NHS
North of England

INDEPENDENT

INVESTIGATION

INTO THE CARE AND TREATMENT PROVIDED TO MR A BY MERSEY CARE NHS TRUST

CONSEQUENCE UK LTD

January 2013

An independent investigation into the care and treatment of a person using the services of Mersey Care NHS Trust

Undertaken by Consequence UK Ltd
Ref Mr A

May 2012

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

The requirement is for an independent investigation of the care and services offered to mental health service users involved in adverse events, defined as including the commission of homicide, where there has been contact with specialist mental health services[1] in the six months prior to the event.

The CUK Investigation Team members were:

- Maria Dineen, Director, Consequence UK Ltd
- Jo Lawrence, Clinical Services Lead, Early Intervention in Psychosis. South London and the Maudsley NHS Trust
- Dr Mark Potter, Consultant Psychiatrist and Associate Medical Director, South West London and St Georges Mental Health Trust

Acknowledgements
The Investigation Team wishes to thank:

- Mr A, the service user,
- The family of Mr V, the victim,
- Merseyside Police Force; and
- Mersey Care NHS Trust;

For their co-operation with the Independent Investigation Team.

[1] Specialist mental health services are those mental health services that are provided by mental health trusts rather than GP and other primary care services. Usually persons in receipt of specialist mental health services will have complex mental health needs.

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1.0 INTRODUCTION

Consequence UK Ltd (CUK) was commissioned by NHS North West Strategic Health Authority to undertake an independent review concerning a serious untoward incident at Mersey Care NHS Trust involving a service user who will be referred to in this report as Mr A.

On 2 November 2008 Mr A was arrested, along with two other individuals, in relation to the unlawful killing of a Mr V. In December 2010 Mr A was convicted of murder and sentenced to life imprisonment. There was no identified mental health component to the crime committed.

Because at the time of the incident Mr A was a patient of the mental health service provided by Mersey Care NHS Trust, the incident fell within the health circular guidance HSG(94) 27. This guidance requires that in such circumstances there is an independent analysis of the service user's care and treatment by mental health services to determine:

- its reasonableness;
- whether or not the incident as it occurred was predictable by mental health services; and
- whether or not the incident as it occurred was preventable by different care and treatment of the service user.

In addition to the above, it is expected that such investigations will be proportionate and not unnecessarily repeat the investigation process where a Trust's own investigation is independently assessed to be reasonable and/or fit for purpose.

Because Mr A received a life sentence as a consequence of his actions and it had been determined pre-incident that he had no treatable severe and enduring mental illness, it was decided that a proportionate approach to this investigation process would be to conduct an initial assessment of Mr A's clinical records in the antecedent period leading to the incident, and an analysis of the Trust's own internal investigation report. The purpose of this was to determine whether:

- there was sufficient documentary evidence to provide an opinion regarding the reasonableness of his care and treatment by Mersey Care NHS Trust
- there was sufficient information set out in the Trust's own internal investigation report, and associated interview records to make a judgement regarding the completeness of the Trust's investigation.

It was agreed between the SHA and CUK that, following this activity, CUK would advise the SHA regarding further steps required, if any. In November 2011 CUK advised the then NHS North West Strategic Health Authority that it considered Mersey Care NHS Trust's Internal Investigation to have met the standard required and that there was nothing in relation to Mr A's care and treatment that mental health services could or should have done differently that could have avoided the incident that occurred. Consequently it was the recommendation of CUK to the then NHS North West Strategic Health Authority that further independent investigation of Mr A's care and treatment could not be justified on the basis of:

- appropriate use of public money;
- proportionality;
- the lack of opportunity for additional learning opportunities to emerge over and above those already identified.

This report sets out

- The chronology of Mr A's contacts with mental health services.
- The Independent Team's analysis of Mersey Care NHS Trust's internal investigation
- The conclusions and recommendations of the Independent Investigation Team

2.0 THE INCIDENT THAT OCCURRED

2.1 Relevant Antecedent Information Gathered After Mr A had been arrested

It is not the usual practice of CUK (henceforth referred to as the Independent Investigation Team) to set out in detail the circumstances of an incident leading to an HSG(94) 27 investigation. However, in this case it believes the circumstances are important as they serve to underline the lack of impact mental health services could have made in terms of preventability.

In November 2009 Mr A was assessed by a consultant in forensic psychiatry. This was 12 months after the death of Mr V. In the report written following this assessment it was recorded that[2]:

> *Mr A told the assessing consultant forensic psychiatrist that on 1 November 2008 he had been drinking in the flat of a friend (Mr X). An argument broke out regarding money. Mr A believed he was owed money by Mr X. Mr A reported to the assessing consultant forensic psychiatrist that Mr X got angry and went to assault him (Mr A), so he (Mr A) 'slapped' Mr X.*
> *The victim (Mr V) Mr A reported meeting through another mutual friend (the male partner of Mr V). Mr A told the assessing consultant forensic psychiatrist (on 23 November 2009) that he considered that Mr V was bullied by his partner. He reportedly described an incident where Mr V's partner had been standing over Mr V with a knife. Mr A reported punching Mr V's partner and removing the knife. This resulted in Mr A spending 9 months on remand in custody on a 'threat to kill' allegation, before the charges against him were dismissed.*
>
> *When Mr A was released from prison, Mr V's partner was in prison. Consequently Mr A reported checking up on Mr V to make sure he was all right. Arguments did occur and the police were called by Mr V regarding Mr A on two occasions. One of these occasions involved an allegation of knife throwing. Mr A denied this, and no charges were brought against him.*
>
> *In the week prior to 5 November 2008, Mr A reported that he had spent several days at Mr V's flat, smoking drugs and drinking alcohol with him. He reported that this was because he (Mr V) was upset that his son was being adopted. The binge was funded by Mr A borrowing money from his mother. Mr A stated that the length of time of the binge was initially eight or nine days, which he later revised to three or four days. It was also noted that, prior to the death of Mr V, Mr A and Mr V had used about £150.00 worth of crack cocaine and heroin. Mr A also reported not having slept for nine days.*

[2] Note. The information set out in this report is a précis of that recorded in the HMP Liverpool files.

2.2 The Events of 31 October 2008

Mr A reported that on 31 October 2008 he and Mr V had run out of alcohol and they had run out of money. Mr A managed to obtain £10.00 from his mother for 'running messages'. This was used to buy beer. Mr A reported that he and Mr V then went to visit Mr X (now out of prison) and borrowed money from him. They then continued drinking in his flat. It was there that the arguments took place. A Play Station was converted into cash at 'Cash Converters' which was then used to purchase more heroin. The information provided by Mr A suggested that at this point Mr A and Mr V had left Mr X's flat. However, the information provided to the consultant forensic psychiatrist suggests that they did return later that same day. At around 8pm, Mr A reported recalling they went to the off-licence and tried to purchase alcohol in exchange for a watch. This he recalled was unsuccessful.

Mr A reported that Mr X and Mr V returned to Mr X's flat after an exchange of words. Mr A returned to his own flat to change his clothes before returning to Mr X's flat. When he returned to the flat of Mr X, Mr A reported that he asked Mr X to ask a neighbour if he could borrow £10.00. Mr X refused and reportedly got aggressive. He allegedly went to punch Mr A, who 'slapped' him. Mr A reportedly then said to Mr V that they should go, which they did after smoking the last of their heroin.

Mr A was noted to have considered himself to be "just normal" at this time.

Mr A told the assessing consultant psychiatrist that Mr V readied himself for sleeping on the couch. He apparently told Mr A that he wanted to see his mother and Mr A said he would take him there the next day. Then, apparently without warning, an incident occurred between Mr A and Mr V. Mr A was noted to recall "seeing 'S[3]' and not 'Mr V'." He did not recall anything else until he was aware of Mr V lying on the floor, covered in blood.

2.3 Other relevant information

The consultant in forensic psychiatry (the consultant) commented in her report on Mr A's reported past experiences as a child and confirmed that there was good evidence to support Mr A's reported history.

The consultant also commented on the diagnosis of post traumatic stress disorder and identified that the evidence for this was less clear. The consultant wrote: "Post-Traumatic Stress Disorder requires exposure to an exceptionally threatening trauma, persistent remembering or reliving the trauma, avoidance of circumstances reminiscent of the original trauma and persistent symptoms of increased psychological arousal."

[3] S was a person Mr A had bad childhood memories of.

The consultant also noted that the latter three symptoms listed above must occur within six months of the trauma and that aspects in favour of the diagnosis were:

- *Mr A's experience of severe abuse;*
- *Mr A's reports of constantly reliving the trauma; and*
- *Some evidence of avoidance of sexual activity.*

However, the consultant also noted there were no corroborative accounts of his symptoms and that Mr A had convictions for sexual offences, including the abuse of a young female child and the rape of a young woman, which involved violence and coercion. The consultant recorded that these incidents and the unconfirmed account of Mr A's rape of another partner were not consistent with the necessary criterion of 'avoidance' for a diagnosis of Post-Traumatic Stress Disorder.

The consultant also noted that a previous psychological report did not refer to any questioning of Mr A about his sexual offending. It was the consultant's documented opinion that the "evidence for a diagnosis of post-traumatic disorder [was] lacking and without at least some corroborative account of the kind of persistent sexual dysfunction [Mr A] describes". The consultant could not make such a diagnosis.

The consultant accepted the diagnosis of depressive disorder but noted at the time of the assessment that Mr A "does not appear to be displaying any current signs or symptoms of a depressive illness". The consultant also went on to say that, "There is no other evidence to suggest that [Mr A] has ever suffered from any other form of mental illness". However, the consultant did conclude that Mr A has many traits consistent with a diagnosis of dissocial personality disorder (ICD -10 F60.2) and a diagnosis of emotionally unstable personality disorder (F60.3).

3.0 THE CHRONOLOGY OF MR A's CONTACTS WITH MERSEY CARE NHS TRUST

A core component of the Independent Investigation Team's analysis was a review of Mr A's contacts with Mersey Care NHS Trust. Consequently a detailed overview of relevant parts of the antecedent chronology alongside relevant information obtained from his prison health records is presented below:

Date	Chronology	
14/9/2004	Domiciliary visit request	Referral from GP requesting assessment of Mr A that week; also that Mr A was willing to come to clinic. Mr A noted to have been discharged from Walton Prison on 7/9/2004. History of Post-Traumatic Disorder following time in a children's home. Currently living with mum. Previous heroin user, but denied any active drug use at this time. Urine sample taken by GP. Mr A noted to have been in prison for most of his adult life, mostly for burglary. Also noted to be reluctant to leave the house and is suspicious /paranoid.
17/9/2004	Outpatients appointment	Mr A attended with his mother. It was noted that: - he was hearing voices telling him to harm himself; - the voices come and go, tell him he is bad, and he hears them in his head; he doesn't recognise them, and they are not there all the time; - no other commands noted; - no commands to harm others reported or admitted to; and - the voices had been present for years. Mr A was noted to report that he sees people come into the room and that he had said to his mum that he had seen a child and a man come into the room. It was also noted that Mr A believed that people are out to get him, talking about him behind his back. His mood was noted to be depressed most of the time. His eating was poor, his sleeping not very good. He was noted to be fearful, paranoid, needing prompting with self-care and that he had just been sitting at home. It was also noted that Mr A did attempt to hang himself in Walton Prison. He reported no alcohol or drugs since his release from prison.

Date	Chronology
17/9/2004 continued	

Forensic History was noted as:

- rape - sentenced to 5 years
- Burglary
- Assault with actual bodily harm
- Kidnap

Impression documented:

- ? depression with psychotic symptoms
- ? continuing drug abuse
- ? personality disorder with quasi-psychotic symptoms.

Medication:
Taken off the tricyclic, the anti-depressant prescribed by his GP, because of risk of overdose.

Risk:
Mr A was noted to be a clear risk to others, but not as a consequence of any mental illness.

Plan:

- Referred to Arundle Day Hospital
- CPN asked to visit
- Mother provided with crisis and home treatment contact details.

17/9/2004	Referred to Arundle House.
21/9/2004	Mr A noted not to attend his 10.30 appointment at Arundle House.
22/9/2004	Mr A's mum contacted Arundle House: apparently, the attendance letter had been received only on 22 September at 1pm. On the same day a new appointment was offered for 28 September at 10.30am.
28/9/2004	Mr A was noted to have attended for assessment. He was interviewed alone, although he had attended with his mother. Low mood was identified and psychotic symptoms expressed. On the basis of the assessment, the day centre staff did not consider that *"this was primary psychotic illness"*; rather, Mr A had a damaged personality due to previous life experiences. Mr A was noted to be distressed by the voices he heard. He was also noted to be withdrawn, staying in his bedroom. The Plan of Care: 1) To offer a 4-6 week period of further assessment focusing on mood, risk, avoidant behaviour, and ability to change and evidence of a serious and enduring mental illness. Mr A was noted to be unsure that he could tolerate this level of assessment/input. 2) Consider CPN follow-up with due consideration to risk (1 worker). 3) Discuss with wider multi-disciplinary team (there was no consultant psychiatrist in team at this time).

Date	Chronology	
28/9/2004	CPA care plan and risk assessment	**Notable features about Mr A:** Offences include: Section 18 assault, Section 47 assault. Note: The rape charge was dropped, owing to insufficient evidence, but he spent 9 months on remand as a consequence of the allegation. The allegation was made by his girlfriend. **The Risk Assessment** This identified suicide indicators, neglect indicators, aggression and violence indicators, and other indicators. Under situational context of risk factors, it said: *"continue to assess".* A historical chronology *re*. risk was set out. There is a clear summary of protective factors. **Plan/needs outcome** 1) To continue with current medication - Venlafaxine 2) Liaise with wider CMHT *re.* long-term needs 3) Suggested social worker, but Mr A declined this offer 4) Achieve increase in mood and activities
28/9/2004 continued	CPA care plan and risk assessment	5) Continue to monitor risk to self and others 6) Consider carer/family assessment 7) Urine drug screen taken. The assessment form noted that the content of what was written was discussed with Mr A and his mother. There were no disagreements regarding content. Mr A's mother was noted to want help for her son.
1/10/2004	Telephone call to speak with Mr A	The telephone call was with Mr A's mother, as he was with an aunt. The records stated that Mr A's mother found her son unchanged. He was reported to believe people were in the room. He was getting angry with himself. He had again threatened to cut himself and said he wanted to cut his throat. Mr A's mum was provided with the crisis and home treatment contact numbers and the day centre worker agreed that she would speak with Mr A on 4 October regarding his treatment options. Medications were noted to continue. Also, Mr A was noted to have met with the benefits office regarding his finances. Mr A's mother was also noted to be concerned about Mr A's ongoing living arrangements, i.e. with her.

Date	Chronology	
4/10/2004	Telephone call to speak with Mr A	Mr A was offered a 4-week assessment period at the day hospital, with 2-3 sessions a week. He was also offered an appointment with Consultant Psychiatrist 1 on 6 October.
6/10/2004	Telephone call from Mr A's mother to staff	Mr A's mother informed the day centre staff that he *"has no money so cannot get to the appointment"*. Consequently, she requested a different date. The records show that staff encouraged attendance by Mr A if possible, as it was important that his mental state was assessed.
11/10/2004	Assessment	The account of Mr A's assessment is difficult to read, but the impression is that the assessment was comprehensive.
11/10/2004	Urine screen	Benzodiazepines, Amphetamine, Cocaine, Opiates, Methadone Metabolites were all found to be negative; however, it was a dilute sample and re-testing was recommended. *(Note: it is not unusual for illicit drug users to drink copious amounts of clear fluids if they are anticipating a urine drug screen.)*
14/10/2004	Face-to-face meeting with Mr A	The treatment plan provided/offered: Attendance at the support group, men's group, and sports group. Mr A was noted to be agreeable to attending. The record also noted that Mr A needed his own accommodation and would need to save a deposit for this. In terms of positive behaviour, the record said that Mr A's brother stole from him during the preceding week but that he (Mr A) didn't retaliate. The Plan: Increase activities in a structured way. Reduce social isolation. Monitor for psychotic/depressive symptoms. Encourage an increase in coping mechanisms.
19/10/2004	Mr A attended day centre	IC started treatment plan/attendance at groups on 18th. The records show that his mother also attended and stayed. She was encouraged to leave, but Mr A was reluctant for her to go. The records show that Mr A's mother did speak with staff and told them that she couldn't cope with bringing Mr A to the service. She was noted *"to appear to be anxious".* It was also noted that there were other dynamics with siblings - reported by Mr A. The Plan: To persevere with day centre attendance and to focus on coping skills. To attend an appointment with Consultant Psychiatrist 1 to review mental state and diagnosis.

Date	Chronology	
20/10/2004	Mr A attended day centre	Attended again with his mother. He had been to the community sports group. He remained very reluctant for his mother to leave the day unit. The records show that day centre staff spoke with Mr A's mother and advised her of the reason why it was not ideal for her to remain. The main reasons were in relation to the over-dependency her son had on her, and issues of confidentiality in the unit. The plan was to speak with Mr A and his mother jointly after the session. However, the record noted that they left before this could be achieved.
21/10/2004	Telephone call to Mr A	Mr A was not available, so the day centre staff spoke with his mother and advised her of an appointment booked with Consultant Psychiatrist 1 on 27 October at 1pm.
25/10/2004	Mr A did not attend	The records noted that the day centre staff planned to telephone Mr A to remind him of his revised appointment on the 27th. Also to remind him about attendance at the men's group on the 26th.
26/10/2004	Mr A attended his appointment	Mr A was interviewed with his mum to reinforce the way forward. The plan agreed was: 1. To have a more positive attitude towards attendance 2. Mr A's mother not to attend 3. Mr A to develop more independence from his mother. Note – The records show that Mr A's mother wanted to know what her son's diagnosis was. She and he were advised to speak with Consultant Psychiatrist 1 about this.
28/10/2004	Medical review	Mr A attended at his medical review. **NB:** Notes look comprehensive but difficult to read.
3/11/2004	Medical review	**NB:** Notes look comprehensive but difficult to read.
8/11/2004	Mr A attended the day centre	Mr A attended late as he had fallen on the stairs at home. He had a significant gash on his leg and was advised to attend A&E. Consequently, an appointment was rearranged for two days' time.

Date	Chronology	
10/11/2004	Mr A attended day centre	Mr A's progress at the centre was reviewed: 1) Mood: some improvement noticed. 2) Mr A reported finding it difficult to mix with others and going out. And described a recent panic attack. On the 10th he travelled on the bus on his own – he found it difficult, but was pleased he had done it. 3) Mr A reported continuing to experience auditory and visual hallucinations. These constituted two men and a little boy. They were in old-fashioned clothes, and repeatedly told him that he was bad and to harm himself. The record shows that Mr A appeared distressed when discussing this with staff. However, it was also noted that there was no objective evidence of this whilst Mr A was in attendance at the day service. 4) Financial Benefits: Mr A was noted to continue to decline help from the social worker. He was, however, bringing in his bus pass forms to the day hospital. Mr A was also noted to agree to referral to the income maximisation service. The Plan: 1) Stay at Arundle House 2) Focus on increasing independent activities 3) group programme, 1:1 support worker, desensitisation 4) Determine long-term activities 5) Offered referral to 'mainstream' – Mr A considering this 6) Refer to income maximisation 7) Repeat drug urine screen.
13/11/2004	Medical review	Mr A attended this and also on the 17th.
13/12/2004	Mr A attended	Day centre attendance.
24/1/2005	A letter was sent to the day centre	The correspondence advised that Mr A had appeared in court that day for driving offences and a breach of the Sex Offenders Act - i.e. he had not registered a change of address.
27/1/2005	Discharge summary	Comprehensive discharge letter setting out the referral to the day centre, Mr A's progress at the day centre. It highlighted Mr A's non-attendance at a recent EEG appointment.
16/6/2005	Letter to Mr A advising of CPN home visit	The letter advised that a CPN would visit Mr A on 22 June. The home visit was requested by the Consultant Psychiatrist for the CMHT, as Mr A had not attended at his outpatient appointments.

Date	Chronology	
22/6/2005	Home visit (unsuccessful)	A male (not Mr A) answered the door to the CPN. This individual advised that Mr A had not been seen for four days. As another address was also mentioned in the case notes, the CPN's plan was to try that also. However, Mr A was not at this address either (29 June).
22/6/2005	Telephone contact	The CPN called as arranged and spoke with (?) a member of Mr A's family. The records note that no-one had seen him for a few days. The CPN advised that she was going to try another contact she had for him. She also asked Mr A's family to get in touch with her if they heard from Mr A.
29/6/2005	Home visit (unsuccessful)	Mr A was not at this alternative address. Another tenant told the staff member that there was no-one by the name of Mr A present.
4/7/2005	Multi-disciplinary CMHT meeting	The plan agreed was to arrange to contact Mr A's GP and also the Criminal Justice Clinical Support Team (CJCST) to try and find the whereabouts of Mr A. A consequence of this was discovering that the GP had not seen Mr A since December 2004. The Dual Diagnosis Team informed the CMHT that Mr A was currently in Walton Prison.
16/8/2005	Psychiatric report	Mr A had pleaded guilty to charges of dangerous driving and failing to sign the Sex Offenders Register. The independent psychiatrist identified that Mr A was known to drug dealers, whom he had previously robbed. It was also noted that Mr A had suffered from low mood since the age of 7 years and that he had reported hearing voices from this time (after being raped). The report set out how Mr A described impulsive acts over the years and 'self-harming' for most of his life. His voices were described as speaking directly to him and that he heard them either in internal space or apparently from the room around him. Mr A was noted to report that the voices commanded him to harm himself. He denied ever hearing voices talking to each other about him in the 3rd person. Mr A also reported that, in association with the voices and visions, he might experience a detachment from events and himself, *"like something takes over your body"*. Mr A reported that this occurred on an occasion-to-occasion basis; for example, after he

Date	Chronology	
16/08/2005 continued		had physically assaulted a man and when he had returned to his *"normal self"*, he remembered being horrified by what he had done. Drug and Alcohol use: Mr A was noted to have used drugs from an early age. Most recently cocaine, crack cocaine, heroin. He had injected heroin in the past. However, he reported that, while at the Day Centre, he had stopped using drugs. This was in 2004. However, he re-started drug use in early January 2005, but had not used them since the end of January 2005. Heavy alcohol use was a feature when he was 23 years old.
Comment		Mr A was followed-up in the community between January 2005 and June 2006. He had 4 medical appointments in this time. Two he did not attend and 2 were cancelled by the Trust.
30/12/2005		This was the expected release date for Mr A from prison.
28/2/2006	Outpatient appointment	It is unclear whether or not Mr A attended for this.
13/3/2006	Outpatient appointment	Mr A did not attend.
26/6/2006	Outpatient appointment	Mr A did not attend – The records note that Mr A was to be asked to contact the service if he wishes. The consultant psychiatrist advised Mr A's GP that if he did not make contact he would be discharged back to primary care.
Mr A was in prison.		
20/10/2006	Multi-agency Protection Panel meeting	The meeting was at South Liverpool probation service. Mr A was due to be released from HMP Wymott on 19 November 2006. On his release, Mr A was to reside at a probation hostel. The criminal justice nurse was to write to Mr A's GP to make him aware of Mr A's mental health issues and to ask for referral to the mental health service.
8/12/2006 to 13/7/2007	HMP Liverpool	This prison health record noted that Mr A had been released from HMP Wymott on 17 November. It also noted that, in the period between 17 November and 8 December, he had been using £40.00 of Heroin a day and £30 of Crack Cocaine. He was started on a methadone programme. He was seen by the prison health team on 16 occasions while at HMP Liverpool.

Date	Chronology	
8/12/2006 to 13/7/2007	continued	One month prior to his release (5 June 2007), the prison record noted: 1. Mr A would not be on licence as he had served his full sentence. 2. That he had no accommodation and had contacted Project 8 about this. 3. That Mr A's case was discussed with CARAT. 4. That Mr A was to be commenced on Naltrexone on his release. 5. That prison health would contact his GP to see if he was still registered. 6.That Mr A's case would be discussed with the Dual Diagnosis Team 7. That an outpatient appointment would be booked with mental health services.
	HMP Liverpool continued	13 June 2007: It was confirmed that he was no longer registered with a GP, and, although his previous GP was content for Mr A to re-register with them, he needed to be within their catchment area, which was to be unlikely. Until his living accommodation could be confirmed, no arrangements could be pursued for GP registration. 5 July 2007: Mr A was informed that he would not be getting his Naltrexone, as he reported having had a *"toot"* (snorting drugs through a straw (http://www.urban75.com/Drugs/snorting.html)). Consequently, he received his mental health medication of Venlafaxine and Olanzapine only. He was also advised that an appointment had been booked with his consultant psychiatrist for 18 July at the day centre.
26/6/2007	Fax from the Dual Diagnosis Service	The Dual Diagnosis Service faxed a referral letter to the Consultant Psychiatrist for the CMHT. The fax noted that Mr A had made good progress while in prison. The referral noted that Mr A was motivated for change and had taken the initiative to enlist in *"a lot of additional support for when he is released".* He was noted to have contacted Project 8 and was working with the CARAT (Counselling, Assessment, Referral, Advice and Through care) team in prison, as well as seeing the Dual Diagnosis Service on a regular basis. Mr A was at this time drug-free and hoping to be released on a

		Naltrexone script. It was noted that Mr A was to be released to his
Date	**Chronology**	
26/6/2007	continued	Mother's address, and who had historically supported him in his engagement with the CMHT consultant psychiatrist's team. The registered mental health nurse (RMN) present noted that Mr A had a history of not turning up for his mental health appointments, but that he hoped, with his current level of commitment, this time it would be different. The RMN also provided the Consultant Psychiatrist for the CMHT with two GP options that Mr A might register with, as he did not have a GP at the time the referral was made.
18/7/2007	Outpatient appointment	There is no record of Mr A having attended at his first outpatient appointment. It may be that this was cancelled and re-arranged for 24 July.
24/7/2007	Outpatient appointment	Mr A attended for this: His poly-substance misuse was noted to be currently in remission. Previously, he was also noted to be suffering from alcohol dependency syndrome and panic disorder. At this appointment, he told the clinician that he thought people were plotting against him. He also said that people were talking about him and that he did not know why. He also reported that a Support Worker from Project 8 was trying to find him suitable accommodation. Mr A also told the clinician that sometimes the voices told him to do bad things to himself and that he continued to experience flashback nightmares about his abuse. Mr A told the clinician that he did not want to wash and that he did not have motivation to do anything. The subsequent letter from the clinician to the GP set out a summary of Mr A's social and mental health history, in addition to the contemporary information. Mental State Examination: • Mr A noted to be co-operative throughout • Objectively and subjectively appeared to be depressed • No evidence of self-harm ideas or suicide ideas • Speech coherent and spontaneous, with normal rate flow quality

		• No evidence of delusion • No evidence of formal thought disorder • No evidence that he was responding to hallucinations of any kind. The management plan was to continue with medication and a further outpatient appointment in 6 weeks.

Date	Chronology	
12/9/2007	Outpatient appointment	Mr A attended this with his mother. He was noted to be complaining of hearing voices, although it was noted there was no evidence of him experiencing hallucinations. Mental State Exam: • No evidence of homicidal or suicidal ideation. • No evidence of psychotic symptoms. • Opinion – Mr A is still reporting hearing voices and experiencing poor sleep. Management Plan: To commence Quetiapine 50mg at night, to be increased to 100mg a night after 1 week. Olanzapine reduced by 5mg every 4 days until it is stopped. Outpatient appointment in 6 weeks.
30/10/2007	Outpatient appointment	Mr A did not attend.
13/11/2007	Outpatient appointment	Mr A did not attend.
11/12/2007	Outpatient appointment	Appointment cancelled by Trust.
13/12/2007	Outpatient appointment	Mr A attended this appointment. A staff-grade psychiatrist reviewed Mr A on behalf of the Consultant Psychiatrist for the CMHT. He attended the clinic with his cousin, who waited outside. He was noted to have a diagnosis of Emotionally Unstable Personality Disorder. Medication was noted as Venlafaxine 150mg once a day. Mr A reported stopping his Quetiapine and his Olanzapine. He reported that Quetiapine was making him feel sick and that he had been vomiting for the past 6 days. It was also noted that he had a dental abscess. The notes state antibiotics *"started today".* Mr A also reported spending most of his time at home watching TV. He only goes out in the company of others because he feels threatened when he goes out on his own. Mr A told the staff-grade that, *"I've robbed many drug dealers".* He

		also complained of broken sleep and not eating well.

Date	Chronology	
15/7/2008	Outpatient appointment	The appointment was cancelled by the Trust.
13/8/2008	CPA Care Plan	The Plan was to: 1) Re-start Venlafaxine 75mg 2) Start Olanzapine 5mg at night 3) Arrange outpatient appointment in 6 weeks.
13/8/2008	Outpatient appointment	Mr A attended this. He reported not having taken his Venlafaxine for two weeks. He also reported feeling depressed and tired. He reported he had been having difficulty in sleeping. His main worry was having access to his son, who was three months old and currently in foster care. It was noted that in September Mr A was due to go to court to find out about access to his son. As previously reported he did not go out on his own, mainly staying at home and going out in the company of his sister. Mr A described his appetite as not good. There was no evidence of self-harm and no evidence of any suicidal ideas. Mental Health Exam: No evidence of psychotic symptoms was identified. However, Mr A reported that from time to time he had voices telling him to hurt himself and that the voices were sometimes located inside his head and sometimes outside his head. Opinion: That Mr A was worried about the court case.
31/8/2008	HMP Liverpool records	Allegation of Grievous Bodily Harm. (Not known to mental health services and identified by the Independent Investigation Team when going through the prison health records.)
24/9/2008	Outpatient appointment	Outpatient appointment was cancelled by Trust.
25/9/2008	Outpatient appointment	Mr A did not attend.
5/11/2008	Telephone contact from the police	Informed that Mr A was arrested on 2 November on suspicion of murder. He was intoxicated with alcohol at the time of his arrest. No issues were noted in his behaviours when in custody and he was deemed fit to be detained. He was interviewed and charged with murder.

Date	Chronology	
	HMP Liverpool records	The prison record of 5 November recorded that: • Mr A had been using heroin on a daily basis, £60.00 a day usage; also illicit methadone. Mode of administration was by injection and/or smoking. However, Mr A reported not using either drug since 1 November. • Mr A admitted to alcohol intake of 3 litres of cider a day and that he had been drinking at that rate for 5 weeks prior to being incarcerated at HMP Liverpool. • Mr A appeared rational and stable. • Mr A was on Venlafaxine and Olanzapine. • No active thoughts of harm to self. Blood and Urine Screen: • Urine opiate level positive. • Urine cocaine level negative. • Urine benzodiazepine level positive. • Urine methadone level positive. On 6 November: The HMP Liverpool record also noted that, *"Dependence on opiates established. Uses 60 pounds worth of heroin. Was abstinent during 6 months sentence. Released 7 weeks ago and relapsed immediately. Objectively withdrawing."*
10/8/2009	HMP Liverpool	The prison health record noted: *"In stark contrast to every other appointment with him, Mr A told me that he had now entered a guilty plea to manslaughter and admitted that he had killed his friend."* Mr A was noted to be: • Angry that his legal advisors had prevented him from entering a guilty plea earlier. • Angry with mental health services for not giving him the treatment he required to prevent the incident and for withdrawing funding when he was attending a day centre which benefited him. • Angry with himself for what he had done to his friend and talked of the impact on the victim's family. • Remorseful. • Upset that no-one had helped him or listened to him in the past, until he attempted to hang himself in his cell some two years previously.

3.1 The Opinion of the Independent Investigation Team

It is the opinion of the Independent Investigation Team members that Mr A was offered a good service by Mersey Care NHS Trust and no root cause or direct contributory factor arising from Mr A's care and treatment provided can be attributed as leading to his index offence.

4.0 THE ASSESSMENT OF MERSEY CARE NHS TRUST'S INTERNAL INVESTIGATION

Mersey Care NHS Trust's own internal investigation report shows a sincere commitment to ensuring that all aspects of practice were analysed and any available learning for the future benefit of safety and quality was achieved.

The chronology presented in Chapter 3 of this independent report shows that:

- Mr A received a diligent service from Arundle House (the day centre).
- The CPN assigned to Mr A in 2005 was persistent in her efforts to try and locate Mr A and effect an assessment of him.
- Mr A received repeat outpatient appointments, in spite of his tendency not to attend. It is possible that in another team he would have been discharged back to primary care more swiftly than the Consultant Psychiatrist for the CMHT and his team considered doing.
- Mr A received attentive care from the prison mental health team and he was encouraged to engage with activities to address his substance misuse and to achieve remission.
- At the point of discharge from HMP Liverpool in July 2007, the prison health and mental health services ensured that:
    - Clarity was achieved regarding Mr A's GP status;
    - Information was provided to mental health services regarding a number of GPs Mr A could register with;
    - An appointment was made with secondary mental health services prior to discharge;
    - Dual Diagnosis Services were involved;
    - Project 8 was involved;
    - Naltrexone was offered to assist in Mr A staying off heroin and other illicit substances.

In short, Mr A was offered a good service from Mersey Care NHS Trust and was provided with reasonable opportunity to engage in therapies, work groups and treatments, including activities relating to substance misuse. He, Mr A, did not avail himself of these opportunities as he could and should have done. His relapse into criminality and illicit drug taking on his discharge from HMP Liverpool in 2008 testifies to this.

4.1 Key observations about Mersey Care NHS Trust's report

4.1.1 The executive summary of the Mersey Care Report says that the Staff Grade Psychiatrist who assessed Mr A's concluded that the diagnosis was a depressive episode, even though Mr A had previously been diagnosed with Emotionally Unstable Personality Disorder and Post-Traumatic Stress Disorder. The Independent Investigation Team's analysis of Mr A's clinical records showed that the staff grade psychiatrist recorded Mr A's diagnosis as 'Emotionally Unstable Personality Disorder' and Post-Traumatic Stress Disorder. Both diagnoses are recorded on the care plan attached to the letters he sent to the GP on the:

- 12 September 2007;
- 27 September 2007;
- 13 December 2007; and
- 13 August 2008;

The Staff Grade also referred to possible psychosis and Mr A's poly-substance misuse after he initially saw Mr A on 24 July 2007.

The Independent Consultant Psychiatrist specifically noted that episodes of depression can commonly occur in service users with Emotionally Unstable Personality Disorder and that the diagnosis reached for Mr A was reasonable on the basis of the clinical assessment set out in the clinical records.

4.1.2 Section 7.1.3 of the Trust's report says that the staff grade psychiatrist did not record the level of Mr A's substance misuse or the treatment provided. Although the Independent Investigation Team concurs with this observation, it could not find any reference anywhere in the records to the amount of illicit substances Mr A was taking. The Independent Investigation Team did find this information in Mr A's prison health records, but it was not available to Mersey Care NHS Trust staff. The Independent Investigation Team is satisfied that the staff grade psychiatrist was mindful that Mr A did have a history of poly-substance misuse and the nature of the illicit drugs he was taking. In his letter to the GP of 27 September 2007, The Staff Grade says: *"he has a history of poly-substance misuse, including opiate dependency, currently in remission"*. In a subsequent letter he also noted that Mr A "robbed many drug dealers".

4.1.3 Section 7.2.6: Mersey Care NHS Trust's report rightly highlights the lack of access to old, and existing, records for Mr A. However, the Trust's report also highlights the inclusion of the community mental health team's (CMHT's) consultant psychiatric court report of 16 August 2005 in the Mr A's clinical records. This report was formulated for court and not clinical purposes. The Mersey Care NHS Trust's investigation team concluded that, *"there was too much emphasis placed on the report and had it not been in the record more investigation might have been undertaken, resulting in further detail of Mr A's history, particularly regarding his offending record and propensity for violence."*

The Independent Investigation Team has read the report of August 2005 very carefully. It considers that this report contained a great deal of very helpful background information as well as a clear summary of Mr A's psychiatric diagnoses. The Independent Consultant Psychiatrist noted that "*in routine clinical practice, particularly when using paper records, many of which are often illegible, I consider it very likely that the vast majority, if not all psychiatrists, would have made significant use of the information contained in such a report."*

The Independent Investigation Team cannot identify on what basis Mersey Care NHS Trust's investigation team formed the conclusion they did. Logic suggests that had the August 2005 report not been in Mr A's clinical record it would have been equally feasible that less information would have been available about him. The Independent Investigation Team is not persuaded that but for the 2005 Court report Mr A's clinical team would have gathered more information about him.

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4.1.4 Section 7.3.10: Mersey Care NHS Trust's report suggests that Mr A should have been on enhanced CPA. The Independent Investigation Team could not find any such evidence. The CMHT consultant psychiatrist had recorded clearly in his records that Mr A was not suffering from a severe and enduring mental illness and that, although he (Mr A) posed a risk, it was not attributable to mental health issues. Previously, whilst at the day centre Consultant Psychiatrist 1 had also identified, in 2004, that Mr A was a risk to others, *"but not as a result of mental illness".* (reference 5.2 (page 8) and 5.3.1 (page 14) of the Trust's report.)

The Mersey Care NHS Trust's 2006 policy said:

8.4.3 "Enhanced Level ECC

8.4.3.1 The characteristics of those service users requiring Enhanced ECC will include some of the following:

a) All service users admitted to in-patient or Crisis Resolution and Home Treatment care **[*not applicable to Mr A*]**

b) They may be in contact with a number of agencies (including the Criminal Justice System) **[*applicable to Mr A*]**

c) They have complex/multiple needs which in general require the input of two or more professionals/agencies **[*not applicable to Mr A*]**

d) They are only willing to co-operate with one professional or agency, but have multiple care needs, including: housing, employment, etc., requiring inter-agency co-ordination **[*not applicable to Mr A*]**

e) They have a high level of social disability that reflects agreed joint criteria **[*not applicable to Mr A*]**

f) They are more likely to disengage from services **[*applicable to Mr A*]**

g) They are more likely to have mental health problems co-existing with other problems or substance misuse **[*not applicable to Mr A; no serious and enduring mental illness*]**

h) They are more likely to be at risk of harming themselves or others **[*applicable to Mr A*]**

i) They are more likely to be at risk of serious self-neglect and/or highly vulnerable **[*not applicable to Mr A*]**

j) They are likely to require more frequent and intensive interventions, perhaps with medication management **[*not applicable to Mr A*].**

8.4.4 Other Enhanced Level Characteristics

8.4.4.1A service user's assessed need will determine inclusion within the enhanced level of ECC and this will be reflected in the care plan. As well as the above characteristics, the following may lead to inclusion:

a) Section 117,Section 49 and Section 41 apply **[*not applicable to Mr A*]**

b) The service user is subject to a Guardianship Order **[*not applicable to Mr A*]**

c) *The service user is on the Supervision Register* **[*not applicable to Mr A*]**
d) *The service user is subject to supervision under Section 25A-J (Supervised Discharge)* **[*not applicable to Mr A*]**
e) *They are prone to relapse* **[*not applicable to Mr A*]**
f) *The service user has sole responsibility for dependent children and there are child protection/welfare issues* **[*not applicable to Mr A*]**
g) *The above represent indicators and do not replace reasoned clinical judgement in relation to deciding what level of ECC a person should be placed on. Risk and case complexity should be the key identifiers."*

The above information shows that Mersey Care NHS Trust included a range of features as highlighting the possible need for enhanced CPA status.

The Independent Investigation team believes that one could argue the extent to which they applied to Mr A. The Independent Investigation Team considers that there would be a diverse range of opinion across mental health professionals with regards to the extent to which Mr A met the criteria for enhanced CPA. Furthermore the allocation of the level of CPA prior to the changes in the CPA system was also dependent on the capacity of the community mental health team as well as documented CPA criteria. For example if a CMHT had six care coordinators each with capacity to take 30 cases, the capacity of the team for enhanced CPA would have been 180. It is established practice in mental health services that the 180 most in need cases would therefore be allocated a care coordinator. This means that there might be more cases allocated to a team which meet the 'written' criteria than actually have a care coordinator. The interview records collected by the Mersey Care NHS Trust investigators did show that there was a high threshold for allocating service users to enhanced CPA level at the time Mr A was in receipt of care and treatment from the Trust.

The overall perspective of the Independent Investigation Team with regards to Mr A's CPA level is that his placement on standard rather than enhanced CPA is difficult to quantify as a lapse in care and treatment. If Mersey Care NHS Trust's investigation team felt strongly on this issue it would have been prudent for them to have conducted a substitution test. That is, to have asked a broad range of appropriately qualified professionals what level of CPA they would have assigned to a service user with similar presenting features as Mr A. This would have assured balance in the presentation of the Trust's findings on this point.

4.1.5 Good Practice: The Trust's report acknowledges that the community mental health staff went to *"extraordinary lengths"* in attempting to remain in contact with Mr A when he did not attend for outpatient appointments and was not at home. This acknowledgement is well placed and the records do indicate that such effort was made.

4.1.6 Facts established (section 5 of Mersey Care NHS Trust's report)
This section of the Trust's report was of a good standard and was appropriately detailed. It reflected accurately what was set out in the patient record. There was one small factual inaccuracy at 5.10, where the report says that Mr A said he had hurt his back, which was why he was late for an appointment. However, the clinical records report that it was his leg. This was the only factual inaccuracy identified.

The Trust report highlights that perhaps consideration should have been given in 2004 to psychological therapies and assessment for Mr A in view of the abuse he had experienced as a child. The Independent Investigation Team agrees that greater consideration could have been given to this. However, the Independent Investigation Team also noted that the day centre staff did offer counselling services to Mr A, which he refused. Indeed, Mr A did not engage fully with the opportunities presented to him by the day centre staff. The Independent Investigation Team considers it questionable whether Mr A would have engaged with psychological therapies, and the necessary assessment for this, even had it been offered. It is important that this is acknowledged.

4.1.7 Section 5.21 of the Trust's report sets out clearly the status of the CMHT's consultant psychiatric report prepared for the court. It noted that a *"full analysis of present and past psychiatric history was provided which referenced the fact that Mr A had tried to kill himself three weeks previously".* The Trust's report also drew out the fact that the CMHT consultant psychiatrist had noted that Mr A's diagnosis remained uncertain and that most likely he had experienced a *"non-psychotic depressive episode. Coupled with his underlying Emotionally Unstable Personality Disorder, this served to exacerbate his chronic quasi-psychotic symptoms."*

4.1.8 Section 5.24 of the Trust's report noted that a second Multi-Agency Public Protection Panel meeting was planned, following that which identified Mr A as a risk to the public, but that this was cancelled due to the fact that Mr A was recalled to prison. The Trust's investigation report appears to infer that the MAPPA process could have continued via the police service. However, from the Independent Investigation Team's experience of this type of service user and mental health homicides, Mr A's forensic history was not of the magnitude where one would expect the MAPPA process to continue. The Independent Investigation Team does not consider there to have been any lapse in service delivery or inter-agency communications because the MAPPA process did not continue.

4.1.9 Section 6 of the Trust's report – points of concern
The authors of Mersey Care NHS Trust's investigation report highlight the following:

I. *The lack of access Mersey Care NHS Trust staff have to prison health records.*

II. *The Mersey care investigation team did not have information regarding the family dynamics for Mr A, and his contribution to any relationship with his GP.*

III. *There was a forensic report dated July 1983, completed by the Scott Clinic, setting out Mr A's forensic and offending history at that time. It raises a concern that this was not available to adult mental health services in 2004, and that the 2004 staff were unaware of it. The broader concern is that there was an insufficient search for evidence of previous contact with mental health services in Liverpool when Mr A was referred and accepted by the service in 2004.*

IV. *Mersey Care NHS Trust staff involved in the delivery of care and treatment to Mr A did not enquire as thoroughly as they should about his past history with services they knew to be involved with him; notably, the prison service and the Dual Diagnosis Service in 2006 and 2007.*

V. *There was an inconsistent reported history regarding Mr A's ability to go out. For example, in 2004 he reported not feeling safe, but was also noted to go out with his sister and to see his aunt.*

In relation to the above, the points of most relevance to the purpose of the Trust's investigation (i.e. an analysis of Mr A's care and treatment) were points I, III, and IV. The Independent Investigation Team agrees that these represented valuable reflective practice opportunities for the Trust, and are issues that were appropriate to address within the recommendations made.

4.1.10 The conclusion of Mersey Care NHS Trust's investigation team
This section of the Trust's report does not constitute a conclusion. Its content and formulation are more consistent with the findings section of an investigation report. Its content built on the 'facts established' as set out in section 5.0 and drew on information told to the investigation team at interview and/or known to the investigation team via additional research, such as policy interrogation.

As a 'findings section' it is reasonable, but does not adhere to the current expected format of clearly identifying 'care management concerns' and then setting out the contributory factors and 'root causes' to each identified concern. A National Patient Safety Agency report writing template was published at the time the Mersey Care NHS Trust's report was written, but its formulation did not make clear how trusts could achieve this within the confines of its template. Furthermore, this section would have benefited from enhanced articulation about how and why staff did, or did not, do certain activities. For example, the staff grade psychiatrist is identified as not having documented the extent of Mr A's substance misuse. However, the staff grade psychiatrist's explanation as to

why not is not set out. Neither is there any articulation of what other similarly qualified staff would have done in similar circumstances. The report's authors also highlight that no evidence was found, except in relation to prison health, that Mr A was offered a psychological assessment. However, it does not set out the outputs of its exploration of this issue with the day centre staff, or the community mental health team, including its medical staff.

The lack of information set out in the Trust's investigation report in relation to the areas where the Trust's Investigation Team had identified where improvements could have been made detracts from an otherwise good investigation report. Mersey Care NHS Trust needs to find a way to support staff in producing investigation reports, following incidents of this severity that properly evidence the findings, conclusions and opinions of its appointed investigators.

The Independent Investigation Team read the Trust's interview records with care. Overall they were of a reasonable standard. However they did not show the depth of exploration expected in relation to staff's understanding of systems and processes, such as how to access historical records, under what circumstances might one consider contacting the criminal justice liaison team, etc. Ensuring the systems issues are explored alongside direct questions about the care and treatment of a service user are an essential component of the investigation model designed by the National Patient Safety Agency. It is this model that NHS Trusts (foundation and non-foundation) are expected to utilise in contemporary investigations.

The above being highlighted the Trust's interview records did offer some greater insight into the contemporary situation for Mr A's clinical team between 2006 and 2008 and also into the decision to keep him on standard CPA than was articulated in the Trust's Investigation Report. The interview records also enabled a better appreciation of the staff grade psychiatrist's perspectives regarding Mr A than was achievable from reading the Trust's investigation report.

Overall the Trust's interview records do show that a detailed approach was taken towards the investigation of Mr A's care and treatment.

4.1.11 Good practice (section 7.4): The Independent Investigation Team agrees with all of the good practice points identified in the Mersey Care NHS Trust report.

4.1.12 Recommendations made by Mersey Care NHS Trust

The following recommendations were made by Mersey Care NHS Trust as a consequence of its own investigation. Most of the recommendations made have been addressed, or have been superseded by developments in the Trust, such as the roll-out of ePEX. Appendix 1 sets out the Trust's updated action plan, with which the Independent Investigation Team is satisfied.

In assessing the quality of the recommendations made, the Independent Investigation Team benchmarked them against S.M.A.R.T criteria. That is whether the recommendations were:

- Specific
- Measurable
- Action orientated
- Relevant and realistic
- Targeted and time bound.

The independent investigation team also assessed the recommendations in relation to their reliability attributes.

In healthcare quality improvement and safety improvement interventions can frequently be grouped under the following headings which give an indication of the reliability of the planned intervention(s) aimed at improving care and service delivery:

- Physical interventions. These are interventions that have designed out as far as possible the human interface and thus reduced as far as possible the opportunity for human error. An example of a Physical Intervention would be an electronic prescribing system that used forced fields and did not allow a prescription to be made without the completion of these fields.
- Natural Interventions: A natural intervention is one that uses naturally occurring elements such as time, distance and place. An example of a natural intervention is the offsite storage of clinical records with companies who specialise in the safe storage and retrieval of clinical records. Another example would be the WHO safer surgery initiative where a time break pause is required immediately before the commencement of interventional treatment to allow all present to make a final check that they have the right patient, are doing the right treatment, on the right body part, on the right side of the body.
- Human Action Interventions: Human action interventions rely of 'telling' individuals what they should be doing.
- Administrative Interventions: Administrative interventions include the development or revision of existing training/skills development programs, the updating of policies and procedures, supervision of practice.

Each of the above groups are considered to have differing degrees of reliability. That is each differs in the uniformity with which it performs the relevant task or process on a day in and day out basis.

- Physical interventions tend to be the most reliable, performing as intended. Physical interventions generally constitute highly reliable

interventions. Unfortunately scope for such intervention in mental health services is very limited.

- Natural interventions could be considered of medium reliability. The institution of activities such as time breaks creates space for clinical staff to identify an error or hazard before an incident occurs. There is scope for this type of intervention in mental health services. For example using a two tier (or person) checking system with a time break in between the checks made.
- Administrative interventions are weak in terms of reliability as they rely on humans to carry them out. Consequently the checks and balances put into regularly test the effectiveness of these interventions and obtaining a good understanding of the contributory factors to any system deficit / non-performance are important in the development or more robust solutions.
- Human interventions, i.e. telling staff what they should be doing, are an unreliable improvement intervention. Consequently recommendations that are targeting human behaviour need to be given specific consideration and understanding why staff are not performing as expected is essential to delivering an action plan of merit. Again, the ongoing audit process for testing the effectiveness of any human action intervention is essential to the success of any action plan focusing on human behaviour.

The Independent Investigation Team has set out its assessment of the Mersey Care NHS Trust recommendations based on the safety and reliability principles set out above.

The Mersey Care NHS Trust's recommendations

1 *A warning should be placed on ePEX for any service user who has been subject to MAPPA. The MAPPA policy should be amended to reflect this.*

Independent Investigation Team comment:
On the basis of this investigation, the Independent Team suggests that a more moderate recommendation could have been made in the first instance; something along the lines of meeting with MAPPA panel representatives to find out what scope there is for Mersey Care NHS Trust staff to be better informed about service users who have been subject to MAPPA, and any restrictions there might be to this. Further exploration of the issues before determining what actions were achievable is often preferable to a fixed action that may not remedy the situation, or achieve the desired outcome.

2 *Clear guidelines and information should be provided to assist clinical teams to appropriately obtain and protect forensic history, MAPPA details, etc.*

Independent Investigation Team comment:
This is an administrative recommendation and, as such, weak in terms of reliability. The Independent Team supports the essence of the recommendation, which is to ensure that Mersey Care NHS Trust staff are well informed about the history of service users with notable forensic histories. However, as with the comment above, on the basis of the investigation undertaken producing guidance *per se* may not adequately address the issue. A recommendation that set out more clearly:

- The need to scope the avenues by which information could be obtained;
- The need to establish a baseline of staffs' existing understanding and practice across services (AMH, CAMH, older people's service, etc),

and to build a practice guidance framework based on the outputs of this would have been more robust and would have provided a framework for auditing the benefit of implementing such a recommendation.

3 *The CPA assessment process should ensure that a service user's criminal history is part of the assessment.*

Independent Investigation Team comment:
The intervention is policy orientated and therefore an administrative intervention if taken at face value. However the recommendation is far more complex than it might appear and the Trust's investigation team needed to think though what the recommendation needed to deliver in more detail. The Independent Team can understand the rationale for mental health workers needing to know of criminality associated with:

- significant risks of harm to others;
- drug dealing;
- risks to vulnerable adults; and
- risks to children.

However, the above recommendation does not acknowledge that eliciting the information it suggests, whilst potentially possible within Mersey Care NHS Trust services, is unlikely to be possible where a mental health service user's criminal history is held by agencies outside of the Trust. Neither does the recommendation acknowledge the limitations imposed by the Data Protection Act on information exchange between relevant public services.

The Independent Investigation Team considers that Mersey Care NHS Trust may wish to revisit this recommendation and assess to what extent :

- The intent of the recommendation has been understood and delivered.
- The process by which Trust staff access essential information about the risk history of a service user from partner agencies such as the police is understood and made use of.

4 *Arrangements to be established for routine review of complex cases on a periodic basis, specifically including those cases repeatedly seen by a single practitioner.*

The Independent Investigation Team's comment:
It is unclear what the authors of the Trust's investigation report were hoping to achieve or why this recommendation was made.

5 *To address the problems of clinicians knowing of the existence and whereabouts of old files from the same and other parts of the Trust. A policy that old paper records be routinely requested for all new referrals and re-referrals should be considered. Also, when a new case file is opened, there must be a mandatory search made for previous records and any archived. (Information from Day Hospitals must also be incorporated.)*

The Independent Investigation Team's:
The impetus for this recommendation is understandable. However, the Independent Investigation Team considers that the recommendation could have been more focused. The assessment process for all new referrals is managed via a single pathway. It seems logical that, when a referral is screened and accepted as appropriate for secondary mental health services, it is integral to the review and acceptance process that a search is undertaken to determine what records are already held by the Trust about the service user. It does not seem logical to wait until a 'new file is opened'.

As it is written, and based on the content of the investigation report, this recommendation raises the issue of why the Trust was not adhering to the principle of 'one patient one set of records'. Excepting psychological therapies, and substance misuse services, there should have been only one set of records for a service user. A review of the interview records showed that this principle had not been achieved in 2004 when Mr A was a patient of the day service. The Independent Investigation Team is aware that Mersey Care NHS Trust is committed to this principle and has been implementing a development programme to achieve this. The current situation is that the Trust has implemented a fully electronic record that is available relatively easily to all who are assessing service users. To some, this achievement leaves the recommendation redundant. It is not wholly redundant, because there will be longer-term service users who continue to have archived paper records, the content of which may have relevance to contemporary case management.

6 *Guidance to be made available on the role that ePEX plays in documenting care and which records (either paper and/or electronic) have primacy.*

Independent Investigation Team comment:
It is the understanding of the Independent Investigation Team that the roll-out of ePex within Mersey Care NHS Trust means that this recommendation is now redundant.

7 *The findings of this report to be shared with Forensic Services, HMP and Primary Care Trust.*

Independent Investigation Team comment:
It should be a standardised expectation that staff and agencies affected by the findings of an investigation are appropriately communicated. Nevertheless, stating it as a recommendation ensures that this good practice activity is not forgotten.

8 *All clinical staff should be made aware of how, where and when offending and forensic history can, and should, be obtained.*

Independent Investigation Team comment: This repeats the principle set out in recommendation 8.2.

9 *Psychological assessments should always be considered to aid assessment and diagnosis.*

Independent Investigation Team comment:
It is difficult to disagree with this statement. However, it is not a well formulated recommendation. As with a number of the earlier recommendations, an exploratory piece of work looking at how frequently such assessments are not considered/ offered in cases where there is merit to do so would have been worthwhile. It would have enabled greater clarity about the specifics of the work required to ensure that clinical staff reliably consider the need for psychological interventions for service users with complex mental health issues.

10 *A 'Lessons Learnt Event' to take place between the agencies involved in delivery of care and treatment to Mr A.*

That includes the following:-

- Procedure for accessing health records of new and re-referrals
- A pathway on how to raise a query on the whereabouts of and access to obtaining historical records
- Procedure for conducting a mandatory search for previous records.

Independent Investigation Team comment: This was a good recommendation.

11 *Development and implementation of an action plan, in response to the above recommendations, which will be monitored by the Trust's Clinical Governance Committee.*

Independent Investigation Team comment:
On one level this is a good recommendation as it acknowledges that further consideration of the recommendations made is required. However, it is not good governance for the authors of an investigation report to assume that all recommendations made will be accepted and implemented. What is important is that:

- Recommendations are considered for implementation and that where a decision is made 'not to act' that there is a clear rationale as to why, and the acceptance of the residual risk in not acting on a recommendation by the relevant Business Unit, or Corporate Committee;
- The intent of the recommendation is clear;
- A decision is made regarding implementation based on pre-existing work, and risk versus benefit;
- There is an auditable trail of the decision-making process;

- When a decision is made to progress a recommendation, thought is given to the detail of the action implementation plan, bearing in mind the inherent reliability characteristics of different intervention types and how the effectiveness of implementation is to be measured.

5.0 CONCLUSIONS OF THE INDEPENDENT INVESTIGATION TEAM

As a result of the analysis work undertaken, the Independent Investigation Team is of the opinion that Mersey Care NHS Trust's internal investigation was sufficiently thorough and searching to render the value of further independent investigation of the Mr A's case questionable with regards to the opportunity for any additional learning to be identified, over and above that already achieved by the Trust.

In addition to the lack of any realistic potential for additional lessons to be learnt is the issue of the offence itself. Although Mr A was a service user of Mersey Care NHS Trust at the time, the circumstances of the incident have no bearing on the care and treatment afforded Mr A. The Independent Investigation Team cannot see how different treatment of Mr A would have impacted on his decision to use illicit drugs and abuse alcohol in the manner that he did. Furthermore, Mr A's recount of the days leading to the offence clearly demonstrate that he was able to make choices and his actions were not influenced by a lack of treatment of his mental health state. Indeed, Mr A was consistently diagnosed as not having a treatable severe and enduring mental illness, a diagnosis that has been further confirmed following detailed forensic assessment in prison.

As a consequence of the above, it is the Independent Investigation Team's recommendation to North West SHA that this is a case that can now be closed. For clarity, the Independent Investigation Team's recommendation takes into account:

- The nature of the offence committed by Mr A and his behaviours in the antecedent period to this.
- The quality and thoroughness of Mersey Care NHS Trust's own internal investigation.
- The Independent Investigation Team's own scrutiny of Mersey Care NHS Trust's interview records with staff involved in the care and treatment of Mr A and the conclusion of the Independent Investigation Team that there is no causal link between Mr A's index offence and the care and treatment afforded to him.
- The Independent Investigation Team's own scrutiny of Mr A's clinical records, between 2004 and the time of the incident.
- The Independent Investigation Team's own scrutiny of Mr A's prison health records.
- The national expectation that any independent investigation commissioned subsequent to the internal NHS investigation will not repeat those elements of the Trust's investigation that are considered to be of an acceptable standard.
- The national expectation that, where subsequent investigation is commissioned, there is a realistic opportunity for additional learning to be achieved and for recommendations to be made that will further enhance the delivery of safe and effective mental health care.

- The national expectation that strategic health authorities and independent providers will take a considered and proportional approach to the independent analysis of cases such as Mr A's.

On the basis of all of the above, the Independent Investigation Team reconfirms its recommendation to NHS North of England as stated above.

6.0 RECOMMENDATIONS OF THE INDEPENDENT INVESTIGATION TEAM

Although the conclusion of the Independent Investigation team is that the Trust's report was of a good standard and is in agreement with its overall conclusion the Independent Investigation Team has a small number of recommendations for Mersey Care NHS Trust as a consequence of the quality assurance activity undertaken.

Recommendation 1: The future conduct of internal investigations within Mersey Care NHS Trust

Although the Trust's investigation report was reasonable, the Trust needs to ensure that those staff leading such investigations:

- Understand that the focus of the retrospective analysis is to understand the care and treatment delivered to, or planned for, a service user. It is not to explore the reasons why a service user involved in a homicide event behaved in such a way, or to determine the root causes of the incident. Key factors to be considered by Trust investigators are:
  - The prevailing standards in place at the time;
  - What staff knew about the service user;
  - What staff reasonably should have known about the service user;
  - What other staff facing a similar set of circumstances would have done. (Often, the clinical advisors to the investigation team are sufficient to determine this. However, where there is a distinct disagreement/difference of opinion, and there is no exploration of this with interviewees, then it is always prudent to consider the substitution test.)
- Work fully with the information/evidence collected when formulating the findings section of an investigation report. There was contextually important information contained within the Trust's interview records that were not set out in the final investigation report. Affinity mapping +/- the fishbone diagram and NPSA's human factors framework are useful tools to assist with this.
- Understand that, because one has been asked to retrospectively analyse a service user's care and treatment, it does not necessarily mean that the opinion of the 'investigators' is right and that of the 'care givers' was wrong. In this case the Trust's investigation team disagreed with Mr A's team about CPA status. However, no convincing argument was set out in the report for this. In such circumstances, Mersey Care NHS Trust investigators need to be confident in their understanding and usage of tools such as the substitution test. It is invaluable in determining whether there is a 'right' or 'wrong' answer and maintaining a balanced perspective.
- Understand the value of broad 'tell all' instructions during the interview scenario. Although the Trust's interview records were reasonable, they lacked descriptive detail. It is often the 'tell all' instruction that reveals the most valuable information to an investigation team. This enables an interviewee's uninterrupted recounting of their recollection of the service

user and their involvement with him/her. Similarly, liberal usage of questions prefixed with:

- Tell me ...
- Describe ...
- How ...?

provide rich text information and good opportunity for the effective use of 'reflect back' by the interviewer.

Recommendation 2: The formulation of investigation reports
Overall, the Trust's investigation report was well structured.

However, for future reports attention needs to be given to:

- The contents page also setting out the relevant page numbers
- The inclusion of a findings section which sets out clearly:
  - A summary overview of the overall impression of the service user's care and treatment;
  - The discrete sub-sections and what aspects of care and treatment are to be addressed in each. These sub-sections could also relate to any significant care management concerns identified, specific elements of the terms of reference, or key questions the investigation team has set out to answer during its investigation. For example, 'Did the community mental health team have a sufficiently detailed understanding of Mr A's clinical history in order to plan and deliver an effective care package to him?'
  - Positive feedback to the staff and/or agencies who provided care and treatment to the service user.
- A section that clearly sets out the investigation team's conclusions in relation to:
  - The predictability of the incident
  - The potential preventability of the incident as a consequence of different mental health care and treatment
  - Each of the terms of reference (in brief).

The above components are in addition to those already included in the Mr A internal report.

APPENDIX 1 MERSEY CARE NHS TRUST'S UPDATED ACTION PLAN

Service User's ID No/ Incident No	Recommendations
ePEX ** Ref **	On analysis, the findings show that opportunities for the reviewing level and nature of risk were missed and, therefore, the following recommendations are made: 1. A warning should be placed on ePEX for any service user who has been subject to MAPPA. The MAPPA policy should be amended to reflect this. ▪ *The Trust could not amend the MAPPA policy as it does not have the jurisdiction; it has, though, included the use of the Red Flag system to identify Service Users on MAPPA within the HRAMM policy. This had the potential to cause confusion; now this has been prevented as the CJLT is the service which manages all MAPPA involvement and therefore removes and places the red flags. This has kept the work to one team and aided implementation and coordination.* 2. Clear guidelines and information should be provided to assist clinical teams to appropriately obtain and protect forensic history, MAPPA details, etc. ▪ *See number 8 below and x number External review.* ▪ *The use of HRAMM has now been established across the organisation; the Criminal Justice Liaison Team (CJLT) co-ordinates the use of both HRAMM and MAPPA meetings across the Trust. HRAMM and MAPPA polices provided. A database is maintained by the CJLT which identifies all service users who are part of the MAPPA or HRAMM process (see definition below).* o *MAPPA – 'Multi-Agency Public Protection Arrangements' are formal arrangements set down by the Criminal Justice and Court Services Act 2000 and which are co-ordinated at a local level by the police, probation and prison services. They are aimed at sharing relevant information regarding high risk individuals with the aim of reducing their level of risk to society.* o *HRAMM is a health co-ordinated risk assessment and management framework for those service users at risk of displaying dangerous behaviour, who would not meet the criteria for MAPPA. The process involves multi-agency partnerships with the aim of sharing reasonable and proportionate information, in line with established data protection principles, identifying risks and co-ordinating a multi-agency action plan. The Trust's Criminal Justice Liaison Team co-ordinates this process.* ▪ *The CJLT also provides guidance to staff on how to access the criminal records of service users and will process the request for clinical teams; they will attend CPA meetings to provide advice and guidance.* ▪ *Police Liaison meetings are held in all in-patient units, with the aim of improving communication and the management of offenders. Terms of Reference and directions re. the management of Police Liaison meetings are found in the Trust's Security Policy. Latest version of the Trust's Security Policy provided.* ▪ *The Trust has invested in a Mental Health Police Liaison Officer, which is a shared post between this organisation and Merseyside*

Service User's ID No/ Incident No	Recommendations
	police. Their (the mental Health Police Liaison Officer) focus is on developing policy and procedure re. joint working, though they do have involvement in providing guidance for the joint management of complex and high risk service users. Job Description provided. ▪ *The Trust has developed an information-sharing protocol with the police to ensure that information about a person's Mental Health and the actions that should be undertaken can be held on the police database, provided PNC share protocol.* ▪ *The Trust also has an information-sharing protocol regarding the information that On Call Managers can provide to the police - - protocol for information-sharing during an incident provided.* ***Evidence Files*** - *HRAMM & MAPPA Policies* - *Latest version of the Trust's Security Policy* - *Mental Health Liaison Officer Job Description* - *Protocol for the Police National Computer Alerts* - *Joint Protocol for Information Exchange in relation to crisis incidents* - *Police Liaison in Mersey Care NHS Trust (Presentation)* - *Minutes of Police Liaison Meetings.* 3. The CPA assessment process should ensure that service users' criminal history is part of the assessment. ▪ *The present CPA assessment documentation does include a section on past criminal history.* 4. Arrangements established for routine review of complex cases on a periodic basis, specifically including those cases repeatedly seen by a single practitioner. ▪ *This case was specifically related to a junior staff doctor, who now has specific clinical supervision with the lead consultant.*

Service User's ID No/ Incident No	Recommendations
	5. To address the problems of clinicians knowing of the existence and whereabouts of old files from the same and other parts of the Trust. A policy that old paper records be routinely requested for all new referrals and re-referrals should be considered. That when a new case file is opened, there must be a mandatory search made for previous records and any archived. (Information from Day Hospitals must also be incorporated.) ▪ *The information below has been included in the body of the current health records policy since the 'Integrated record' has been in place:* ***ALERT SYSTEM TO HIGHLIGHT EXISTENCE OF 'OTHER' RECORDS HELD WITHIN MERSEY CARE NHS TRUST*** *It is essential to provide a high standard of care and to reduce the element of risk for the Trust and Service Users and that identification is made of any 'other' sets of records that may be in existence within Mersey Care NHS Trust. The search process must be performed upon a service user being referred to the services within Mersey Care NHS Trust. A thorough search should be undertaken on the Patient Information System. If a Service User has attended another service, then it must be recorded on the Alert sticker which must be completed and stuck onto the inside Alert notification located inside the front cover of the health record folder, identifying that other records exist and the site at which they are located. It is the decision of the Healthcare Professional to whom the service user has been referred to make a decision to request records from other internal services.* *All records are now on the electronic information system and can be accessed relatively easily by Administrative staff. This has made the process of accessing records easier and made it much clearer as to what information exists. – April 2011.* 6. Guidance to be made available on the role that ePEX plays in documenting care and which records (either paper and/or electronic) have primacy. ▪ *ePEX is now the major form of documentation and all professional groups will be expected to use this. A process is now underway to make all paper records electronic – termed the EDMS project. The CBUs are moving towards being paper-light.* 7. The findings of this report to be shared with Forensic Services, HMP and Primary Care Trust. ▪ *This information was disseminated via the PCT Mental Health Lead.*

Service User's ID No/ Incident No	Recommendations
	8. All clinical staff should be made aware of how, where and when offending and forensic history can, and should, be obtained. ▪ *The Criminal Justice Liaison Team is the central recourse for the Trust, and which will co-ordinate access to criminal justice histories. It has undertaken Road Shows throughout the Trust on HRAMM, which has included this information. It keeps records of all requests for information to enable the CJLT to monitor usage across the organisation. Between 1 November 2009 and 31 October 2010, the Trust processed 228 requests for information regarding a service user's criminal records history.* ▪ *These figures are an increase from the previous year (2009), as the protocol continues to be used widely and has become more commonplace. The Trust expects an increase again in 2011, as there continues to be a month-on-month increase.* ***Evidence File*** - *Information sent to all teams* - *A joint protocol developed with the police and Road Show dates and times.* 9. Psychological assessments should always be considered to aid assessment and diagnosis. ▪ *Psychological assessments are considered as part of the assessment process; though availability of specialists is not at an optimum, the Trust recognises this as a deficit and is working to increase the number of Clinical Psychologists available, as well as enhancing the availability of the existing professional to give advice and guidance – see x* – number 11.* ▪ *NICE guidelines are used to direct the way staff work with Service Users with a Psychotic illness. The adherence to the guidance was first audited in 2007 and a new audit is now being facilitated which is due to be completed in January 2011. There is a NICE Guidance in Schizophrenia Implementation group which oversees the implementation of the guidance and raises deficits in provision to the CBU Directors. At present the key gaps are in the level of psychology within CMHTs and the Acute Care Team to deliver the required 16 sessions of CBT and family engagement.* ▪ *NICE Guidance recommends 1.5 WTE psychology posts within each community team; at present the average per team is 0.5. A Business Case/Protocol has been developed within Liverpool CBU to increase the level of Assistant Psychologist posts to deliver more intensive individual work within the Acute Care Team.* ▪ *The role of an Acute Care Psychologist has been developed for both Liverpool and PCP CBUs, with the aim of providing increased psychological care to people in the Acute Phase of their illness and to champion and lead the development of therapeutic interventions within an acute setting. The first post-holder is now in place in Liverpool CBU. The post in PCP CBU has now been re-advertised, as it was not appointed to initially.*

Service User's ID No/ Incident No	Recommendations
	Evidence File - *Update on psychological provision for psychotic patients and the difficulties in meeting guidelines* - *Review of pilot work into the development of a Recovery Group 2010* - *Protocol. Business case developed to increase the level of psychological interventions in ward areas; appointment of assistant psychologists*.

APPENDIX 2 INVESTIGATION METHOD

The methodology for conducting this investigation was a retrospective case notes review, and retrospective quality assurance analysis of Mersey Care NHS Trust's internal investigation report.

The records utilised were:

- The Mersey Care Clinical Records of Mr A
- HMP Liverpool's health records relating to Mr A
- The Mersey Care interview records of interviews conducted during its internal investigation
- Mersey Care NHS Trusts Policy and Procedure for Effective Care Co-ordination (June 2006)
- Mersey Care NHS Trusts Policy and Procedure for the Care Programme Approach (August 2008)

The main investigation tool used was a tabular timeline, as prompted by the National Patient Safety Agency to assist in the forensic analysis of clinical records.

A gap analysis was then undertaken. The purpose of this being to identify where Mersey Care NHS Trust's internal investigation report and/or the interview records contained sufficient answers to the Independent Investigation Team's questions.

The gap analysis was the core activity used to determine that no further independent investigation of the care and treatment afforded Mr A was required.

In terms of inter team reliability amongst the Independent Investigation Team, each team member was required to review the information independently, coming to their own professional conclusion. The Independent Investigation Team then met to discuss individual and shared perspectives about Mr A's care and treatment and the completeness of Mersey Care NHS Trust's internal investigation report.

In this case each member of the Independent Investigation Team independently came to the same conclusion about Mr A's care and treatment and the same conclusions and considerations about Mersey Care NHS Trusts internal investigation report.

APPENDIX 3 BRIEF BIOGRAPHIES OF THE INDEPENDENT INVESTIGATION TEAM

Maria Dineen - Director of Consequence UK.

Maria originally trained as a Midwife, and then developed her career in clinical risk management in 1994 developing one of the first clinical risk management and incident reporting systems in England for the Women's Centre at the John Radcliffe in Oxford. This was part of a research project in conjunction with Oxford University. From here she developed her knowledge and expertise in the field as an assessor for the Clinical Negligence Scheme for Trusts, and then as a Research Fellow at the Health Services Management Centre, Birmingham. In 2000 she was invited to work with the Organisation with a Memory Team at the Department of Health in the early set up phase of the National Patient Safety Agency. This work lead to her being retained by the National Patient Safety Agency between 2001 – 2003 to work with its in-house team to develop and road test the now national model of incident investigation and root cause analysis.

With regards to independent investigation work Maria has extensive experience in leading independent investigations for Strategic Health Authorities in England and also the Health and Safety Executive in the Republic of Ireland. These investigations have largely been focused on Homicide investigations, and Safeguarding – Adults, investigations.

To date she has led the independent investigation of over 35 independent investigations, of varying degrees of complexity.

In addition to the above Maria published a book in 2002 on how to conduct an effective investigation that targeted health and social care professionals. This book Six Steps to RCA, is now in its 3rd edition and has sold over 7,000 copies to date. It is a referenced text on the National Patient Safety Agencies RCA e-learning toolkit and also on the Social Care Institute for Excellence resource page.

Related but separate to her investigation work, Maria has a long standing interest in

- facilitating workshops for staff wishing to improve their investigative skills; and
- supporting organisations and teams in developing meaningful critical success factors and facilitating a dynamic risk assessment regarding the team or organisation's ability to deliver these.

She has led an extensive range of workshops over the last nine years to Safeguarding Boards, professional safeguarding leads, NHS Trusts (all disciplines) and the Private Sector. Notably she was engaged by the following organisations to deliver investigation training to their officers and to advise on how internal processes could be improved:

- The Nursing and Midwifery Council;
- The Royal College of Nursing;
- The Royal College of Midwives;
- The Mental Welfare Commission in Scotland; and
- King Faisal Specialist Hospital Saudi Arabia.

Dr Mark Potter: **Consultant Psychiatrist**

Place of Work: **South West London and St Georges Mental Health Trust**

Dr Potter has been working as CMHT consultant psychiatrist since November 1991.

He leads a Community Health Team serving a population of 45,000. The catchment area served is an inner city area with significant pockets of deprivation. The service has a clear focus on serving the needs of the long term mentally ill. There are strong links with Social Services, and Social Workers are fully integrated into the CMHT. As the Consultant Psychiatrist within the Team Dr Potter functions as the Clinical Team Leader. The responsibilities of his role include ensuring that the Team provides care which is safe, effective and efficient. To ensure clear accountability arrangements including supervision and appraisal for all staff within the Team and to be ultimately responsible for ensuring allocation of each individual service users care and to direct the Teams overall resources accordingly.

In addition to his day to day clinical work Dr Potter is the Head of Psychiatry in the adult services directorate which requires him to provide professional leadership to the medical staff within the adult directorate and advise the Clinical Directors on medical issues. Other responsibilities include overseeing appraisal for consultant staff and non-training grade doctors. He has also published extensively in peer review journals.

Mrs Joanne Lawrence

Place of work: South London and Maudsley NHS Foundation Trust (SLaM)
Current Role: Clinical Services Lead for Early Intervention in Psychosis services across the four SLaM Boroughs (Southwark, Lambeth, Lewisham & Croydon)

Joanne has nineteen years experience in community mental health services. Her experience encompasses:

- Five years practice as a CPN;
- Fourteen years experience as a community manager spanning CMHT, Assertive Outreach, and Early Intervention Services.

Her current role is as the clinical services lead for Early Intervention in Psychosis services across the four South London and the Maudsley Boroughs (Southwark, Lambeth, Lewisham, and Croydon). Consequently she is well versed with the complexities of working within a multi-cultural environment and families where English is not the first language, and/or is not spoken at all.

Her vast experience of delivering specialist mental health services in the community made her the ideal nurse advisor for this case.

CUK has worked with Joanne previously, in her role as nurse advisor on HSG investigations within NHS London and NHS North West. In terms of her approach she is:

- grounded;
- pragmatic;
- evidence based;
- practice focused; and
- credible.

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