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HEALTH & SAFETY LABORATORY

An independent investigation into the care and treatment of a service-user at South Essex Partnership University NHS Foundation Trust (SEPT), formerly known as Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust

A report for East of England NHS Strategic Health Authority

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We are grateful to the victim's family for allowing us to interview them. We realise how difficult they must have found the process. Their evidence has greatly assisted our work.

In undertaking our investigation we have received cooperation from South Essex Partnership University NHS Foundation Trust (SEPT). We are also grateful for the assistance provided during the investigation by Bedfordshire NHS Primary Care Trust (PCT) and the East of England NHS Strategic Health Authority (SHA).

FOREWORD

All members of the Independent Investigation Team would like to offer their condolences to both the family and friends of the victim. We understand that carrying out an independent investigation into the mental health treatment provided prior to a homicide is distressing for victims' families, particularly when it is carried out some time after the offence and subsequent criminal justice processes.

Independent investigations such as these are entirely separate from the legal processes that take place following a homicide. The aim of these investigations is not to investigate the circumstances of the offence, but to enable the providers of care to learn lessons and make improvements for the benefit of future patients, their carers and the public. Very few patients receiving NHS treatment for mental health problems are a danger to other people, and the fact that a patient commits a criminal offence does not necessarily mean that their mental health led or contributed to them committing it.

The benefit of hindsight can introduce unfairness into any investigation and we have therefore been careful to assess the care provided prior to the incident against the good practice standard which would have applied had the incident not occurred.

In carrying out the investigation we have needed to remain objective and impartial, whilst being mindful throughout of the devastating impact that this violent offence has had on the family and friends of the victim. There was also the need to carry out a robust investigation which, where possible, answers the questions and takes into account the comments that they had, as well as addressing the terms of reference set for this investigation.

The Health & Safety Laboratory (HSL)

The Health & Safety Laboratory (HSL) is an independent organisation that specialises in providing research, investigation and consultancy services to a wide range of organisations. As well as being involved in the protection of people at work, HSL also provides services that address public and patient safety issues. HSL works with a variety of NHS organisations to help them to improve patient and public safety, both proactively and following incidents where harm has occurred.

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EXECUTIVE SUMMARY

Within NHS organisations, good practice requires that whenever an incident occurs, timely action is taken to identify and address any improvements necessary to prevent future harm to patients, the public and healthcare staff. In cases involving a Serious Untoward Incident (SUI), where an event occurs which caused or had the potential to cause serious harm, a formal investigation will need to be carried out. The exact nature of this investigation will depend upon the circumstances of the incident.

Within mental health services, when a service-user who is receiving treatment commits a homicide, for example a murder or manslaughter, Department of Health guidance specifies that in addition to a robust internal investigation being carried out by the NHS organisation providing care and treatment, an investigation independent of the organisation should also be carried out.

This investigation report details an investigation carried out by the Health & Safety Laboratory (HSL), an organisation independent of the NHS, into the care and treatment provided to a mental health service-user. This followed a homicide of the service-user's partner on 30 December 2006, which occurred during care and treatment being provided by Bedfordshire and Luton Partnership NHS Trust (BLPT), now the South Essex Partnership University NHS Foundation Trust (SEPT). At the time of the incident a child was present in the property, although it is not clear what, if any, part of the incident or the events preceding it the child witnessed, and the child was not physically injured as a result.

HSL engaged a multi-disciplinary team of specialists in order to carry out a robust investigation; this team included medical, nursing and social care specialists, in addition to specialists in systematic investigation techniques and human & organisational factors.

Objectives

The objectives were to carry out a robust investigation into the care and treatment received by the service-user prior to the incident, in order to determine whether this met with good practice. Furthermore, the objectives were to ensure that the investigation was compliant with the terms of reference agreed with NHS East of England and published good practice, in particular the guidance published by the

Department of Health (DH) and the National Patient Safety Agency (NPSA) which addresses independent investigations of incidents involving NHS mental health services.

Main findings

The investigation reviewed the actions taken by BLPT prior to the incident occurring, whilst being careful to exclude hindsight bias. In addition, the actions taken by the Trust following the incident to investigate and learn from the circumstances were reviewed.

Actions prior to the incident

The following key themes emerged as examples of good practice, which were noted prior to the incident occurring:

- The first Care Coordinator involved in the service-user's care made regular visits to the service-user, kept good notes and implemented most of the actions identified.
- The Community Mental Health Team (CMHT) provided timely, coherent and complete accounts of all outpatient appointments attended by the service-user to the general practitioner across the whole of her care and treatment.
- The first Care Coordinator invested significant effort into assisting the service-user with her housing issues over a prolonged period.
- The CMHT Acting Team Manager took action to inform the service-user of the duty system during the period when the service-user was without a care coordinator due to team resource pressures.
- There was thorough medical engagement with the service-user between November 2003 and June 2004.

The following key themes were identified by the Independent Investigation Team as departing from good practice prior to the incident:

- The Trust did not ensure that effective measures were in place for health and social care staff to develop a truly effective therapeutic relationship with the service-user.
- The measures put in place by the Trust to ensure the effective assessment and management of risks were not suitably robust.

- The Trust did not create an environment in which it was routine to engage with service-user's carers and family, including using this engagement to further inform risk assessment.

- The measures the Trust put in place to provide adequate supervision and support to health and social care staff, in particular for inexperienced staff, were not sufficient.

Actions following the incident

The measures taken by BLPT to internally investigate the incident, identify learning and ensure actions were implemented were poor. In particular the Trust:

- Did not make all staff involved in the care and treatment of the service-user aware that a homicide had occurred, either formally or informally. This resulted in one member of staff being unaware that a patient they had provided care to had committed a homicide until 3½ years after the incident.

- Did not appoint an investigator within the organisation who was suitably independent of the operational team delivering services prior to the incident.

- Did not appoint an investigator with suitable training in the investigation of adverse incidents.

- Did not attempt to contact the victim's family to offer the opportunity to gain their input or to provide support to them during the period following the incident.

- Did not attempt to contact the service-user's family following the incident to gain their input or to provide appropriate support.

- Did not carry out interviews of key staff involved in the delivery of care or obtain written statements from them.

- Did not capture and retain key documentation, such as policies, procedures and supervision records at both a corporate and operational level, as part of the internal investigation or to be available to the external independent investigation.

- Did not ensure that staff involved in the provision of care and treatment were made aware that an external independent investigation might take place.

- Did not adequately ensure version control of the different versions of the internal investigation report and did not adequately share subsequent changes made to the report with the original author, or share the learning arising from each version throughout the Trust.

However, it was noted during the independent investigation, that the Trust has made substantial improvements to the way in which internal investigations are carried out. There is now a dedicated 'Head of Serious Incidents & Quality' who ensures that there is board-level oversight of the investigation of serious incidents, that staff are engaged and supported during internal investigations and, most importantly, that lessons learned as a result of investigations are shared and actioned appropriately.

Conclusions and Recommendations

The Trust witnesses expressed their belief that the death of the victim on 30 December 2006 was not a result of the service-user's mental health and this appears to be borne out by the nature of the conviction and sentence that the service-user received for this crime. The Independent Investigation Team agree that it is extremely difficult to argue against this perspective, however the investigation team does believe from reviewing the evidence that the Trust could have engaged in a more proactive therapeutic alliance, which would have better captured the risks associated with the service-user's mental health and substance misuse problems. This would have enabled the provision of a more appropriate package of care for a patient on the enhanced category of the Care Programme Approach (CPA). The Independent Investigation Team would like to make the following points clear:

- Based on the information established, the Independent Investigation Team agree that the victim's death could not have been predicted based on the information that was available to the Trust prior to the incident. However, a more proactive and objective approach to the collation of risk information may have provided the Trust with a greater opportunity to more accurately assess the service-user's risks.

- The Independent Investigation Team would like to acknowledge the fact that it is very difficult to treat patients who do not wish to fully engage and who may not cooperate fully with their care plan and that, even with perfect systems, it is not always possible to prevent an individual's mental health deteriorating.

- The Independent Investigation Team does believe that the service-user's care and treatment should have been managed in a more coherent and timely manner particularly in the preceding 12 months of her care. The fact that her care plan and risk assessment were more than four months out of date prevented her from receiving a comprehensive or coherent plan of care and treatment. The Trust's failure to provide a care coordinator for a period of one month was considered entirely inappropriate for a service-user on enhanced CPA. The Independent Investigation Team believes that the service-user's care and treatment could have been managed significantly differently.

Recommendations

Arising from analysis of pre-incident actions

The recommendations below have been developed via the systematic analysis of root causes associated with the case.

Recommendation 1 - The Trust should demonstrate that they have put in place a suite of measures to ensure that all staff are aware of the importance of the therapeutic relationship in allowing an effective care plan to be delivered. This should include ensuring that supervision discussions include a review of the therapeutic alliance between each service-user and member of staff. The Trust should put in place measures to provide assurance that a therapeutic alliance between service-users and practitioners is being achieved in practice. These measures will need to draw on a range of data sources.

The Trust should ensure that Care Coordinators are provided with clear guidance on the action to take where they identify that a therapeutic relationship has not been adequately developed or sustained, including the requirement to develop a time-bound plan of action when appropriate.

The Trust should collate 'Did Not Attend' (DNA) data on a quarterly basis for all service-users on CPA. The Trust should also consider monitoring the number of different psychiatrists and care coordinators a service-user sees over a quarter to minimise service fragmentation.

Recommendation 2 - Robust and timely supervision needs to be provided to all nursing, social work and clinical staff. Compliance with this activity should be monitored on a quarterly basis, and the results should be communicated formally and informally across the Trust. The organisational causes (for example, workload) of significant non-compliance should be identified and addressed.

Recommendation 3 - The Trust should continue to develop and refine a training management system, covering all staff, that builds in mandatory training requirements with refresher courses and other courses around key themes. The system should prompt the staff member and their line manager in advance of a training requirement, and should record attendance and monitor compliance levels. The Trust should monitor mandatory and refresher attendance by staff on a quarterly basis.

Recommendation 4 – The Trust should continue to work on the cultural and organisational issues to increase the sustainability of the above recommendations. The Trust should therefore consider undertaking a safety culture audit to identify further areas for improvement within the next 12 months. Such an audit should take into account service-user, carer and staff perceptions, and include, for example, measurement of:

- The culture of involving carers in management plans and decision making;
- Risk assessment processes;
- Processes for handovers between care coordinators and cross agency communication;
- Systems in place for managing appointment 'Did Not Attend' (DNAs) and disengagement of service-users, and for monitoring fragmentation of contacts between healthcare professions and across professional disciplines.

Recommendation 5 - The Trust should ensure that adequate liaison arrangements are in place between the providers of addiction services and Community Mental Health Teams (CMHTs) to ensure that a holistic view is taken of a service-user's alcohol and/or drug use, and that this is used to inform the risk assessment

Recommendation 6 - The Primary Care Trust (PCT) should put in place measures to assess the effectiveness of the interactions between Primary and Secondary care for service-users on CPA, for example by auditing the attendance of GPs at service-user's CPA review meetings held by the Trust. The PCT should use the results of such assessments to drive improvements.

Arising from analysis of post-incident actions

The following recommendations have been developed following a review of the Trust's actions to internally investigate and learn from this incident.

Recommendation 7 - The Trust should coordinate SMART and targeted strategies to strengthen the support staff receive following serious untoward incidents, including participation in an external, independent investigation.

Recommendation 8 - The Trust should communicate with the victim's and service-user's families immediately following an incident to offer condolences, explain the Trust's investigative processes and where appropriate offer an apology and provide support options. The Trust should consider, where contact with the family has not been established, that action is taken to apologise and retrospectively offer support services to the family.

Recommendation 9 - The Trust should seek to determine whether the current arrangements to internally investigate serious untoward incidents would identify whether a child or other vulnerable witnesses were present, in order to determine whether psychological support should be provided by the Trust.

1 INTRODUCTION

Within NHS organisations, good practice requires that whenever an incident occurs, timely action is taken to identify and action any improvements necessary to prevent future harm to patients, the public and healthcare staff. In cases involving a Serious Untoward Incident (SUI), where an event occurs which caused or had the potential to cause serious harm, a formal investigation will need to be carried out. The exact nature of this investigation will depend upon the circumstances of the incident.

Within mental health services, when a service-user who is receiving treatment commits a homicide, for example a murder or manslaughter, Department of Health guidance (HSG94(27)) specifies that, in addition to a robust internal investigation being carried out by the NHS organisation providing care and treatment, an investigation independent of the organisation should also be carried out.

This investigation into the care and treatment of a service-user[1] was commissioned by the East of England Strategic Health Authority. It follows guidance in Department of Health circular HSG (94) 27, *The Discharge of Mentally Disordered People and their Continuing Care in the Community and the updated paragraphs 33-36,* issued in June 2005 [1,2]. The terms of reference for the investigation are given in full in section 2 of this report.

On 30 December 2006, the service-user stabbed her husband to death. She was originally charged with the murder of her husband, but the Crown accepted a guilty plea to manslaughter at Crown Court on 02 July 2008. It is important to note that the reason that the plea to manslaughter was accepted was on the basis of a judgement by the prosecuting authorities that the service-user had not intended to kill or seriously injure her husband, rather than because of her mental state. The service-user did not at any stage enter a plea to manslaughter on the grounds of diminished responsibility due to her mental health problems. Court records show that the service-user did not previously have any criminal convictions prior to the incident, with the exception of a minor motoring offence when she was younger.

[1] *NB: In accordance with the terms of reference, this report provides anonymity to all those involved, therefore the term 'service-user' will be used throughout the remainder of the report.*

In September 2008, the service-user was sentenced to four years imprisonment and it was ordered that the 196 days that she had already spent in custody count towards the serving of her sentence.

The service-user was first referred to Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (the Trust), on 15 September 2003; this Trust is now known as South Essex Partnership University NHS Foundation Trust (SEPT). Her care and treatment was overseen by Biggleswade Community Mental Health Team (CMHT). It is the care and treatment that the service-user received from this organisation that is the subject of this investigation.

Sections 2 and 3 of the report provide the Terms of Reference for the investigation and then the methodology that was used to ensure that an effective and systematic approach was taken throughout the investigation process. Section 4 provides background information, which describes the Trust involved and the changes that have occurred over time. Sections 5 and 6 contain a chronology of events from which the critical issues were identified. The critical issues identified were:

- Care Programme Approach (section 7);
- Carer and Service-User Engagement (section 8);
- Developing a Therapeutic Relationship with the Service-user (section 9);
- Clinical Risk Assessment and Risk Management (section 10);
- Supervision and Clinical Experience (section 11);
- Record Keeping, Documentation & Communication (section 12).

The care and service delivery problems associated with the critical issues are described in each of the above sections and recommendations are listed in Section 13. Section 14 describes a review of the adequacy of the Trust's own internal investigation into the incident, including the action taken since 2006 to address the internal report's recommendations. The Independent Investigation Team was keen to capture examples of good practice taken by the Trust and this is shown within section 14.5.

2 TERMS OF REFERENCE

The following Terms of Reference were agreed with the East of England NHS Strategic Health Authority (SHA) for the independent investigation. The wording below has been slightly amended from that agreed with the Trust in order to preserve anonymity and to make the wording consistent with terminology used throughout the rest of the report.

2.1 BACKGROUND

Under Department of Health Guidance HSG (94)27 (amended in 2005), SHAs are required to undertake an independent investigation *"when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event".*

On the 30 December 2006 the service-user stabbed her husband, killing him. The service-user was in receipt of care under the Care Programme Approach (CPA).

2.2 AIM OF THE INVESTIGATION

The aim of the investigation was to provide an independent report into the care and treatment provided to the service-user from her first contact with Mental Health Services up to the time of the offence.

This investigation is commissioned in accordance with the Department of Health guidance and follows the National Patient Safety Agency Good Practice guidance for Independent Investigations.

Stage 1

Following the review of clinical notes and other documentary evidence, the Independent Investigation Team will:

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan, and identify any notable good practice.
- Review the progress that the Trust has made in implementing the action plan.

- Agree with the SHA any areas (beyond those listed below) that require further consideration during and following the completion of the independent investigation.

Stage 2

- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service-user's first contact with primary care and mental health services up to the point of her offence.
- Compile a comprehensive chronology of events leading up to the homicide and establish the circumstances of the incident itself.
- Review the appropriateness of the treatment, care and supervision of the mental health service-user in the light of any identified health and social care needs.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service-user harming herself or others.
- Examine the effectiveness of the service-user's care plan including the involvement of the service-user and her family.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence of a similar incident.
- Provide a written report to the SHA that includes SMART recommendations which are written in such a way as to maximise the chance of them being sustained over the longer term.

Method of working

- The Independent Investigation Team will examine all appropriate documentation pertaining to the care of the service-user and seek evidence from those involved in her care, in order to properly carry out its investigation.
- The Independent Investigation Team will agree appropriate communication arrangements with family members and give an opportunity to the families of the victim and of the service-user to contribute to the investigation, as is felt necessary. The final report will be shared with the service-user, and the victim's family, if requested.

- The Independent Investigation Team will consider, at the Investigation Team Leader's discretion, inclusion of generic learning points from published summaries of lessons learned from other national independent mental health investigation reports so that any significant common factors can be identified.
- The Independent Investigation Team will conduct its work in private.

Output and reporting arrangements

- The Independent Investigation Team will provide a written report including recommendations specific to the care and treatment of the service-user to NHS East of England, the Trust and the commissioning Primary Care Trust.
- The SHA will make the findings and the recommendations of the investigation public.
- The report will be written so as to provide anonymity to all those individuals involved.

2.3 THE INDEPENDENT INVESTIGATION TEAM

Members of the Independent Investigation Team will need to be properly appointed with formal appointment letters. From the outset, one member of the Independent Investigation Team will need to be the designated lead for the investigation process.

In order to create independence and avoid any conflict of interest, no member of the Independent Investigation Team should be in the employment of the organisation(s) or should have had any clinical involvement with the victim or the service-user, subject to investigation.

The skills and expertise of the Independent Investigation Team appointed should include:

- relevant clinical, social care and managerial expertise;
- other expertise where appropriate, for example housing or probation;
- expert investigation skills, such as Root Cause Analysis (RCA) or similar;
- excellent report writing skills;
- interviewing and communication skills; understanding of the independent investigation process;

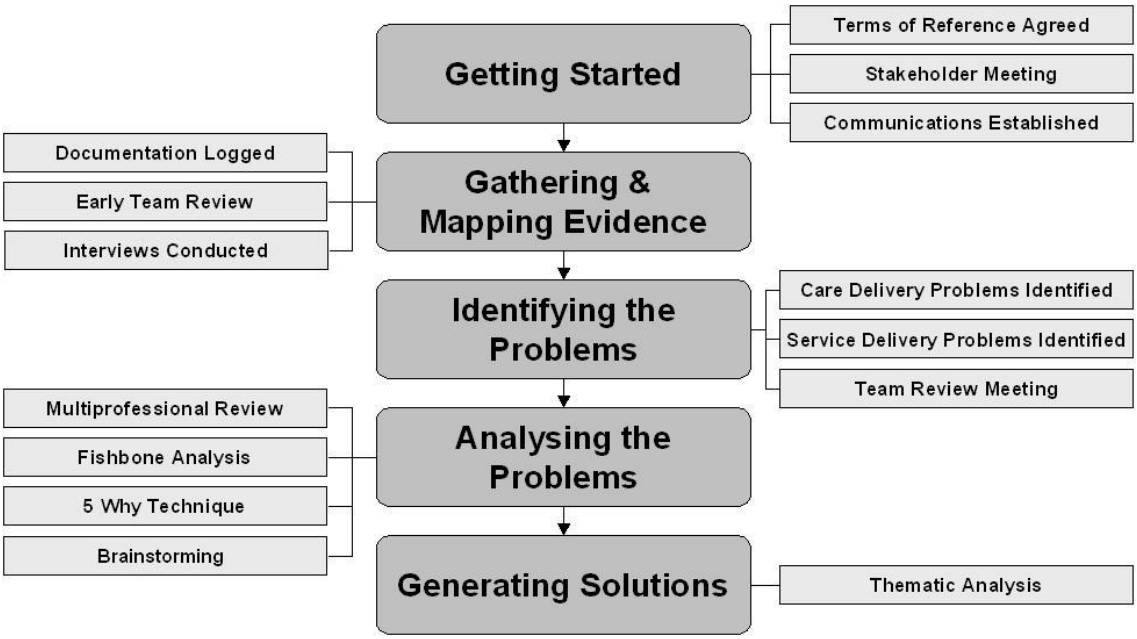
- the treatment of witnesses using *Being Open* principles;
- other specific skills or experience may be required depending on the nature of the case and the findings of the internal investigation report.

2.4 TIMETABLE

- The panel should complete the investigation and report within six months of commencing the Investigation.

3 METHODOLOGY

In July 2010, the East of England Strategic Health Authority commissioned the Health and Safety Laboratory (HSL) to conduct an independent investigation under the Terms of Reference set out in section 2 of this report. The investigation methodology is set out below.



3.1 COMMUNICATION

3.1.1 Consent and communication with service-user

At the start of this investigation, the service-user was contacted by the East of England Strategic Health Authority in order to obtain her consent for the Independent Investigation Team to access her clinical records and associated material. On 28 June 2010, the service-user signed a consent form giving the Independent Investigation Team full permission to access her clinical records. On 16 August 2010 one member of the Independent Investigation Team went to the Trust to access and photocopy all clinical records.

The Investigation Team Leader contacted the service-user via the Probation Service to offer the opportunity to speak to the team. The service-user was in the process of moving house, but provided her telephone and postal contact details which the Probation Service passed on with her consent. Having checked that she was not still in receipt of mental health services in order to give consideration to liaison arrangements, the service-user was contacted by phone by the Investigation Team Leader and a follow up letter was sent on 14 October 2010 describing the process and offering the opportunity to speak to the team. It was made clear that any involvement was purely voluntary and that the service-user would be welcome to bring a friend or family member to any meeting for support. The service-user agreed to meet the team and an interview was carried out on 21 October 2010. The interview was carried out by a trained investigative interviewer and a social care specialist. The interview was transcribed and a copy was provided for checking to the service-user by post.

3.1.2 Communication with the victim's family

The Investigation Team Leader wrote to the victim's family on 26 August 2010 to explain the purpose of the independent investigation and provided a copy of the draft terms of reference. It was proposed that the team meet with the family to discuss their level of involvement within the investigation. The investigation team did not receive a reply from the victim's family and therefore the Investigation Team Leader wrote to them again on 01 November 2010 to give them an update on the investigation thus far and to make a further offer to meet with them. On 16 November 2010 the victim's parents and younger brother met with two members of the Independent Investigation Team. During this meeting they had the opportunity to raise their concerns regarding the care and treatment that the service-user received, and to express their grief about the death of their son/brother and the impact that this has had on them and the rest of the victim's family and friends.

3.1.3 Communication with the service-user's family

The investigation team offered via the service-user to meet with members of her family, but this offer was not taken up. It was decided not to attempt to contact the service-user's family independently given the concerns the service-user had about the effect of an interview given the timescale elapsed since the incident and ongoing ill-health suffered by a member of the service-user's family.

3.1.4 Communication with the South Essex Partnership University NHS Foundation Trust (SEPT)

On 08 July 2010 the East of England Strategic Health Authority (SHA) wrote to the Investigation Team Leader to formally appoint HSL to carry out the independent investigation. The SHA was keen that the investigation team meet with key stakeholders to make sure that the organisations involved were aware of the investigation process and to detail liaison arrangements. On 09 August 2010 a meeting was held at SEPT Trust headquarters in Luton between HSL, East of England SHA, SEPT and the Bedfordshire Primary Care Trust (PCT). The purpose of the meeting was to clarify the investigation process, to agree the draft terms of reference, to address any concerns or questions that the various other stakeholders may have had, to agree the reporting arrangements between HSL and the stakeholders, and for SEPT to provide a designated Trust liaison person within the Trust to facilitate the transference of core data sources and access to potential interviewees still employed by the Trust.

3.2 APPROACH TAKEN

Root Cause Analysis (RCA) is a structured and systematic approach to incident investigation and analysis of healthcare incidents. Its primary aim is to understand what, why and how an incident occurred by focusing on systemic failures and thus moving away from individual blame. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility. The use of RCA tools facilitates the identification of root causes, which enables targeted and specific recommendations to be generated to mitigate the likelihood of similar failures occurring in the future. It should be noted that a root cause normally refers to the organisational cause of one or more problems in relation to the care of a service-user. It does not follow that a root cause was the ultimate reason that a particular incident occurred.

This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service [3]. RCA is essentially composed of five main steps detailed overleaf:

1. Getting started
2. Gathering and mapping evidence
3. Identifying the problems
4. Analysing the problems
5. Generating recommendations and solutions

The investigation began with a review of key policies and procedures and the service-users clinical records. A full list of all documents reviewed is contained in Table 1.

Table 1 Information and Evidence Reviewed by the Investigation Team

Document	**Date of Issue (if listed)**
BLPT Trust Internal '7 Day' Investigation Report	January 2007
BLPT Trust Internal Investigation Report v1	April 2007
BLPT Trust Internal Investigation Report v2	August 2007/updated June 2008
BLPT Trust Internal Investigation Report v3	December 2009
BLPT Service-user Clinical Notes – blue file	2003-2007
BLPT Service-user Clinical Notes – beige file	2003-2007
Service-user Primary Care (GP) Records	2003-2006
Crown Court Sentencing Hearing Transcript	September 2008
BLPT CMHT Weekly Team Meeting Minutes	January 2006 – December 2006
BLPT CMHT Business Meeting Minutes	January 2006 – July 2006
BLPT – CP4 - Policy and Procedure for Reporting Adverse Incidents	March 2005
SEPT – CP3 – Adverse Incident Policy	July 2010
SEPT – CPG3 – Adverse Incident Procedural Guidelines	July 2010
BLPT Care Programme Approach Policy v4i	August 2004
BLPT Integrated Care Programme Approach (CPA), Non CPA and Care Management Policy	October 2009
BLPT GCPG43 – Procedural Guidelines for CPA, non-CPA and Care Management	October 2009
BLPT GC30 – Non Compliance Policy	August 2004
BLPT GC48 – Non Concordance and Disengagement Policy	February 2008
BLPT CP15 – Patient Access Policy – No version number (marked review January 2007)	Issue - January 2004
BLPT CP15 – Patient Access Policy – No version number (marked review April 2011)	Issue – January 2004
SEPT Summary Response Document to HSL Documentation Request	September 2010
SEPT Staff Involved in Care Relevant to the Incident - Summary Document	September 2010
SEPT – 'Tunedin' Staff Magazine incorporating 'Lessons Learned' column	July 2010 & October 2010
SEPT – 'Grapevine' Clinical Governance Update	August 2010
SEPT – Safety Alert following an incident	Undated

The Independent Investigation Team examined the case notes of the service-user in great detail and produced a timeline, highlighting in chronological order the main events associated with the care and treatment of the patient, along with the staff delivering care (please note the names and identity of staff are anonymous within this report). The timeline is an extension of the one produced in the Trust's internal investigation report. The extended timeline is available in Appendix A.

3.3 WITNESSES CALLED BY THE INDEPENDENT INVESTIGATION TEAM

The Independent Investigation Team was not able to interview all of the individuals involved in the care and treatment of the service-user. This was due to the passage of time, as some of the witnesses that the Investigation Team wanted to call were either living abroad (and no longer in the employment of SEPT), had died or were not contactable. However in one instance, the Independent Investigation Team was able to make contact with a previous employee of the Trust in order to carry out an interview. A total of 11 witnesses were interviewed by the Independent Investigation Team. Interviews were held between October and November 2010.

Prior to the interview each witness received a letter from the Investigation Team Leader explaining the following items:

- The nature of the investigation and the purpose of the interview;
- Who they would be interviewed by;
- Date, time and location of the interview;
- Option to bring a friend or colleague for support.

Each witness interview was chaired by the Investigation Team Leader and attended by at least one but no more than two other members of the investigation team. To ensure the interviews were targeted, credible and sensitive, the expertise of the investigation team member was linked to the area of work and expertise of the interviewee. For example our nursing expert attended all nursing interviews, etc. The clinical notes were reviewed by our two medical experts to provide a medical opinion of the care and treatment received by the service-user. This approach streamlined the investigation process and offered proportionality.

All but one interview was transcribed using an MP3 player. In the one interview not transcribed, the interviewee was not comfortable being recorded and so handwritten notes were taken. Following interview transcription/note taking, each interviewee was given a copy of the transcript/notes of their interview and encouraged to correct any errors or to add anything they felt had been omitted. This transcript/notes was then returned with any corrections or amendments to the Investigation Team Leader. The transcripts were then sent to all investigation team members to review. The full list of formally recorded interviews with resultant transcripts and their dates is shown in Table 2.

Table 2 Interviews conducted by the Investigation Team

DATE	INTERVIEWEE	INTERVIEWERS
15/10/2010	• Care Coordinator 2 (Community Psychiatric Nurse) • Biggleswade CMHT Team Manager at time of incident	Investigation Team Leader Investigation Team Nurse Expert Investigations Expert
21/10/2010	• Care Coordinator 1 (Assistant Social Worker) • Service-user	Investigation Team Leader Investigation Social Care Expert
01/11/2010	• Biggleswade CMHT Interim Team Manager and Senior Social Worker (pre incident) • Trust Executive Director of Clinical Governance and Quality (Interim) • Trust Head of Serious Incidents & Quality	Investigation Team Leader Investigations Expert
04/11/2010	• Senior House Officer	Investigations Team Leader Investigation Medical Expert
16/11/2010	• Victim's Father • Victim's Mother • Victim's Brother	Investigation Team Leader Investigations Expert

The timeline (incident chronology) together with the evidence contained in the transcripts of interviews and the other documentary evidence have enabled the investigation team to identify the principal Care or Service Delivery Problems (C/SDPs – acts of omission or commission) within the case. However, as with many mental health investigations these tend not to be specific errors or omissions by individuals but more themes and areas for concern. Each of the C/SDPs are identified within the main body of the report, in bold text, along with their associated contributory factors. Fishbone diagrams were created for 14 C/SDPs as a mechanism to collate the variety of contributory factors associated with the C/SDP.

The fishbone diagrams were completed, using the National Patient Safety Agency (NPSA) contributory factor framework [4]. This analysis allowed the investigation team to identify the main reasons why a C/SDP had occurred and make reasoned judgments on the most likely root causes. The fishbone diagrams associated with each C/SDP are contained in Appendix B.

During the analysis good practice was considered and this is identified throughout the report, and is also summarised in section 14.5 of the report.

3.4 SALMON COMPLIANT PROCEDURES

The ‘Salmon Principles’ were established in 1966 by Lord Justice Salmon and were intended to ensure the fair treatment of witnesses at inquiries and tribunals [5]. They establish the need for investigations to be transparent, open, inclusive, timely and proportionate. Independent investigations of incidents within the NHS are carried out with the primary purpose of establishing corporate learning to ensure continuous improvement for the protection of the public and patients. The terms of reference for this investigation also provide anonymity for all those who provided the investigation team with information. Therefore, whilst the Salmon Principles are not directly applicable in many investigations, it is considered good practice to adhere to them when carrying out independent investigations. Guidance published by the National Patient Safety Agency (NPSA) confirms this approach [6].

Each witness interviewed as part of the investigation was written to formally prior to the interview and were informed of the reason that the investigation was taking place. They

were provided with details of the investigation process, together with the opportunity to bring along someone to support them during the interview process. The interviewees were interviewed by experienced investigative interviewers and were given the opportunity to add or clarify any point not covered by the interview question guides.

Although the investigation report provides anonymity to all witnesses and focuses upon corporate learning, in order to meet best practice, the Investigation Team Leader wrote to those witnesses who may have perceived criticism of them in the report. This communication, carried out following the interviewee transcript checking previous described, provided the witness with relevant extracts from the draft report and invited the provision of any further information that would contradict any critical conclusions or provide further context.

4 PROFILE OF THE TRUST & BIGGLESWADE CMHT

The Bedfordshire and Luton Mental Health & Social Care Partnership NHS Trust (BLPT) was created in 2005 when health and social care services for people with mental health problems were integrated into one NHS body. As well as directly employed staff, for example nursing and medical staff, other professionals, for example social care specialists, were seconded into the organisation from Bedfordshire County Council. These staff remained in the employment of the County Council, but became part of multi-disciplinary teams, for example Community Mental Health Teams (CMHTs), which were organised and run by the Trust. BLPT was not at any stage a Foundation Trust although it had a stated intention of working towards this status.

Biggleswade CMHT was a multi-disciplinary team based within Biggleswade Hospital, and providing services at several other locations within the community. In January 2006 the CMHT manager left the team. The team was then managed on a temporary basis by the team's Senior Practitioner (Social Work) until a permanent appointment was made in September 2006. The team was then managed by this permanent manager during the period leading up to and following the incident. The period between January and September 2006 was described by several members of staff as being very challenging for the team. Management time was very stretched at a time when staff were struggling with the process of integration. The Senior Practitioner was struggling with both the responsibilities of managing the team as well as providing social care services to his existing client caseload.

During 2006, all the Trust's CMHTs were contained within a 'Working Age' directorate, managed by an associate director, who in turn reported to an operations director on the Trust Board. In the autumn of 2006, BLPT took steps to start to bring those staff who were seconded into the organisation from the local authority into the direct employment of BLPT, and this process was completed in January 2007.

The Bigglewade CMHT was a multi-disciplinary team and in 2006 consisted of:

- 3 medical staff - a Consultant Psychiatrist, middle grade Doctor and Senior House Officer (SHO);

- 4 social care staff – a Senior Practitioner and 3 Social Workers;
- 3 mental health nursing staff;
- 1 Psychologist;
- A number of health and social care support workers.

In addition to the staff within the CMHT, the team was also able to refer clients to other services provided by the Trust and other organisations, including those within the voluntary sector. The team accepted referrals from inpatient units, the acute Trust's Accident & Emergency department, and referrals from GPs within the community. The CMHT covered a geographical location away from major population centres such as Bedford and Luton and the transport links were described as making access to some services more challenging for service-users than those living in the more populated areas.

During 2006 the local authority employees and the Trust's employees recorded their work on two different IT systems. The local authority employees used a system called SWIFT and the Trust employees, for example Community Psychiatric Nurses (CPNs), used a system called CONTINUUM. These two systems were not linked in any way, although it was common practice for electronic entries on the SWIFT system to be printed out and then added to the patient notes file for use by Trust staff.

Throughout 2009-2010, BLPT worked with the East of England NHS Strategic Health Authority to find an established NHS organisation to acquire BLPT. This had the stated aim of bringing the benefits of NHS Foundation Trust status to local people. In April 2010, BLPT was taken over by South Essex Partnership University NHS Foundation Trust (SEPT), which as a result became a larger Trust, providing services in Essex, Bedfordshire and Luton. With the exception of one Executive Director, this Trust had a different board of executive directors to that originally leading BLPT.

The CMHTs are no longer organised by age-specific client groups, instead they are organised into geographical directorates. Different CMHT managers report to a locality director, so, for example, there is now a central Bedfordshire locality directorate. Within SEPT, IT systems and policy have been rationalised so that all professionals working for the Trust have access to common systems and processes.

5 CHRONOLOGY OF EVENTS

Background information

Personal history

The service-user was born in a town in Scotland in 1974. There were no complications at birth. When she was 14, she moved to the Bedfordshire area, due to her father's employment. She often missed school due to teasing about her accent but in spite of this she achieved some low grade passes in her GCSE exams.

Past medical history

The service-user received infertility treatment during 2006.

Family history

Her mother and father are both in their late 50s. Her father is a bus driver and her mother is a housewife. The service-user reported that her mother had suffered from some health problems. The service-user has two brothers, one who lives abroad and the other is married and lives in the UK.

Employment history

The service-user has had a variety of jobs over the years including working as a cleaner, van driver, care assistant in a nursing home, working in a pub and within a management role. Her longest job was for six years working for an engineering retail company, where she was promoted to the branch manager. She has not worked since October 2004.

Relationships

Until 2002 she had had a relatively stable 11 year relationship with another man, her fiancé. During the subsequent three years she had a number of intermittent relationships. In January 2006 she met her new partner, the victim in the incident, and they were married on 02 September 2006. During the subsequent court case, their relationship was described as volatile and it was said that there were many arguments, some of which resulted in the victim leaving the house to stay overnight with his parents.

Habits

Prior to the offence it is suggested that the service-user smoked approximately one packet of cigarettes every two days. Evidence suggests varying degrees of alcohol use ranging from moderate to heavy use between 2003 and 2006. During the last six months of 2006 it was noted that the service-user was drinking heavily. This amounted to half a bottle of vodka and at least a can or two of lager, 2-3 times a week. She also used to intermittently smoke cannabis. The service-user denied ever using cocaine, crack cocaine or any other illicit drugs. The Independent Investigation Team has heard evidence that would suggest that the service-user's drinking was increasing during the latter months of 2006. There were concerns that she was becoming increasingly involved in conflict, with the last incident occurring on Christmas Eve with a fellow female drinker at a local pub involving a confrontation. However the Independent Investigation Team has not been able to corroborate or triangulate the frequency or nature of this conflict from more than one source.

Forensic history

The service-user had no criminal convictions other than a driving offence when she was 17, which involved driving without 'L' plates.

Past psychiatric history

The service-user reported at a psychiatric assessment following the incident that she took her first overdose at age 13 and she has taken further overdoses, at age 29 and at least two subsequently. Her last overdose was in October 2006 when she took six Paracetamol tablets. She had also previously held a knife to her neck, and superficially cut her wrist 4 or 5 times as well as a superficial stabbing attempt on herself.

Summary narrative timeline

The following information provides a narrative chronology summarising the main features and dates associated with the care and treatment received by the service-user. Appendix A provides a complete timeline of the care and treatment received by the service-user, along with relevant supplementary information.

07 December 1992, the service-user was seen by her GP complaining of depression and irritability type symptoms.

16 July 2003, the service-user was seen by her GP for symptoms of tearfulness, tiredness and lack of motivation.

29 July 2003, service-user reviewed by GP, her condition had worsened and was actively suicidal. A psychiatric referral was made to Bedford Hospital, but there was no further evidence to show what happened as a result of this referral.

03 September 2003, service-user takes overdose of 15 Paracetamol, 15 Ibuprofen and 28 Lofepramine tablets and alcohol.

04 September 2003, service-user assessed by the Mental Health Liaison Nurse, on the Medical Admission Unit at Bedford Hospital. It is noted by the nurse that the service-user specifically requests not to be referred to her local Community Mental Health Team (CMHT). The nurse also raises concern that she "may pose a higher risk to herself than is apparent" due to her lack of honesty.

11 September 2003, GP1 refers the service-user to the Trust's local CMHT after she took an overdose of Paracetamol, Ibuprofen and Lofepramine.

04 November 2003, the service-user was seen at the Lawns Psychiatric Outpatient Clinic by CMHT Consultant Psychiatrist 1. She reported feeling depressed since 2001. Her mood had deteriorated over recent months leading to her overdose in early September 2003. A number of stressors were identified over the past two year period: the ending of a long-term relationship with her fiancé in 2001, the ending of a more recent relationship, infertility problems, difficulties at work leading to her giving up her job, starting a new job in March 2003, and conflict with her mother. The service-user had not found the anti-depressants prescribed by her GP helpful and was reluctant to take further anti-depressants. Furthermore, the CMHT Consultant Psychiatrist wanted to exclude an organic reason for her depression, wishing first to test her thyroid functioning. The service-user was managed on the Standard Care Programme Approach (now known as Non CPA status). A further outpatient appointment was offered for December 2003, which she attended.

03 December 2003, the service-user attended her next outpatient appointment and reported that tests carried out by Consultant Psychiatrist 1 at the previous appointment

to rule out an organic contribution for her depression had not been completed. In the follow-up letter to the GP, Consultant Psychiatrist 1 stated that no medication would be considered until the results of the tests had been reviewed.

01 February 2004, the service-user did not attend her next scheduled outpatient appointment.

03 March 2004, the service-user did not attend her next scheduled outpatient appointment.

04 March 2004, the service-user attended the Accident and Emergency Department at Bedford Hospital for an emergency assessment. She was seen by Consultant Psychiatrist 1. She was tearful and low in mood during the appointment, being preoccupied with work-related problems and feeling physically tired. She was not assessed as being suicidal. She was advised not to work for the next four weeks and to commence Venlafaxine 75mg twice daily, Chlorpromazine 10mg and Zopiclone 7.5mg as required at night. The plan was to see the service-user in the outpatient clinic in four weeks time.

31 March 2004, the service-user was seen at the Lawns Outpatient Clinic by Consultant Psychiatrist 1. She reported some improvement in her mood and sleep patterns. Venlafaxine medication was increased to 150mg once daily and she was advised to remain on sick leave from work for a further four weeks.

19 April 2004, the service-user's autoimmune serology results became available. They showed positive for gastric parietal cells.

21 April 2004, the service-user was seen by Consultant Psychiatrist 1, where she reported going back to work due to pressure from her employer. She reported some improvement in her mood since the increase in medication, but she stated that she was still experiencing some bad days. She was advised to continue with the higher dose of Venlafaxine.

09 June 2004, the service-user was seen at the Lawns Outpatient Clinic by Consultant Psychiatrist 1, where she reported that she had not continued with the higher dose Venlafaxine as she felt it made her confused. She was still experiencing difficulties at

work which had contributed to her low mood and she reported feeling quite exhausted, although the CMHT Consultant Psychiatrist felt there were signs of improvement since the last appointment.

11 August 2004, the service-user did not attend her outpatient appointment at the Lawns.

13 October 2004, the service-user attends her outpatient clinic appointment and is seen by the locum consultant psychiatrist. She reports ongoing difficulties at work although when she was at home with her family and friends she was much happier. The Locum Consultant Psychiatrist felt there were signs of a depressive illness with anxiety symptoms. The service-user stated that she had stopped taking her medication but was persuaded to re-commence Cipramil 10mg, increasing to 20mg once daily.

27 October 2004, the service-user was seen at CMHT outpatient clinic by Staff Grade Psychiatrist 1. She presented as very tearful throughout the interview and stated that she was experiencing suicidal thoughts and panic attacks, though was not considered to be actively suicidal. She reported severe weight loss during recent months and a preoccupation with obsessional worries relating to her work. She was advised to take some time off work due to continued pressure, though she was reluctant to do so. She was advised to continue the Cipramil 20mg and was commenced on Chlorpromazine 10mg as required. It was agreed that she would be reviewed in the outpatients clinic in four weeks time.

22 December 2004, the service-user was seen eight weeks later at a CMHT outpatient appointment by a locum consultant psychiatrist. She presented as quite distressed and tearful, particularly in relation to ongoing difficulties at work. She reported experiencing panic attacks at home, poor sleep and increased use of alcohol.

26 January 2005, the service-user was seen at the outpatient clinic by a Staff Grade Psychiatrist and she reported she had been low in mood over the Christmas period, but that she had been compliant with her medication, which she felt had helped.

01 March 2005, the service-user did not attend her outpatient clinic appointment.

29 March 2005, the service-user's referral to Barford Avenue Day Centre was closed as she had not made contact.

01 June 2005, the service-user did not attend her outpatient appointment.

13 June 2005, Staff Grade Psychiatrist 1 discharged the service-user back into the care of her GP as she did not attend a further outpatient appointment.

16 August 2005, the service-user was re-referred back to the CMHT by her GP as an 'urgent referral' due to a reported increase in alcohol use and signs of depression. It seemed that the service-user had misunderstood some comments made at a consultation within the practice, thinking that she had been told to stop her medication and to return to work. She felt panicked and depressed, resigned from her job and went to Spain with friends. On her return she went to stay with her brother in Scotland before moving back to her parents address. She was described as tearful, though not suicidal, and had been using alcohol. She was prescribed Citalopram 20mg by her GP.

30 August 2005, the service-user did not attend her outpatient appointment.

07 September 2005, the service-user was assessed at the Lawns Outpatient clinic by SHO 3, and a Community Psychiatric Nurse (who would later become Care Coordinator 2). She confirmed that she had been taking her medication (Citalopram 20mg) on most days over the past three weeks and indicated some improvement in her mood. She denied having had any recent suicidal ideas and talked about her future and wanting to improve her life. The service-user stated that she had been drinking excessively, which led to amnesia, and had been smoking large amounts of cannabis. She was counselled about the need to stop using cannabis due to its effect on her mood. The service-user's increased alcohol intake was discussed in detail and it was suggested that a referral be made to the James Kingham Project, a specialist alcohol service, but she preferred at that time to try and reduce her alcohol intake herself with a view to re-considering a referral at her next outpatient appointment in six weeks time. The following day she was referred by Staff Grade Psychiatrist 1 to Barford Avenue Day Centre.

17 October 2005, the Trust's internal investigation report suggests that the service-user was allocated Care Coordinator 1 as her status was changed from standard to enhanced CPA. However, the Independent Investigation Team has not been able to validate this date in terms of the service-user's transfer to enhanced CPA.

02 November 2005, the service-user was seen at the Lawns Outpatient Clinic by SHO 3. She presented as tearful, low in mood and physically tired. She had recently moved out of her parents house to a rented flat, with some support from Care Coordinator 1. The housing officer from the Housing Association was also providing substantial help and assistance to the service-user at this time. The service-user reported that she had stopped using cannabis in the last two weeks and was now drinking only occasionally. She did not present any suicidal intent and stated a wish to change her life. Her medication was reviewed and changed from Citalopram to Fluoxetine 20mg. A discussion around referral to the James Kingham Project was not pursued further.

30 November 2005, Care Coordinator 1 undertook a home visit to the service-user following communication from Barford Avenue the previous day that she was very low in mood. The service-user agrees to weekly meetings with Care Coordinator 1.

04 January 2006, the service-user was assessed at Lawns Outpatient Clinic by SHO 3, accompanied by Care Coordinator 1. She reports that the Fluoxetine medication she had been taking for about one month was working and she felt her mood was more stable. She had been having regular contact with Care Coordinator 1, who had engaged other services to provide opportunities for the service-user to work on decreasing her alcohol intake, structuring her time more positively and securing temporary accommodation as she had been informed that she would need to leave her current accommodation by the end of January 2006.

10 February 2006, a CPA care plan was completed by Care Coordinator 1. This document clearly specified that the service-user was on enhanced CPA. On the same day a discussion was held between Care Coordinator 1, the service-user and her mother regarding the service-user's debt management issues. The CPA document was signed by the service-user on 10 February 2006, signed by Care Coordinator 1 on 20 January 2006 and signed by the SHO on 24 January 2006. The next CPA review meeting was due in six months time (10 August 2006).

January to March 2006, there was much activity between Care Coordinator 1 and the service-user with regard to her housing needs during this time. There were 15 face-to-face or telephone contacts between the service-user and Care Coordinator 1 during this period, as well as a further three telephone calls and a letter from the care coordinator to the service-user when the service-user was out of contact.

01 March 2006, the service-user was seen at the Lawns Outpatient Clinic by SHO 2, accompanied by Care Coordinator 1. She stated that her mood had deteriorated over the last couple of weeks because she had nowhere to live and that her parents didn't want to know her. She was sleeping on a couch at her friend's house. She wasn't sleeping well, had difficulty falling asleep and woke early. Her appetite was poor, only eating one meal a day. She had started a new relationship and her partner was supportive of her. The previous weekend she had got drunk to try and forget things; she denied having drunk alcohol for a long time prior to this and denied having an alcohol problem. She was tearful and made poor eye contact. Her speech was of normal rate, rhythm and character and she described her mood as being depressed. There were no formal thought disorders, auditory or visual hallucinations. She admitted to having suicidal thoughts a few days before, but no plans and has no thoughts now. Her Fluoxetine was increased to 40mg and the management plan was to see her in one month.

05 April 2006, the service-user did not attend her outpatients appointment at the Lawns due to illness.

March to 7 August 2006, Care Coordinator 1 makes various visits or contacts with service-user. Much activity during this time is concerned with resolving her housing needs. Service-user meets erratically with Care Coordinator 1 during the period June to August 2006.

10 August 2006, CPA review not completed for service-user at this time and remained so until the incident.

02 September 2006, the service-user gets married.

14 September 2006, a letter was sent from Acting Team Manager 1 explaining why and apologising for the fact that a care coordinator had not been allocated. Details of the duty officer system were made available to the service-user.

15 September 2006, a letter was sent to the service-user from Care Coordinator 1 stating that the Care Coordinator was leaving the CMHT and that the service-user would be allocated a new care coordinator.

27 September 2006, the service-user did not attend her outpatient appointment at the Lawns. A subsequent appointment was arranged for 15 October 2006, however this was re-arranged again as service-user was attending a funeral.

10 October 2006, service-user takes overdose of five tablets, collapses and visits Casualty.

16 October 2006, the service-user visits GP following the small overdose six days earlier. GP indicates that he will make contact with any new Care Coordinator as he is aware that Care Coordinator 1 has left the CMHT.

17 October 2006, GP makes contact with CMHT Manager. The GP records state that a care coordinator had not been allocated as the service-user was considered by the CMHT to be 'stable'. The GP had complained to the CMHT manager about the lack of allocation and also advised what had happened to the patient the previous day.

17 October 2006, Care Coordinator 2 was assigned to service-user.

01 November 2006, the service-user was seen in the outpatient clinic by SHO 1 on her own. She was currently living with her husband; they were married six weeks ago and she reported that her husband was very supportive. During the interview she was quite tearful, stating that when she took her medication, she feels much better and then she stops taking it and becomes depressed again. The service-user has been taking her Sertraline tablets for the last two weeks and is slowly getting better. She also stated that she sometimes gets suspicious of her husband and does not let him in the house, she does not know why and feels guilty about it. Although she has been feeling low, she stated that she did not feel suicidal and has no intent to self-harm. She also

explained that she had anxiety attacks at times, mainly when she had to go out alone. She explained that she wanted to have a child, and was experiencing abdominal pains and period problems; SHO 1 advised that she discuss with the GP. SHO 1 increased the Sertraline to 50mg bd and started a small dose of Chloropromazine 25mg bd. The next appointment was requested to be in one month's time but she was advised that she could call CMHT staff or her GP in the meantime. The service-user stated that she had not been drinking heavily. SHO 1 was unaware that a care coordinator had been assigned to the service-user.

04 and 07 December 2006, Care Coordinator 2 made two attempts to contact service-user, but without success. Makes contact with service-user's mother on 04 December to confirm her address.

27 December 2006, the service-user does not attend her outpatient appointment at the Lawns.

06.30 30 December 2006, the service-user's husband died from a single stab wound to his chest at their home address. Following her arrest the service-user denied that she inflicted the stab wound, but she admitted pushing her husband outside the flat overnight, as she had done on previous occasions. When she awoke the next morning she stated that she had found her husband deceased outside her flat. When the ambulance arrived, the service-user informed the paramedics that she had inflicted the stab wound and showed them a kitchen knife that she stated she had used and cleaned. The knife was subsequently forensically tested and confirmed to be the knife used to inflict the fatal wound.

30 December 2006, the Emergency Duty Team were asked by Bedfordshire Police to assess the service-user's ability to be interviewed following her arrest and to act as an Appropriate Adult in accordance with Police and Criminal Evidence Act (1984). A Section 12 Approved Doctor was asked to carry out an assessment of service-user's mental state and concluded that there was no evidence of psychosis, delusional thoughts or depression. She was therefore deemed fit to be interviewed and detained in police custody to assist with ongoing enquiries. Following the interview the service-user was formally charged with the murder of her husband, although she pleaded not guilty.

02 July 2008, the service-user attended a hearing at the Crown Court Inner London, where she pleaded guilty to manslaughter.

11 September 2008, the service-user was sentenced to four years imprisonment.

6 TIMELINE AND IDENTIFICATION OF THE CRITICAL ISSUES

Timeline

The Independent Investigation Team formulated a timeline in tabular format (Appendix A) and also a chronology in a narrative format (section 5) in order to understand and plot significant data, and to identify the critical issues and their relationships with each other. This represents the second stage of the RCA process and maps out all of the emerging issues and concerns held by the Independent Investigation Team.

Critical issues arising from the timeline

On examining the timeline, the Independent Investigation Team initially identified six critical junctures that rose directly from the care and treatment that the service-user received from the Trust. These critical junctures are set out below under key headings.

1 - Care Programme Approach. The Independent Investigation Team could find no evidence to support the notion that the Care Programme Approach was being implemented coherently in keeping with both national and local policy. This is evidenced by the following facts:

- A service-user who was on enhanced CPA was without a care coordinator for a period of one month.
- The CPA review which was due in August 2006 was not undertaken and remained so until the incident occurred in December 2006.
- Relevant stakeholders were not invited to attend CPA reviews for the service-user.
- Issues of child protection were not identified, although it is documented at points that the service-user was caring for her young niece on occasions and in fact was doing so on the evening of the incident. There is also evidence, explored later in the report, to suggest that the Trust did not have embedded training programs to ensure staff competency in this area.

2 - Carer and service-user engagement. Throughout the investigation process, the Independent Investigation Team could find no evidence to suggest that the service-user's mother or husband had been offered a formal carer's assessment. There is

evidence to suggest that Care Coordinator 1 made significant efforts to engage with the service-user, however the focus of care centered on the provision of social care and the Independent Investigation Team can find little evidence to suggest her mental health care was considered by the Trust during this time.

3 - Developing a therapeutic relationship with the service-user in order to provide effective care and treatment. The Independent Investigation Team believes that, overall, the professionals involved failed to develop a therapeutic relationship with the service-user, which prevented the development of a care and treatment plan that would meet her complex and changing needs. In total, the service-user was offered 21 outpatient appointments to see the medical team between 4 Nov 2003 and 27 Dec 2006. The service-user attended 13 appointments and missed eight appointments. Analysis of the tabular timeline would support the view of greater disengagement between 2005/6 rather than during the early parts of her care and treatment. During the period 30 November 2005 to 16 September 2006 when Care Coordinator 1 was coordinating care for the service-user, there was the potential for 36 contacts. However, successful face-to-face or telephone contact was made in 21 of those opportunities and 15 were not successful. Review of the tabular timeline shows that the service-user was actively disengaging during March 2006, but due to the proactive approaches (of good frequency and quality) made by Care Coordinator 1 at this time, the service-user was re-engaged with service provision. The service-user began to disengage again in June 2006, but less proactive measures were implemented by Care Coordinator 1 at this time to engage the service-user and therefore she disengaged more significantly from this point forward. Care Coordinator 1 reported that the service-user felt that the level of contact was intrusive around this time, which may have influenced the frequency of future contacts. Care Coordinator 2 was appointed as the service-user's care coordinator on 17 October 2006. In the notes, she recorded three attempts to contact the service-user from the date of handover to the date of the incident on 30 December 2006, all in early December 2006, which further highlights the lack of proactivity in developing a therapeutic relationship with the service-user. Care Coordinator 2 suggested that she would have made further attempts to contact the service-user but these were not documented, as it was not her practice to record every unsuccessful contact with a service-user. The Independent Investigation Team could not find adequate evidence to suggest the dual diagnosis aspects (i.e. the coexistence

of the service-user's mental health and alcohol/drug problems) of the service-user were being adequately managed by the Trust.

4 - Clinical risk assessment and risk management. The evidence used to collect data on the service-user's likely risk relied heavily on self-report, therefore important information was missed by not collecting additional information from other sources. Risk assessments were not up-to-date and the service-user had not had a risk assessment completed since 20 February 2006.

5 - Supervision and clinical experience. The practice and process of both clinical and caseload supervision was poor within this case. The Independent Investigation Team can find no evidence that Care Coordinator 2 received management/caseload or clinical supervision during the period 15 October 2006 – 26 February 2007. Further to this, there were no standardised systems in place at the time to collate this activity. The frequency and quality of supervision provided to the Assistant Social Worker (Care Coordinator 1) is also questioned. The Independent Investigation Team is also concerned regarding the suitability of the Assistant Social Worker providing the care coordination for a patient on enhanced CPA, although the CPA policy is ambiguous as to whether this policy is acceptable. It must be stressed that these issues in themselves do not necessarily have a direct causal bearing upon the incident, but they provide evidence for concerns about the culture towards safety and provision of care and treatment to vulnerable clients.

6 - Record keeping/documentation & communication. The overall quality of the service-user's clinical record was found to be satisfactory, however not all entries were time stamped, and not all had the name of the member of staff printed and their job title stated. The Trust did not provide an integrated nursing and social care record system to ensure adequate communication between all members of the CMHT, and this significantly impeded handover of key information between the social care coordinator and the subsequent nursing care coordinator. Key members of staff failed to record unsuccessful contacts with the service-user and to escalate this information in a timely way to the CMHT Manager. There is evidence of good communication between the medical team and the GP following outpatient appointments. However, the interactions between the primary and secondary care teams could have been strengthened in order to increase the chances of the service-user being compliant with the medication treatment plan. This strengthening could have been facilitated by greater use of the

formal processes (for example inviting the GP to a CPA review) and informal (e.g. telephone contact) where appropriate.

The above six critical issues were identified by the Independent Investigation Team as requiring an in-depth review. It must be stressed that critical issues in themselves do not necessarily have a direct causal relationship to the incident.

In the next sections, each critical issue will be addressed by providing a context to the issue, from a national/local perspective. A further discussion will be provided which highlights the main evidence related to the critical issue, along with the associated care or service delivery problems. Fishbone or five why diagrams have been created for some but not all Care and Service Delivery Problems (C/SDP). Appendix B contains the fishbones related to each care and/or service delivery problem, which highlights the essential contributory factors and where appropriate identifies the root causes. It is important to note that sometimes root causes emerge due to the fact that they exhibit themselves on more than one fishbone, so whilst their existence on one fishbone may not suggest a root cause, the fact that they occur on multiple fishbones is thematically important.

7 CARE PROGRAMME APPROACH.

Context

The Care Programme Approach (CPA) was introduced in England in 1990 to improve community care for people with severe mental illness [7]. Since its introduction it has been reviewed twice by the Department of Health in 1999 [8] to incorporate lessons learned about its use since its introduction and again in 2008 [9].

“The Care Programme Approach is the cornerstone of the Government’s mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services” [10]. This is an important consideration as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients.

This section reviews the Trust’s policy on the Care Programme Approach (CPA) and the CMHT’s application of the policy, including the action when patients do not attend appointments (DNAs). The Trust had an agreed CPA policy implemented from August 2004 (*The Care Programme Approach Policy (V4i), Integrated Care Programme Approach (CPA) Non CPA and Care Management Policy (GC43)*). The policy was Trust wide and therefore all CMHTs were expected to use the policy to guide their work.

The Care Programme Approach does not replace the need for good clinical expertise and judgment but acts as a support and guidance framework which can help achieve those positive outcomes for service-users by enabling effective co-ordination between services and joint identification of risk and safety issues. It can also be a vehicle for positive involvement of service-users and their carers in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary

function is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

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

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication being clear between members of the care team, the service-user and their carers.

At the time of the incident there were two 'levels' of CPA care – 'standard' and 'enhanced'. 'Enhanced' CPA applied to people with more severe and/or persistent mental health problems, irrespective of care setting. The Trust's policy stated that the person requiring enhanced CPA will demonstrate either or both of two key criteria:

1. are a medium or high risk to themselves or others, have a risk of exploitation by others or risk a relapse, if effective care is not delivered (= medium/high vulnerability)
   and/or
2. requires a medium or high level of intervention from more than two disciplines/agencies (=multidisciplinary/agency care).

The Trust's CPA policy states that carers form a vital part of the support required to aid a person's recovery and therefore their own needs should be recognised and supported. It also states that the carers are involved in all the processes of CPA. This is because care assessment and planning views a person in the round seeing and

supporting them in their diverse roles and the needs they have including family, parenting, relationships, housing, employment, education and leisure. The CPA policy 2004-06 provided the framework for the service-user's and carer's needs to be assessed and a target of 100% of carers to have an assessment. The policy is explicit in that if a care plan is established which includes carer input, then that carer should be involved in drawing up the care plan.

There is a responsibility on service directors to ensure that all care coordinators have the relevant skills, knowledge and expertise to carry out their duties in the manner expected, irrespective of whether they are nursing and medical staff employed by the Trust or social care staff employed by the local authority. Both policies provide advice on who can be a care coordinator. For those instances when service-users are on standard CPA and only seeing one professional, then that professional can take on the care coordinator responsibilities i.e. medic, occupational therapist, etc. For those on enhanced CPA it is more likely to be a social worker or a community psychiatric nurse. The policy was not specific on whether an Assistant Social Worker can take on this role.

The Care Programme Approach, when used effectively, should ensure that both inter-agency communication and working takes place in a service-user-centric manner. Since 1995 it has been recognised that the needs of mental health service-users who present with high risk behaviours cannot be met by one agency alone. Investigations into other incidents have criticised agencies for not sharing information and not liaising effectively. The Department of Health *Building Bridges* [10] sets out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

Findings

The Trust's internal investigation report suggested that the service-user was moved onto an enhanced level of CPA on 17 October 2005, however the Independent Investigation Team cannot find evidence to confirm that this action was taken on this date. It appears that, following the service-user being seen in the outpatients clinic on 04 January 2006, a referral was made for her to attend the James Kingham Project, related to her alcohol consumption. This would have meant that the service-user was

now receiving intervention from two agencies, due to her dual diagnosis which would have moved her into the enhanced CPA category.

Care Coordinator 1 completed a care plan for the user on 10 February 2006. However, it appears from the documentary evidence that the care plan was facilitated without a meeting of all stakeholders, as Care Coordinator 1 signed the CPA form on 20 January 2006, SHO 3 on 24 January 2006 and the service-user on 10 February 2006.

There is evidence within the clinical records that the service-user, her mother and care coordinator 1 met on 10 February 2006 to discuss the service-user's debts and how best to manage that situation. This was on the same day that the CPA documentation was signed by the service-user. The notes do not specify that this meeting represented a dual purpose in reviewing the service-users CPA arrangements and inviting the service-user's mother to contribute to that discussion.

The Independent Investigation Team can find no documentary evidence to support the view that appropriate stakeholders were invited to the service-user's CPA meeting, or indeed that a formal meeting occurred.

CDP(#1) = Failure to invite appropriate stakeholders (e.g. carers, GP, housing representatives) to CPA reviews to discuss service-users CPA.

The service-user's care plan dated 10 February 2006 identifies her mother within the specific care plan interventions:

> *"for the service-user to increase her weekly activity levels, by doing her food shopping regularly with her mother on a Wednesday morning".*

Yet the Independent Investigation Team can find no evidence to support the fact that the service-user's mother was invited to attend her daughter's CPA review, or was consulted or involved in the drawing up of the plan.

CDP(#2) = CPA assessments did not include the views of all appropriate stakeholders, particularly the carers.

The Independent Investigation Team can find no evidence to support the fact that a carer's assessment had been completed in this case. Evidence from the case records and discussions with staff at interview strongly suggests that in 2006 this service followed older service delivery models, where the value of carers and their support was not adequately recognised.

CDP(#3) = Care Coordinators 1 and 2 did not undertake an assessment of carers' needs.

The Trust's CPA policy states that a service-user on enhanced CPA should receive a CPA review within six months from the date of their last review. The date of the service-user's previous CPA review was 10 February 2006. This would suggest that the service-user was due a CPA review by 10 August 2006. The Independent Investigation Team discussed the systems and processes in place within the Biggleswade CMHT to ensure and monitor compliance with CPA reviews. The newly appointed CMHT Manager (appointed September 2006) was in the process of familarising himself with the team, its systems and processes, and within a short time of his appointment had begun to implement systems to monitor compliance with CPA reviews, but this had not been commenced at the time of this incident. Therefore at the time of this incident the Biggleswade CMHT had limited systems to ensure and monitor compliance with CPA review deadlines.

CDP(#4) = Care Coordinators 1 and 2 did not undertake a CPA review at appropriate time intervals as stated in the policy (this became due on 10 August 2006)

SDP(#5) = Failure of the Trust to undertake regular auditing of the CPA process both in terms of quality and deadline compliance.

On or around 15 September 2006 the service-user was notified both by Care Coordinator 1 and the Acting CMHT manager that Care Coordinator 1 would be leaving the Trust and that a subsequent care coordinator could not be provided to the service-user immediately, therefore information on the duty emergency system was offered. This information was not communicated to the service-user's general practitioner. On 10 October 2006, the service-user took an overdose of five tablets, collapsed and

visited Casualty. Subsequently, on 16 October 2006, the service-user visited her GP following her overdose. The GP recorded that he would make contact with the care coordinator, although he was aware the care coordinator has left the CMHT. Therefore on 17 October 2006, the GP made contact with the new CMHT Manager. The GP records state that a care coordinator had not been allocated as the patient was considered 'stable'. The GP had complained to the CMHT manager about the lack of allocation and also advised what had happened to the patient the previous day. On 17 October Care Coordinator 2 was assigned to the service-user. A transfer summary had not been completed by Care Coordinator 1 (as per policy) highlighting the work that had been undertaken with the service-user to date along with a chronology of events. A transfer summary and handover should have been done as this was an enhanced CPA case.

The Trust CPA policy (2004-06) was consistent with national guidance and provided the framework for a modern mental health service. The investigation team's examination of the evidence raises concerns about compliance with the CPA policy. The Independent Investigation Team asked for audit data from 2005/6 relating to CPA compliance but the Trust could not locate any.

It is important with any service delivery system that staff have the skills and knowledge to deliver that service effectively. Therefore in each of the interviews with frontline staff, interviewees were asked what training staff had received in the CPA policy and, in particular, if there had been any differences in the way the new policy had been implemented in comparison with the older policy. Whilst some staff struggled to recall this information, all stated that training had consisted of briefings and the new policy being made available via the intranet. Most staff reported having had varying degrees of risk assessment and risk management training, however Care Coordinator 1 had not completed risk assessment training and was not a qualified social worker. The Trust was not able to provide a log of the training received by staff up until the end of December 2006, so the Independent Investigation Team has been unable to specifically comment on the skills and knowledge of the other members of staff in relation to CPA and risk assessment.

At the time of the incident the service-user was babysitting her cousin's three year old daughter. It is documented in the notes during October 2004 and January 2005 that the

service-user had regular access to and care of children and Care Coordinator 1 was aware that the service-user had some limited contact with children. The investigation team discussed this issue with Care Coordinator 1, who wasn't aware that any child was spending a lot of time with the service-user. Further to this, Care Coordinator 1 was not aware of the policy on children and thought that she only had to take action if the child was living in the household. This showed very low awareness of the policy about encountering children during visits to service-users and the need to risk assess the situation.

The policy and guidance were strengthened in the 2009 version of the CPA policy. However, this is only valuable if the policy is being implemented fully and the staff have the skills to assess risk and have a good understanding about holistic assessment.

CDP(#6) = The Trust failed to provide a service-user on enhanced CPA with a care coordinator for a period of one month (non adherence to CPA policy).

SDP(#7) = Failure of the Trust to ensure that systems were in place to handover reallocated enhanced CPA service-users to a new care coordinator and ensure that a CPA review occurs.

CDP(#8) = Failure of Acting CMHT Manager 1 to copy letter to GP advising that service-user was without an allocated care coordinator and what interim support was available.

SDP(#9) = Staff did not comply fully with the Trust's CPA Policy in order to ensure that:

- ***Child protection risks were identified***
- ***The transfer of the care review was carried out following allocation of a new care coordinator***
- ***There was provision of a care coordinator at all times***

There is evidence within the chronology that this service-user would periodically disengage from the service. During March 2006 and June/July 2006 she disengaged and then through the persistence of Care Coordinator 1 continuing contact, re-engagement was established. The last contact Care Coordinator 1 had with the service-user was on 7 August 2006 and thereafter the only contact the CMHT had with her was on 01 November 2006 at her outpatient appointment with SHO 1. The care

plan dated 10 February 2006 stated weekly contact with the care coordinator, which was not adhered to from mid-August 2006 through to 30 December 2006.

The Trust's CPA policy is vague on the issue of loss of contact. It states that:

"*if it becomes apparent, through the processes of CPA care planning, that either contact with the service-user has been lost or s/he is refusing care, a discussion must be held with the relevant professionals within 1 working day to agree the appropriate course of action".* The policy fails to define what disengagement of a service-user might look like and the fact that this could occur outside the process of care planning.

SDP(#10) = The Trust did not have clear guidance for staff outlining what action should be taken when a service-user begins to disengage.

As noted previously, the apparent rationale for placing the service-user on enhanced CPA was due to the fact that on or around 17 October 2005, the Staff Grade Psychiatrist made a referral for her to attend the James Kingham Project, related to her alcohol consumption. Hence the fact that the service-user was now receiving intervention from two agencies moved her into the enhanced CPA category. Evidence obtained from interviews with the staff involved in the delivery of care and treatment to the service-user seemed focused on the fact that she was only on enhanced CPA due to a number of professional agencies involved; they failed to consider her multiple care needs, her mental health problems co-existing with other problems such as substance misuse, and other higher risk factors such as unsettled accommodation, history of conflict in the family, problems with relationships, self-confidence and physical health problems resulting in surgery. In addition, when she was without a care coordinator for one month, the CMHT Manager suggested this was because she was "stable". The Independent Investigation Team felt that the 'mindset' of those who provided care and treatment for the service-user was that she didn't really meet the enhanced CPA criteria, and therefore did not provide care and treatment on the basis of the policy for a service-user with complex and enhanced CPA needs. In coming to this conclusion, it is not suggested that individual members of staff were deliberately complacent about the level of risk posed by the service-user or her needs. Instead the individuals involved, as a matter of habit, had come to expect certain features/cues of an enhanced CPA service-user and when the service-user in this case did not meet these expectations,

this absence of these features/cues did not unconsciously trigger their normal responses towards enhanced CPA status service-users.

SDP(#11) = A mindset existed whereby everyone associated with the care and treatment of this service-user believed she was getting enhanced CPA care without the evidence or the cultural belief that she met the criteria and she was not therefore receiving the necessary input.

In September 2003, the service-user's GP referred her to the Biggleswade CMHT following treatment for depression-like symptoms and taking an overdose. The service-user's care and treatment was coordinated by Biggleswade CMHT, which involved the services of a care coordinator, psychiatric medical input and medication management by the GP. The investigation team finds consistently good practice of prompt and useful update letters being provided to the GP following the service-user being seen in outpatients by one of the psychiatric medical team.

Between November 2003 and November 2006 the service-user had seen six different members of the Biggleswade CMHT medical team. Table 3 provides an overview of the contacts the service-user had with the various medical staff from Biggleswade CMHT.

Table 3 Contact dates between the service-user and members of the Biggleswade CMHT medical team

Job Title of Biggleswade CMHT Medical Team Member	**Date of contact with service-user**
Consultant Psychiatrist 1	4 Nov 2003, 3 Dec 2003, 4 Mar 2004, 31 Mar 2004, 21 Apr 2004, 9 Jun 2004
Locum Consultant Psychiatrist	13 Oct 2004, 22 Dec 2004
Staff Grade Psychiatrist	27 Oct 2004, 26 Jan 2005, 13 Jun 2005
SHO 3	7 Sep 2005, 2 Nov 2005, 4 Jan 2006
SHO 2	1 Mar 2006
SHO 1	1 Nov 2006

These six members of staff had provided 17 contact appointments with the service-user. The continuity of care provided to the service-user during the early stages of her

care and treatment was largely with Consultant Psychiatrist 1. In her interview with the Independent Investigation Team, the service-user recalled the input of this member of staff with her care in a very positive light. This table also highlights that at the beginning of the service-user's care and treatment she was seen regularly by the Consultant Psychiatrist; six times in nine months. Thereafter the frequency of interaction with the medical staff reduces and the last 15 months of her care and treatment was provided by junior members of the team in the form of Senior House Officers. The service-user felt that the psychiatric medical team were "not interested" in her. She went on to say:

> *"…..so I go back, then I get somebody else, so I go back and then there's somebody else, and all these people, every time you see them they ask you different questions, you know its not right, they're not interested in me….".*

Whilst the Independent Investigation Team were not able to interview either of the two Consultant Psychiatrists involved in the care and treatment of the service-user because they had left the employment of the Trust, the review of the clinical notes and other available information has not clearly identified that those doctors participating in a training rotation had clear consultant responsibility and involvement in the management of the service-user during 2005/6.

Further to this, the Independent Investigation Team reviewed the majority of weekly team meeting minutes between January 2005 and January 2007 (it should be noted that some team meeting minutes are missing, e.g. October and November 2005). Evidence from the team meeting minutes finds that the service-user was discussed on 28 February 2006, concerning her emergency housing situation. On 13 September 2005 she was discussed in relation to her referral to Barford Avenue and the James Kingham project. It was also noted that Care Coordinator 2 would be allocated to the service-user on a short-term basis. It is unclear what time frame this short-term basis referred to, but Care Coordinator 1 undertook her first home visit of the service-user on 30 November 2005. Care Coordinator 2 did not meet with the service-user during this time. Thereafter, the service-user was not discussed again until 19 September 2006, when the new CMHT Manager took over chairing the team meetings. The service-user's name was noted in the minutes on 26 September 2006, 03 October 2006 and 10 October 2006, where it is recorded that she was waiting allocation of a care coordinator. On 17 October 2006 she was discussed again and Care Coordinator 2

was formally assigned as her care coordinator. The final time the service-user was discussed at the CMHT team meeting was on 07 January 2007, where it is noted she was in police custody; no further information is recorded.

Attendance at these meetings was consistently good by all team members (team management, care coordinators (CPNs and social workers) and the medical team). The focus of these meetings, however, largely centered on discharge planning, new referrals and care coordination allocation. Minutes of the meetings do not reflect much detailed discussion between the team regarding specific service-users.

CDP(#12) = The CMHT medical team failed to provide continuity of care for the service-user.

SDP(#13) = Failure of CMHT Managers to ensure balance of discussion between service-user's allocation and detailed discussion of service-users at weekly CMHT team meetings.

8 CARER AND SERVICE-USER ENGAGEMENT

Context

The recognition that all carers, especially those of people with severe and/or enduring mental health problems have needs, has received significantly more attention in recent years. The Carer (Recognition and Services) Act 1995 [11] gave carers a clear legal status. It also provided for carers who give a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. The Act also outlines the need that services take into account information from a carer's assessment when making decisions about the type and level of service provision required. Standard Six of the NHS National Service Framework for Mental Health [12] states that all individuals who provide regular and substantial care for a person on CPA should:

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

Findings

It is apparent from the clinical records that only on one occasion did the service-users mother formally meet with Care Coordinator 1. This was on 10 February 2006, where there was a discussion between the service-user, her mother and Care Coordinator 1 regarding the service-user's debts and how this could be best managed. There is no evidence to suggest a carer's needs assessment was made.

Care Coordinator 1 recalls in her interview that during the early stages of her care for the service-user and when she was living at home, the Care Coordinator spoke to the service-user's mother and father by telephone. However, over time this contact abated. These contacts with the family were not recorded in the clinical records.

Care Coordinator 1 recalls in her interview that:

> *"the service-user tried very hard, because she was acutely aware that her mum had these physical health problems and she didn't want to worry her, so she kind of asked me not to really bother them, worry them with it, so the only times I spoke to them was if I had concerns and that was mainly in the first three, four maybe six months when she was living at home……but as time went on I had less contact with them".*

On 01 March 2006 at the service-user's outpatient appointment, she makes reference to the fact that she had started a new relationship with a man. She made further reference in her subsequent psychiatric outpatient appointment on 01 November 2006 that she had recently been married and that her partner was supportive of her.

Care Coordinator 1 stated that she wasn't really aware of the partner's existence; she had a suspicion that the service-user had a boyfriend, but the service-user never wanted to talk about it so she respected her privacy not to do so. Whilst the Independent Investigation Team can understand the care coordinator's reticence to discuss this relationship with the service-user, the Independent Investigation Team considered that this was a missed opportunity to gain further information about the service-user, her carer support and whether a carer assessment was necessary.

There is evidence within the clinical records that Care Coordinator 2 made telephone contact with the service-user's mother on 04 December 2006, where she left a message for the service-user to contact her. The Independent Investigation Team consider this to have been a missed opportunity to have asked the service-user's mother about the health and wellbeing of both herself and the service-user.

Therefore the main carer was not formally identified in order to offer them a needs assessment. This included the service-user's mother and, later, her husband. Therefore the Independent Investigation Team concludes that staff did not comply with the CPA policy regarding the provision of carer assessments and the fact that this should have occurred when the service-user was moved to enhanced CPA. There was no evidence that this service was striving to work with carers as partners, which is what

would be expected from a modern mental health service, particularly given the learning which has emerged from other adverse incidents which underline this point.

C/SDP(#14) = The Trust failed to identify the carer and therefore did not offer a carer assessment to both the service-user's mother and later her husband.

9 DEVELOPING A THERAPEUTIC RELATIONSHIP

Context

The therapeutic relationship or alliance, as it is sometimes known, is the relationship between healthcare and social work professionals and a service-user. The therapeutic relationship is one of the most important aspects of successful recovery from addiction and mental health problems. Trust is a fundamental component of the therapeutic relationship and therefore the service-user needs to trust her healthcare or social care practitioner. To facilitate trust the service-user and practitioner need to collaborate and work as a team to develop mutual understanding, and to set and follow through on valid goals. To achieve this the service-user needs to feel able to talk openly and honestly and in return needs to know that the practitioner will listen without judgment.

There is evidence [13] that a good quality therapeutic relationship improves both service-user satisfaction, professional fulfillment, saves time and, importantly, increases compliance especially with prescribed medication, particularly within primary care.

Findings

During the eight-month period between November 2003 and June 2004 the service-user attended five appointments with Consultant Psychiatrist 1. There is evidence from the clinical notes of a proactive medical approach, particularly in relation to establishing if the service-user's problems were associated with an organic problem. This was an important factor in creating a therapeutic relationship between the service-user and her psychiatrist. During this time the service-user was compliant with her medication and her treatment plan. The service-user can recall the input of this member of staff, and that the psychiatrist felt genuinely interested in her issues and was trying to remedy her problems with a suitable solution.

Thereafter the service-user was seen by five other members of the medical team, which probably did not facilitate a therapeutic relationship with her.

On 07 September 2005, at the service-user's outpatient appointment with SHO 3 and Care Coordinator 2, her alcohol consumption was discussed in detail. It was decided that a referral would be made to the James Kingham project (specialist alcohol service). This referral led to the service-user being placed on enhanced CPA and Care Coordinator 1 being assigned. The Independent Investigation Team can find no other evidence within the notes or via interviews with staff that the service-user's alcohol consumption was actively managed. For example, there is no evidence to suggest that the medical team attempted to gain more objective methods than the self-report regarding the extent of the service-user's drinking problem. However, opportunities were made available to the service-user to address her alcohol problems, but there was no evidence that her alcohol consumption was actively managed.

The service-user had Care Coordinator 1 appointed as her care coordinator on 17 October 2005. Their first contact with each other was on 30 November 2005. Thereafter Care Coordinator 1 had regular contact with the service-user, at her home, over the telephone and at outpatient appointments. In total this equated to 22 contacts between 30 November 2005 and 07 August 2006. Evidence within the notes and during the interview with Care Coordinator 1 would substantiate the view that during the period January through to the end of March 2006, the service-user had significant issues concerning her housing needs and Care Coordinator 1 was proactive in this aspect of her care. However, examination of those contacts finds that the large proportion of contacts concern her housing needs rather than her mental health needs. There was a failure to develop a relationship of trust with the service-user, therefore the service-user was resistant to share thoughts and feelings with Care Coordinator 1. The service-user, as previously specified, actively lied and hid things from the care coordinator.

The service-user in her interview with the Independent Investigation Team stated that:

> *".....drink everyday, every single day and lying, lying to everybody you know, I lied to my family, lying to these rambling psychiatrists …whenever they see me".*

Further to this, the service-user could not recall any input from Care Coordinator 1. On 4 September 2003, following the service-user's first overdose when she was seen at Bedford Hospital by the Mental Health Liaison Nurse, a concern was raised that the

service-user *"may pose a higher risk to herself than is apparent"* due to her lack of honesty.

In the service-user's care plan generated on 10 February 2006, it was stated that the service-user would receive weekly support from Care Coordinator 1 to monitor the service-user's mental health and to support her access to available resources. Review of the timeline finds that the service-user received 15 contacts from Care Coordinator 1 between 10 February 2006 and 07 August 2006. Care Coordinator 1 made 11 further attempted contacts between 02 March 2006 and 17 August 2006 either to the service-user's home or by telephone, but these were not successful. The Independent Investigation Team can find good documentary evidence within the notes that when Care Coordinator 1 could not make contact, this information is recorded in the notes. The Independent Investigation Team can also find evidence to suggest that on several occasions when contact could not be made with the service-user, the care coordinator contacted her parents for an update.

Care Coordinator 2 was allocated as the service-user's care coordinator on 17 October 2006. In the notes, three attempts to contact the service-user are recorded. These were:

- Telephone contact, attempted on 08 November, but failed.
- On 04 December 2006 Care Coordinator 2 made a further attempt to contact the service-user, but was only able to talk to the service-user's mother.
- A letter was sent to the service-user on 07 December 2006 from Care Coordinator 2, where it was stated that she would attend the service-user's next outpatient appointment on 27 December 2006, which the service-user subsequently failed to attend.

It is also recorded in the notes of 04 December that Care Coordinator 2 made sporadic attempts to contact the service-user, but there is no specific evidence of dates contact was attempted but not successful within the notes. Care Coordinator 2 suggested that she would have made additional attempts to contact the service-user but it was not her practice to always record those instances where contact was attempted but failed. There is no evidence that Care Coordinator 2 discussed the service-user's failure to engage with the CMHT team manager or at the CMHT weekly team meetings. The reason stated was that the systems in place would highlight non-attendance at a

booked appointment as disengagement, but the care coordinator did not view a lack of other contact as disengagement at that time.

There is evidence from reviewing the clinical notes that there are periods in the service-user's care and treatment that she disengages with the service. This occurred in February 2005 when she misunderstood information provided by the GP suggesting she should return to work. In response to this she disappeared to Spain and Scotland. Subsequent to this there were shorter periods of disengagement in March 2006 and July 2006. Whilst there is evidence to suggest Care Coordinator 1 actively pursued contact with the service-user, there is no evidence to suggest that the care coordinator raised this lack of engagement with her supervisor, line manager or within the CMHT weekly meetings.

This information along with the pattern of disengagement (specified in section 6) would suggest that this service-user was potentially more complex and difficult to engage than anyone had considered, and therefore the failure to engage the service-user therapeutically limited the team's capability to deliver a care and treatment plan that would meet her changing and complex needs.

C/SDP (#15) = Failure to develop a therapeutic relationship with the service-user which prevented the development of a care and treatment plan that would meet her complex and changing needs.

CDP (#16) = Care Coordinator 1 did not raise concerns about lack of contact with service-user with Acting CMHT Manager.

CDP (#17) = Care Coordinator 2 did not formally raise concerns about lack of contact with service-user with the CMHT Manager.

CDP (#18) = The medical team did not gather objective measures of the service-user's alcohol consumption.

10 CLINICAL RISK ASSESSMENT AND RISK MANAGEMENT

Context

Safety is at the heart of all good health care provision. There has been an implied requirement under the Health and Safety at Work Act for an assessment of risk to be carried out since 1974 [14]. No mental healthcare organisation can afford not to have a programme that actively seeks to reduce and where possible eliminate risk, not only because of financial consequences, but more importantly, as solid risk management programmes can significantly improve patient care.

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is “about making good quality clinical decisions to sustain a course of action that, when properly supported, can lead to positive benefits and gains for individual service-users” [15]. The “management of risk is a dynamic, ever changing characteristic, perhaps best considered on a continuum from very low to high and imminent risk” [16]. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and/or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving the identification of potential for harm to service-users, staff and the public. The priority is to ensure that a service-user’s risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service-users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service-users. It supports the provision of the Care Programme Approach and is a proactive method of analysing the service-user’s past and current clinical presentation to allow an informed professional opinion about assisting the service-user’s recovery. It is essential that risk assessment and management is supported by a positive

organisational strategy and philosophy as well as efforts by the individual practitioner. Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service-user's history and current clinical presentation to allow for a professional judgment to be made identifying whether the service-user is at risk of harming themselves and/or others, or of being harmed themselves. The assessment and management of risk should be a multi-disciplinary process which must include, where possible and appropriate, the service-user and their carer(s). Decisions and judgments should be shared amongst clinical colleagues and documented clearly.

Findings

The Trust's local Care Programme Approach 'The Care Programme Approach (V4i)' gives appropriate guidance on the assessment of risk. Risk profiling (assessing and managing risk) is the shared responsibility of all mental health practitioners who are involved in the care of the service-user. The Trust has adapted the CORE (British Psychological Society, 1997) risk profiling tool and requires the completion of:

a. Brief Risk Assessment (CPA4 – Part 1): overall judgments about the service-user's current risk status and recommendations concerning further assessment.
b. Risk Checklist (CPA4a): a summary of historical and current warning signs indicative of risk.
c. Risk Chronology (CPA4b): a chronological record of historical and concurrent risk incidents, summarising the specific details of such incidents.
d. Risk Descriptor (CPA4 – Part 2): a free text description of current risk factors and relevant circumstances, requiring a detailed consideration of past and current factors which may be indicative of, or contribute to, an assessed level of risk.

There are two completed risk assessments (CPA – Part 1) for the service-user within her notes. The first is dated 01 January 2006 and the second 20 February 2006. Table 4 provides the risk scores at these two times. An entry of '0' indicates that the risk was not present and an entry of '1' indicates that it was present, so for example at both assessments the service-user was never considered a risk of violence or harm to

others but was considered at risk of suicide. Prior to 2006 there were also no documented indications that the service-user may have been a risk to others.

Table 4 Evidence of risk and risk scores for the service-user at two time intervals

Types of Risk	Date & Time 1/1/2006	Date & Time 20/2/2006
Risk of violence OR harm to others	0	0
Risk of suicide	1	1
Risk of deliberate self harm	0	0
Risk of accidental self harm e.g. falling	1	1
Risk of severe self neglect	1	1
Risk to children	0	0
Risk of abusing others	0	0
Risk of being exploited	0	1
Risk of committing an offence	0	0
Risk of injury to self/others through moving and handling	0	0

A CPA review meeting with a selection of stakeholders was not held for this service-user, nor were the opinions sought from such individuals independently. Care Coordinator 1 recognised that the service-user hid things from her and was reluctant to disclose what was happening in her life, but a judgement was made about risk without adequate information being sought through consultation with stakeholders, including seeking the views of the family if possible. The service-user required an updated risk assessment to be completed on or before 20 August 2006, but this remained outstanding until the incident on 30 December 2006.

Overall there was a lack of understanding about the service-user's multiple care needs and the impact on her mental health. For example, when she moved onto enhanced CPA the reason given was that she "had more than one professional" involved. This underplayed the risks and complexity of the service-user. She met a number of characteristics, for example 'multiple care needs' and 'mental health problems co-existing with other problems such as substance misuse'.

There is no evidence to show that Care Coordinator 1 had received risk assessment and risk management training from the Trust, which the Independent Investigation team considered to compromise her capability to undertake effective risk assessments of service-users.

The CMHT Team Manager was informed by the service-user's GP on 17 October 2006 that the service-user had taken an overdose. This information would suggest that the risk of suicide had increased and would invoke a re-assessment of the service-users risks. This was not completed by Care Coordinator 2 between 17 October 2006 and 30 December 2006.

CDP(#19) = Care Coordinators 1 and 2 did not ensure that the service-user's risk assessments were up-to-date.

CDP(#20) = Failure of the Trust to ensure an up to date risk assessment for the service-user, which was due in August 2006.

CDP(#21) = Failure to ensure objective information was used to inform risk assessment of the service-user in addition to that self-reported.

11 SUPERVISION AND CLINICAL EXPERIENCE

Context

The NHS Management Executive defined clinical supervision in 1993 as [17]:

> *"….a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations"*

Clinical supervision is used in many disciplines in the NHS such as counselling, psychotherapy, and other mental health disciplines. Supervision provides the opportunity to discuss case work and other professional issues in a structured manner. In the United Kingdom clinical supervision has been seen by both the Department of Health and the statutory healthcare professional regulatory bodies as an integral part of professional health and social care practice since the early 1990s. The Department of Health sees supervision as a central aspect of all nursing practice.

Findings

The Independent Investigation Team cannot comment on the Trust's supervision policies in place at the time of the incident. Requests were also made to the Trust regarding clinical and managerial supervision arrangements, but none were provided.

The Independent Investigation Team asked all service delivery staff about the arrangements, frequency and quality of supervision during interviews. The senior social work practitioner and Acting CMHT Manager (January 2006 – September 2006) explained that:

> *"I saw everyone on a monthly basis and was very strict, because I know how easy it is to put things off, to book the follow-on meeting at the end of each meeting, and I think from my recollection I achieved this pretty well…..monthly supervision looking at their workload, looking at development, looking at training*

issues, as far as I was able".

The senior social care practitioner provided supervision to all the more junior social workers within the Biggleswade CMHT, which included the Assistant Social Worker (Care Coordinator 1). Care Coordinator 1 agreed that she had regular supervision with the senior social care practitioner. Occasionally supervision extended beyond the month, but this was because he was temporarily the Acting CMHT Manager and therefore his workload was high. However, it was also stated that if Care Coordinator 1 was concerned about a case she could discuss it with the senior practitioner, but Care Coordinator 1 had not thought this necessary in this case.

Supervision discussions were written and recorded by the senior social care practitioner and then both members of staff signed the paperwork. A copy was given to the staff member being supervised and a copy remained on file. The frequency and mechanism of recording would appear satisfactory, however, the quality of the supervision records cannot be commented on, as the Trust could not locate this information. The Trust has also not been able to provide any audit data to assure the Independent Investigation Team that monthly supervision for staff was complied with.

The Independent Investigation Team was concerned that a service-user on enhanced CPA was allocated to an unqualified and inexperienced member of staff. Further to this, the member of staff had not completed risk assessment, risk management or carer issues training. The CPA policy states that *"for service-users who require an enhanced CPA care plan, the Coordinator will usually be a Community Mental Health Nurse or a Social Worker, with responsibility for co-coordinating the service-user's care plan".* Therefore the policy is not specific on whether an assistant social worker can take on this role. The Independent Investigation Team considered that, whilst it might be appropriate for a more junior member of staff to take on the care coordination role with an enhanced CPA client, it is fundamental that they receive regular and high quality supervision, along with appropriate training.

Clinical and managerial supervision for Care Coordinator 2, a community psychiatric nurse (CPN), was provided separately by the Biggleswade CMHT Manager. It was agreed by both Care Coordinator 2 and the CMHT Team Manager that the CPN had received no clinical or management supervision between 15 October 2006 and 13 April

2007. The last supervision session the CPN had received was with the acting team manager on 03 August 2006.

The Independent Investigation Team was able to interview SHO 1 as part of their enquiries. It was stated that he didn't have dedicated one-to-one supervision time set aside, however, he did believe he was supervised by Consultant Psychiatrist 2 and was able to discuss individual cases with her and the staff grade doctor on an as needs basis.

CDP(#22) = Failure of CMHT manager to provide management supervision for care coordinator 2 between 15 October 2006 – 26 February 2007

The Trust have stated that the current arrangements in place in 2011 for supervision are that all staff receive managerial supervision every 4 – 6 weeks and that clinical/professional supervision is also undertaken every 4-6 weeks. For some professional disciplines the supervision may be more frequent than this.

12 RECORD KEEPING/DOCUMENTATION & COMMUNICATION

Context

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

The Medical Protection Society Ltd state that [18]:

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

Pullen and Loudon writing for the Royal College of Psychiatry state that [19]:

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

Findings

Systems for recording information concerning the care and treatment of the service-user were seriously compromised by the Trust recording systems in operation at the time. The social workers employed by the local authority recording patient-related information in the SWIFT system and the NHS staff were recording information in CONTINUUM. Care Coordinator 1 was recording information on SWIFT and then printing information and incorporating that within the paper-based clinical records that the psychiatrist accessed. When Care Coordinator 2 took over the care coordination

role in October 2006, Care Coordinator 1 had already left the Trust and therefore for Care Coordinator 2 to access all materials written by Care Coordinator 1, she had to ask fellow social work colleagues to give her access to the SWIFT system, which in a busy working environment was not always possible. The Independent Investigation Team considered this dual data recording system limited communication between different professional groups with the CMHT, which affected care and treatment of the service-user.

SDP(#23) = Failure of Trust and LA to provide a single system for record keeping to ensure timely communication between all members of the CMHT and provide a safe service.

The Independent Investigation Team is aware that the Trust now operates a single electronic patient record system, which will eradicate the issue identified above.

Overall the Independent Investigation Team considered the clinical notes to be of a reasonable quality. However, the team noted that not all entries within the clinical records were time stamped and the name of the member of staff printed and their designation stated. The team also noted that Care Coordinator 2 did not record all attempted contacts with the service-user within her clinical records. Recording in the notes was also not always carried out at the time of the contact, on occasions being carried out some time later.

The investigation team found that the professionals involved in this case had not been sufficiently assertive in addressing the service-user's disengagement from the service. There was evidence from reviewing the clinical notes that there were periods in the service-user's care and treatment during which she disengaged with the service. In February 2005 she misunderstood information provided by the GP suggesting that she should return to work. In response, she disappeared to Spain and later Scotland. Subsequent to this there were shorter periods of disengagement in March 2006 and July 2006. Whilst there is evidence to suggest Care Coordinator 1 actively pursued contact with the service-user during this time, there is no evidence to suggest that the care coordinator raised this lack of engagement with her supervisor, line manager or within the CMHT weekly meetings. There is also no evidence that Care Coordinator 2

discussed the lack of contact with the service-user between 17 October 2006 and 30 December 2006.

SDP(#24) = Failure of the Trust to ensure all entries into clinical records are time stamped, name of member of staff printed and their designation stated.

CDP(#25) = Care Coordinator 2 did not record all unsuccessful attempts to contact the service-user in the clinical records.

CDP(#26) = Care Coordinator 2 did not record the content of her discussion with the service-user's mother (04 December 2006) in the clinical record.

SDP(#27) = Failure of the Trust to have a service-user disengagement policy

The communication between the CMHT medical team and the GP was certainly of a high quality and occurred in a timely way. However there had been weaknesses in the communication between the GP and the CMHT medical team relating to the client's medication compliance and overall wellbeing. The creation of an enhanced therapeutic relationship and continuity of care for the service-user would have been better supported if the GP had communicated medication compliance with the CMHT on a regular basis.

SDP(#28) = Failure of the General Practitioners to provide regular information on medication compliance to the CMHT medical team

The service-user was struggling with physical health issues and wished to start a family. She believed that by not taking her anti-depressant medication some of these issues would be resolved. This belief may have been reinforced on 01 November 2006 when she was advised by SHO 1 that if she became pregnant she would have to stop taking her anti-depressant medication. She subsequently ceased to take her medication. It is accepted that the management of psychiatric medication during pregnancy is a complex one requiring an analysis of benefits and risks and there is not necessarily a consensus of opinion within the medical community on what risks are tolerable. However the CMHT medical team should have ensured that there was an

agreed approach amongst themselves to discussing the risks and benefits of medication during pregnancy in collaboration with the service-user.

SDP(#29) = Failure of the CMHT medical team to agree an approach to interacting with service-users regarding assessing the risks and benefits of medication during pregnancy.

The Independent Investigation Team requested information from the Trust on the specific training members of staff involved in this case had received, but none could be found. Members of staff who attended for interview were asked questions around the training they had received e.g. risk assessment, CPA, safeguarding children, etc. All staff had difficulty in recalling this information, due to the time that had elapsed between the incident occurring and the independent investigation occurring. It was therefore not possible for the Independent Investigation Team to draw factually accurate conclusions about specific skills and knowledge of individual practitioners involved in this case.

The Independent Investigation Team is aware that after the incident, in 2008, the SEPT Trust (which at that time had not formally taken over BLPT) passed the NHS Litigation Authority (NHSLA) Risk Management Standards Assessment, being assessed as 'Level 3'. The BLPT Trust was last assessed in December 2009 when it was assessed as 'Level 1'. This means that since the incident, for SEPT, there would be some systems in place for monitoring staff attendance at training and an action plan to improve the system. However the Trust has not provided the Independent Investigation Team with evidence that such a system was in place and effective at and before the incident in 2006.

SDP(#30) = Failure of the Trust to ensure adequate systems to record and/or retain all training received by staff.

13 RECOMMENDATIONS

13.1 OVERVIEW OF ROOT CAUSES

This investigation and analysis has adopted a systematic approach utilising appropriate root cause analysis tools. The process started with the development of a detailed and evidence-based chronology (see section 5 and Appendix A). This allowed the Independent Investigation Team to identify the care and service delivery problems associated with the case. Fishbone and Five Why diagrams (see Appendix B & C) were developed for some of the C/SDP to identify the contributory factors using the NPSA Contributory Factor Framework Taxonomy. The rationale used to decide on which C/SDP were to have further RCA analysis was based on the fact that the C/SDP was a more significant issue, and where a RCA tool would facilitate a deeper analysis. The Independent Investigation Team's expert on root cause analysis then undertook a thematic review of all contributory factors associated with each of the critical issues e.g. CPA, risk assessment and risk management, etc. This analysis (see Appendix D) facilitated the identification of significant contributory factors that were occurring on multiple fishbones, and Five Whys, and hence could be considered root causes. There appeared good correlation between root causes identified across critical issues.

The root causes associated with this case are as follows:

1. Lack of therapeutic relationship developed between CMHT staff and service-user, which led to a lack of understanding and knowledge about her life and her needs.

   Linked to this root cause are the following root causes:

   1.1 Mind-set of staff that service-user was low risk and "stable".

   1.2 The CMHT team was culturally unaware and desensitised to the fact that the service-user was on enhanced CPA and what package of care such a service-user should receive.

2. Inadequate clinical and managerial (caseload) supervision for key members of staff e.g. care coordinators, social workers and medical staff.

3. Inadequate skills, knowledge and provision of training to junior members of staff in key areas of service provision e.g. risk assessment, carers assessment, etc.

4. Inadequate local and corporate monitoring systems within the Trust to provide a strong culture of safety for all staff and service-users.

Recommendations

The links between the C/SDPs, root causes and recommendations are shown in the thematic analysis table in Appendix D.

It is essential to note that the following recommendations made by the Independent Investigation Team are in addition to those recommendations already identified by the Trust (detailed in the next section), which address the root causes. For example, the Trust has already identified the need to review CPA monitoring arrangements.

Recommendation 1 - The Trust should demonstrate that they have put in place a suite of measures to ensure that all staff are aware of the importance of the therapeutic relationship in allowing an effective care plan to be delivered. This should include ensuring that supervision discussions include a review of the therapeutic alliance between each service-user and member of staff. The Trust should put in place measures to provide assurance that a therapeutic alliance between service-users and practitioners is being achieved in practice. These measures will need to draw on a range of data sources.

The Trust should ensure that Care Coordinators are provided with clear guidance on the action to take where they identify that a therapeutic relationship has not been adequately developed or sustained, including the requirement to develop a time-bound plan of action when appropriate.

The Trust should collate 'Did Not Attend' (DNA) data on a quarterly basis for all service-users on CPA. The Trust should also consider monitoring the number of different psychiatrists and care coordinators a service-user sees over a quarter to minimise service fragmentation.

Recommendation 2 - Robust and timely supervision needs to be provided to all nursing, social work and clinical staff. Compliance with this activity should be monitored on a quarterly basis and the results should be communicated formally and informally across the Trust. The organisational causes (for example workload) of significant non-compliance should be identified and addressed.

Recommendation 3 - The Trust should continue to develop and refine a training management system, covering all staff, that builds in mandatory training requirements with refresher courses and other courses around key themes. The system should prompt the staff member and their line manager in advance of a training requirement, and should record attendance and monitor compliance levels. The Trust should monitor mandatory and refresher attendance by staff on a quarterly basis.

Recommendation 4 – The Trust should continue to work on the cultural and organisational issues to increase the sustainability of the above recommendations. The Trust should therefore consider undertaking a safety culture audit to identify further areas for improvement within the next 12 months. Such an audit should take into account service-user, carer and staff perceptions, and include, for example, measurement of:

- The culture of involving carers in management plans and decision-making;
- Risk assessment processes;
- Processes for handovers between care coordinators and cross agency communication;
- Systems in place for managing appointment 'Did Not Attend' (DNAs), disengagement of service-users and for monitoring fragmentation of contacts between healthcare professions and across professional disciplines.

Recommendation 5 - The Trust should ensure that adequate liaison arrangements are in place between the providers of addiction services and Community Mental Health Teams (CMHTs) to ensure that a holistic view is taken of a service-user's alcohol and/or drug use and that this is used to inform the risk assessment

Recommendation 6 - The Primary Care Trust (PCT) should put in place measures to assess the effectiveness of the interactions between Primary and Secondary care for service-users on CPA, for example by auditing the attendance of GPs at service-user's CPA review meetings held by the Trust. The PCT should use the results of such assessments to drive improvements.

14 REVIEW OF THE TRUST'S INTERNAL INVESTIGATION

14.1 CONTEXT - SYSTEMATIC INCIDENT INVESTIGATION

In June 2000, the expert report *Organisation with a Memory* [20] described a lack of consistency and variable quality around investigation of adverse events in the NHS. The document reported that "Even after a decision has been taken to conduct some form of inquiry or investigation, there is often little by way of consistent support or expertise available to NHS organisations or to inquiry teams in the conduct of the process" .

Following publication of Organisation with a Memory, the implementation document Building a Safer NHS for Patients [21] described the necessary steps to set up the new national system. This included "*building expertise within the NHS in root cause analysis*". The need for root cause analysis (RCA) methodologies to be applied to incidents has also been specified in Controls Assurance and CNST Standards. The reference guide *Seven Steps to Patient Safety* [22] has been accepted as the template of good practice for patient safety in the NHS. As part of the systematic and methodical approach to improving patient safety the guide recommends the use of root cause analysis and aims to "help local organisations ensure that the investigation team they create is proficient in RCA by providing both online and face-to-face training".

In March 2003 the National Patient Safety Agency initiated a national training programme for all Trusts in England and Wales to attend a specialist incident investigation and analysis training programme called Root Cause Analysis (RCA). Trusts were invited to send up to eight staff to attend this three day networked training programme. The training was provided free of charge and was delivered by the NPSA's Patient Safety Managers. This training was delivered between March 2003 and July 2004, with mental health organisations being prioritised for early training provision. It was confirmed during the interview with the Trust's Head of Serious Incidents & Quality that the Trust had in fact received this training at some point during this time.

In the summer of 2005 the health service guidance on the discharge of mentally disordered people and their continuing care in the community, known as HSG (94)27, was amended. Within this document it states that when a serious incident concerning mental health patient(s) has occurred, then it is necessary for the Trust to undertake a

systematic investigation using techniques such as root cause analysis. When the Strategic Health Authority considers an independent investigation or review is necessary, an independent team of investigators will be appointed for this activity. It is considered that all hospital Trusts have been provided with RCA training and the NPSA maintains an e-learning toolkit, so that all mental health organisations should be in a position to provide complete, robust and effective local investigation reports. In September 2008 the NPSA produced guidance on three types of investigation [23]:

- Level 1 - Concise investigation - for no, low or moderate harm incidents.
- Level 2 - Comprehensive investigation - which is suggested for those incidents where actual harm or potentially severe harm or death could occur.
- Level 3 - Independent investigation - will be independently commissioned and conducted for homicides committed by patients in receipt of mental health services in the six months preceding the offence to meet Department of Health guidance.

The NPSA has also produced guidance on the required components of each of these types of reports along with a report framework template. Please note that this guidance was unavailable to support the first three reports, hence our rationale for reviewing these four reports pre- and post-guidance.

14.1.1 Being Open

The National Patient Safety Agency issued the *Being Open* [24] guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies which are themselves cited in this document. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- Are told about the patient safety incidents which affect them;
- Receive acknowledgement of the distress that the patient safety incident caused;
- Receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- Receive a factual explanation of what happened;
- Receive a clear statement of what is going to happen from then onwards;
- Receive a plan about what can be done medically to repair or redress the harm done.

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers, it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure. The NPSA Guidance on Being Open was updated in November 2009.

The Trust had a policy and procedure for the reporting of adverse incidents in place from March 2005 to March 2008, which was reasonable. However the Trust's current Adverse Incident Procedural Guidelines (CPG3) provides much clearer guidance on the reporting and handling of adverse incidents, including serious incidents.

14.2 FINDINGS: INTERNAL INCIDENT INVESTIGATION(S)

Following this incident a total of four internal investigation reports have been completed by the Trust. The first report relates to a seven day management review; the subsequent three are more detailed incident investigation reports. The first and fourth investigation reports will be reviewed separately; investigation reports 2 and 3 will be reviewed together in summary form. The fourth report was the final version and therefore will be reviewed in more detail than the others.

14.2.1 The Trust's first internal investigation report

The first report was a seven day management review report compiled by the Biggleswade CMHT Manager. This three page report provides outline information on nine key areas:

1. Key service-user details
2. Details of incident
3. Brief summary of psychiatric history
4. Recent psychiatric history
5. Chronology of events leading up to the incident
6. Conclusions
7. Areas of concern
8. Recommendations
9. Action Plan

The seven day management review report provided a satisfactory immediate review of the circumstances surrounding the incident. However, the CMHT Manager did not interview or take statements from anyone involved in the delivery of care to the service-user and relied totally on the clinical records to undertake the review. Consequently the seven day management report is not comprehensive or robust. It does, however, provide a useful summary of the service-user's psychiatric history. The areas of concern identified *was "process of engagement with care coordinator"* and the recommendation that was generated was *"engagement problems should be taken to clinical team meeting for discussion".* An action plan table is available on the last page of the report, but this has not been completed. It is therefore unclear how the recommendation/action will be taken forward within the Trust, who is responsible, a suggested completion date and progress achieved on implementation of the recommendation.

14.2.2 The Trust's second and third internal investigation reports

The second report was a revised report compiled by the then Assistant Risk Manager and now Trust Head of Serious Incidents & Quality, with the assistance of the CMHT Manager, dated April 2007. This report provides an executive summary and background to the incident, no terms of reference and a reasonable narrative chronology. It identifies just one finding (essentially a care delivery problem) *"Care coordinator did not discuss the problems she was having in making contact with the service-user during November and December 2006*". No contributory factors or root causes were identified. One recommendation was produced: *"Care coordinators should ensure that if they are making contact with Enhanced CPA status service-users who are felt to be at risk of disengaging cases should be discussed at the weekly multi-disciplinary meetings or brought to the attention on the CMHT Manager sooner if the risk is felt to be high".* This recommendation fed into the action plan, where the CMHT Manager was identified for taking this action forward and the completion/target date was identified as ongoing.

The third report was compiled by the Biggleswade CMHT Manager dated August 2007/updated June 2008. This report essentially builds on the previous report by identifying five care/service delivery problems and root causes, which relate to the following issues:

- Care coordinator not discussing problems in making contact with a service-user;
- Continuity of care issues;
- Discharge of service back to the care of her GP in 2005, in line with policy;
- Robust management systems for enhanced CPA patients;
- Policy for patients who disengage.

Four recommendations (see section 14.2.4) have been generated in this internal investigation report, three of which relate to the care/service delivery problems. The fourth relates to the monitoring of the legal proceedings associated with the incident. All four recommendations are integrated within the action plan, where lead responsibility for action implemented is extended to a wider number of staff than in report two. All four actions have been specified as complete.

14.2.3 Independent systematic review findings on reports 1 - 3: Issues and comments

No Terms of Reference were produced for any of these three investigation reports, which does not constitute good practice.

The internal investigation was undertaken by the Biggleswade CMHT Manager, who was manager of the team that was providing care and treatment for this service-user. Whilst this complied with the Trust's Policy and Procedure for Reporting Adverse Incidents, March 2005, this lack of suitable independence would not be considered good practice.

Evidence used to facilitate this investigation relied on clinical records and policy documents. Statements or interviews with key witnesses were not undertaken as part of the data-gathering exercise. For an incident of this severity, this would not be considered good practice, nor did it comply with the Trust's Policy and Procedure for Reporting Adverse Incidents, March 2005.

A narrative chronology that identifies the main care provided to the service-user has been used in all three reports, which is considered entirely appropriate for an internal investigation report.

The first and second reports did not identify care or service delivery problems, contributory factors or root causes and link these three elements with recommendations and actions. This would suggest lack of systematic and robust methodologies being employed within the Trust's internal investigation report.

All three reports make no assessment of the contributory factors that have impacted the incident and then drilled down to the root causes. The third report states that it has identified root causes, but there is no explanation of how this has been achieved within the text and therefore replication of these results becomes difficult.

The second and third reports make reference to the fact the Biggleswade CMHT Manager was involved in the production of the reports, yet this manager had not seen

these reports until a few weeks before being interviewed by the Independent Investigation Team.

The staff involved in this incident were not provided with support following this incident in accordance with the policy (Policy and Procedure for Reporting Adverse Incidents, March 2005). Furthermore staff were not made aware that an external investigation might take place until after the appointment of the independent team in 2010. Indeed, one member of staff was not even made aware (either formally or informally) that a homicide had occurred at all until the Independent Investigation Team made contact. Although this individual has since left the Trust, the incident occurred whilst they were still working for BLPT.

Notable good practice was not identified in any of the three reports, which represents a missed opportunity to provide a sense of balance and to acknowledge the positive actions of staff in this case.

The investigation reports made no efforts to engage the service-user, her family or the victim's family as part of their investigation or as part of the Being Open process. This does not comply with the Trust's Policy and Procedure for Reporting Adverse Incidents, March 2005 or national guidance from the NPSA.

The CMHT Manager who undertook this investigation had not received investigations or RCA training and whilst advice was available from the Assistant Risk Manager, she too had limited expertise in investigations at this time.

The investigation reports were not shared with key witnesses to check for accuracy or to gain an opinion on the appropriateness of the recommendations generated.

The internal investigations failed to consider non-Trust stakeholders, who could have assisted in greater understanding regarding the service-user, and her care and treatment. In particular the GP, the service-user's and victim's parents and family could have been invited to participate in the process.

14.2.4 The Trust's fourth internal investigation report

This report was produced in December 2009, three years after the incident. The Biggleswade CMHT Manager was the author, but it was reviewed and revised by the PSI Consultant Nurse. This report provides information on the following:

- Executive summary
- Main report
    - Brief incident description and consequences
    - Incident date
    - Incident type
    - Healthcare specialty
    - Background and context of incident
    - Scope and level of investigation
    - Terms of reference for investigation
    - Chronology of incident
    - Detection of incident
    - Findings
    - Risk assessment
    - Care planning
    - Care and service delivery problems
    - Root cause
    - Areas of notable practice
    - Lessons learned
    - Recommendations
- Appendix 1 - Detailed chronology
- Appendix 2 - Action plan

A level 2 comprehensive investigation report format has been applied to this investigation report. It provides a reasonable executive summary detailing the essential features of the incident. The main body of the report provides greater detail on what, why and how this incident occurred. Importantly, a joint clinician review was undertaken in accordance with the Trust Policy (*Adverse Incident Procedural Guidelines, CPG3*) by the CMHT Team Manager and Consultant Psychiatrist for the Biggleswade CMHT. This was then reviewed by the Consultant Nurse, and the root cause analysis

methodology was applied. Additional documents were reviewed as part of the investigation. This included the service-user's written and electronic care records, the Trust's Care Programme Approach Policy and the Team's Operational Policy. A concise set of terms of reference were developed to guide the scope and breadth of the investigation.

The author of the fourth report included a detailed chronology in an appendix, which represented a largely narrative chronology in a tabular format. The findings are outlined under two key headings, 'Risk assessment' and 'Care planning'.

The investigation report makes reference to the fact that care and service delivery problems, contributory factors and root causes have been identified for this incident. The NPSA Contributory Factor Taxonomy has been used to globally unpack the contributory factors associated across the case, but not for each care/service delivery problem. The report makes no reference to using RCA tools to facilitate the contributory factor analysis such as fishbone or spider diagrams, five why technique, etc. The investigation report states *"that there are no clear identifiable root causes where action could have been taken to prevent this tragic incident from happening".* The report identifies areas of notable practice and lessons learned, which is a helpful addition to the previous incident investigation reports.

The action plan contains four recommendations which are the same as those specified in the third investigation report, but has been supplemented with two further recommendations. The recommendations are shown overleaf:

Table 5 Action Plan in Fourth Report (Recommendations from third investigation report with additional recommendations 5 and 6 added following review December 2009)

Recommendation	**Lead Responsibility**	**Completion/ Target Date**
1. Care coordinators should ensure that where there are problems in making contact with service-users on Enhanced CPA status that those cases are discussed at the weekly multi-disciplinary team meetings or brought to the attention of the CMHT Manager and the team consultant if the risk of non attendance or potential disengagement is felt to be high. The GP should also be contacted	WAMH CMHT Managers MHOP CMHT Managers Practice Development Chairs	Completed
2. The CPA Policy should be reviewed and updated to provide clearer guidance to staff about required actions when a service-user begins to disengage	CPA Manager	Completed
3. A Non- Concordance and Disengagement Policy should be implemented which strengthens the guidance in the CPA Policy outlining expected action to be taken when a service-user on Enhanced CPA status begins to disengage.	Director for Practice Standards and Policy	Completed
4. The progress and outcome of the legal proceedings should be monitored by the Risk Management Team through liaison with Bedfordshire Police colleagues and updates provided to Bedfordshire PCT and the East of England Strategic Health Authority as required	Assistant Risk Manager – Practice Support	Completed
5. As a further recommendation, the CMHT Manager must ensure the implementation of an effective method for quality assuring the completion of care process components, in accordance with the Trust's CPA policy (BLPT 2009), which should include: • the timely allocation of a suitably qualified care coordinator • The timely completion of a needs assessment • The timely completion and regular review of a descriptive risk assessment and the development of a risk management plan where required • The completion of regular formal multi-disciplinary care reviews	Mid Beds CMHT Manager Service Director	30.4.2010 (work in progress)
6. The Service Director must provide assurance that staff are working to the guidance listed in the Non-Concordance Policy by way of an audit	Service Director	30.4.2010 (work in progress)

14.2.5 Independent systematic review findings on report 4: Issues and comments

This investigation report represents a review of the previous reports and has been usefully extended by the use of RCA and application of a level 2 investigation report template, which is compliant with national guidance from the NPSA. There is a measure of suitable independence within this report due to the Consultant Nurse taking on the review role. The review was also commissioned by an executive director, which also represents good practice.

The executive summary is comprehensive and complete and the overall report is of a reasonable, if basic, standard. The terms of reference provide some guidance to the investigating officer, but fail to include items such as involvement of the service-user and her carer(s) in the care and treatment plan, engagement with external stakeholders such as the general practitioner to gain a more holistic understanding of the care and needs of this service-user.

The chronology is of an acceptable format, however, greater use could be made of this tool if the tabular timeline also identified the care/service delivery problems, contributory factors, root causes and notable practice in a more systematic way. This would ensure that the timeline becomes a more useful tool in problem identification and analysis.

This investigation does not clearly or systematically identify the care/service delivery problems and then use root cause analysis tools to unpack the contributory factors that have contributed to each C/SDP. This would not represent good practice. The report also makes reference to its use of the fishbone technique to identify influences, but the investigation team cannot find any evidence of this.

The Independent Investigation Team believes that the Trust's internal investigation does not provide a complete list of care and service delivery problems. Some of the key care and service delivery problems are not phrased specifically enough to facilitate analysis. For example the Trust's internal reports state the following C/SDP *"The service-user had been seen by several different medical staff throughout the period of treatment and care with the Biggleswade CMHT".*

The staff involved in the incident did not participate in any service delivery identification, causal analysis, recommendations or validation, which does not constitute good practice within a learning organisation.

It is the opinion of the internal investigators that there is “no clear identifiable root cause where action could have been taken to prevent this tragic incident from happening”. The Independent Investigation Team agree that it is extremely difficult to argue against this perspective, and agree that the incident could not have been predicted based on the information available to the Trust. However the investigation team does believe from reviewing the evidence that if a more systematic analysis of the contributory factors had been undertaken, then it is more likely that the root causes could have been established by either theming up the significance of contributory factors by virtue of their individual power or frequency on multiple fishbone diagrams. This is likely to have identified the issues around lack of therapeutic relationship, disengagement and failure to adhere to CPA policy, etc which have all contributed to providing sub-optimal care to a service-user on enhanced CPA who has subsequently gone on to commit a homicide.

The fourth report usefully identifies notable and good practice. However, the Independent Investigation Team does not agree with all these findings. For example “the service-user’s first care coordinator made considerable efforts to engage and actively involve the service-user in her own treatment and care between November 2005 and August 2006.” Whilst the investigation team can see Care Coordinator 1 made efforts to engage with the service-user during this time, nearly all contacts related to her social needs rather than her health needs. In addition to this, the service-user herself cannot remember this care coordinator at all during this time, therefore contradicting this conclusion.

The investigation report and its associated action plan was produced three years after the incident, which is a long time after the event and limits early and robust organisational learning. It also reduces the likelihood of preventing or mitigating the consequences of similar events occurring in the future.

The recommendations are not linked specifically to the care/service delivery problems or root causes, therefore it is difficult for the reader to determine whether the

recommendations are dealing with the issues identified in the case, or issues just considered valid by the investigators. Apart from recommendations 5 and 6 all recommendations are recorded as complete, however it would be useful to see what initial timescale was placed on implementation and whether the Trust met the deadline. The action plan document does not outline the activity and/or costs needed to meet the recommendation deadline. The recommendations are not SMART(ER) (Specific, Measurable, Accountable, Reasonable, Timely, (effective, reviewed)). It is also difficult to see how the Trust has sustained and spread the current recommendations.

SDP(#31) = Lack of investigations training for CMHT Manager at the time of the incident

SDP(#32) = Lack of robust, systematic, suitably independent and evidence based internal investigation report (reports 1-3)

SDP(#33) = Failure of the Trust to ensure that internal incident investigation reports were shared with key stakeholders

SDP(#34) = Lack of support for staff at time of incident and currently

SDP(#35) = The Trust failed to provide appropriate communication and support to victim and service-user's families in line with Being Open and its Adverse Incident Policy

SDP(#36) = ***The Trust failed to offer support to the child who possibly witnessed the later stages of this homicide***

The Independent Investigation Team has received verbal assurance from the Trust that staff have now been trained in root cause analysis, and that suitably independent investigators investigate serious incidents. The internal incident investigation reports associated with this case were not shared with key stakeholders, however, we have been assured that this would not occur within the newly formed Trust. Report 4 highlights a more systematic and robust incident investigation methodology and analyses and therefore we do not consider that recommendations are needed to manage these particular service delivery problems. However, from the evidence

provided, the Independent Investigation Team believes that the Trust should consider implementing recommendations associated with the final three service delivery problems cited above (i.e. SDP 34-36).

14.3 RECOMMENDATIONS

In addition to the five numbered recommendations detailed in section 13, the following recommendations are made by the Independent Investigation Team:

Recommendation 7 - The Trust should coordinate SMART and targeted strategies to strengthen the support staff receive following serious untoward incidents, including participation in an external, independent investigation.

Recommendation 8 - The Trust should communicate with the victim's and service-user's families immediately following an incident to offer condolences, explain the Trust's investigative processes and where appropriate offer an apology and provide support options. The Trust should consider, where contact with the family has not previously been established, that action is taken to apologise and retrospectively offer support services to the family.

Recommendation 9 - The Trust should seek to determine whether the current arrangements to internally investigate serious untoward incidents would identify whether a child or other vulnerable witnesses were present, in order to determine whether psychological support should be provided by the Trust.

14.4 REVIEW OF THE TRUST'S PROGRESS WITH RECOMMENDATIONS

In August 2010, the Independent Investigation Team requested that the Trust provide evidence on how each recommendation has been achieved, sustained and, where appropriate, spread across the Trust. The Trust advised that in 2006 the previous organisation (BLPT) relied heavily on verbal assurance from service directors in terms of the implementation of recommendations and although evidence was requested, it was not always received. Since the inception of the new Trust in April 2010 completed serious incident reports and their learning are shared through agreed rigorous governance structures. The newly formed Trust has a Learning from Experience

Group, Serious Incident Database, Director's position statement, use of Trust Today, Tuned In and Grapevine to monitor and share the learning from individual incidents across the whole organisation.

The Independent Investigation Team has requested written evidence in the form of items such as audit data, minutes from key committee meetings, quality metrics, percentage of service-users disengaging, etc. Whilst some verbal assurances have been made this does not constitute good practice and therefore, at this time, the Independent Investigation Team cannot provide evidence-based assurance that the recommendations have been fully implemented, spread and sustained within the Trust.

14.5 NOTABLE GOOD PRACTICE

During the course of the Independent Investigation, several areas of notable practice were identified and it is important that the Trust is made aware of these.

1. CC1 made regular visits to the service-user, kept good notes and implemented most of the actions identified.
2. The CMHT medical team provided timely, coherent and complete accounts of all outpatient appointments with the service-user to the general practitioner across the whole of her care and treatment.
3. CC1 put significant effort into assisting the service-user with her housing issues over a prolonged period.
4. The Acting Team Manager notified the service-user of the duty system if she required urgent assistance, whilst waiting for a care coordinator to be allocated.
5. Thorough medical engagement and input with the service-user between November 2003 and June 2004.
6. The CMHT held regular team meetings, with good attendance at meetings by all team members.
7. There is good evidence that the Trust is now communicating and sharing learning from incident investigation across the whole Trust.

APPENDIX A - TABULAR TIMELINE

In accordance with good practice, all documents and interviews were logged and numbered. The tabular timeline was constructed with an evidence column, which was populated with the relevant reference and page number. In this report, the evidence column has been removed from the timeline to aid readability.

Date & Time	Event	Supplementary information
07 December 1992	Service-user seen by GP 2 complaining of depression and irritability type symptoms	The primary care notes do not indicate any further entries relating to mental health until the next entry in 2003
16 July 2003	Service-user seen by GP 2 for symptoms of tearfulness, tiredness, and lack of motivation	
29 July 2003	Service-user reviewed by GP 2.	Her condition had worsened and was actively suicidal. Psychiatric referral made to Bedford hospital. There is no evidence to validate that a hospital appointment was actually arranged or attended
03 September 2003	Service-user takes overdose of 15 Paracetamol, 15 Ibuprofen and 28 Lofepramine with alcohol	
04 September 2003	Service-user assessed by the Mental Health Liaison Nurse, on the Medical Admission Unit at Bedford Hospital.	It is noted by the nurse that the service-user specifically requests not to be referred to her local CMHT. The nurse also raises concern that she **"may pose a higher risk to herself than is apparent"** due to her lack of honesty
11 September 2003	Service-user first referred to the CMHT by GP 2 following an overdose	Overdose consisting of paracetamol, ibuprofen and lofepramine on 3 Sept. The referral letter from the GP indicated she had suffered from depression since July 2003 and was being treated with Paroxetine

Date & Time	Event	Supplementary information
19 September 2003	CMHT Consultant Psychiatrist 1's PA writes to service-user inviting her to attend for appt and asking her to make contact to arrange an appointment	
07 October 2003	CMHT Consultant Psychiatrist 1's PA writes to service-user confirming appointment on 04 November 2006	
04 November 2003	Service-user seen at the Lawns Psychiatric Outpatient Clinic by CMHT Consultant Psychiatrist 1	Assessed by CMHT Consultant psychiatrist 1, at which time she reported feeling depressed since 2001. Her mood had deteriorated over recent months leading to her overdose in early September 2003. The service-user stated that she had taken the overdose, though was unsure whether this was an attempt to end her life and that she regretted her actions. A number of stressors were identified over the past two year period: the ending of a long term relationship with her fiancé in 2001, the ending of a more recent relationship, infertility problems, difficulties at work leading to her giving up her job, starting a new job in March 2003, and relationship conflict. The service-user had not found the anti-depressants prescribed by her GP (GP2) helpful and was reluctant to take anti-depressants. Furthermore, the CMHT Consultant Psychiatrist wanted to exclude an organic reason for her depression, wishing first to test her thyroid functioning. The service-user was managed on Standard Care Programme Approach (now known as Non CPA status)
03 December 2003	Service-user attended her next outpatient appointment with CMHT Consultant Psychiatrist 1	Service-user reported that the tests previously requested by the CMHT Consultant Psychiatrist had not been completed. In the follow-up letter to the GP (GP2), the CMHT Consultant Psychiatrist stated that no medication would be considered until the results of the tests had been reviewed
17 December 2003	Service-user's blood test results available	Shows raised ESR and potassium
01 February 2004	Service-user did not attend her scheduled outpatient appointment	

Date & Time	Event	Supplementary information
03 March 2004	Service-user did not attend her scheduled outpatient appointment at the Lawns Psychiatric Outpatient Department	
04 March 2004 3.45pm	Service-user attends Accident & Emergency Department at Bedford Hospital for emergency assessment	Service-user was reviewed by the CMHT Consultant Psychiatrist 1, who was on site. She was tearful and low in mood during the appointment being preoccupied with work-related problems and feeling physically tired. She was assessed as not suicidal. She was advised not to work for the next four weeks and to commence Venlafaxine 75mg twice daily, Chlorpromazine 10mg and Zopiclone 7.5mg as required at night. Plan was to see service-user in outpatient clinic in four weeks time
04 March 2004	CMHT Consultant Psychiatrist 1 sends urgent medication change to service-users GP 1	First mention of depression diagnosis made
31 March 2004	Follow up of service-user in outpatients by CMHT Consultant Psychiatrist 1	Service-user reported some improvement in her mood and sleep pattern. Her Venlaflaxine medication was increased to 150mg once daily and she was advised to remain on sick leave from work for a further four weeks.
31 March 2004	Urgent medication change sent to GP 2 from CMHT Consultant Psychiatrist 1	
05 April 2004	Letter from CMHT Consultant Psychiatrist 1 to GP 2 outlining care for service-user following outpatient appointment on 31 March 2004	
19 April 2004	Service-users autoimmune serology results available. Shows positive for gastric parietal cells	

Date & Time	Event	Supplementary information
21 April 2004	Service-user was seen by the CMHT Consultant Psychiatrist 1	The service-user reported going back to work due to pressure from her employer. Although the service-user reported some improvement in her mood since the increase in medication, she stated that she was still experiencing some bad days. She was advised to continue with the higher dose of Venlafaxine
09 June 2004	Service-user was seen by the CMHT Consultant Psychiatrist 1	The service-user reported that she had not continued with the higher dose Venlafaxine as she felt it made her confused. She was still experiencing difficulties at work which had contributed to her low mood and she reported feeling quite exhausted, although the CMHT Consultant Psychiatrist felt there were signs of improvement since the last appointment
11 August 2004	Service-user did not attend her outpatient appointment	
13 October 2004	Service-user attends CMHT outpatient appointment and sees locum Consultant Psychiatrist	Service-user reports ongoing difficulties at work although when she was at home with her family and friends she was much happier. The locum Consultant Psychiatrist felt there were signs of a depressive illness with anxiety manifestations. The service-user stated that she had stopped taking her medication but was persuaded to re-commence Cipamil 10mg, increasing to 20mg once daily
27 October 2004	Service-user seen at CMHT outpatient appointment by Staff Grade Psychiatrist 1	She presented as very tearful throughout the interview and stated that she was experiencing suicidal thoughts and panic attacks, though was not considered to be actively suicidal. She reported severe weight loss during recent months and a preoccupation with obsessional worries relating to her work. The service-user was advised to take some time off work due to continued pressure, though was reluctant to do so. She was advised to continue the Cipramil 20mg and was commenced on Chlorpromazine 10mg as required. To be reviewed in outpatients clinic in four weeks time. To refer to CMHT with a view to supporting her through this difficult crisis period. The main concern is her serious suicide attempt a year ago and a similar stressful situation building up and repeated suicidal thoughts
22 December 2004	Service-user seen at CMHT outpatient appointment by locum Consultant Psychiatrist	She presented as quite distressed and tearful, particularly in relation to ongoing difficulties at her work. She reported experiencing panic states at home, poor sleep and increased use of alcohol

Date & Time	Event	Supplementary information
05 January 2005	Letter sent to GP1 from locum Consultant Psychiatrist outlining him/her of the facts associated with outpatient review of service-user on 22 December 2004	
26 January 2005	Service-user seen at CMHT outpatient appointment by Staff Grade Psychiatrist 1	She reported feeling low during Christmas and New Year period, but indicated that she had been compliant with her medication, feeling that it had helped her mood. A referral was made to Barford Avenue Day Centre for self esteem training, cognitive re-appraisal, coping with depression, activity scheduling and anxiety management, though she did not attend her assessment appointments. The Cipramil medication was increased to 30mg. In a subsequent letter to GP1, the CMHT Consultant Psychiatrist requested a review of the psoriasis complaint that was causing significant discomfort
25 February 2005	Service-user seen by GP1	
01 March 2005	Service-user did not attend her outpatient appointment	
29 March 2005	Service-user's referral to Barford Avenue Day Centre was closed as she had not made contact	
01 June 2005	Service-user did not attend her outpatient appointment	
01 June 2005	A brief risk assessment was completed by her care coordinator	Risk of suicide, accidental self harm and severe self neglect were each graded as low, with all other risks being graded as very low. The risk assessment was signed by the care coordinator and service-user, there were no significant risks
13 June 2005	Staff Grade Psychiatrist 1 discharged the service-user back into the care of her GP (GP1)	Due to not attending two outpatient appointments
16 August 2005	Service-user re-referred to the CMHT by her GP (GP 1) for an urgent review	It seemed that the service-user had misunderstood some comments made at a consultation within the GP practice, thinking that she had been told to stop her medication and to return to work. She felt panicked and depressed, resigned from her work and went to Spain with friends, then returning to stay with her brother in Scotland before moving back to her parents address. She was described as tearful, though not suicidal, and had been using alcohol. She was prescribed Citalopram 20mg by her GP (GP1)

Date & Time	Event	Supplementary information
30 August 2005	Service-user did not attend her outpatient appointment	
07 September 2005	An appointment was offered though re-arranged for 7 September 2005, where the service-user was assessed in the outpatient clinic by the Senior House Officer A and Care Coordinator 2 (CC2)	She reported that she had gone to Spain in Feb 2005 with friends, and that she had stopped her medication, following a misunderstanding at a consultation within the primary care practice. She stated that she had been drinking excessively and smoking large amounts of cannabis. She returned to the UK in April 2005 and stayed with family in Scotland, where her substance misuse continued. She returned to live at her parents address in Aug 2005. She reported being unemployed and receiving incapacity benefit. She confirmed that she had been taking her medication (Citalopram 20mg) on most days over the past three weeks and indicated some improvement in her mood. She denied having had any recent suicidal ideas and talked about her future and wanting to improve her life. She was counselled about the need to stop using cannabis due to its effect on her mood. The service-user's increased alcohol intake was discussed in detail and it was suggested that a referral was made to the James Kingham Project, a specialist alcohol service should be made, but she preferred at that time to try and reduce her alcohol intake herself with a view to re-considering a referral at her next outpatient appointment. It is also stated that she suffers amnesia following drinking. To be seen in outpatients in six weeks time
08 September 2005	Staff Grade Psychiatrist 1 made a further referral to Barford Avenue Day Centre	
13 September 2005	Service-user was discussed at CMHT meeting	It is specified in the Trust internal investigation report that the service-user had been referred to Barford Avenue and the James Kingham Project. Care Coordinator 2 was assigned to the service-user on a short-term basis. However, the service-user refused referral to the James Kingham Project at her outpatient appointment on 07 September 2005 and suggested this option should be discussed at her subsequent appointment
17 October 2005	Service-user was allocated a care co-ordinator (Care Coordinator 1)	This is specified in the Trust in the internal investigation report, however, the Independent Investigation Team can find no evidence to support this date.
02 November 2005	Service-user was reviewed in the out-patient clinic by Senior House Officer 3	She presented as tearful, low in mood and physically tired. She had recently moved out of her parents house to a rented flat. She reported that she had stopped using cannabis in the last two weeks and was now drinking only occasionally. She did not present any suicidal intent and stated a wish to change her life. Her medication was reviewed and changed from Citalopram to Fluoxetine 20mg. The Trust's internal investigation report suggests that the service-user's Care Programme Approach status was changed from Standard to Enhanced CPA around this time as she was being seen by more than one professional. However, the Independent Investigation Team cannot establish the exact date at which the service-user's CPA status was changed

Date & Time	Event	Supplementary information
02 November 2005	Fax to service-user's GP at primary care practice outlining urgent changes to service-users medication from SHO 3	
29 November 2005	Telephone call to CC1 from Barford Avenue	Service-user was assessed at Barford Ave today and it was felt she was too unwell to attend there at the moment as she is unable to engage with groups and is very emotional. Barford Ave suggested and arranged for a 1:1 worker to visit the service-user once a week for a short time to help her get used to seeing people. She has requested that CC1 feedback to her following my appointment with the service-user tomorrow, which CC1 agreed to
30 November 2005	CC1 undertakes home visit of service-user	Service-user was very tearful and low in mood. She described feeling tired despite having lots of sleep. She is receiving 1:1 support from the GP at Barford Ave. She is currently changing from Citalopram 40mg to Fluoxetine 20mg. She is unable to stop herself crying and is feeling like a burden to her family. Agreed to meet weekly for ongoing support
09 December 2005	Service-user cancels visit with CC1	
22 December 2005	CC1 undertakes home visit of service-user	Service-user is less tearful now than when CC1 last saw her. She is no longer seeing personnel at Barford Avenue, but she is still open to seeing them in the future. She has been spending lots of time at her house and has had lots of visits and support from her friends. She feels the medication is having more of an effect than previously. She is not looking forward to Xmas as she feels that her family are overwhelming her and forcing her to be with people all the time. She has an OPA on 6/1/05. Arrange to contact by telephone on 28/12/05, next visit arranged for 4/1/06
01 January 2006	Risk assessment completed by Care Coordinator 1	Risk of violence or harm to others, deliberate self harm, risk to children, risk of abusing others, being exploited, committing an offences, injury to self/ others through moving and handling all graded as 0 (very low risk), whereas risk of suicide, accidental self harm or severe self neglect was graded as 1 (low risk)
04 January 2006	CC1 undertakes home visit of service-user	Service-user says she is feeling a bit more motivated to do things, but still a little emotional. She wants to get her life back on track. We talked about finding more of a routine for her each day, which she thought was a good idea. After some discussion she agreed she would go shopping with her mum every Weds and buy herself a swimming costume so she can go swimming every week. She will have to move out of her current accommodation by end of Jan, she has not been back to see the housing dept, and does not want to go back to her mum's as it makes her feel worse and her mum is ill. CC1 agreed to contact CAB to get advice on housing issues and also to contact the Housing Association on her behalf

Date & Time	Event	Supplementary information
04 January 2006	Service-user assessed at outpatients clinic by SHO 3, accompanied by her care coordinator	She reported that the Fluoxetine medication she had been taking for about one month was working and that her mood was more stable. She had been having regular contact with her care coordinator who had been supporting the service-user in decreasing her alcohol intake and structuring her time. She had not used cannabis for some three weeks and though she reported lacking a purpose in life, she did not report suicidal ideation and talked of plans to become a primary school teacher. Her Fluoxetine medication was increased to 30mg. It was agreed for her to visit the James Kingham Project, to commence regular activities, to agree a care plan, to undertake a thyroid function test and to review again in two months
12 January 2006	CC1 undertakes home visit to do care plan	Service-user and CC1 discuss the care plan. Also discussed service-user's need to go to the Housing Association to register with them for housing. She said she could go with her mum, but would prefer to go with CC1. CC1 agrees and they will go tomorrow
13 January 2006	CC1 and Service-user visit Housing Association regarding housing situation	CC1 and service-user visit the Housing Association to apply for housing and also to make emergency housing application. Housing officer explained she maybe offered some temporary accommodation in Dunstable. Service-user was happy with this. The Housing Association suggested talking to the landlord of the house the service-user is currently looking after, to see if she can takeover the tenancy. Service-user thinks they want a £1800 deposit, which she has not got. She is going to find out over the weekend. The Housing Association would like to know the situation with the current landlord by 23rd Jan, so they can make alternative arrangements if needed
18 January 2006	CC1 undertakes home visit of service-user	Service-user has realised she does not need to be out of house until 24th Feb, rather than 31st Jan. She is going to let the Housing Association know the new dates. CC1 and service-user have agreed to look at her finances and debt at next visit on 25/1/06@ 10am
10 February 2006	Discussion between service-user her mum and CC1 concerning service-user's debts.	Service-user's mum attended meeting today as she has more information regarding her debts. Service-user had found most of the paperwork and rang up the bank, Mid Beds council and the power company to find out the amount of her debts. CC1 and service-user agreed to go to the CAB on Thursday to get advice on the best way to proceed. Service-user's debts were noted, though with an unknown amount for her mobile phone

Date & Time	Event	Supplementary information
10 February 2006	CPA Care Plan completed by Care Coordinator 1 and is signed by service-user	CPA care plan states that service-user has depression and suffers from severe low mood and tearfulness. She has had feelings of suicidal ideation, which have begun to lessen. She finds it difficult to talk to friends and family as she becomes very tearful and because she feels guilty about upsetting them. She is currently living at her friend's house until the lease runs out on 31st Jan 2006; at this time she will have to move out and find some permanent accommodation. She feels unable to live with her parents as it exacerbates her mental health. She has difficulty sleeping and a poor appetite. She has frequent contact with her fiends, but is finding it difficult to engage with them. She has no daily routine and has lost enthusiasm for normal activities. She also has low self-confidence and some self-esteem issues surrounding her body image. Specific Care Plan Interventions include: 1. Weekly support from Care Coordinator 1 to monitor service-user's mental health and to support her access to available resources. 2. To contact the Housing Association to make an application for re-housing and for emergency housing. 3. To contact the Citizen's Advice Bureau for a full benefits review before service-user moves. 4. For service-user to continue to attend outpatient clinic at the lawns on a three monthly basis. 5. For the service-user to increase her involvement with the Barford Avenue Day Centre to access therapeutic groups and activities. 6. Service-user to continue to see her GP for her medication and monitoring of her mental health. 7. Service-user to increase her weekly activity levels, by doing her food shopping regularly with her mother on a Wednesday morning. 8. Service-user is to begin to increase her exercise levels to help with her body image and her mood. She is to go swimming regularly with her friend and look into joining a gym. Signed by service-user 10/2/06. Signed by Care Coordinator 20/1/06. Signed by SHO 24/1/06. Next CPA review meeting due in six months time (August 2006). Box on form ticked to show that this service-user is now on Enhanced CPA
20 February 2006	Brief risk assessment reviewed by service-user's care coordinator	Risk of suicide 1, accidental self harm 1, severe self neglect 1, and risk of being exploited 1 were each graded as low, with all other risks being graded as very low, as there were no significant risks
20 February 2006	CC1 undertakes home visit of service-user	Service-user was extremely anxious and agitated when CC1 arrived. She has not been able to get hold of the Housing Association to find out what is happening on Friday when she has to move out. CC1 phones the Housing Association, they weren't sure about the specifics of service-user's case but felt that she would not qualify for the duty of care to house her in an emergency. The Housing Association personnel would speak to her supervisor and call CC1 back
20 February 2006	CC1 receives telephone call from Housing Association	Housing Association personnel did not know the details of the service-user's application, but felt that the association may not have a duty of care to house service-user in emergency accommodation. However after further discussion it was agreed that they would house service-user in emergency accommodation from Friday until they receive the report from the District Medical Officer, at which time they will make a decision on their duty of care to the service-user. They are expecting the report next week

Date & Time	Event	Supplementary information
23 February 2006	CC1 makes telephone call to Bedford Housing Link for advice on housing	CC1 advised that service-user has 21 days to appeal the Housing Association's decision on their duty of care. During this time the service-user should remain in temporary accommodation through the Housing Association. For the appeal evidence can be provided if appropriate from the GP and the psychiatrist
23 February 2006	CC1 and service-user attend meeting with the Housing Association	The Housing Association gave service-user details of emergency accommodation. She will be staying at a B&B in Dunstable from Friday 24/2/06. Service-user will have to pay £13.50 a week towards the cost of heating and lighting, which she has agreed to. The Housing Association completed a form for Housing Benefit, which will be processed ASAP to pay for the cost of the B&B. CC1 on annual leave Friday and Monday, so service-user has arranged for her friends and family to support her to move her things to Dunstable. CC1 agreed to leave her details with the duty desk, so that if she has any problems they will know the current situation, service-user was happy with this arrangement
27 February 2006	Phone calls between CC1 and service-user regarding her housing and mental health issues	
28 February 2006	CC1 undertakes home visit and sees service-user	Service-user was very low in mood today and tearful. She has had a very difficult weekend and left her B&B because she felt it was too dirty to be lived in. She has been staying with friends for the last three nights. Service-user told CC1 that she had got very drunk on Fri night as she felt very low. Her parents were away, so she began drinking at their house and then went out with a friend. Since then the service-user has not taken her medication. CC1 advises her to continue to take her medication and to get the new prescription at a higher dose from the chemist, she agreed. She was also upset that she was missing support from her family and friends. She admitted that they had been upset that she had been drinking and had not faced up and dealt with her problems, she found it hard to understand their view. CC1 spoke to service-user's mother who was upset that her daughter had been drinking again. Service-user agreed to return to the B&B if still available. CC1 will contact the Housing Association to discuss current situation. Service-user had had suicidal thoughts over the weekend, but she did not have a plan and she no longer felt that way

Date & Time	Event	Supplementary information
28 February 2006	CC1 makes telephone call to the Housing Association. Then calls service-user	Service-user has two possible choices for accommodation a) the Housing Association will confirm that they are able to continue to provide the B&B, and b) service-user can accommodate herself until the accommodation in Sandy becomes available, which may take a week and it is unfurnished. Service-user may have to pay the B&B for the time she has spent there and has had the keys (from Saturday until today). CC 1 explained that service-user was not able to check-in on Saturday as personnel not there to let her in. Service-user needs to take the keys back to the B&B ASAP to avoid further charges. T/C to service-user who said that she would prefer to wait for the emergency housing in Sandy to be available. She will speak to her friends to see if she can stay with them for a few more days. She is also going to ask her brother
28 February 2006	CMHT meeting	Awaiting report from district medical officer on duty to re-house. CC1 looking into other emergency accommodation if it becomes necessary. Service-user is waiting for temporary housing in Sandy through the Housing Association
28 February 2006	Service-user leaves message for CC1	Service-user has left the B&B. She has lost her mobile phone. Visit today will be at service-user's mother's house. No further information available on the service-user's wellbeing
01 March 2006	The service-user was seen in the outpatient clinic by SHO 2, accompanied by Care Coordinator 1	Service-user was accompanied by CC1. Her mood had deteriorated over last couple of weeks, because she has nowhere to live and that her parents don't want to know her. She is currently sleeping on a couch at her friend's house. She isn't sleeping well, has difficulty falling asleep and wakes early. Her appetite is poor, only eating one meal a day. CC1 states that a bed at the Housing Association will be available next week and once settled arrangements will be made for her to be reassessed at Barford Avenue. She has started a new relationship and he in supportive of her. Last weekend she had got drunk to try and forget things, she denies having drunk alcohol for a long time prior to this and denies having an alcohol problem. She was tearful and made poor eye contact. Her speech was of normal rate, rhythm and character and she describes her mood as being depressed. No formal thought disorders, auditory or visual hallucinations. She admits to having suicidal thoughts a few days ago, but no plans and has no thoughts now. Will review service-user in one month
02 March 2006	CC1 telephone call to service-user, unable to contact	CC1 unable to contact service-user, so message left on answer phone to contact CC1

Date & Time	Event	Supplementary information
03 March 2006	CC1 telephone call to service-user's mother	CC1 has been unable to get hold of service-user for two days. Service-user's mother told CC1 that she has gone to Scotland for a wedding, she went Thursday night and is due back on Sunday night. She has a GP appt on Monday. CC1 left a message with service-user's mother to call her when she got back
07 March 2006	CC1 makes telephone call to service-user	CC1 not able to make contact with service-user. Spoke to service-user's mother who said she is back from Scotland and that she is expecting her at her house sometime today. CC1 left a message for service-user to contact her with mother and on service-user's mobile phone
08 March 2006	Telephone call to the Housing Association by CC1	The original temporary accommodation in Sandy may not be available now as service-user did not get back to them last week. Service-user is going to go to the Housing Association tomorrow to discuss other available options. The Housing Association will keep CC1 informed of any changes
09 March 2006	CC1 visits service-user at her aunt's house	Service-user had stayed longer in Scotland as she had somewhere to stay. She said her mobile battery had run out and she was unable to use it. Service-user is still feeling low, no suicidal thoughts. No update for the Housing Association, she is waiting her temporary accommodation
10 March 2006	Letter from CC1 to service-user to rearrange appointment to see her on 17th March 2006	
17 March 2006	Telephone call to the Housing Association	Service-user has been allocated a temporary bedsit in Sandy. She moved in last Wednesday. The Housing Association have accepted the duty of responsibility to re-house her and will find her permanent accommodation as soon as it becomes available
17 March 2006	CC1 visits service-user at her bedsit	Service-user was at home with one of her friends. She appeared much calmer today. She said she has been feeling considerably better since she has had somewhere to stay. She has been sleeping better and as a result is beginning to recover from her severe cold
23 March 2006	CC1 visits service-user in her bedsit	Service-user is feeling much better, as well as looking better. She had forgotten our appt today. She has been offered a permanent one bed flat in Ardsley, which should be available in the next four weeks, which she is pleased about. She is receiving a lot of help from her Tenancy Support Officer A, who is debt counselling trained, so will support her with her debt management and also apply for a community care grant for her. Service-user is undergoing some investigations at the hospital right now, which is causing her some discomfort, her friends and family have been supporting her through it. CC1 on annual leave next week, visit arranged for 07 April 2006
05 April 2006	Service-user did not attend her outpatient appointment	Service-user was unwell

Date & Time	Event	Supplementary information
19 April 2006	Telephone call to tenancy support worker A by CC1	CC1 unable to contact service-user. CC1 spoke to Tenancy Support Worker A who saw service-user yesterday. In her opinion the service-user seems well, she was moved into her new property and has begun decorating. Service-user and Tenancy Support Worker A have begun the debt management and Tenancy Support Worker A would like a letter from CC1 regarding service-user's ability to work
27 April 2006	Appt cancelled by service-user	Service-user left a message cancelling appt today with CC1. Unable to contact to rearrange
05 May 2006	Service-user seen by GP1	Service-user's condition the same, coping badly with gynaecological abnormal cell diagnosis.
09 May 2006	CC1 unable to contact service-user	
10 May 2006	Letter sent for appt on 17 May 2006 @11am	
17 May 2006	CC1 visits service-user at home	Service-user said she has been average to low recently. She was initially very excited about the flat and began decorating, but has since found it difficult to motivate herself. She is still unable to pick up voicemail messages on her mobile and she requested that I text her if she does not answer and she will contact me from a pay phone. She is still having disturbed sleep and has a poor appetite although she is still eating. She is still tearful, but controlling the tears. She is going into hospital on 23rd or 28th June to have a gynaecological procedure undertaken, which she is very worried about. Service-user and CC1 discussed Barford Avenue and she thought some relation classes would be beneficial. She is willing to take the bus to Bedford. Next visit arranged for 25 May 2006 at 2pm
25 May 2006	CC1 visits service-user at home	Service-user is quite isolated at the moment. She does not see many people as she has no funds to use public transport. She seemed to have low mood. She had rearranged her living room. She told me that she did not receive the grant that the Tenancy Support Worker A applied for and so is now worried about how she will pay the money back she borrowed. Agreed to apply for DLA, although CC1 unsure if she will receive it. Next appointment is arranged for 06 June 2006
31 May 2006	Service-user referred to Barford Avenue	Referred for developing confidence group, women's stotfold group and possibly swimming
31 May 2006	CC1 refers service-user to Barford Avenue Day Centre	

Date & Time	Event	Supplementary information
05 June 2006	Letter sent from CC1 to Tenancy Support Worker A	Letter states that service-user continues to suffer from low mood, which affects her appetite, sleep and motivation levels. Her recent move to Arlesey has had a huge impact on her ability to cope with her depression and therefore changes in her life. The subsequent loss of contact with her family and friends has had a severe negative impact on her mental health. She is suffering a physical illness and is in constant pain, she is awaiting an admission to have this treated. As a result, the service-user's progress with the CMHT has been limited. She has been referred to Barford Avenue Day Centre for group therapy, etc. She also attends three monthly reviews with the psychiatrist in outpatients clinic. In CC1's opinion the service-user will not be ready to return to work for at least six months and when she does return it will be recommended that she does it slowly
06 June 2006	CC1 visits service-user at home	Saw service-user at home. She was very quiet today and not very talkative. She said she is still in pain from her abdomen and is finding it difficult to want to do anything because of this. She said she is fed up of people coming and asking her how she is feeling as she feels there is nothing anyone can do to help her until she has had this operation. She became quite annoyed when she was telling CC1 this. It was agreed that CC1 would visit service-user just before her operation. Service-user agreed to make contact if her mood changed. Currently she is stable, with low mood, but no suicidal ideation. Next visit 23 June 2006
26 June 2006	CC1 makes home visit to service-user, but she was not in	Service-user was not in for appt. CC1 has left a message for her on her mobile phone, asking her to contact CC1
30 June 2006	Telephone call to service-user by CC1	Service-user has had the operation and she is at home resting, unable to walk, due to pain. In addition to this the service-user is waiting to see a dentist for some major work on her teeth, which is causing her discomfort. As a result of this the service-user is very tearful and cried throughout most of the call. She said she is feeling low and hates her flat. She denied any thoughts of self-harm or suicide. If she continues to feel so upset, she is going to go to her parents tonight for some company. She does not have another OPA, she has not had one sent to her. Visit arranged for Monday at 3.30pm
03 July 2006	Visit by CC1 cancelled by service-user	Message left by service-user explaining she is unwell and to re-arrange the appt. CC1 was unable to contact her regarding re-arrangement
04 July 2006	CC1 unable to make contact with service-user	
11 July 2006	Service-user seen by GP1	Service-user's condition has worsened, stopped taking the medication, feels worse, cannot cope with anything, stuck a knife into herself though no real suicidal intent. To try different antidepressants and see in 2 weeks

Date & Time	Event	Supplementary information
24 July 2006	CC1 makes telephone call to talk to service-user (unable to make contact). Therefore contacts service-user's parents	Service-user's mother explained that service-user had just left her parents house and was on her way home. CC1 was unable to make contact with service-user by mobile phone, to try again later
25 July 2006	CC1 makes telephone call to service-user - no answer	
02 August 2006	CC1 undertakes home visit and meets with service-user	Service-user is feeling better, she has had the operation and is no longer in pain. She has a further procedure with the dentist later next week. Service-user's GP has changed her medication to Sertraline 50mg daily, as she had previously stopped taking the Fluoxetine. She says she is feeling much more stable and less tearful on the new medication. Service-user is having problems with her housing and council tax benefits. She has not received any since moving to Arlesey and is receiving letters from the Housing Association, she would also like to attend some groups at BAC, CC1 agreed to arrange a review for her. Service-user has not received a new OPA either, to investigate next appointment
02 August 2006	CC1 calls Tenancy Support Officer	Tenancy Support Officer is trying to chase up the housing benefit claim. She is hoping they will fast track the service-users application as the arrears are so high. Service-user has been added to the waiting list for a tenancy support officer, this may take up to six weeks. Tenancy support officer to keep CC1 informed of progress
07 August 2006	CC1 undertakes home visit and meets with service-user	Service-user feeling brighter. She has been put on new medication, which is helping. Talked about the future and service-user outlined she would like to do something that keeps her mind active. She is going to ask about a free course at the job centre & local college. Also wants to apply for a housing transfer once the housing benefit and council tax benefit is up to date. Arranged next visit for 17 August 2006
08 August 2006	Service-user seen by GP1	Service-user's condition improved, feels better on this dose of Sertraline – to stay on this dose for now
10 August 2006	Formal CPA review not carried out at required time interval	
17 August 2006	Home visit by CC1, service-user not in	Text message left for service-user as this was the only other means of contact

Date & Time	Event	Supplementary information
14 September 2006	Letter sent from Acting Team Manager 1 explaining and apologising why a care coordinator has not been allocated	Due to staff shortages a care coordinator cannot be made at present. Duty officer system information made available to care coordinator
04 September 2006	CC1 attempts to visit service-user, who was not in	Called her phone nos, no answer
16 September 2006	Letter sent to service-user by CC1 stating that she was leaving the CMHT and that she would be allocated a new care coordinator	The letter states that there will be a short delay before a new care coordinator is allocated. Apologised for not being able to give service-user this news personally. Contact for emergency duty team provided
27 September 2006	Service-user did not attend her outpatient appointment	Service-user attending a funeral. A further appointment was offered for 15 Oct 2006, though this was subsequently rearranged by staff for 1 Nov 2006. The service-user's Care Coordinator wrote to her Tenancy Support Officer on 5/6/09 to summarise her recent progress and advise that she was not ready to return to work for at least a further six months
10 October 2006	Service-user takes overdose of five tablets, collapses and visits casualty	
16 October 2006	Service-user visits GP1 following a small overdose six days earlier	GP1 records she will make contact with care coordinator, although she is aware care coordinator has left CMHT
17 0ctober 2006	GP1 makes contact with CMHT Manager	The GP records state that a care coordinator had not been allocated as the patient was considered 'stable'. GP1 points out this was the case whilst she was having regular input and therefore advised what had happened to the patient the previous day
17 0ctober 2006	CMHT Manager assigns Care Coordinator 2 to service-user	

Date & Time	Event	Supplementary information
01 November 2006	Service-user seen in outpatients by SHO 1	Service-user attends alone. She has missed several appointments since being seen by SHO 2 in March 2206 due to flu and chest infections. She is currently living with her husband; they were married six weeks ago. Husband is very supportive. During the interview she was quite tearful, stating that when she takes her medication, she feels much better and then she stops taking them and becomes depressed again. Has been taking her Sertraline tablets for the last two weeks and is slowly getting better. But she also stated that she sometimes gets suspicious of her husband and does not let him in the house, she does not know why and feels guilty about it. Although she has been feeling low, she stated that she did not feel suicidal and has no intent to self-harm. She also explained that she had anxiety attacks at times, mainly when she has to go out alone. She explained that she wants a child, as well as abdominal pains and period problems, SHO 1 advised that she discuss with GP. SHO 1 increased the Sertraline to 50mg bd and start a small dose of Chloropromazine 25mg bd. Next appt in one month's time or to call us or GP in the meantime. Stated that she has not been drinking heavily. However, other evidence suggests that the service-user was in fact drinking heavily at this time
08 November 2006	CC2 tries to contact service-user	Contact made via service-user's mobile phone
04 December 2006	CC2 tries to contact service-user and leaves message with service-user's mother	Progress notes state that CC2 sporadically tries to contact service-user, but does not make contact. Leaves message with mother for service-user to ring her
07 December 2006	CC2 still not heard from service-user so decides to write her a letter	It is also noted that CC2 would attend service-users outpatient appt on 27/12/06
07 December 2006	Letter from Care Coordinator 2, attempting to make contact with service-user	Care Coordinator 2 advises service-user that she is her new care coordinator and invites the service-user to make contact. She also suggests that she attend with the service-user at the service-user's next outpatient appt on 27 Dec 2006
27 December 2006	Service-user did not attend outpatient appointment	Reminder letter sent on 7 Dec 2006
30 December 2006	It is reported that the service-user's husband died from a single stab wound to his chest at their home address	The service-user stated that prior to his death, he had been drinking heavily and that they had been having arguments. She had been upset as she claimed he had wanted to drink alcohol in the presence of her relative's daughter, aged 3. She states that after the argument she decided to end the relationship and had shoved him outside of the house. She states she noticed some "orange stuff" and a wet knife on the floor, which she put back

Date & Time	Event	Supplementary information
30 December 2006 06.30hrs	When service-user woke the next morning, she stated that she had found her husband deceased on the doorstep of their home	She contacted her husband's family and they in return called an ambulance to go to the home address. When the ambulance arrived, the service-user allegedly informed the paramedics that she had inflicted the stab wound and showed them a kitchen knife that she stated she had used and cleaned. The post mortem revealed that the service-user's husband had bled to death. The knife was subsequently forensically tested and it was confirmed to be the knife used to inflict the fatal wound. Following her arrest the service-user denied that she inflicted the stab wound but she admitted pushing her husband outside the flat overnight, as she had done on previous occasions
30 December 2006	The Emergency Duty Team (EDT) were asked by Bedfordshire Police to assess the Service-user's ability to be interviewed following her arrest and to act as an Appropriate Adult in accordance with Police and Criminal Evidence Act	A section 12 Approved Doctor was asked to carry out an assessment of the service-user's mental state and concluded that there was no evidence of psychosis, delusional thoughts or depression. She was therefore deemed fit to interview and detained in police custody to assist with on-going enquiries. Following the interview, the service-user was formally charged with the murder of her husband, although she pleaded not guilty. A trial date of 03 December 2007 was set
30 December 2006 12.55hrs	Telephone call to EDT from Dunstable Custody Sgt	Service-user arrested this morning for attempted murder of her husband. She has been seen by police medical examiner (section 12 Approved Dr) who was seeking information re her mental health. Client appeared to be in denial and confused as to why she was at police station. Dr felt that service-user was fit for interview, but requested any information available. No record found on SWIFT nor on the health CIS system under the service-user's married name, message left for service-user's consultant psychiatrist requesting any information
30 December 2006 17.30hrs	Dunstable custody Sgt makes request for Appropriate Adult	
30 December 2006	Appropriate Adult attends	Service-user presented as fairly vulnerable. She is known at Spring House and has just been allocated a new CPN (she could not remember her name) and is on Cipramil and chlorpromazine. Service-user gave an account of yesterday, a friend, came round with her 3 yr old daughter who stayed the night. Service-user remembers going with her friend to buy a bottle of vodka and some beers. Service-user and her husband had argued about the drink and the child staying. She describes husband bashing about from room to room then finding him laying down on the bedroom floor with orange stains. She subsequently pushed him out of the door, as she had done before, and went to sleep. She found him slumped on the doorstep in the morning when she released his care was there. She described him as cold and called for assistance. Police have conducted preliminary interviews and will be picking things up again in the morning. Representations have been made to give service-user her medication and have some sleep before she is questioned again

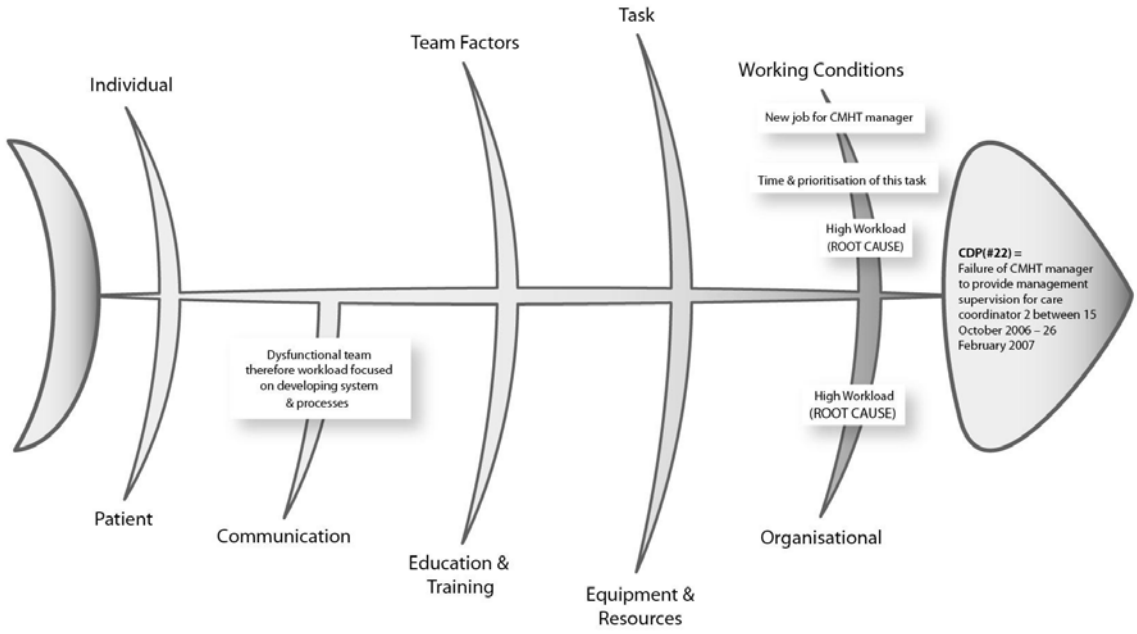
Date & Time	Event	Supplementary information
31 December 2006	Telephone call from custody sergeant who advised that service-user would need an appropriate adult as officers from CID were intending to interview her in relation to the stabbing and death of her husband	Arranged that EDT 1 to attend at 10.30 with ASW 1
31 December 2006 10.30hrs	AA2 attended. Service-user's solicitor felt that his client's mental state had deteriorated overnight and had requested a further medical assessment to ascertain whether she was fit for interview	
31 December 2006 >10.30hrs	Paramedic attended to service-user	Service-user was teary and shaking during the assessment, she kept stating that she could see her husband's face and that she wanted to die herself. Conclusion was that service-user was not fit to interview and paramedic wanted a doctors opinion and called a medical contractor to request a section 12 approved doctor.
31 December 2006 14.00hrs	ASW 1 attended Dunstable Police Station and spoke with Section 12 approved police Dr	Section 12 Approved police Dr 2 stated that he had assessed the service-user and found her fit to be detained and to be interviewed
31 December 2006 >14.00hrs	Full MHA assessment completed by Dr 3	Dr 3 interviewed service-user for 45 mins during which she was able to respond reasonably well despite being obviously distressed at her circumstances. Section 12 approved Dr 2 had prescribed Diazepam and Paracetamol a short while earlier. No evidence of clinical depression, psychosis nor delusional thoughts. Service-user was able to provide a chronology of her activities, including names and places and a sequence of events from Xmas Day through to the evening of the alleged offence, but was unable to detail any specifics regarding the stabbing, claiming she could not recall anything to do with the matter

Date & Time	Event	Supplementary information
31 December 2006 17.20hrs	Appropriate Adult 2 attended Dunstable Police Station and saw service-user in presence of her solicitor and explained appropriate adult role to her	Service-user at this time was quite agitated and appeared to be very frightened, huddled in the corner of the room. Her solicitor was concerned that she had not eaten for two days, although she had taken some liquid. Service-user refused to be interviewed
31 December 2006 18.20hrs	Service-user was seen in her cell and warned that refusing to be interviewed a court could draw an inference about this and asked if she would consent to be interviewed	Through her solicitor she declined. She was then cautioned and two questions about the incident relating to whether anyone else was involved were put to her in her cell. She replied to each that "I don't remember"
31 December 2006 >18.20hrs	Service-user was charged: that between 28 - 31 December 2006 at Arlesey Beds, she did murder her husband. Bail was refused, despite representations made by solicitor	Service-user was held in custody to appear at Bedford Magistrates Court on Monday 1/1/2007
02 July 2008	Service-user was put on trial at the Crown Court Inner London, where she pleaded guilty to manslaughter	

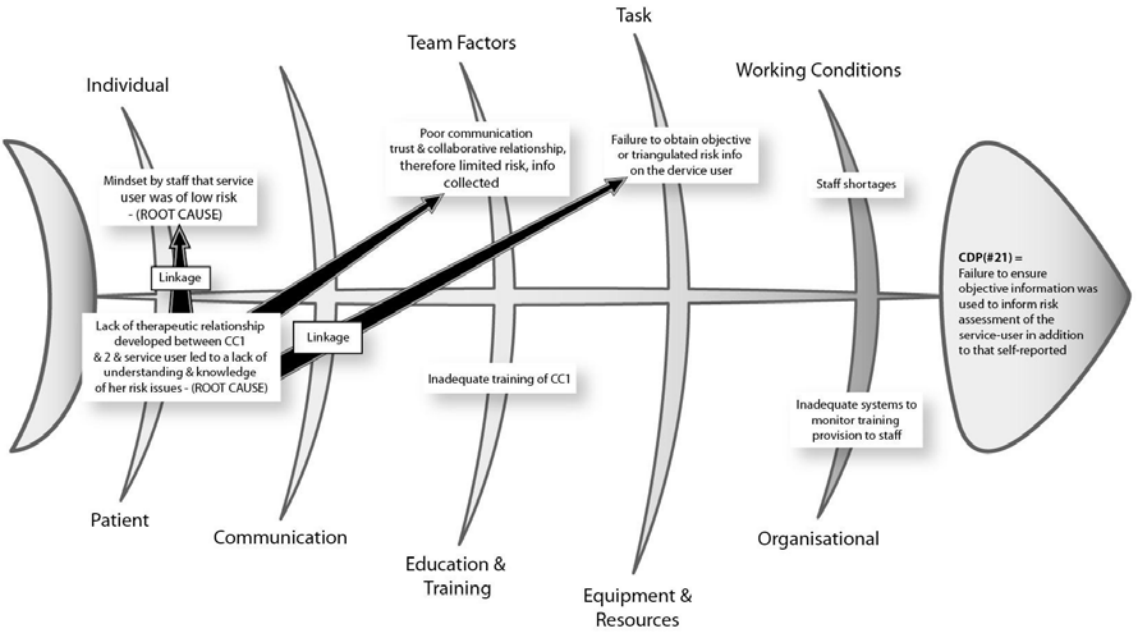
APPENDIX B - FISHBONE DIAGRAMS

Explanatory notes

The fishbone diagrams used to generate contributory factors are shown below. For some Service and Care Delivery Problems there are no contributory factors or they are readily determined without needing to use the formal process. Therefore there is not a diagram for each C/SDP.



Fishbone 1



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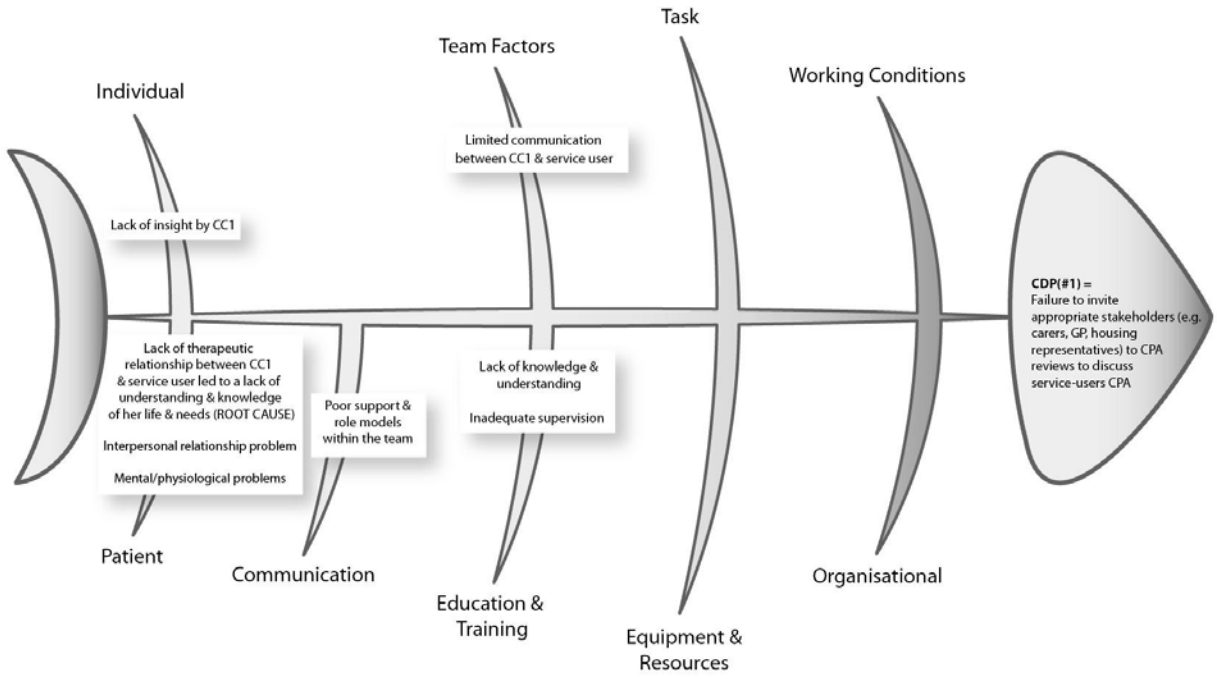

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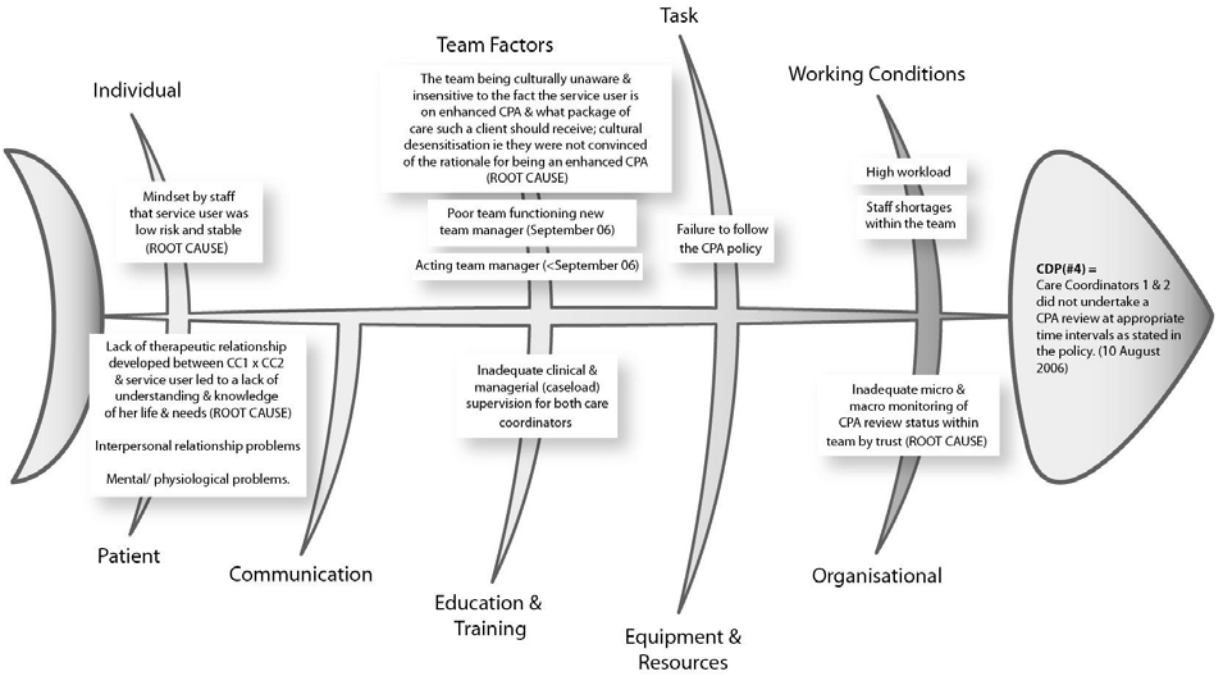

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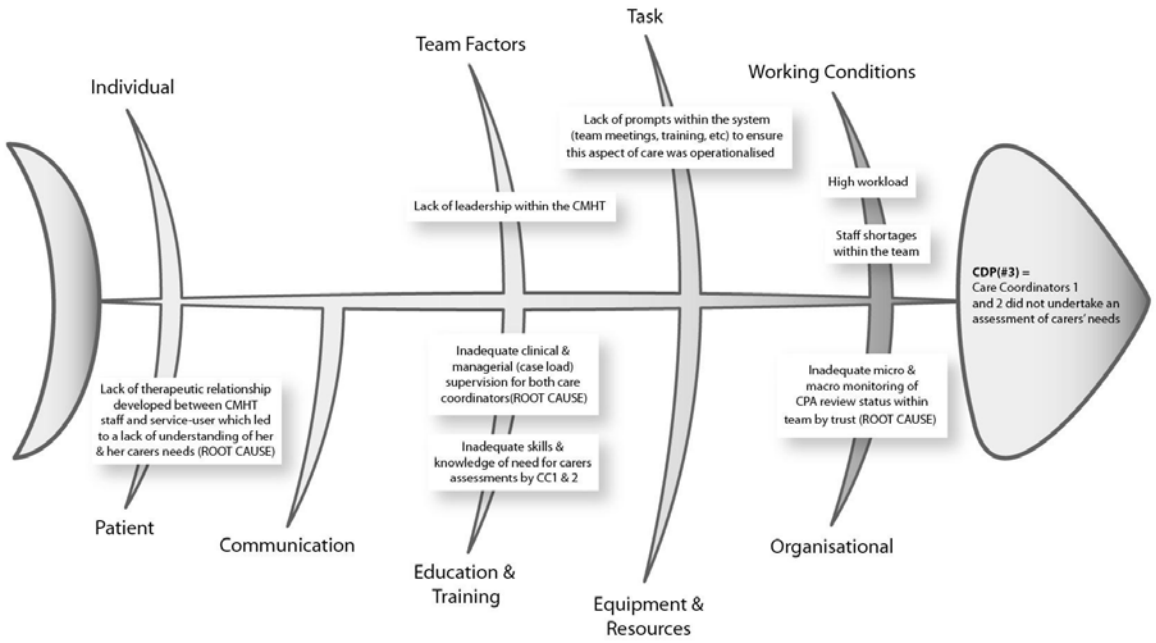
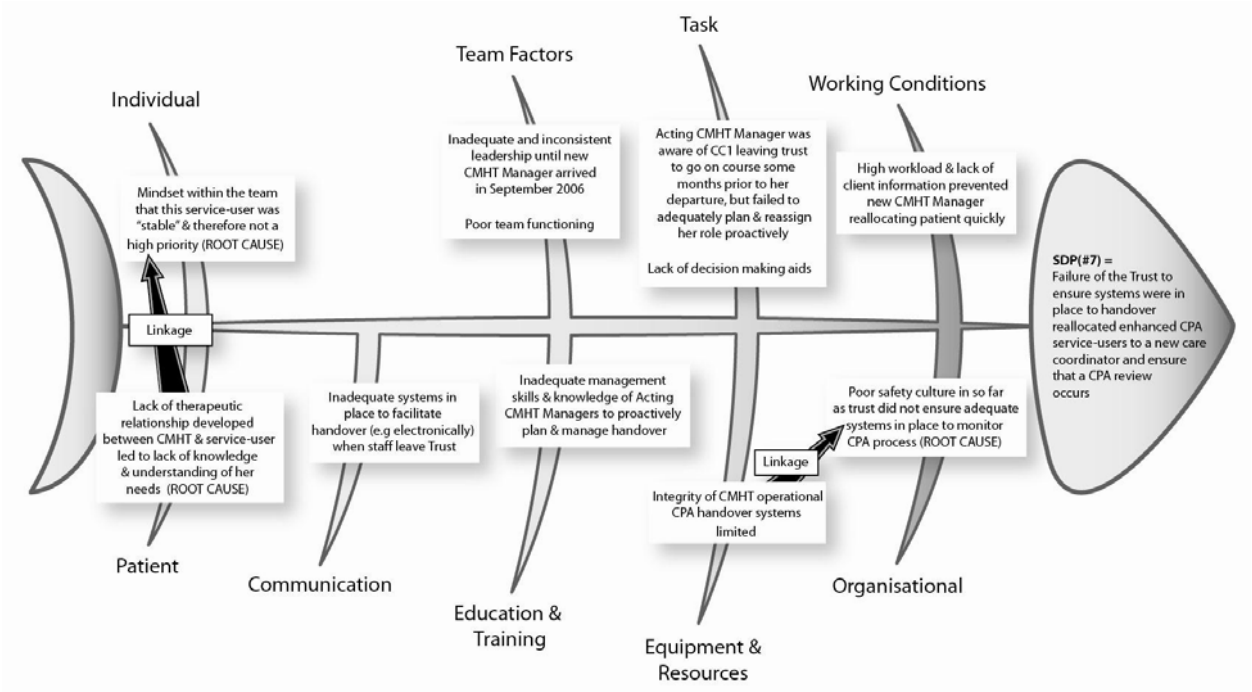
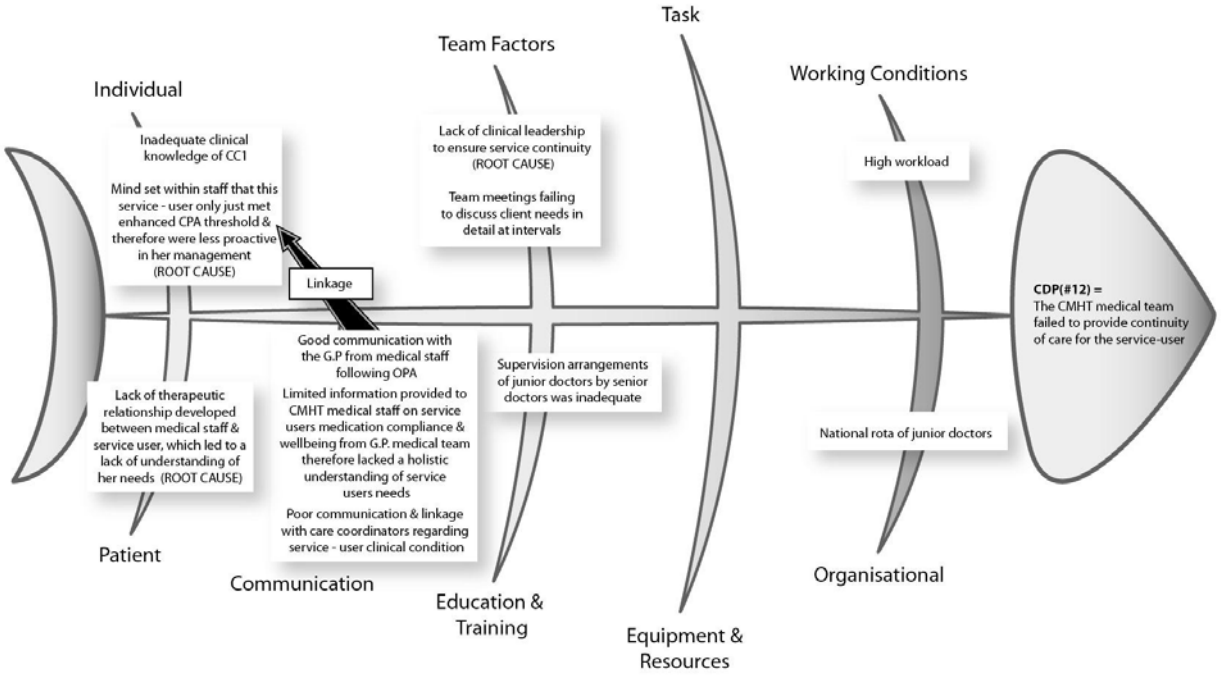


Fishbone 5



Fishbone 6



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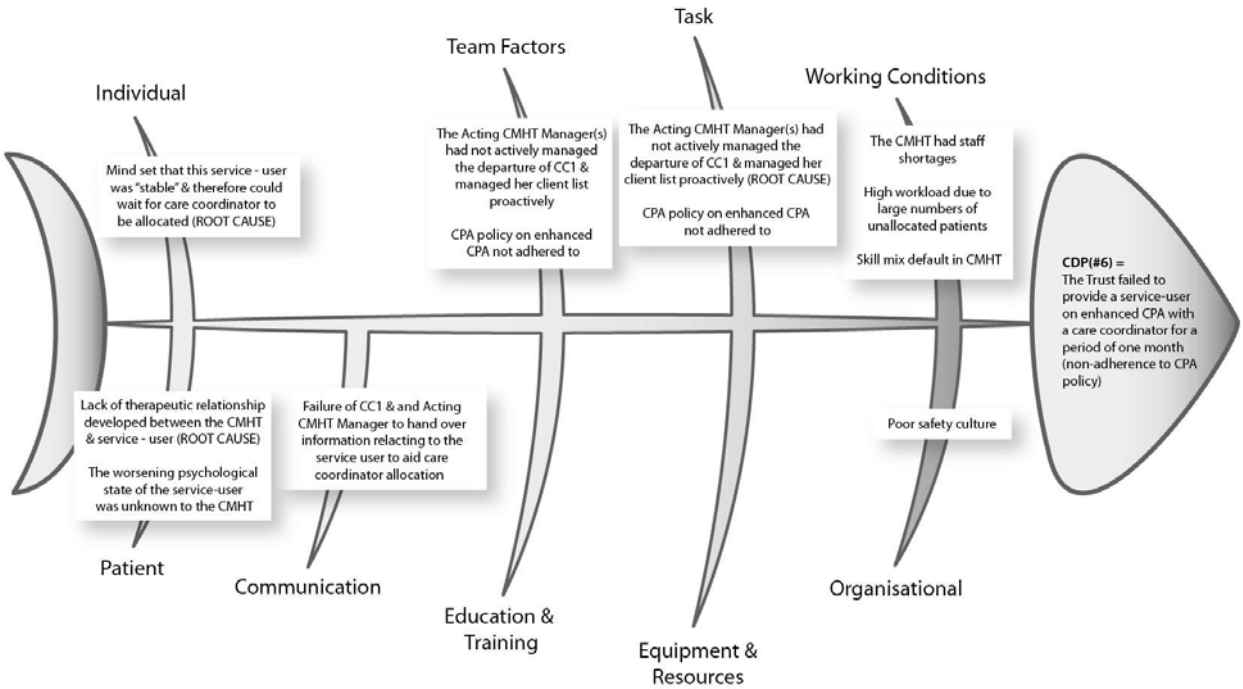

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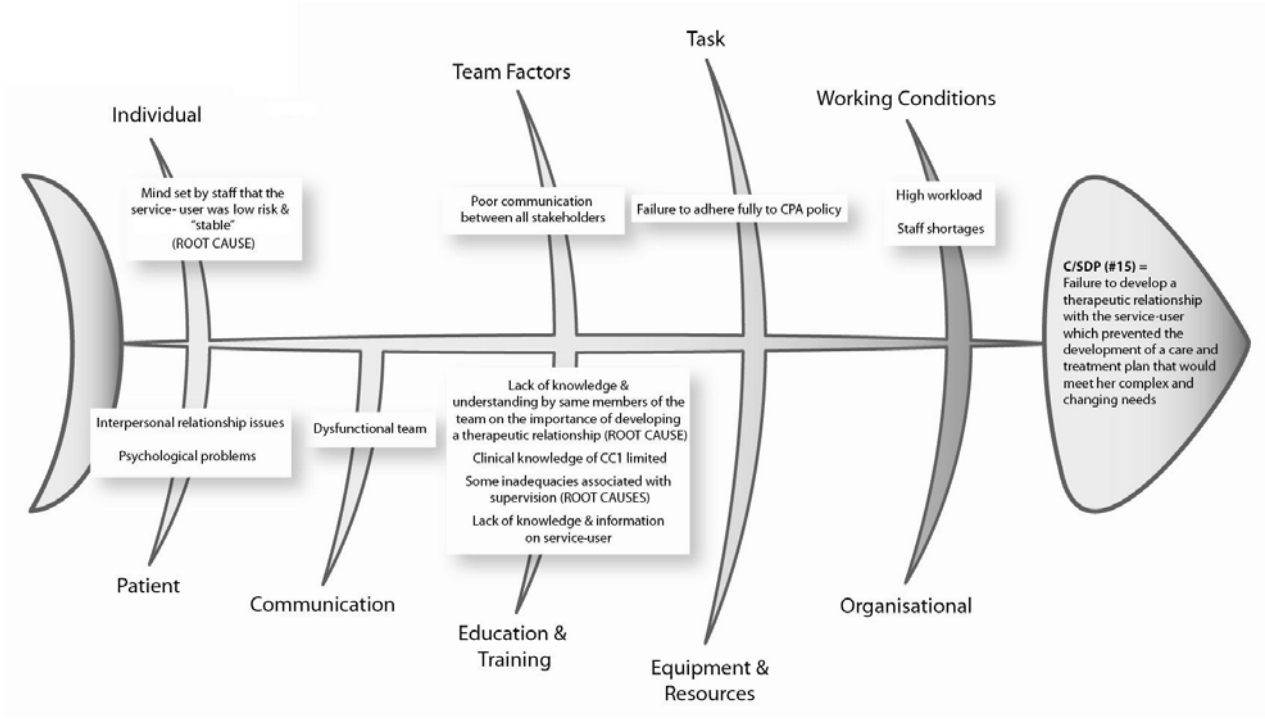

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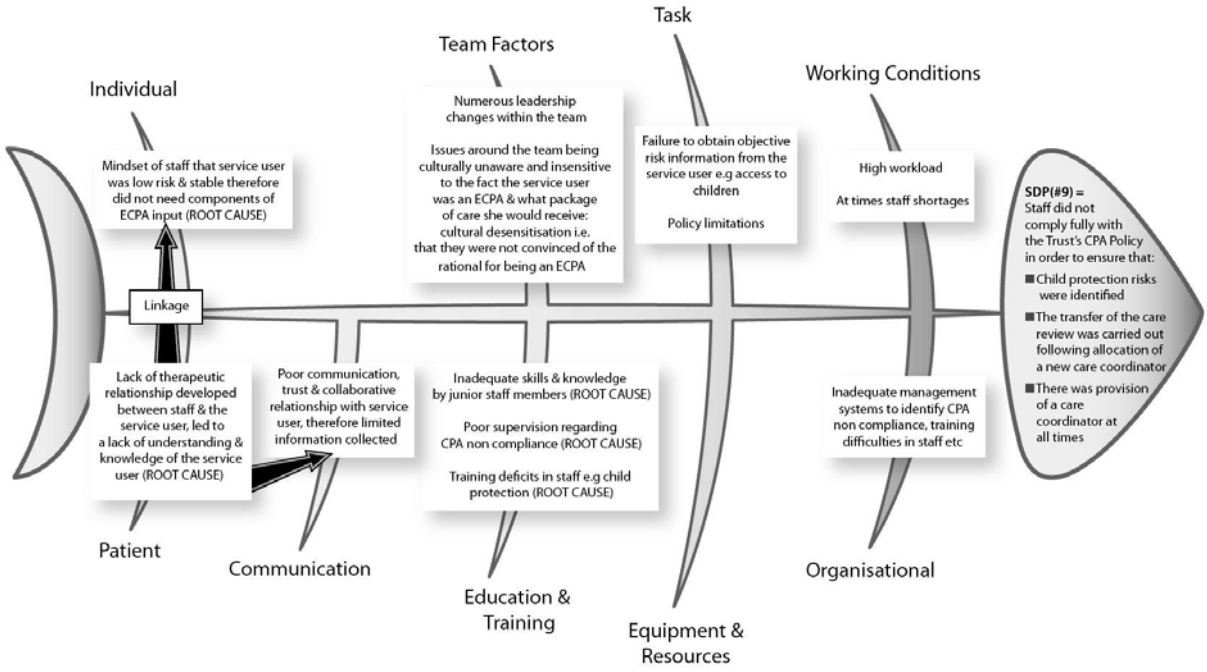

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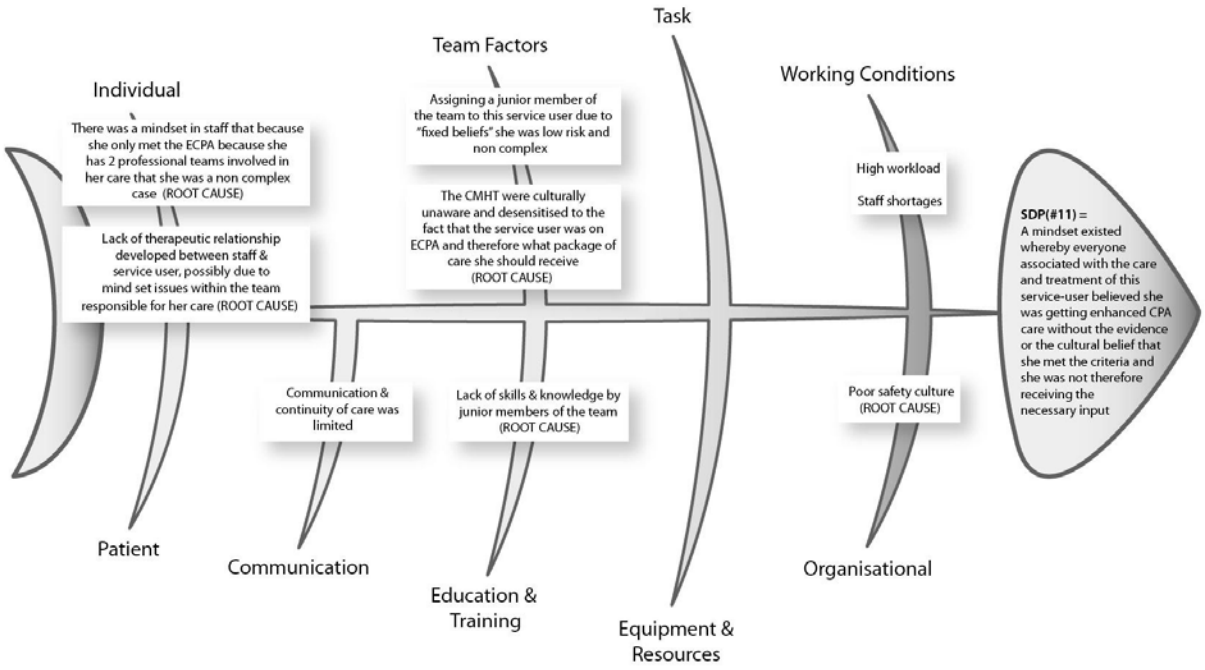

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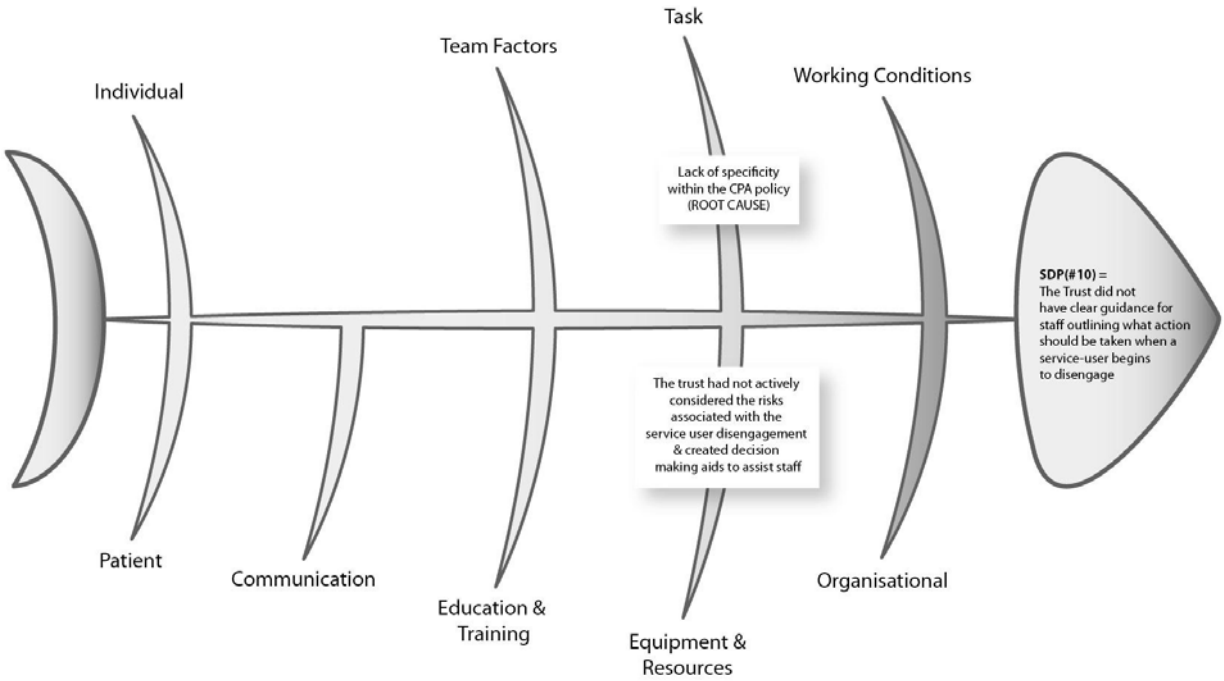

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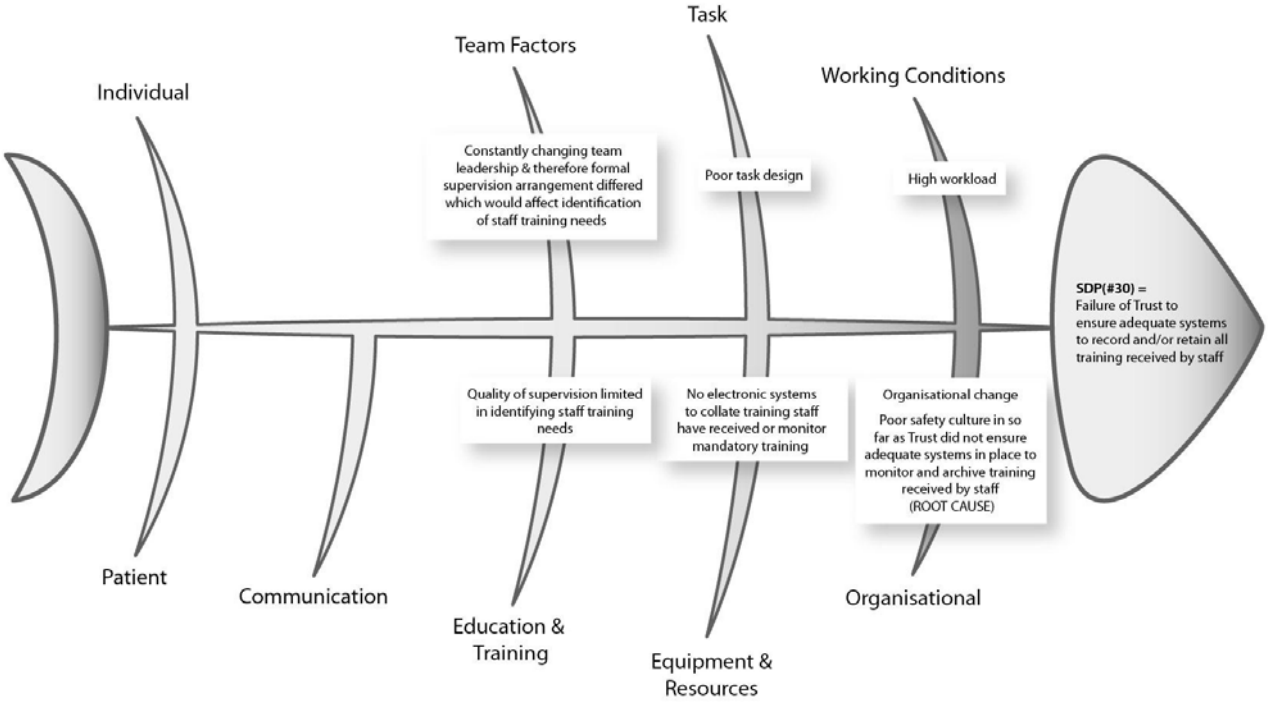

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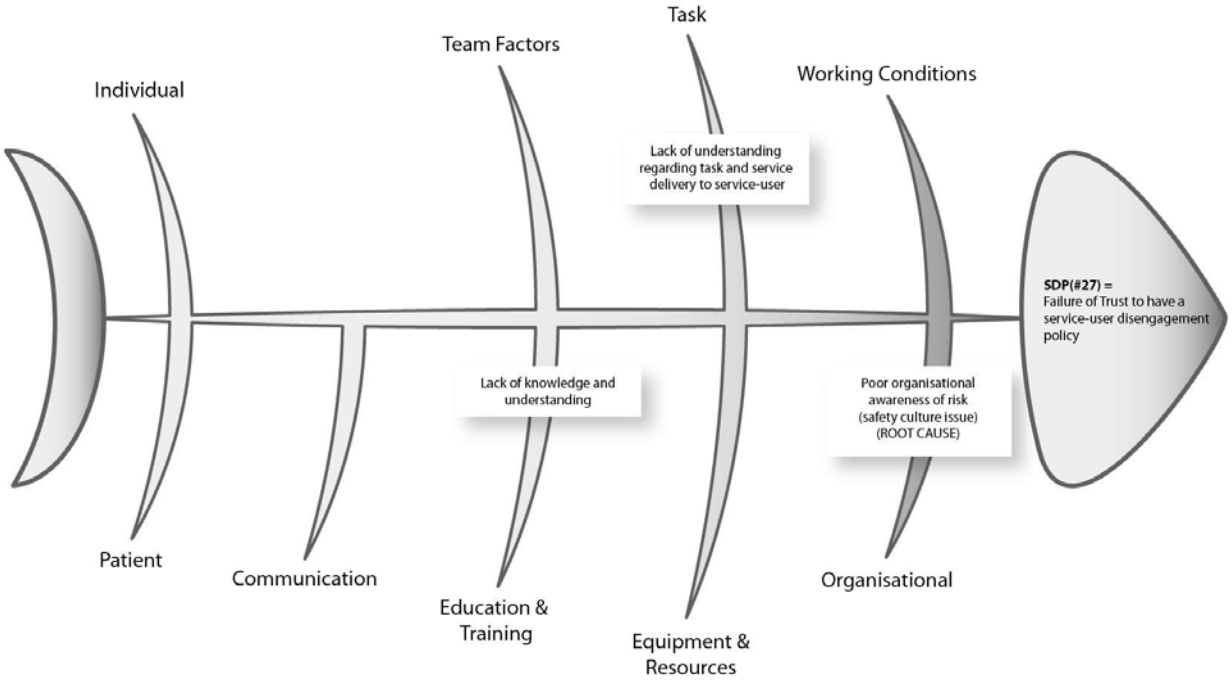
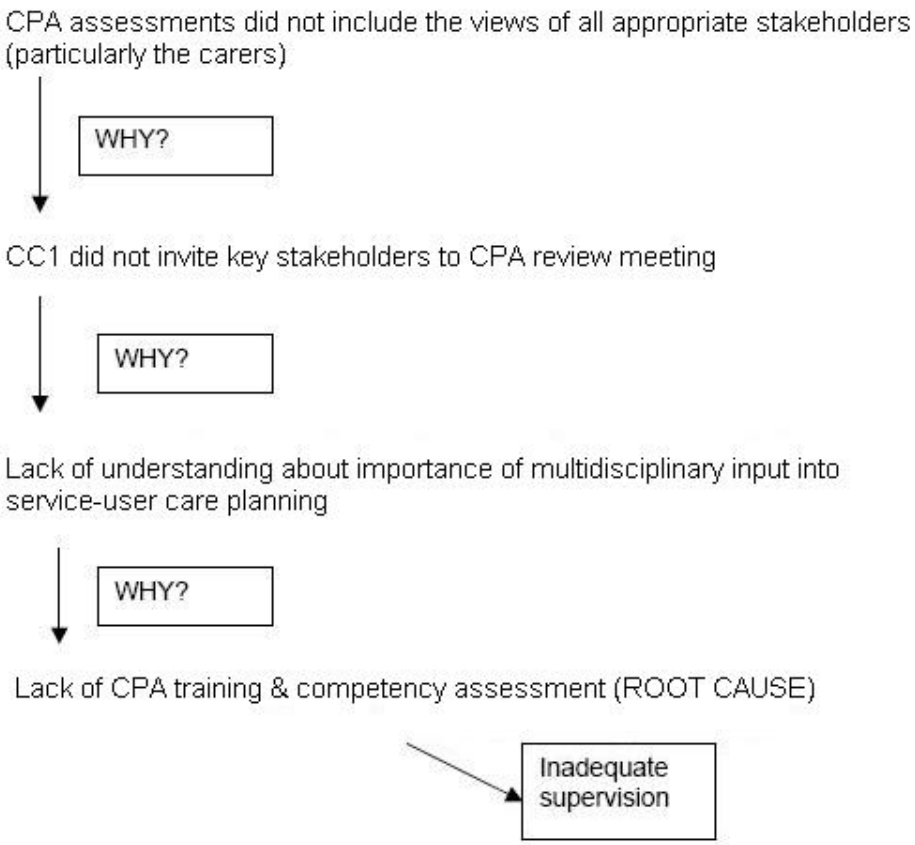
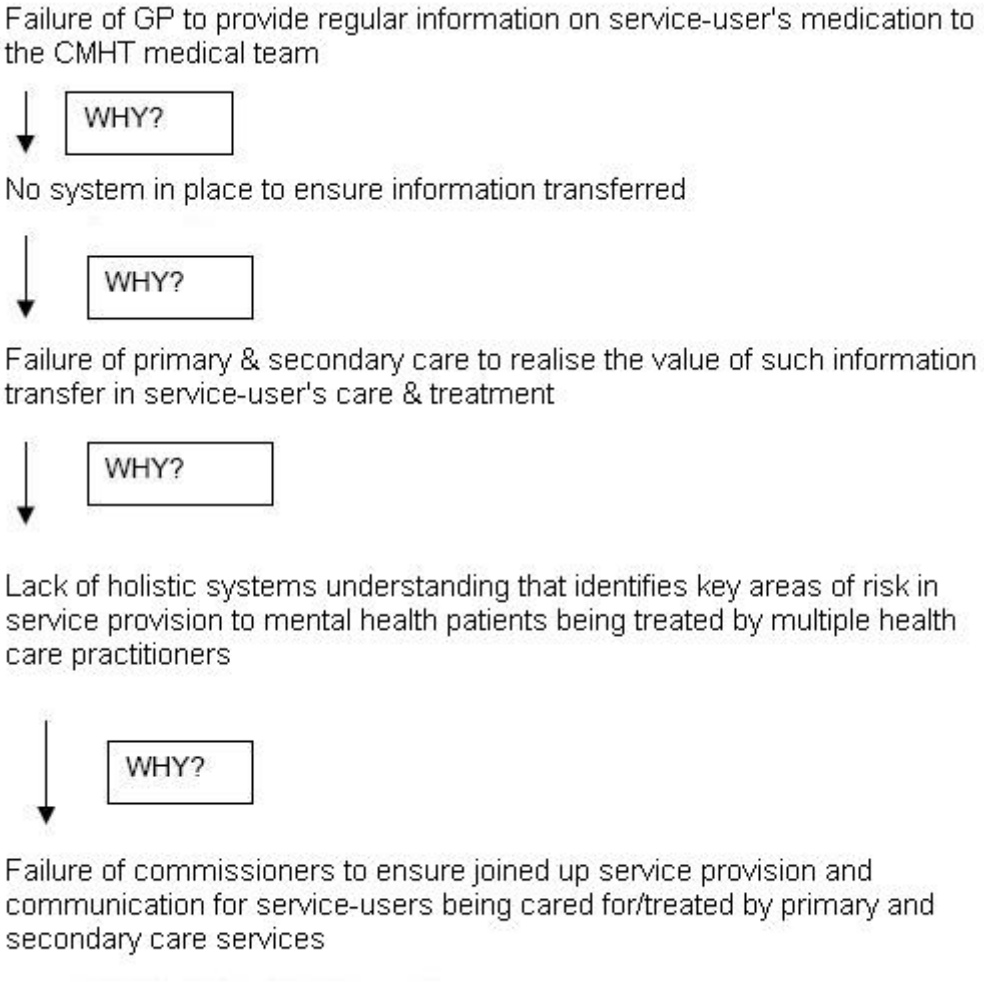


Fishbone 14

APPENDIX C – 'FIVE WHY' ANALYSIS



Five Why Diagram 1



Five Why Diagram 2

APPENDIX D - THEMATIC REVIEW TABLE

Care and service delivery problems linked to root causes and recommendations

Care/service delivery problem	Root cause(s)	Relevant fishbone / Five Why	Relevant recommendation(s)
CDP(#1) = Failure to invite appropriate stakeholders (e.g. carers, GP, housing representatives) to CPA reviews to discuss service-users CPA	• Lack of therapeutic relationship developed between CMHT staff and service-user led to a lack of understanding & knowledge of her life and needs	Fishbone 3	Recommendation 1
CDP(#2) = CPA assessments did not include the views of all appropriate stakeholders, particularly the carers	• Lack of CPA training and competency assessment • Lack of supervision	Five Why 1	Recommendations 2 & 3
CDP(#3) = Care Coordinators 1 and 2 did not undertake an assessment of carers' needs	• Lack of therapeutic relationship developed between CMHT staff and service-user led to a lack of understanding & knowledge of her life and needs as well as those of her carers • Inadequate clinical and managerial (caseload) supervision for both care coordinators	Fishbone 5	Recommendations 1 & 2
CDP(#4) = Care Coordinators 1 and 2 did not undertake a CPA review at appropriate time intervals as stated in the policy (this became due on 10 August 2006)	• Lack of therapeutic relationship developed between CMHT staff and service-user led to a lack of understanding & knowledge of her life and needs • Mindset by staff that service-user was low risk and stable • The CMHT team were culturally unaware and desensitised to the fact that the service-user was on enhanced CPA and what package of care such a client should receive	Fishbone 4	Recommendations 1, 4 & 5

SDP(#5) = Failure of the Trust to undertake regular auditing of the CPA process both in terms of quality and deadline compliance	• Poor safety culture in so far as Trust did not ensure adequate systems in place to monitor CPA processes		Addressed by the Trust
CDP(#6) = The Trust failed to provide a service-user on enhanced CPA with a care coordinator for a period of one month (non-adherence to CPA policy)	• Lack of therapeutic relationship developed between CMHT staff and service-user led to a lack of understanding & knowledge of her life and needs • Mindset by staff that service-user was low risk and stable • The Acting CMHT manager had not actively managed the departure of CC1 and managed her list proactively, possibly due to workload, not picked up by supervision	Fishbone 8	Recommendations 1, 4 & 5
SDP(#7) = Failure of the Trust to ensure systems were in place to handover reallocated enhanced CPA service-users to a new care coordinator and ensure that a CPA review occurs	• Lack of therapeutic relationship developed between CMHT staff and service-user led to a lack of understanding & knowledge of her life and needs • Mind-set by staff that service-user was low risk and stable • Poor safety culture in so far as Trust did not ensure adequate systems in place to monitor CPA process	Fishbone 6	Recommendations 1, 4 & 5
CDP(#8) = Failure of Acting CMHT Manager 1 to copy letter to GP advising that service-user was without an allocated care coordinator and what interim support was available	• Possibly due to workload, not picked up by supervision		Recommendation 2

SDP(#9) = Staff did not comply fully with the Trust's CPA Policy in order to ensure that: • Child protection risks were identified • The transfer of the care review was carried out following allocation of a new care coordinator • There was provision of a care coordinator at all times	• Lack of therapeutic relationship developed between CMHT staff and service-user led to a lack of understanding & knowledge of her life and needs • Mindset by staff that service-user was low risk and stable • Inadequate skills and knowledge by junior members of staff • Poor supervision regarding CPA non-compliance • Training deficits in staff e.g. child protection	Fishbone 10	Recommendations 1, 2, 3, 4 & 5
SDP(#10) = The Trust did not have clear guidance for staff outlining what action should be taken when a service-user begins to disengage	• Lack of specificity within the CPA policy	Fishbone 12	Addressed by Trust in latest CPA Policy
SDP(#11) = A mindset existed whereby everyone associated with the care and treatment of this service-user believed she was getting enhanced CPA care without the evidence or the cultural belief that she met the criteria and she was not therefore receiving the necessary input	• Lack of therapeutic relationship developed between CMHT staff and service-user led to a lack of understanding & knowledge of her life and needs • Mindset by staff that service-user was low risk and stable • The CMHT team were culturally unaware and desensitised to the fact that the service-user was on enhanced CPA and what package of care such a client should receive • Inadequate skills and knowledge by junior members of staff • Poor safety culture	Fishbone 11	Recommendations 1, 4 & 5

CDP(#12) = The CMHT medical team failed to provide continuity of care for the service-user	• Lack of therapeutic relationship developed between CMHT staff and service-user led to a lack of understanding & knowledge of her life and needs • Mindset by staff that service-user was low risk and stable • Lack of clinical leadership to ensure service continuity	Fishbone 7	Recommendations 1, 4 & 5
SDP(#13) = Failure of CMHT Managers to ensure balance of discussion between service-user's allocation and detailed discussion of service-users at weekly CMHT team meetings	• Mindset by staff that service-user was low risk and stable • Lack of knowledge and understanding by some members of the team on the importance of developing a therapeutic relationship • Some supervision inadequacies		Recommendations 1,2, 4 & 5
C/SDP(#14) = The Trust failed to identify the carer and therefore did not offer a carer assessment to both the service-user's mother and later her husband			Recommendation 4
C/SDP (#15) = Failure to develop a therapeutic relationship with the service-user which prevented the development of a care and treatment plan that would meet her complex and changing needs	• Some supervision inadequacies • Lack of knowledge and understanding by some members of the team on the importance of developing a therapeutic relationship • Mindset by staff that service-user was low risk and stable	Fishbone 9	Recommendations 1, 2, 4 &5
CDP (#16) = Care Coordinator 1 did not raise concerns about lack of contact with service-user with Acting CMHT Manager			

CDP (#17) = Care Coordinator 2 did not formally raise concerns about lack of contact with service-user with the CMHT Manager			
CDP (#18) = The medical team did not gather objective measures of the service-users alcohol consumption			
CDP(#19) = Care Coordinators 1 and 2 did not ensure service-user's risk assessments were up to date	• Lack of therapeutic relationship developed between CMHT staff and service-user led to a lack of understanding & knowledge of her life and needs • Mindset by staff that service-user was low risk and stable		Recommendations 1, 4 & 5
CDP(#20) = Failure of the Trust to ensure an up to date risk assessment for the service-user, which was due August 2006			
CDP(#21) = Failure to ensure objective information was used to inform risk assessment of the service-user in addition to that self-reported	• Lack of therapeutic relationship developed between CMHT staff and service-user led to a lack of understanding & knowledge of her life and needs • Mindset by staff that service-user was low risk and stable	Fishbone 2	Recommendations 1 & 4
CDP(#22) = Failure of CMHT manager to provide management supervision for care coordinator 2 between 15 October 2006 – 26 February 2007	• High workload	Fishbone 1	Recommendation 2

SDP(#23) = Failure of Trust and LA to provide a single system for record keeping to ensure timely communication between all members of the CMHT and provide a safe service	Issue now resolved via integrated electronic system		Issue addressed by the Trust
SDP(#24) = Failure of Trust to ensure all entries into clinical records are time stamped, name of member of staff printed and their designation stated			
CDP(#25) = Care Coordinator 2 did not record all unsuccessful attempts to contact the service-user in the clinical records			
CDP(#26) = Care Coordinator 2 did not record the content of her discussion with service-user's mother (04 December 2006) in the clinical record			
SDP(#27) = Failure of Trust to have a service-user disengagement policy	• Poor organisational awareness of risk (safety culture issue)	Fishbone 14	Recommendation 4
SDP(#28) = Failure of the General Practitioners to provide regular information on medication compliance to the CMHT medical team	• Failure of commissioners to ensure joined up service provision for service-users being cared for or treated by primary and secondary care	Five Why 2	Recommendation 6
SDP(#29) = Failure of the CMHT medical team to agree an approach to interacting with service-users regarding assessing the risks and benefits of medication during pregnancy			

SDP(#30) = Failure of Trust to ensure adequate systems to record and/or retain all training received by staff	• Poor safety culture in so far as Trust did not ensure adequate systems in place to monitor and archive training received by staff	Fishbone 13	Recommendation 4
SDP(#31) = Lack of investigations training for CMHT Manager at the time of the incident			Addressed by the Trust
SDP(#32) = Lack of robust, systematic, suitably independent and evidence based internal investigation report (reports 1-3)			Addressed by the Trust
SDP(#33) = Failure of the Trust to ensure that internal incident investigation reports were shared with key stakeholders			Addressed by the Trust
SDP(#34) = Lack of support for staff at time of incident and currently			Recommendation 7
SDP(#35) = The Trust failed to provide appropriate communication and support to victim and service-user's families in line with Being Open and its Adverse Incident Policy			Recommendation 8
SDP(#36) = The Trust failed to offer support to the child who possibly witnessed the later stages of this homicide			Recommendation 9

Please note for those care and service delivery problems without root causes, this is due to no fishbone or other tool being implemented.

Frequency counts of each root cause were applied to the root causes to establish those having the greatest impact on this incident, which are as follows:

1. Lack of therapeutic relationship developed between CMHT staff and service-user, which led to a lack of understanding and knowledge about her life and her needs.

   Linked to this root cause are the following root causes:

   a. Mindset by staff that service-user was low risk and “stable”.

   b. The CMHT team were culturally unaware and desensitised to the fact that the service-user was on enhanced CPA and what package of care such a client should receive.

2. Inadequate clinical and managerial (caseload) supervision for key members of staff e.g. care coordinators.

3. Inadequate skills, knowledge and provision of training to junior members of staff in key areas of service provision e.g. risk assessment, carers’ assessment, etc.

4. Inadequate local and corporate monitoring systems within Trust to provide a strong culture of safety for all staff and service-users.

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GLOSSARY

BLPT	Bedfordshire and Luton Mental Health and Social Care Partnership Trust
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
C/SDP	Care or Service Delivery Problem
DH	Department of Health
DNA	Did Not Attend [an appointment]
GP	General Practitioner
HSL	Health & Safety Laboratory
NHSLA	NHS Litigation Authority
NPSA	National Patient Safety Agency
PCT	Primary Care Trust
RCA	Root Cause Analysis
SEPT	South Essex Partnership University NHS Foundation Trust
SHA	Strategic Health Authority
SHO	Senior House Officer (*a term often still used to describe junior doctors*)
SUI	Serious Untoward Incident