of Mental Health Act Manager should continue to include legal aspects of the MHA, but be augmented by training to raise awareness of complex clinical presentations;	***Organisational*** There was no psychology available to the ward when Mr. A was an inpatient. Mr. A did have one session of CBT with a CPN in the community, but nothing when an inpatient which is recommended by NICE with regards to CBT. (No guarantee he would have complied). **Recommendation 3** Where a service user has psychotic symptoms psychological interventions should be used as soon as practical. The service user should have access to a

presentations;			psychological therapist as an inpatient and a psychological approach tried
Internal Investigation	**Second Internal Investigation**	**Serious Case Review**	**Independent Investigation**
• Advice on clinical issues from an appropriately qualified and experienced clinician who is independent of the MHA Review process.		• Advice on clinical issues from an appropriately qualified and experienced clinician who is independent of the MHA Review process.	whilst other variables may be more controlled. It is often too late if this approach is left until after discharge back to the community.
	Governance Arrangements Within six months : Review of the Trust Governance arrangements which includes: • process for identification, management and review of serious incidents; • process for Corporate notification and sharing of risk; • process for sharing learning and seeking assurance from services; • process for review of action plans and communication to Trust Board.	***HASCAS*** **Recommendation** Every member of staff interviewed or otherwise involved in a serious untoward incident must be included in the feedback of the learning and the development of recommendations to check that they will be effective in preventing any mistakes being replicated.	The two members of staff interviewed by HASCAS had not been very involved in the work after the initial Internal Investigation took place nor after the recommendations of the External Review by Plymouth. One person saw the second Internal Report only 30 minutes prior to being interviewed.
	Trust Policies Within three months: • develop policy to manage professional differences; develop policy for escalation of operational difficulties from team manager up through the organisation in order that risks are identified and shared appropriately;		***Risk Assessment*** Mr. A was known to be drinking heavily towards the end of 2009 and to have taken cannabis and magic mushrooms. This did not figure on his risk assessment but could have been an exacerbating factor in making him less inhibited and increasing the likelihood

			of violence.
Internal Investigation	**Second Internal Investigation**	**Serious Case Review**	**Independent Investigation**
	• develop a policy to trigger staff response to concerns raised by others regarding service users. Staff will be prompted to: ➢ review a service user's care; ➢ hold a multi-agency risk management meeting; ➢ review any contact with children and identify risk; (Where concern relates to a child there must be a parallel process and need for staff to follow child protection procedures. Named nurse should be invited to risk meetings). ➢ request information from other agencies; ➢ action plan to respond to care needs/risks. ***<u>Communication and Information Sharing</u>*** Within one month: • all staff sent a reminder of their responsibility to share information and a copy of information sharing pocket guide HM *Government Information Sharing: Pocket Guide.* This to be		**<u>Recommendation 4</u>** When a service user is known to have used violence in the past any additional risks should be identified and used to prepare an updated risk assessment and a management plan for that risk. Drinking alcohol and using illicit substances should always be recorded and included in the risk assessment. Any change which increases risk should be recorded and where possible acted upon.

	circulated as a controlled document;		
Internal Investigation	**Second Internal Investigation**	**Serious Case Review**	**Independent Investigation**
	• guidance for notification to DVLA to be circulated to medical staff, sent as a controlled document.		***Clinical Discussion*** The consultant treating Mr. A did not use any clinical forum to discuss what was a complex case. He discussed the case with his 'cross-over' consultant but not with his peer group. **Recommendation 5** Senior clinical staff must be encouraged to seek the advice of their colleagues when they have a complex situation. Peer group and/or senior Multidisciplinary Team Meetings must be held to seek alternative approaches. Where cases are especially complex and/or risky and or intractable, senior clinical staff should engage in Multidisciplinary Team discussion and peer group consultation and ensure this is documented.
	Mental Health Service Configuration Within six months CPFT to have reviewed current service configuration with consideration of the following: formation of a single HTT, a single CMHT and a single AOT service with satellite bases		

	for geographical coverage preventing		
Internal Investigation	**Second Internal Investigation**	**Serious Case Review**	**Independent Investigation**
	individual team geographical boundaries imposed by service operational policies becoming a barrier to delivering care. ***Service User Involvement*** Within three months: Patient centred care plans must reflect: • location of the delivery of care, and include reason for office based appointments i.e. patient choice, risk to staff/others, carer consideration etc.; • information to relatives and carers about treatment, progress, future plans; • child protection information sharing and processes.		***Communication*** Staff tended to take what Mr. A said at face value. They did not challenge him as forensic staff might do to try to get behind the 'facade'. **Recommendation 6** Where serious risks are identified as a result of non-engagement, staff should probe the reasons and not accept the rationalisations the service user presents. To help understand the issues more assertive and focused questioning is required and a pragmatic approach to optimise contact should be taken. The rationale for the approach to be taken must be documented with the preferred response identified.
	Interagency Working / Partnership Working • Mental Health Services to establish close working relationships with new Local Policing Teams (in place by May 2011 in new policing arrangements)		

Internal Investigation	**Second Internal Investigation**	**Serious Case Review**	**Independent Investigation**
	using the Neighbourhood Sergeant as a point of contact to enhance information sharing and interagency risk management strategies; • The Trust reviews its process for making requests to police for welfare checks on service users. Clear parameters to be established when it is a mental health responsibility to assess and when a welfare check is required from the police.		
	Team Operational Policies Within six months review of HTT, AOT and CMHT team operational policies to include: • shared care requirements with teams locally, in other areas and out of County; • transfers of care to other services without further assessment. Receiving team has responsibility to review and discharge as appropriate; • process for escalation of operational difficulties from team manager up through the organisation in order that risks are identified and shared appropriately;		

Internal Investigation	**Second Internal Investigation**	**Serious Case Review**	**Independent Investigation**

	• case load and line management processes to include a prompt to identify and discuss:
	  • case load capacity;
	  • issues of dispute across services to be escalated via line managers to senior operational managers for resolution;
	  • the welfare of any children should be considered and formally recorded – advice sought from Named Nurse as required;
	  • AMH staff should receive child protection supervision by an appropriate competent and qualified professional;
	• use of a multi-agency risk management meeting to facilitate the sharing of information across agencies. Where the adult has contact with a child the named nurse for child protection should be invited;
	• use of an agreed Trust-wide template (example available in the MAPPA policy) to be used for a comprehensive record of the risk meeting with the relevant data protection exemptions		

	noted to enable sharing of patient information;		
Internal Investigation	**Second Internal Investigation**	**Serious Case Review**	**Independent Investigation**

	• use of a Trust-wide template for recording MDT meetings to include those present, actions agreed and who is responsible for the action; • use of a 'trigger' process which will prompt staff to take action when concerns are raised about service users (as per recommendation under trust policies); • as part of routine health screening consider the wider use of illicit drug screening in patients presenting with variable psychotic symptoms. ***<u>Documentation and Record Keeping</u>*** **Within 12 months** All Mental Health Staff to attend record keeping training which includes specific emphasis on the following: • recording specific details of service user's presentation, description of behaviour and staff impression of presentation when in receipt of third party information the documentation must reflect:		
Internal Investigation	**Second Internal Investigation**	**Serious Case Review**	**Independent Investigation**

	➢ who the information was received from, when... ➢ specific details of what the information is about ➢ identify an action plan to address third party concerns ➢ details of the discussion should be fully recorded including rationale for decision making. **Within 3 months:** Review RIO risk documentation to establish if a prompt can be added to remind staff to consider using the information sharing protocol with police.		
	Feedback to Family Members The Chief Executive to consider how feedback and findings from this report will be given to both the family of Mr. A and the family of his wife.		
	Arrangements for Sharing Learning To be agreed with Chief Executive for CPFT.		