



IMPROVEMENT THROUGH INVESTIGATION

## **Independent investigation into the care and treatment of Mr H**

A report for  
NHS South of England (formerly NHS South East Coast)

November 2013

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## 1. Introduction

1.1 On 25 March 2006 Mr H killed Mr K with a single stab wound to his back.

1.2 Mr H walked into a police station two days later and confessed to the murder. Police found Mr K's body in a flat in Surrey.

1.3 Mr H was sent to a secure hospital in October 2006 while on remand. He pleaded guilty to murder at the Old Bailey on 19 March 2007. He was detained indefinitely under sections 37/41<sup>1</sup> of the Mental Health Act (1983).

1.4 Mental health services had treated Mr H since 1991 and first diagnosed him with alcohol abuse, depression, suicidal ideas and blackouts.

1.5 During his contact with mental health services, Mr H's diagnosis included alcoholism, emotionally unstable personality disorder and depression.

1.6 Mr H had regular therapeutic treatment from a consultant psychiatrist and care coordinator at Surrey and Borders Partnership Trust. He occasionally took antidepressants though the consultant psychiatrist did not want Mr H to take long-term psychotropic medication because it had not previously been effective.

1.7 Mr H had regular contact with the community mental health team (CMHT) through a community psychiatric nurse, social worker, community support worker, consultant psychiatrist, support housing and a drug and alcohol team worker.

1.8 Mr H was subject to enhanced care programme approach (CPA) from 13 September 2000 until the offence. He had regular CPA meetings during his treatment by mental health services.

1.9 Mr H had a history of deliberate self-harm, mainly taking overdoses and self-laceration.

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<sup>1</sup> Section 37/41 is a court order, which can only be made by the Crown Court, that imposes a s37 hospital order together with a s41 restriction order. The restriction order is imposed to protect the public from serious harm. The restrictions affect leave of absence, transfer between hospitals, and discharge, all of which require Ministry of Justice permission.

**1.10** Mr H was physically aggressive on a number of occasions. In 1993 he punched a wall at the Abraham Cowley Unit<sup>1</sup>, breaking a bone in his hand. In 1996 Mr H was charged with criminal damage after behaving aggressively at the Abraham Cowley Unit. In 2002 he was asked to leave a service-user group because his behaviour was threatening and he caused damage.

**1.11** Mr H was not physically violent towards others before the offence. He never acted upon the occasional threats he made to staff and specific people in his community.

**1.12** Mr H was living in rented council accommodation in Englesfield Green, Surrey at the time of the offence in March 2006.

**1.13** In an interview at HMP Highdown on 19 April 2006 (after the offence) Mr H told specialist registrar 1, based in the forensic mental health service, that he had known Mr K for 25 years.

**1.14** In July 2006 the chief executive of Surrey and Borders Partnership Trust commissioned an internal investigation into the care and management of Mr H. Four trust staff and a carer representative, an independent nurse director and a manager from Surrey County Council carried out the investigation. The internal investigation panel did not meet Mr H, his family or the victim's family.

**1.15** The internal investigation panel completed its report in November 2006 and made 16 recommendations, mostly about managerial and operational matters. The panel did not share its findings with Mr H, his family or the victim's family.

**1.16** In June 2011 NHS South East Coast, the responsible strategic health authority, commissioned Verita to carry out this independent investigation into the care and treatment of Mr H.

**1.17** Amber Sargent, senior investigator for Verita carried out the investigation supported by Ed Marsden, managing partner.

**1.18** Barry Morris, partner, peer-reviewed this report.

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<sup>1</sup> A specialist mental health unit based at St Peter's Hospital in Chertsey, providing treatment and support to inpatients. It is run by Surrey and Borders Partnership NHS Foundation Trust.

## 2. Terms of reference

2.1 This independent investigation is commissioned by NHS South East Coast with the full cooperation of Surrey and Borders Partnership NHS Trust (the trust). It is commissioned in accordance with guidance published by the department of health in HSG 94(27) *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-6 issued in June 2005. It also takes into account the good practice guidance issued by the National Patient Safety Agency in February 2008.

2.2 The investigation will provide independent scrutiny of the care and treatment of Mr H largely by means of a documentary review. The investigation will be conducted by a single investigator, supported by a peer reviewer. The work will be conducted in private and take as its starting point the trust's internal investigation.

2.3 The documentary review will examine the following:

- the extent to which care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies, in particular:
  - the adequacy of any risk assessments and risk management plans carried out for Mr H, specifically any relating to his long forensic history and the potential for him to harm others
  - any relevant gaps or issues found which were not investigated as part of the internal investigation in relation to the care and treatment provided to Mr H, from his last episode of care with services to the time of the offence on 25 March 2006
  - the care programme approach and how it was carried out in relation to Mr H's care and trust policy;
  - the progress made against the recommendations from the trust's internal investigation

- any new developments or improvements in services since Mr H's engagement with mental health services.

**2.4** A report will be written for NHS South East Coast that includes:

- a general overview of the care and treatment of Mr H from his first contact with services. This will be followed by a detailed chronology of events of the last episode of care leading up to the offence
- an analysis highlighting any missed opportunities and findings based on the evidence received
- any areas of notable good practice, new developments or improvements put in place since this incident which are relevant to this case
- measurable, achievable recommendations for action to address the learning points to improve systems and services.

### **3. Executive summary and lessons to be learnt**

**3.1** Mr H killed Mr K with a single stab wound to his back on 25 March 2006. Mr H walked into a police station two days later and confessed to the murder. Police found Mr K's body in a flat in Surrey.

**3.2** Mr H had been known to mental health services since 1991. He was under the care of a consultant psychiatrist and a care coordinator at the time of the offence.

**3.3** In July 2006 the chief executive of Surrey and Borders Partnership NHS Trust commissioned an internal investigation into the circumstances leading up to the incident on 25 March 2006. The scope of the review was limited because it was undertaken during the criminal proceedings, but it still contained helpful insights into the care and treatment of Mr H.

**3.4** The internal investigation team found that the incident would probably not have been prevented by the actions or omissions of the team and services responsible for Mr H's care and treatment.

**3.5** The internal investigation report made 16 recommendations about managerial and operational matters. The trust wrote an action plan to address the recommendations and supplied evidence to show all actions were completion.

**3.6** In June 2011 NHS South East Coast, the responsible strategic health authority, commissioned Verita to carry out this independent investigation into the care and treatment of Mr H.

#### **Care and treatment**

**3.7** Mental health services had known of Mr H since 1991. His diagnoses between then and the incident in 2006 included alcoholism, emotionally unstable personality disorder and depression. He often saw the community mental health team (CMHT), crisis team and had some inpatient episodes at the Abraham Cowley Unit between 1991 and 2006. The consultant psychiatrist and the care coordinator regularly reviewed Mr H in the last four years of his engagement with trust services.

**3.8** Mr H did not have a long-term management plan despite his long engagement with trust services and regular CPA reviews. Trust staff did not think he was ready to be referred to Henderson Hospital<sup>1</sup> because of his heavy drinking. There was no plan to prepare him for referral.

**3.9** There was a plan for Mr H to be referred to a clinical psychologist, for one-on-one psychological sessions to explore personality disorder issues. This was good practice and a good example of the benefits of multidisciplinary attendance at CPA review meetings. However, Mr H was never referred to the clinical psychologist.

**3.10** CPA meetings were held regularly. They were well attended and provided a good forum for Mr H's risk, care planning and treatment to be regularly reviewed by the clinical team. Risk indicators for deterioration were identified during these meetings, yet no one intervened when Mr H's behaviour showed his mental health was deteriorating.

**3.11** Mr H's risk was regularly reviewed but was not the subject of a risk management plan to provide clear advice about what to do if his risk escalated or if he displayed signs of behaviour associated with deteriorating mental health.

**3.12** Trust services recognised in 1991 that Mr H needed help to manage his drinking. Staff responsible for Mr H's care and treatment also recognised that his drinking had a direct impact on his mental health. Trust services tried to engage Mr H with alcohol services early in his care and treatment. This included a referral to a detoxification unit.

**3.13** A nurse specialist from the Windmill drug and alcohol service reviewed Mr H seven times between 23 May 2002 and 12 March 2003. No one from the alcohol team saw him between 12 March 2003 and the offence in March 2006, despite plans to refer him to the alcohol service. Alcohol was a constant feature in Mr H's deteriorating mental health. His clinical records do not make clear if any attempts were made to engage Mr H with alcohol services during these three years.

**3.14** Mr H attended accident and emergency (A&E) departments of acute hospitals many times - 17 in one year. He occasionally stayed at the Abraham Cowley Unit for short

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<sup>1</sup> The Henderson Hospital was a residential therapeutic community and outreach service which offered treatment to up to 29 people aged between 18-60 who had been diagnosed with personality disorder. It was run by South West London & St George's Mental Health NHS Trust. This service is no longer available.

periods. Mr H did not spend more than four continuous days as an inpatient. Trust staff often saw his inpatient episodes as a cooling-off period after a suicide attempt, rather than as an opportunity to reassess his care and treatment needs.

**3.15** Mr H had a long history of self-harming and he often drank heavily after brief periods of stability or abstinence. On these occasions it was likely that his mental health would deteriorate and he would require input from mental health services. It might have been possible to manage Mr H better in the community if these triggers had been acted upon sooner. Instead, he deteriorated to the point where he felt the need to go to A&E and on some occasions needed an inpatient admission.

**3.16** There were occasions when Mr H was clearly not coping in the community, even with the support of the care coordinator and consultant psychiatrist. This meant that he continually went in and out of inpatient services. A longer-term view of his treatment needs might have helped staff to understand and manage him better.

**3.17** Agencies sometimes shared information appropriately but on occasion they could have worked together better to provide a more holistic approach to Mr H's care and treatment, particularly when he was in the community.

**3.18** Mr H was difficult to engage when his mental health deteriorated, but when he did engage, trust staff could have formulated a long-term care management plan, including long-term management of his personality disorder.

### **The trust internal investigation**

**3.19** Five managerial and clinical trust staff, a carer representative and an external nurse director carried out the investigation in July 2006. The internal investigation panel did not meet Mr H or the victim's family.

**3.20** The scope of the review was limited because it was undertaken during the criminal proceedings, but it still contained helpful insights into the care and treatment of Mr H.

**3.21** The review found deficiencies in risk management planning, multi-disciplinary team working and staff training. However, the review team concluded that the incident

itself would probably not have been prevented by the actions or omissions of the team and services involved in Mr H's care and treatment.

**3.22** The internal review report was presented to Surrey and Borders Partnership Trust Board in November 2006 and made 16 recommendations about managerial and operational matters. The panel did not share its findings with Mr H, his family or the victim's family.

**3.23** The trust wrote an action plan to address the 16 recommendations and supplied evidence to show all actions had been completed.

## **Lessons**

**3.24** We chose to make no recommendations in this case for the following reasons: the incident took place in 2006, the trust's internal action plans were comprehensive and the trust provided evidence to show it had changed its practices. Instead we have identified seven areas in which the trust should continue to improve and evaluate practice.

**L1** The trust should continue to ensure, through personal development plans and supervision, that all staff in direct contact with patients receive training in the assessment, planning and management of risk. The trust should ensure that staff receive risk assessment training and are declared competent before conducting any risk assessments. The clinical governance team should audit training records at least every three months. The team should then report its findings to the trust board at appropriate times, as defined by the trust's governance processes.

**L2** The trust should ensure that the process for the Care Programme Approach (including care planning, risk assessment, risk management planning) is robust. The clinical governance team should audit compliance at least every six months and report its findings to the board.

**L3** The trust should ensure that all staff adhere to its policy and procedure for managing formal and informal service users' non-compliance with treatment and managing DNA (did not attend) or cancelled appointments.

**L4** The trust should ensure that staff have received training in its latest adult protection policy. The trust should monitor compliance through a regular audit programme.

**L5** The trust should continue to develop relationships with partnership agencies. This should include reviewing the protocols with partnership agencies to ensure effective communication and information sharing. This should take place within the next three months.

**L6** The trust should assure itself that appropriate arrangements are in place to ensure a service user's CPA requirements are fulfilled in a team member's absence.

**L7** The trust should continue to encourage risk panel meetings. Cases where there is significant uncertainty about an individual patient's diagnosis and/or treatment plan should automatically be discussed in an appropriate forum with other clinical colleagues. This will assist in developing an appropriate care and risk management plan.

## 4. Approach and structure

### Approach to the investigation

4.1 This investigation was undertaken in private. It comprised a review of documents related to Mr H's care and an interview with the medical director, the deputy medical director and the director of quality and performance about the progress made against the recommendations made in the internal report. We did not interview staff directly involved in Mr H's care and treatment because Mr H's records were comprehensive and we considered the internal review report and supporting papers to be of a good standard.

4.2 We had full access to the trust's papers produced at the time of the internal review. The trust prepared an up-to-date evidenced action plan that included the original recommendations and the supporting paperwork, e.g. a policy document to show what had changed in the intervening years.

4.3 We met Mr H at the start of the investigation at the medium secure hospital, where he is detained under the Mental Health Act 1983. We explained the nature of our work but did not interview him. We did not think he would be able to recall details because of his poor health and the time since his treatment by trust services. We agreed with Mr H's responsible medical officer (RMO) that we would send a list of questions for Mr H to work through with his primary nurse. We used his responses to these questions to help inform our report.

4.4 Mr H gave written consent to our access to his medical and other records for the investigation. We told him that the SHA were likely to publish the report in some form. Mr H was given the opportunity to comment on this report before it was finalised.

4.5 The terms of reference specified that this investigation should be a documentary review with interviews with senior trust managers to assess only the progress of implementing recommendations from the internal report. We have not met with the victim's families. Mr H has no relatives with whom he is in contact.

4.6 Within the main body of the report our findings from interviews and documents are in ordinary text and our comments and opinions are in ***bold italics***. This does not apply in section 6 as this analysis section largely consists of comment and opinion.

## **Structure of this report**

**4.7** Section 5 sets out the details of the care and treatment of Mr H. The terms of reference state that the investigation will focus on Mr H's last episode of care before committing the offence in March 2006. We include a brief chronology of his care in order to provide the context in which he was known to trust services. His last episode of care was from February 2005 until the offence in March 2006. This is because he was never discharged from mental health services and had regular contact with trust services between February 2005 and the incident in March 2006.

**4.8** Section 6 examines in greater detail the themes arising from Mr H's care and treatment.

**4.9** Section 7 reviews the trust's own internal review and reports on its progress in addressing the organisational matters the review identified.

**4.10** Section 8 sets out our overall analysis and learning points.

## **5. The care and treatment of Mr H**

### **Family background**

**5.1** Mr H was born and raised in Egham, Surrey. In his early years he lived with his mother, father and sister. Mr H had an unhappy childhood. His father was an alcoholic who physically abused his mother.

**5.2** Mr H was bullied at secondary school and subsequently played truant. He left school at 15, by which time he was already drinking alcohol. At 17, Mr H left home with his mother. They moved to Addlestone where they lived until his mother died in 1991, when Mr H was 36. At the time of the offence Mr H had not spoken to his father or sister for many years.

**5.3** Mr H spent many years in charge of machinery for engineering firms. This responsibility caused him stress and became too much for him to cope with. He became unreliable at work once he started to drink heavily. Mr H stopped working when he was 40 because of excessive alcohol use and deteriorating mental health.

### **1991 to 1995: first contact with mental health services**

**5.4** Mr H was first referred to mental health services in 1991. The referral from his GP said he was suffering from alcohol abuse, depression, suicidal ideas and blackouts. This initial contact was followed by several admissions to the inpatient and day service at the Abraham Cowley Unit for depression and detoxification.

**5.5** Mr H was assessed as an inpatient under Section 3<sup>1</sup> of the Mental Health Act in 1993. He acknowledged that his drinking was causing his difficulties and he agreed to stay in hospital. He stayed in contact with his care coordinator through home visits and phone conversations after he was discharged.

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<sup>1</sup> Section 3 of the Mental Health Act is a treatment order and allows compulsory admission for treatment, for duration of up to 6 months, although this can be extended.

## **1996 to 2001: community support and inpatient episodes**

**5.6** Mr H went to the A&E department of acute hospitals several times during this period after overdosing on paracetamol and other medication.

**5.7** Mr H was treated with electroconvulsive therapy (ECT) at the Abraham Cowley Unit while he was an inpatient.

**5.8** Mr H had several referrals to the drug and alcohol service during this time although he was not considered suitable for the six-week programme or one-to-one counselling.

**5.9** Mr H sometimes left the ward to drink and behaved violently when he returned, causing significant damage. He was charged with criminal damage after one such incident.

**5.10** Mr H moved from Runnymede to Woking in August 1997. He returned to Runnymede in 1999.

**5.11** A CPA meeting was held on 13 September 2000 and Mr H's identified problems included long-term alcohol abuse and a history of overdosing and self-harming.

### *Comment*

***Mr H's clinical records did not say whether the CPA meeting on 13 September 2000 was the first time Mr H was assessed and managed under CPA arrangements.***

**5.12** Runnymede CMHT recorded concerns about Mr H's mental state during this period because he had threatened to stand in the middle of the road. The CMHT worker visited Mr H at home and found him drunk, making it difficult to complete a comprehensive assessment.

**5.13** Mr H was diagnosed with depression, self-harm and alcoholism. He was treated with anti-depressants and received support from the drug and alcohol team. Despite this, a summary of risk assessment during this period recorded that Mr H was at low risk of

harm in all categories; suicide, deliberate self-harm, neglect, violence towards others, risk to children, abuse by others and risk to property.

## **2 January 2002 to 27 February 2003: community support**

**5.14** Mr H maintained regular contact with his care coordinator during this period. He also had several inpatient admissions and was assessed under section 136<sup>1</sup> of the Mental Health Act. He stayed in hospital voluntarily.

**5.15** Social worker 1 wrote to Mr H on 18 January 2002 to tell him he was no longer allowed to attend a support group at the Addlestone Community Centre because of his recent anti-social behaviour, which had caused staff serious concern. He had broken group rules by being drunk during sessions and asking other members for money.

**5.16** The ward manager at Windmill House<sup>2</sup>, wrote to Mr H on 15 March 2002 to tell him he had reached the top of the waiting list for admission for detoxification. His expected date of admission was 19 March 2002. We found no documentation to suggest that he accepted the place nor how this referral came about.

**5.17** The consultant psychiatrist and the nurse specialist from the Windmill Drug and Alcohol Team, reviewed Mr H on 23 May and 26 June 2002.

**5.18** Mr H told police during this period that he had been raped. He could not recall by whom, when or where.

**5.19** An enhanced CPA meeting took place on 29 August 2002. Mr H, the consultant psychiatrist, the care coordinator, a housing worker and the nurse specialist from the Windmill Drug and Alcohol Team attended the meeting. Mr H said he wanted help with his housing because he was felt vulnerable in his home. He also wanted help controlling his drinking and help with depression. He said he felt he was sometimes a physical threat to others. He reported a series of violent incidents, against person and property, but there is no record of the extent of the violence or of his involvement in violent incidents. Signs

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<sup>1</sup> Part of the Mental Health Act 1983 (section 136) details removing a mentally ill person from a public place to a place of safety. It details police powers and the rights of someone in this position.

<sup>2</sup> Windmill House is a 12-bedded inpatient detoxification and stabilisation, residential rehabilitation or residential crisis intervention unit.

that might indicate a relapse were recorded as increased alcohol and drug intake, increased reports of violence in the community and presenting at his GP or A&E after self-harming.

**5.20** The consultant psychiatrist and the nurse specialist from the Windmill Drug and Alcohol Team reviewed Mr H on 11 September and 9 October 2002. He was recorded as drinking a bottle of cider and up to 10 cans of lager a day. He had reduced his cannabis use to chewing an eighth of an ounce a month. Mr H was not taking prescribed medication.

**5.21** Woking Police Vulnerable Person Unit, a representative from Surrey Community Development Trust<sup>1</sup>, a member of the outreach team and the care coordinator met to discuss Mr H's rape allegations on 15 November 2002. They noted that Mr H was at risk of:

- deterioration of health due alcohol and drugs
- financial abuse and unwarranted demands for money
- physical abuse by others.

**5.22** The consultant psychiatrist and the nurse specialist from the Windmill Drug and Alcohol Team reviewed Mr H on 22 January 2003. The consultant psychiatrist noted in a subsequent letter to Mr H's GP on 29 January 2003 that Mr H claimed to be drinking less and said he had not taken drugs recently.

#### *Comment*

***Mr H made a rape allegation during this period. This should have triggered management in line with the trust's vulnerable adult policy. This point is discussed further in section 6.***

***The CPA meeting on 29 August 2002 noted Mr H's increased drinking, reports of violence and self-harm, all of which had previously been noted as signs that Mr H's mental health may be deteriorating. The team was to be told if any of these features of relapse were identified. Mr H said he was drinking heavily in October***

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<sup>1</sup> Surrey Community Development Trust provides accommodation and support services to vulnerable people across Surrey, Sutton and Wokingham. They are a registered charity and housing association.

*2002, but staff did not see this as a sign of relapse, even though his CPA documentation had warned it might be.*

*Mr H said he was drinking less by January 2003. This was a positive step. However, we found no evidence of a long-term plan to support him with continued abstinence/reduction in alcohol use.*

#### **28 February 2003 to 3 March 2003: inpatient episode**

**5.23** Mr H phoned emergency services on 28 February 2003 saying he was going to kill himself and harm others. He ran off when paramedics tried to take him home. Police later stopped him. He was taken to the Abraham Cowley Unit on a section 136 and was admitted to Laureate Ward<sup>1</sup>. He was discharged on 3 March and a discharge summary was sent to his GP on 10 March 2003 detailing the plan for follow-up in the community. This included a referral to the drug and alcohol team and he was to continue with regular reviews with the consultant psychiatrist.

#### **12 March 2003 to 31 January 2005: community support**

**5.24** The consultant psychiatrist and the nurse specialist from the Windmill Drug and Alcohol Team saw Mr H at a scheduled outpatient appointment on 12 March 2003. After this, the consultant psychiatrist wrote to Mr H's GP to say that Mr H had not been drinking since his brief inpatient admission two weeks before. Mr H also denied taking drugs. The plan was for the consultant psychiatrist and the nurse specialist from the Windmill Drug and Alcohol Team to review Mr H again in four weeks, to "*continue our regular supportive intervention to him*" and for the consultant psychiatrist to liaise with the care coordinator.

**5.25** Mr H, the consultant psychiatrist, the care coordinator and a member of the outreach team attended a CPA meeting on 16 July 2003. They recorded that Mr H needed new accommodation because he felt vulnerable at his current address. They also noted that he was depressed and needed help socialising and drinking less. They recorded his

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<sup>1</sup> Psychiatric Intensive Care Unit with seven beds serving Surrey Heath and North East Hampshire.

medication as stelazine<sup>1</sup> 10mg oral, nightly. Relapse signs were noted as increased alcohol intake and lack of engagement with mental health services.

**5.26** Mr H, the care coordinator, the consultant psychiatrist and a representative from Surrey Community Development Trust attended a further CPA meeting on 3 March 2004. They noted that Mr H wanted to move house because he was being intimidated in his community. They recorded that the warning signs suggesting possible relapse were Mr H presenting as aggressive or difficult to contact.

**5.27** The consultant psychiatrist reviewed Mr H on 28 October 2004. Mr H felt that his mood had been deteriorating over the previous two weeks and said he had been having sado-masochistic thoughts again. The consultant psychiatrist found no other symptoms of major depressive disorder and Mr H was not considered to be psychotic. He had not harmed himself recently. His alcohol intake was generally controlled but with occasional binge drinking. The consultant psychiatrist advised Mr H to continue without regular psychotropic medication.

**5.28** Mr H, the care coordinator and the consultant psychiatrist attended a CPA meeting on 15 December 2004. The care coordinator completed a risk indicator, CPA screening document and a comprehensive risk assessment form. The care coordinator recorded that Mr H was at medium risk of self-harm and self-neglect. The care coordinator also assessed Mr H as posing a medium, non-immediate risk of harm to others. The plan was to review his CPA documentation in six months. The consultant psychiatrist and Mr H were to meet at clinical reviews every two months and the care coordinator was to see Mr H fortnightly.

#### *Comment*

***Trust staff recognised that Mr H's increased drinking may be a sign that his mental health was deteriorating but they took no action.***

***On 15 December 2004 the consultant psychiatrist and the care coordinator recognised that Mr H was a medium risk of harm to others. We found no documentary evidence to explain why his risk had escalated from low to medium, nor evidence***

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<sup>1</sup> Stelazine is an antipsychotic drug

*that staff formulated or amended a risk management plan to reflect this increased risk.*

#### **February 2005 to December 2005: community support and A&E presentations**

**5.29** Mr H phoned the crisis team four times on the evening of 8 February 2005. He phoned again on 14 February and in late February and again on 2 March 2005. The crisis team took no action on these occasions other than arranging for Mr H's appointment with the consultant psychiatrist to be brought forward.

**5.30** The consultant psychiatrist reviewed Mr H in his clinic on 16 February 2005. The consultant psychiatrist then wrote to Mr H's GP on 18 February 2005 telling him that he had seen Mr H for a brought-forward appointment because he kept contacting the crisis team. Mr H complained of being intimidated and harassed in his home and was planning to move into private rented accommodation. Mr H was taking diazepam 10mgs once a day, buspirone 10mgs twice a day and mirtazapine 30mgs at night. The consultant psychiatrist recommended that Mr H continue with his current medication but considered that he was unlikely to benefit from longer-term psychotropic medication, because he had not done so before.

**5.31** The consultant psychiatrist reviewed Mr H in his outpatient clinic on 23 February 2005. He then wrote to Mr H's GP on 1 March 2005. The letter said that Mr H was under significant stress because he was being harassed and victimised in his home and threatened to take the law into his own hands if it continued. He was angry during the interview and felt that services had let him down. The consultant psychiatrist noted that Mr H had cut himself on several occasions over the previous week and he was drinking up to two bottles of cider a day. The consultant psychiatrist advised Mr H to continue without any regular psychotropic medication and arranged to see him again in clinic in three weeks' time.

**5.32** Mr H went to A&E on 28 February 2005, though we could find no further detail relating to this in Mr H's clinical records.

*Comment*

***By 23 February 2003 Mr H was drinking heavily again and behaving in a threatening way. The consultant psychiatrist and the care coordinator had identified these two factors and recorded them on Mr H's CPA documentation as warning signs that his mental health may be deteriorating. Despite these warning signs, trust staff took no action and planned to review Mr H in three weeks. Five days later he went in crisis to the A&E department of a hospital.***

***Mr H threatened to "take the law into his own hands", but we found no documentary evidence that his risk of harm to others was reviewed. Neither was a risk management plan formulated or amended to reflect these threats.***

**5.33** On 11 March 2005 Mr H told a worker at the Friday group he attended that he was afraid he might hurt himself or others because he was feeling upset and angry about being refused a care grant. The Friday Group worker told an approved social worker of the discussion with Mr H and arranged an appointment for him. Mr H was told to contact the crisis team over the weekend if his mood deteriorated.

**5.34** Social worker 2 recorded on 15 March 2005 that the consultant psychiatrist had said that staff, especially female staff, should not see Mr H alone at his home because he had the potential to become angry and hostile. The consultant psychiatrist was also worried about the things Mr H discussed with social worker 2, including relationships, money spent on chat lines and having sex in hospital. The consultant psychiatrist agreed to offer Mr H additional support.

*Comment*

***The discussion between the consultant psychiatrist and social worker 2 on 15 March 2005 after social worker 2's visit to Mr H at his home indicates that they considered the risk of harm Mr H posed to others. They decided that staff were not to visit Mr H at home by themselves. However, we found no documentary evidence to suggest that following this decision, Mr H's risk of harm to others (primarily staff) was reviewed. Nor was this decision reflected in Mr H's care plan or risk assessment.***

**5.35** The consultant psychiatrist reviewed Mr H in his clinic on 16 March 2005. He then wrote to Mr H's GP on 23 March 2005. The consultant psychiatrist said he had found a "*significant change in his mental state from his last review*". The clinical notes or letter say no more about this change. Mr H still complained of low mood and hopelessness about the future. The consultant psychiatrist said Mr H had moved into a new flat where he felt safer and more secure. Mr H had started to binge drink recently. He was using up to 10mgs diazepam in the morning but no other regular psychotropic medication. The consultant psychiatrist did not consider Mr H to be expressing specific suicidal ideation or intent. The plan, outlined in the consultant letter, was for Mr H to try to return to controlled drinking, continue without regular psychotropic medication and to attend a review with the consultant psychiatrist in six weeks.

**5.36** Psychiatric liaison nurse 1 saw Mr H in the A&E department of St Peter's Hospital on 20 March 2005. Mr H said he felt suicidal after heavy drinking. Psychiatric liaison nurse 1 did not identify any acute mental health concerns or consider that Mr H posed a risk to himself or others. Medication was not prescribed and the plan was for Mr H to be discharged home and followed up in the community by the CMHT, which he was.

**5.37** Mr H phoned the Abraham Cowley Unit on 27 March 2005 making suicide threats. A liaison nurse at St Peter's Hospital assessed Mr H and did not consider him to be acutely psychotic. No medication was prescribed. Mr H was admitted to Clare Ward<sup>1</sup> overnight and was discharged home next day.

**5.38** Mr H went to the A&E department of St Peter's Hospital on 2 April 2005. A member of the psychiatric liaison service saw him. Mr H complained of forgetfulness and confusion over the past two months. He described having intrusive violent thoughts. He was worried that he might harm himself or others. He was discharged that day and the follow-up arrangements were recorded as:

- crisis team to follow-up tomorrow
- community mental health team to arrange to follow-up
- arrange an appointment with the consultant psychiatrist to review Mr H's treatment.

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<sup>1</sup> Clare ward is an inpatient mental health ward serving adults aged between 18 and 65 in the Woking - Runnymede - West Elmbridge and Spelthorne areas

**5.39** Mr H phoned the crisis team on 6 April 2005 complaining about the treatment he had received from psychiatric services. He made “*veiled threats*” to harm someone if he did not receive the help he wanted. This information was shared with the CMHT and the consultant psychiatrist.

*Comment*

*Mr H was not coping in the community between the end of March and beginning of April 2005. He was drinking heavily, making suicidal threats and described intrusive violent thoughts.*

*Such thoughts were becoming a theme of his presentation when his mental health deteriorated. We found no documentary evidence that trust staff explored with Mr H the cause or nature of these violent thoughts.*

**5.40** Mr H missed an appointment on 7 April 2005 with a CMHT worker, who was due to see him in the absence of the care coordinator and social worker 2. The CMHT worker tried without success to phone Mr H.

**5.41** Mr H attended the Friday Group on 15 April 2005 and appeared to be low in mood. The CMHT worker saw Mr H put his wrists under boiling water. He told the CMHT worker he was having difficulties with his neighbour and if his neighbour was not evicted then Mr H would attack him. He reported that he got “*flashes*” and could not help himself. The CMHT worker raised his concerns with Dr X (title unknown). We found no evidence that any further action was taken.

**5.42** The consultant psychiatrist and social worker 1, reviewed Mr H on 27 April 2005. The consultant psychiatrist subsequently wrote to Mr H’s GP on 3 June 2005. The letter said Mr H was feeling low and desperate and had claimed that on 26 April 2005 he took an overdose of mirtazapine and called an ambulance but then refused to go to hospital. Mr H also said that he had continued with controlled drinking but this appeared to be up to four cans of lager a day.

5.43 During the review on 27 April, the consultant psychiatrist and social worker 3 planned for Mr H to continue without regular psychotropic medication, maintain drinking at controlled levels and continue contact with his social worker and accommodation development officer. The consultant psychiatrist was to review Mr H again in due course.

5.44 Psychiatric liaison nurse 2, saw Mr H at the A&E department of Ashford Hospital, Middlesex on 9 May 2005. He was complaining of feeling anxious, unable to cope and wanting to harm himself. Psychiatric liaison nurse 2 noted that Mr H had a superficial laceration to his wrist. He was discharged home and the plan was for the CMHT to follow up and an appointment with the consultant psychiatrist to be arranged.

5.45 A CPA meeting took place on 11 May 2005 but Mr H did not attend because he was drunk. The meeting noted the following concerns about Mr H:

- he continues to be in emotional crisis
- he was angry with services and felt he had been denied help
- he had been to A&E 17 times that year
- he had thoughts of self-harm, a history of taking small overdoses
- he had a superficial cut on his wrist
- he was threatening to take poison and had burnt himself with hot water
- he would like a diagnosis and to be referred to the Henderson Hospital for a second opinion.

#### *Comment*

***Mr H disclosed having violent thoughts, most recently on 15 April 2005. However, no one at the CPA meeting on 11 May 2005 recorded concerns about his potential to behave violently.***

5.46 Surrey Police contacted the social services emergency duty team (EDT) in the evening of 11 May 2005 to say that Mr H had made a 999 call threatening to harm himself. He sounded drunk and was verbally abusive. The EDT agreed that the police would visit Mr H at his home and report back anything important. The EDT had no further contact with the police.

5.47 Police told the crisis team in the evening of 12 May 2005 that Mr H had been wandering the streets saying he was going to harm himself and others. Police had told Mr H to contact his GP. A member of the crisis team contacted Mr H. He was drunk and was verbally abusive towards her before he ended the phone conversation. The crisis team took no further action that evening.

*Comment*

*Mr H had further difficulty coping in the community during this period and his mental health continued to deteriorate. He had taken an overdose and made threats to harm others. These were all identified in his CPA documentation as signs that his mental health may be deteriorating. Despite this, we found no documentary evidence to suggest that any action was taken or that a risk management plan was put in place at this time.*

*Mr H was not under the care of the drug and alcohol team during this period despite the detrimental impact alcohol had on his mental health.*

*Mr H was regularly presenting in crisis to A&E departments at acute hospitals. This would suggest that he was not coping with the current support arrangements in the community. It might have been helpful for those looking after him to review his long-term treatment plan to see whether he would benefit from any other form of support.*

*The notes of the CPA meeting that took place on 11 May 2005 indicate that Mr H was asking for a diagnosis and a referral to Henderson Hospital for a second opinion. The clinical notes do not say whether any diagnoses other than personality disorder and alcohol misuse were being considered. The notes say that Mr H could not be considered for treatment at the Henderson Hospital until he had reduced his drinking.*

5.48 Mr H went to the A&E department of St Peter's Hospital in Chertsey on 30 May 2005 after an overdose of paracetamol. He had taken 80 500mg tablets but refused medical treatment. He said he took the overdose because he was being bullied.

**5.49** A duty doctor and a liaison nurse reviewed Mr H and noted that he was known to the consultant psychiatrist and the care coordinator. The care coordinator was made aware of Mr H's admission to the medical assessment unit.

**5.50** The duty doctor and liaison nurse completed a risk assessment. They considered Mr H at high risk of serious self-harm. They recorded the risk as immediate because he was refusing medical treatment. They assessed him as a low risk of harm to and from others. They noted that he had a history of personality disorder, depression, alcohol misuse and that he had gone to A&E because he was self-harming. He remained in the medical assessment unit in the acute hospital.

**5.51** The care coordinator completed a summary of risk status and CPA on 1 June 2005. The care coordinator found that Mr H was at medium risk of suicide, violence to others and severe self-neglect. He was deemed to be low risk of non-threatening behaviour and abuse by others.

**5.52** On 1 June 2005 a CPA meeting also took place at the medical assessment unit. Mr H discharged himself from hospital against medical advice shortly after the meeting. The plan, which was agreed with Mr H before discharge, was for him to:

- be re-referred to the drug and alcohol team
- be referred for a specialist psychology assessment
- continue to be reviewed in relation to his accommodation needs
- be reviewed by the consultant psychiatrist in six weeks
- continue without regular psychotropic medication.

**5.53** Mr H referred himself to the crisis team the next day. He was feeling lonely and wanted to talk. He said he had stopped drinking and wanted to "*sort his life out*" and wanted help with "*personality issues*".

**5.54** The consultant psychiatrist reviewed Mr H on 3 August 2005. In a letter to Mr H's GP on 11 August 2005 he said Mr H's overall mental state had been reasonably stable in the past few weeks, although he continued to feel victimised and exploited by others. The plan was to review Mr H at the next CPA meeting later that month. In the meantime, Mr H was to continue without regular psychotropic medication and avoid binge drinking.

**5.55** A CPA review meeting took place on 24 August 2005 with the consultant psychiatrist and the care coordinator. The resulting plan was for Mr H to continue without psychotropic medication, to attend an appointment with the drug and alcohol team and to maintain contact with the community mental health team and his care coordinator.

*Comment*

*The CPA meeting on 1 June 2005 agreed that Mr H would be re-referred to the drug and alcohol team. The clinical notes suggest that despite Mr H's continued heavy drinking, no one from the drug and alcohol team had seen him since 12 March 2003, over two years earlier. The records of the meeting on 24 August 2005 imply that an appointment with the alcohol team had been arranged. There is nothing in the clinical notes to suggest it took place.*

*By this point Mr H was frequently in contact with the crisis team and presenting at A&E departments of acute hospitals. This suggests that he needed out-of-hours support beyond what was in place for him. His crisis and contingency plan, which says that the consultant psychiatrist or the care coordinator are to be informed in the event of a relapse, does not reflect this.*

**5.56** Staines Police contacted the emergency duty team on 28 August 2005 saying that Mr H had reported that he had been raped. He did not want to press charges but wanted to make a statement. He was due to see a CMHT worker on 30 August 2005, so the crisis team did not take any action.

**5.57** Mr H telephoned the care coordinator on 1 September 2005 saying he felt everyone was against him. He was low in mood but did not mention feeling suicidal. He had bought two bottles of cider and arranged to sell his property to punish himself. The care coordinator noted that he listened to Mr H but took no further action.

**5.58** The emergency duty team sent the care coordinator a fax on 4 September telling him that Mr H had moved out of his flat and was staying with a friend. Police had responded to a complaint by Mr H on 3 September and found him behaving in an unstable

way. The Police said that the plan was for Mr H to attend Woking police station to make a formal complaint and undergo forensic tests in connection with the alleged rape.

#### *Comment*

*Mr H's mental health continued to deteriorate during this time and he found it hard to cope in the community. He was showing the signs of deterioration, as identified in his CPA documentation. These included increased drinking and an overdose, but no one appears to have acted to manage the signs of deterioration.*

*Mr H's clinical records do not say whether anyone told the consultant psychiatrist of Mr H's contact with trust services after the CPA meeting on 24 August 2005. It might have been useful for the consultant psychiatrist to have been told about Mr H's rape allegation or that the police had found him to be unstable in mood.*

*After Mr H's rape allegations the professionals looking after Mr H should have discussed what needed to be done to support him, especially since he had already been subject to adult protection proceedings in November 2002. Their actions should have been in line with the trust's adult protection policy. We discuss this further in section 6.*

**5.59** In light of the rape allegation Mr H was offered emergency accommodation out of the area on 5 September 2005. The care coordinator told the vulnerable person's liaison officer (VPLO) about Mr H attending Woking police station.

**5.60** The VPLO told the care coordinator on 6 September 2005 that police had interviewed Mr H about the rape allegations. Police had recommended to the housing department that Mr H should not return to the area. Mr H planned to move to Slough.

**5.61** Mr H contacted the care coordinator on 15 September 2005 and told him he was feeling in a much better mood since moving to Slough.

**5.62** The care coordinator visited Mr H at his temporary accommodation in Slough on 6 and 13 October 2005. The care coordinator noted that Mr H was in bright mood on both occasions.

**5.63** A staff member from Runnymede Borough Council told the care coordinator on 19 October 2005 that Mr H had returned to Runnymede (near Egham) and that he wanted to be rehoused there.

**5.64** On 20 and 24 October 2005 the care coordinator met Mr H at his new temporary home in Englefield Green (near Egham). Mr H appeared to be in a bright mood on both occasions.

**5.65** Police interviewed Mr H subject to vulnerable adult protection<sup>1</sup> on 26 October 2005 about the rape allegations he had made on 28 August 2005. A full medical examination of Mr H yielded no evidence to support his allegation.

**5.66** The police, Runnymede Borough Council, the consultant psychiatrist, and the care coordinator also met that day to discuss Mr H's allegations of sexual abuse. They agreed that the care coordinator would explore accommodation options and tell Mr H. They arranged a further meeting for 11 November 2005, though we found no record that it took place.

**5.67** The care coordinator visited Mr H at home on 1 November 2005 and found him in a bright mood and "*on top of things*". Mr H said he felt much safer in Englefield Green and hoped to move there permanently.

**5.68** The care coordinator visited Mr H at home on 7 November 2005. He appeared to be settled. His next appointment with the care coordinator was arranged for 14 November. The care coordinator visited Mr H at home on 20, 24, 25 November and 21 December 2005 and noted that Mr H did not raise any major concerns.

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<sup>1</sup> Interviewing vulnerable adults, in the appropriate environment, ensuring that appropriate support is made available to them taking into account their cognitive ability, comprehension and communication needs.

## Comment

*We found nothing to suggest that anyone reviewed Mr H's risk, particularly his vulnerability and risk of harm from others, after the rape allegation.*

*The care coordinator visited Mr H at home many times during this period, even though the consultant psychiatrist had said on 15 March 2005 that Mr H should not be seen in his home on his own. We found nothing to suggest that this risk had been reviewed and downgraded before the care coordinator began unaccompanied home visits again or that team discussions took place to consider this issue.*

*Little information is recorded about the nature of these home visits but they were clearly Mr H's main contact with mental health services. The information that is available suggests that the purpose of these visits was to monitor Mr H's mental health and ability to cope. The care coordinator's notes give no clear sense of a long-term management plan for Mr H.*

## January 2006 to February 2006: community support and A&E presentations

**5.69** Psychiatric liaison nurse 3 saw Mr H in the A&E department of Ashford Hospital on 10 January 2006. He had taken an overdose of paracetamol and had drunk a lot of alcohol. He was discharged home that day because he was not considered a risk to himself. No medication was prescribed and no follow-up arrangements were made.

**5.70** The care coordinator visited Mr H at home later that day. Mr H said he had been drunk when he took the overdose. He had drunk six litres of cider over the weekend. Mr H said he took the overdose as a way of harming himself to release the pressure because he was overcome by all the changes in his life. The plan was for Mr H to contact the care coordinator, the CMHT duty team or the crisis team if he had any more thoughts of self-harm.

## Comment

*Mr H's CPA documentation had already noted the link between his drinking, the deterioration in his mental health and the escalation in risk. Yet when he started drinking heavily again, staff involved in Mr H's care did nothing to address his deteriorating mental health.*

*Mr H went to A&E departments many times. This was one way he signalled his distress and inability to cope in the community. However, his care in the community was not reviewed to ensure that he was being provided with appropriate support and seen by the appropriate services.*

*Drug and alcohol services did not see Mr H during this time. The clinical records show that he had not seen a member of the drug and alcohol team since 12 March 2003 when the nurse specialist from the Windmill Drug and Alcohol Team attended a review with the consultant psychiatrist. That was almost three years earlier.*

*The records do not make clear whether Mr H's lack of involvement with drug and alcohol services during these three years was because of his reluctance to engage with the service or because trust services had failed to refer him and encourage his engagement.*

5.71 The care coordinator visited Mr H at another new address in Englefield Green, Surrey on 17 January 2006. Mr H appeared settled in his new flat. A further home visit took place on 24 January 2006.

5.72 Mr H attended a CPA meeting on 26 January 2006. The notes say he had moved into permanent council accommodation in Englefield Green and that his drinking was more stable. Mr H agreed that he had been more stable since his last CPA review (on 1 June 2005). The plan was for him to continue without regular psychotropic medication, to maintain regular contact with the care coordinator and the consultant psychiatrist and to continue with controlled alcohol use. The care coordinator was also to refer Mr H to the clinical psychologist, to see whether he would benefit from a “*managing your emotions*” course.

## Comment

*Mr H attended A&E on 10 January 2006 having drunk heavily. Yet during a CPA meeting on 26 January 2006 the notes say that Mr H's drinking had settled to a more stable limit. It is clear that Mr H's drinking continued to fluctuate and he could not reduce his drinking without support.*

*It was good practice and a positive step to refer Mr H to a clinical psychologist to explore behaviour traits relating to his diagnosis of personality disorder. It might have become part of a clear plan for Mr H's treatment and management. However, it appears that Mr H was never formally referred to the clinical psychologist.*

5.73 The care coordinator visited Mr H at home on 30 January 2006. Mr H answered the door dressed as a woman and said he could do this because he felt safe in his new flat. The care coordinator and Mr H discussed the outcome of his recent CPA review.

5.74 Mr H contacted police on 11 February 2006 to report a burglary. He said a blue folder was missing from under his mattress. There were no signs of forced entry and the alarm system was working. Police were aware of Mr H's mental health history and alerted social services.

5.75 Mr H's GP wrote to the consultant psychiatrist on 15 February 2006 saying Mr H wanted to be referred to Charing Cross Hospital to discuss his gender dysphoria<sup>1</sup>.

5.76 Police told Mr H on 17 February 2006 that they were closing his vulnerable adults' case (relating to the rape allegations) after six months of investigation because of a lack of evidence. Mr H was disappointed but understood their decision.

5.77 The care coordinator visited Mr H at home on 21 February 2006 and noted that he was in bright mood. The care coordinator noted that Mr H said he had been in better spirits since the police closed their investigation.

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<sup>1</sup> Gender dysphoria is a condition where a person feels that they are trapped within a body of the wrong sex.

**5.78** On the same day the care coordinator presented Mr H's case in a group supervision session attended by social care staff and facilitated by the clinical psychologist. The meeting agreed that Mr H would be referred to the clinical psychologist for three sessions to discuss personality disorder issues and to look at providing him with emotional support. There is no evidence that these sessions took place.

**5.79** The consultant psychiatrist wrote to Mr H's new GP, GP 2, on 23 February 2006 with a summary of Mr H's history and involvement with trust services. He said Mr H had complex psychological problems, including cross-dressing, self-harming and substance misuse. The letter said that the exploration of Mr H's underlying issues triggered or exacerbated his psychological problems. However, the letter continued, Mr H had been stable over the last 18 months. The preferred course of action was to refer him as a first step for a generic in-house psychological approach. He would then be referred for specialist psychological assessment at a later date.

**5.80** The care coordinator visited Mr H at his home on 27 February 2006. The care coordinator and Mr H discussed the possibility of trust staff seeing Mr H outside of his home because of his sexual fetish of wearing women's clothes and becoming sexually aroused. The plan was for the care coordinator to continue to see Mr H weekly and then reduce the visits to fortnightly and then monthly.

#### *Comment*

*The consultant psychiatrist had agreed with social worker 2 on 15 March 2005 that staff should not visit Mr H's flat unaccompanied. This concern arose again nearly a year on. In the meantime, the care coordinator had continued to visit Mr H alone on many occasions. We found nothing to explain why the care coordinator had continued to visit Mr H despite the consultant psychiatrist's advice. Neither was Mr H's risk reviewed after this decision on 27 February 2006.*

*The consultant psychiatrist thought that Mr H had been relatively stable for 18 months of relative stability. It may have been as a result of this stability that the care coordinator planned to reduce his weekly visits to fortnightly. This may have been appropriate but it should have been considered as part of a long-term management plan with multi-disciplinary input. As part of this, consideration should*

*have been given to Mr H's vulnerability given he had previously been identified and managed as a vulnerable person.*

## **2 March 2006 to 20 March 2006: community support and inpatient episode**

**5.81** Mr H went to a Surrey A&E department with a self-inflicted cut to his penis on 2 March 2006. The care coordinator and a psychiatric liaison nurse jointly assessed him. He was discharged from A&E and the plan was for him to:

- have support from the crisis team over the weekend
- keep his appointment with the care coordinator on 6 March
- call for support as appropriate to his needs
- return to A&E to have his stitches removed in six days.

**5.82** Later that day, Mr H flagged down a police van. The police took him to the Abraham Cowley unit under a Section 136 and he was admitted to Laureate Ward.

### *Comment*

*Mr H was seen in A&E and discharged the same day but later in the day police had to take him to the Abraham Cowley Unit on a Section 136. This suggests that he could not cope in the community and needed more support than was in place when he was discharged.*

*Only three days earlier the care coordinator had considered reducing his input into Mr H's care. Given Mr H's poor coping abilities in the community at that time this would have been a good time to review the care and treatment being provided to see what other support he might have benefited from.*

**5.83** The consultant psychiatrist and the care coordinator reviewed Mr H on Laureate Ward on 3 March 2006. He said he would be better off dead though he did not describe specific suicidal thoughts. He was not taking medication.

**5.84** Later that day a Mental Health Act assessment took place on Laureate Ward. It said that, following a decision in February 2006, Mr H should not be seen alone because he posed a risk in the categories of; self, vulnerable adult, suicidal tendencies, violence in the form of verbal abuse.

**5.85** The care coordinator noted that Mr H had borderline personality disorder and drug and alcohol problems in the past two years but that his mood had been more stable in the last 18 months.

**5.86** Mr H was to be discharged and referred to the crisis team. The care coordinator was to visit Mr H on 6 March and update his risk assessment to reflect recent events.

**5.87** Mr H was referred to the crisis team later that day. His diagnosis on the referral form was of borderline personality disorder and his mood was described as low. The consultant psychiatrist assessed Mr H as being at low to medium risk of self-harm, neglect and harm to others and at low risk from others. The risk was not assessed to be immediate in any of the categories. The form said Mr H was being managed under enhanced CPA.

#### *Comment*

*Mr H's diagnosis was consistently recorded as personality disorder. However, by this stage his therapeutic input and treatment was limited. His contact primarily consisted of weekly visits from his care coordinator, and they seemed to focus on monitoring his mental health rather than on working towards longer-term treatment goals. He was also due to have six-weekly reviews with the consultant psychiatrist, however they appear to have taken place slightly less regularly.*

*Irrespective of diagnosis, Mr H's risk should have continually been assessed based on his presenting symptoms and behaviour.*

**5.88** The crisis team tried several times without success to phone Mr H on 4 March 2006, following a referral from the Abraham Cowley Unit. The crisis team sent a fax to the care coordinator to tell him they had not been able to contact him. They took no further action.

**5.89** On 6 March 2006 the care coordinator received a telephone call from Runnymede Borough Council. Mr H had been disturbing neighbours and had broken his front door. They said that Mr H might lose his tenancy if the situation deteriorated.

**5.90** Police phoned the crisis team on 11 March 2006 and said Mr H had confessed to a murder committed about 10 years earlier. Apparently, Mr H had overheard someone talking about the murder and mentioning his name so he thought he should phone the police to confess even though he did not recall the offence. The crisis team took no action and we do not know whether the police did.

**5.91** The care coordinator was due to meet with Mr H on 17 March 2006 but was off work sick that day and no one took his place.

#### *Comment*

***Mr H's behaviour in the community was clearly deteriorating during March 2006. He was displaying behaviour highlighted in his CPA plan that might signify a deterioration in his mental health, such as self-harming, yet no action was recorded in his medical records.***

#### **21 March 2006 to 25 March 2006, date of offence**

**5.92** Mr H tried to jump in front of a train on 21 March 2006 while under the influence of alcohol and lorazepam. Police took him to Maudsley Hospital under Section 136 of the Mental Health Act.

**5.93** The next day Mr H was transferred to Clare Ward, Abraham Cowley Unit and informally admitted for further assessment. Mr H was reviewed by on-call SHO 1, and was noted as being subject to enhanced CPA.

**5.94** SHO 1 noted that Mr H had a history of “*personality disorder, gender dysphoria, alcohol abuse and transvestism*”. Mr H told SHO 1 he had felt down the night before and had been drinking in pubs before going to Soho where he hired a male prostitute. Afterwards he felt that ‘*life is not worth living*’ and tried to jump in front of a train. He

denied any depressive symptoms; he said that he just wanted to punish himself for his “*wrong doings*”. He said that he had stolen goods from a shop that day. He also said two young people in his community had been threatening him for some time.

**5.95** SHO 1 noted that Mr H had a history of taking overdoses and of alcohol abuse. He also noted many past episodes of self-harm. Mr H said he was not sure whether he would self-harm or attempt suicide again if he was discharged from hospital. SHO 1 assessed Mr H as posing a medium risk of harm to himself and a medium risk of harm from others. He was assessed as a low risk of harm to others and of self-neglect. Risk factors were identified as: threatening and verbal abuse, social factors and alcohol abuse. Further management of Mr H was to be discussed the next day.

**5.96** The care coordinator met with Mr H on Clare Ward on 24 March 2006. Ward staff had observed Mr H for two days and noted no suicidal behaviour.

**5.97** Later that day, specialist registrar 2 saw Mr H during his ward round. Specialist registrar 2’s assessment was that Mr H did not display any signs of thought disorder or psychosis. Mr H said he was no longer depressed but that his sleep was disturbed. The general impression from the ward round was that Mr H’s mood was stable. The plan was for Mr H to be discharged home and for the care coordinator to see him in the community on Monday.

**5.98** The care coordinator was to refer Mr H to the drug and alcohol team and a follow-up was arranged with the consultant psychiatrist. SHO 2, updated Mr H’s risk assessment put him in low risk categories for self-harm, self-neglect and harm to others.

**5.99** Mr H was discharged on 24 March 2006 and collected by a friend.

#### *Comment*

***Mr H was assessed as at low risk of self-harm despite his considerable history of self-harm and his attempt to jump in front of a train less than three days earlier. We saw no evidence to support this conclusion. Nor do we know whether SHO 2 who conducted this assessment had received risk assessment training and been declared competent in assessing risk.***

*The plan was for the care coordinator to follow up Mr H in the community. He had been having regular input with the care coordinator over the recent months, although the long-term plan for Mr H's treatment and management is unclear from Mr H's clinical notes.*

*The plan was also for Mr H to be referred to the drug and alcohol team. Despite previous plans to refer Mr H to their service, we found nothing to suggest they had seen him since 12 March 2003.*

### **Immediately after the offence**

**5.100** Police told social services on 27 March 2006 that Mr H had confessed to murdering a man two days earlier. The victim's body was later found in a flat with a single stab wound. They said Mr H was to be interviewed that evening by the forensic medical examiner and would then be interviewed by police if he were medically fit.

**5.101** SHO 3, SHO to the consultant psychiatrist, completed a discharge summary on 29 March 2006 (for Mr H's inpatient admission between 22 and 24 March 2006). The discharge letter noted that Mr H had not been on regular psychotropic medication since April 2004. The psychiatry team reviewed him regularly. He had seen the consultant psychiatrist while an inpatient on 3 March 2006 and in the community for a CPA review on 26 January 2006. The discharge letter says Mr H was admitted for general observation to provide him with a calming down period after he had tried to kill himself. He appeared much more settled and interacted well with other patients. Specialist registrar 2 reviewed his case and he was discharged from the ward to his home on 24 March 2006. His risk for self-harm, harm to others and self-neglect was documented as low. The care coordinator also saw him on the ward and agreed with the following discharge plan:

- to be followed-up by care coordinator and psychiatrist
- to be referred to drug and alcohol team
- advised to reduce alcohol use.

Comment

*SHO 3 was clearly unaware of the offence when he/she completed the discharge summary. Mr H was assessed at the point of discharge as posing a low risk of harm to others. His clinical notes contain no suggestion that his behaviour warranted a different assessment but given he had tried to jump in front of a train the week before Mr H's risk of harm to himself should have been considered to be higher.*

## **6. Arising issues, comment and analysis**

**6.1** In this section we review policies and procedures (where available) in place at the trust while Mr H was involved with services and we identify shortfalls in performance in relation to Mr H's care and treatment. We also consider the trust's current policies and procedures and other documentation to establish what improvements and developments in governance have been made since the incident in March 2006. A full list of the documents reviewed can be found at appendix A.

**6.2** We comment on the trust's compliance with national policy and review subsequent improvements to trust policy and practice. We rely on information from the trust.

**6.3** We considered the key issues relating to policies and practice the internal review team identified in November 2006 as well as areas that emerged during our investigation.

**6.4** The trust's internal review highlighted concerns about risk management planning, multi-disciplinary team working and staff training in a variety of areas.

**6.5** Our terms of reference ask us to assess the following areas:

- the adequacy of any risk assessments and risk management plans carried out for Mr H, specifically any relating to his long forensic history and the potential for him to harm others
- any relevant gaps or issues found which were not investigated as part of the internal investigation in relation to the care and treatment provided to Mr H, from his last episode of care with services to the time of the offence on 25 March 2006
- the care programme approach and how it was carried out in relation to Mr H's care and trust policy
- any new developments or improvements in services since Mr H's engagement with mental health services.

1) The adequacy of any risk assessments and risk management plans carried out for Mr H, specifically any relating to his long forensic history and his potential to harm others

6.6 The deputy medical director told us that in 2006 trust services used a paper-based system to record risk. This involved extensive hand-written notes. This system involved a risk that different teams and services involved in a patient's care would not get an overview of a patient's risk or previous involvement with services.

6.7 The internal review team raised concerns about the consistent use of the "Pink Card" system. The process at that time was for a summary of previous risk assessments, risk management plans and serious incidents to be recorded at the front of the patient's case file but this did not always happen.

6.8 The trust could not find the risk management policy in place at the time Mr H was known to trust services. However, they provided a copy of the "CPA risk assessment and management procedure" which came into effect in June 2007, 15 months after the offence. This policy says:

*"For service users in the community, the care co-coordinator or the professional assessing the patient at the point of referral will complete the part 1, the initial risk assessment and screening form and part 2, the risk findings and management form...The care co-coordinator is responsible for ensuring that the risks are reviewed on a regular basis and the care plan reflects any changes using part 2, the risk findings and the action plan form".*

6.9 Mr H's risk was last assessed on 24 March 2006, when he was an inpatient at the Abraham Cowley Unit, after he tried to kill himself. He was assessed at discharge as posing a low risk for self-harm, self-neglect and harm to others. The justification for this assessment was not documented. The risk assessment may have reflected Mr H's presentation at the time of discharge, but given his extensive history of self-harm, it is surprising that the reason for reaching such a view was not recorded.

6.10 Mr H's risk was last comprehensively assessed on 1 June 2005 when the care coordinator completed a summary of risk status and CPA. The care coordinator assessed Mr H as a medium risk of suicide, violence to others and severe self-neglect. The care

coordinator deemed him to be at low risk of non-threatening behaviour and abuse by others. Given that the care coordinator had the most frequent contact with Mr H, and given the time he had worked with him, this was probably the most insightful assessment of risk.

**6.11** Trust staff involved in Mr H's care primarily saw him as vulnerable and at risk of self-harm. He sometimes made threats of violence towards others, but we found no evidence that his risk was reviewed or amended in light of these threats. His notes make clear that he had a number of incidents of aggression, one of which in 1996 resulted in his being charged with criminal damage. Beyond this, no other forensic history appears to have been recorded.

**6.12** Mr H was generally considered throughout his engagement with trust services to pose a low risk of harm to others. His risk of harm to others increased on three occasions:

- the consultant psychiatrist and the care coordinator assessed Mr H as posing a medium risk of harm during a CPA review meeting on 15 December 2004
- the care coordinator assessed Mr H as a medium of risk violence to others during an inpatient stay at an acute hospital after a paracetamol overdose 1 June 2005
- 3 March 2006, after an inpatient stay at the Abraham Cowley Unit, in a referral to the crisis team Mr H was assessed as medium risk of harm to others.

**6.13** The care coordinator and the consultant psychiatrist identified that Mr H was at risk from others on a number of occasions, for example, when he made rape allegations. He was subsequently perceived by those involved in his care as vulnerable but was not always managed accordingly. Over time, he was no longer regarded as vulnerable but there is no documented assessment to support this change.

**6.14** There were occasions when his risk should have been reviewed and was not, for example when it was decided by the consultant psychiatrist, on 15 March 2005, that Mr H should not be visited at home by a lone member of the CMHT.

**6.15** No risk management plan for Mr H appears to have been in place irrespective of the level of risk he was assessed as posing. There was also a lack of long-term planning in the management of Mr H's care and treatment needs. Mr H's CPA documentation often highlighted the factors that led to deterioration in his mental health. However, when

these factors were present, such as increased alcohol use, disengagement with service and making threats to others, staff involved in his care took no action. There was a lack of comprehensive risk management planning throughout Mr H's engagement with trust services.

**6.16** Staff involved in Mr H's care sometimes appeared preoccupied with managing him in line with a diagnosis rather than assessing risk based on his presenting symptoms.

**6.17** Mr H often went to A&E departments of acute hospitals when in he was in crisis. He went 17 times one year. There was no provision for Mr H to be given direct admission to a mental health ward when his health deteriorated. A&E staff often failed to recognise the need for him to receive more intense intervention. The consultant psychiatrist and the care coordinator tried regularly to manage Mr H in the community but he frequently deteriorated nonetheless.

**6.18** Mr H had been known to mental health services for 15 years and presented with essentially the same symptoms; low mood, suicidal intention, self-harm and occasional violent thoughts. His diagnosis during this time consisted of alcohol dependence syndrome, emotionally unstable personality disorder and depressive disorder.

**6.19** Mr H would have benefited from a longer-term view of his care and treatment needs with a clear plan.

**6.20** Mr H frequently made contact with the crisis team, which would suggest he regularly needed out-of-hours support. This was not identified in a risk management plan and no contingency arrangements were made.

### *Finding*

***Mr H's heavy drinking was known to prevent treatment/exploration of his personality disorder yet when he returned to drinking too much, as he often did, staff involved in Mr H's care did not act on the triggers of deterioration that they had identified. More could have been done to engage him with alcohol services. Trust staff should have formulated a long-term plan for him. His engagement with alcohol services is discussed later in this section.***

***Disconnection between mental health services and addiction services throughout Mr H's care and treatment meant that his care was not managed in a holistic way.***

*Learning points*

**L1** The trust should continue to ensure, through personal development plans and supervision, that all staff in direct contact with patients receive training in the assessment, planning and management of risk. The trust should ensure that staff receive risk assessment training and are declared competent before conducting any risk assessments. The clinical governance team should audit training records at least every three months. Findings should then be reported to the trust board at appropriate times, as defined by the trust's governance processes.

**L2** The trust should assure itself that the current process for Care Programme Approach (including care planning, risk assessment, risk management planning) is robust. The clinical governance team should audit compliance at least every six months and report its findings to the board.

**2) Any relevant gaps or issues found which were not investigated as part of the internal investigation in relation to the care and treatment provided to Mr H, from his last episode of care with services to the time of the offence on 25 March 2006**

**6.21** We identified four areas that required further exploration. The internal investigation team highlighted some of these but we felt they required further exploration. These were:

- the role of the drug and alcohol service
- Mr H's status as a vulnerable adult
- communication between teams and agencies involved in Mr H's care
- Mr H's diagnosis, treatment and medication.

## *The role of the drug and alcohol service*

**6.22** Trust staff recognised, from Mr H's first engagement with mental health services in 1991 that he needed help with his heavy drinking and that it had a direct impact on his mental health. Trust staff tried, early in his engagement, to encourage Mr H to work with the drug and alcohol team. On one occasion, on 15 March 2002, Mr H was referred to the detoxification unit but appears not to have accepted the place.

**6.23** The nurse specialist from the Windmill Drug and Alcohol Team, reviewed Mr H with the consultant psychiatrist on seven occasions between 23 May 2002 and 12 March 2003. We found no evidence that she ever saw Mr H for one-to-one sessions and it is unclear therefore whether Mr H was ever formally under the care of the drug and alcohol team. The nurse specialist from the Windmill Drug and Alcohol Team attended a CPA review meeting on 29 August 2002. She stopped attending review meetings after 12 March 2003. The reason is not recorded in Mr H's notes. On several occasions (e.g. after a CPA meeting on 1 June 2005 and an inpatient episode on 24 March 2006) part of the follow-up plan was to refer Mr H to the drug and alcohol team. We found no evidence that the drug and alcohol team had input into Mr H's care after March 2003.

**6.24** The trust could not find a copy of the policy in place to manage non-attendance (DNA) during Mr H's involvement with drug and alcohol services (from May 2002). The trust has, however, provided a copy of the DNA policy introduced in February 2006, when Mr H was still involved with mental health services but not the drug and alcohol service. The policy says that if a service-user fails to attend a follow-up appointment, the trust professional should assess risk and liaise with the referrer and any appropriate others. In Mr H's case we found no evidence that his risk was assessed when he disengaged from the service.

### Finding

***Alcohol clearly played a significant role when Mr H's mental health deteriorated. Staff involved in Mr H's care tried to support him to reduce his alcohol consumption, but more could have been done to encourage his continued engagement with services. More could have also been done to align mental health and drug and alcohol services to ensure a holistic approach to his care and treatment.***

## Learning point

**L3** The trust should ensure that all staff adhere to its policy and procedure for managing formal and informal service users' non-compliance with treatment and managing DNA (did not attend) or cancelled appointments.

### *Mr H's status as a vulnerable adult*

**6.25** Trust staff involved in Mr H's care viewed him as a vulnerable adult after his allegations of rape (November 2002 and August 2005). In line with this, meetings were held between trust services and the vulnerable person's liaison officer. However, when his risk was assessed this appeared to have been ignored as he was often viewed to be at low risk of harm from others.

**6.26** The trust could not find the safeguarding adults' policy in place when Mr H was involved with trust services. We have, however, reviewed "*Policy and procedure on adult protection - safeguarding adults*", introduced in March 2006. It says:

*"The Trust has representatives on the Multi-agency Adult Protection Committees for Surrey, Hampshire and Croydon. Trust staff are also members of specific sub groups or local working groups so that they can both influence and learn from the work of the committees and other organisations in relation to adult protection issues."*

**6.27** A meeting took place between Woking Police Vulnerable Persons Unit, a representative from Surrey Community Development Trust, a member of the outreach team and Mr H's care coordinator, on 15 November 2002 to discuss his vulnerable status.

## Finding

***There was an inconsistency in trust staff's assessment of Mr H as a vulnerable adult and their subsequent assessment of his risk and vulnerability. As a result he was not always managed in line with the requirements of the safeguarding adults' policy.***

## Learning point

**L4** The trust should ensure that staff have received training in the trust's latest adult protection policy. Compliance should be monitored through a regular audit programme.

### *Communication between teams and agencies involved in Mr H's care*

**6.28** Teams and agencies involved in Mr H's care and treatment often shared information appropriately. For example, the crisis team regularly told the care coordinator, about their involvement with him. However, there were occasions when services could have worked together better to provide more comprehensive care and treatment, especially when Mr H was in crisis. For example, it is unclear whether the consultant psychiatrist was always informed when Mr H had gone to A&E or made contact with the crisis team.

**6.29** Trust staff involved in Mr H's care and treatment should have done more to establish a long-term management plan involving multi-disciplinary input from those involved in Mr H's care and treatment.

**6.30** The care coordinator saw Mr H regularly in the years leading up to the offence. The consultant psychiatrist reviewed his case every few months. The notes of meetings with Mr H, particularly those of the care coordinator, make clear there was no long-term plan for Mr H's care and treatment or how the various services planned to work together to provide a holistic approach to his treatment.

## Finding

***Better communication between the various teams involved in Mr H's care and treatment might have resulted in a better understanding of his needs. This in turn might have helped trust staff to develop a long-term plan for the care and management of Mr H.***

### *Partnership working*

**L5** The trust should continue to develop relationships with partnership agencies. This should include reviewing the protocols with partnership agencies to ensure effective communication and information sharing. This should take place within the next three months.

### *Mr H's diagnosis, treatment and medication*

**6.31** Mr H's diagnosis during his contact with mental health services included alcohol dependency, emotional unstable personality disorder and depressive disorder.

**6.32** Medical professionals recognised throughout Mr H's engagement with mental health services that he suffered from personality disorder. We found no evidence of a plan for the long-term management of this condition.

**6.33** A CPA meeting on 11 May 2005 discussed the possibility of referring Mr H to the Henderson Hospital but this referral never took place. The notes say that Mr H needed to address his housing needs and stabilise his drinking before his personality disorder could be explored.

**6.34** The care coordinator presented Mr H's case to a group supervision meeting on 21 February 2006. The meeting was attended by social care staff and facilitated by the clinical psychologist. The meeting agreed that Mr H would be referred to the clinical psychologist for three sessions to discuss personality disorder and to consider options for providing Mr H with emotional support. However, Mr H was never referred to the clinical psychologist for her input and she was never asked to risk assess Mr H.

**6.35** Mr H was under the care of the consultant psychiatrist from 2002 until the time of the offence and his engagement with him mainly consisted of reviews every few months. The consultant psychiatrist also reviewed Mr H when he was admitted to the Abraham Cowley Unit for brief inpatient episodes. Mr H was assessed as having personality disorder but no immediate or long-term plan was in place to address this.

**6.36** Mr H's other main input from mental health services was through the care coordinator, under whose care he had been since 2002. The care coordinator was having

weekly meetings with Mr H in the months before the offence. The notes imply that the purpose of the visits was to monitor Mr H rather than provide him with active therapeutic intervention.

**6.37** Mr H was sporadically taking antidepressant medication throughout his engagement with mental health services. The consultant psychiatrist thought Mr H would not benefit from long-term psychotropic medication based on his past response to it. He had not been on regular medication since April 2004.

#### Finding

*Mr H was recorded throughout his engagement with trust services as having alcohol dependency, emotionally unstable personality disorder and depressive disorder. Despite this there was no clear management or treatment plan. Nor were there clear arrangements in place between mental health and alcohol services.*

*The consultant psychiatrist did not consider that Mr H would benefit from long-term psychotropic medication because he had not in the past. Instead, Mr H's management was predominantly therapeutic through reviews with the consultant psychiatrist and regular meetings with the care coordinator.*

*Learning in this area is incorporated in learning point 2 detailed above.*

**3)** The care programme approach and how it was carried out in relation to Mr H's care and trust policy

**6.38** Mr H's clinical notes suggest that he was first managed under enhanced CPA on 13 September 2000. His identified problems included long-term alcohol abuse, history of overdosing and self-harming.

**6.39** A "summary of risk assessment" during this period recorded that Mr H was at low risk of harm in all categories: suicide, self-harm, neglect, violence towards others, risk to children, abuse by others and risk to property.

**6.40** Further enhanced CPA meetings took place on:

- 14 February 2002
- 29 August 2002
- 16 July 2003
- 3 March 2004
- 1 June 2005
- 26 January 2006.

**6.41** The last CPA meeting in relation to Mr H took place on 26 January 2006, two months before the offence. This was in line with enhanced CPA requirements as set out by the Department of Health which say that a CPA should be reviewed at least every 12 months.

**6.42** The record of the meeting on 26 January 2006 says that Mr H had moved into permanent council accommodation and his drinking had settled. Mr H agreed that he had experienced a period of stability since his last CPA review on 1 June 2005. The plan recorded in the CPA documentation was for Mr H to continue without regular psychotropic medication, to maintain regular contact with the care coordinator and the consultant psychiatrist and to continue to drink only in moderation. The care coordinator was also to refer Mr H to the clinical psychologist, to see whether he would benefit from attending a “*managing your emotions*” course. Mr H appears never to have been referred to the clinical psychologist.

**6.43** Carers’ assessments did not take place during Mr H’s involvement with trust services because he did not appear to be in contact with any of his relatives and there was nobody else that trust staff could meaningfully engage with in order to support Mr H in the community.

### *Finding*

***CPA meetings were held regularly and were generally well attended by the services involved in Mr H’s care and treatment. Risk accelerators and potential features of relapse were identified and recorded on Mr H’s care planning documentation on a number of occasions. However, we found little in the record to suggest that anyone***

*did anything to act on these signs when they happened, such as when Mr H began drinking heavily again. Instead, they managed Mr H as and when he presented in crisis.*

*The care coordinator saw Mr H weekly in the months leading up to the offence. A CPA meeting took place on 26 January 2006. We found no evidence that Mr H's care coordinator saw him between 6 - 24 March 2006, though his care plan stipulated weekly visits. The care coordinator told the internal review panel that he had been due to visit Mr H on 17 March 2006 but had been unwell and no one stood in. In the care coordinator's absence another member of the team should have followed-up.*

*The care coordinator last reviewed Mr H on 24 March 2006 on Clare Ward after he had been admitted to hospital with ideas of jumping in front of a train. The care coordinator's plan was to review Mr H in the community later that week. However, Mr H committed the offence within a day of being discharged from Clare Ward.*

#### *Learning point*

**L6** The trust should assure itself that appropriate arrangements are in place to ensure that a service user's CPA requirements are fulfilled in a team member's absence.

**4)** Any new developments or improvements in services since Mr H's engagement with mental health services

**6.44** Service provision and delivery have changed considerably since 2006. Improvements linked to the recommendations of the internal review are documented in the table in Section 7.

**6.45** We commented earlier in this section on practice at the time Mr H was involved with trust services - such as in the areas of risk management, communication, training and CPA. Below we document improvements to the service and provide examples of current good practice. We also identify other developments in service provision such as in relation to the services available for people with personality disorder.

### *Current trust risk management arrangements*

**6.46** The trust now uses an electronic system called RiO. It keeps notes on each patient's care record so that up-to-date client information is available when it is needed, rather than remaining filed as a paper record in the area or service where treatment was given. This enables healthcare professionals to provide a more comprehensive approach to care and treatment and to take a holistic view of the patient. This system has also helped practitioners to consider risk both in the short and long term and helps them to describe risk more accurately. Trust managers said RiO had transformed the ability of staff to manage risk.

**6.47** The medical director told us:

*"In the presence of a history of significant risk, if you do want to feel that someone is presenting as low risk, you do need to write that you have considered and you are aware of whatever it was and you have used it in making your judgement."*

**6.48** In relation to risk assessment and management, the trust's policy entitled "*Care Planning and Assessment Procedure*" (implemented September 2010) states:

*"Effective care planning requires good risk assessment and clear risk management planning."*

It goes on:

*"A comprehensive multi-disciplinary assessment of the person's needs for health and social care and any risks they face or present and the subsequent agreement on the person's outcomes, managing risk and including crisis and contingency plans will take place. Assessment is an ongoing process which involves constant monitoring of any changes in needs. Assessments will be integrated where possible; in some circumstances assessments carried out separately by different agencies will be combined."*

**6.49** The policy puts emphasis on taking a multi-disciplinary approach to risk assessments. Mr H was under a care coordinator and a consultant psychiatrist and regularly received support from the crisis team. He therefore did receive considerable support in

the community. However, when his mental health deteriorated, no one intervened. This frequently resulted in him attending A&E departments in crisis.

#### Finding

*The trust has taken significant steps to improve the way risk is assessed, managed and reviewed. This has included the introduction of a new electronic system for recording, reviewing and summarising risk. All trust staff have access to this system. The trust also undertakes regular audits to ensure the systems are functioning effectively and staff are using them appropriately. The trust must ensure that all staff undertaking risk assessments have received the appropriate training and have been declared competent before conducting risk assessments.*

#### *Current communication arrangements between trust teams and external agencies*

**6.50** The trust has taken significant steps to improve communication between teams and agencies since 2006. For example, all trust staff now have access to RiO.

**6.51** Staff involved in Mr H's care and treatment would have had easier access to risk information and a summary of his involvement with services if they had had this access when Mr H was involved with trust services. This might have given them a clearer overall understanding of his involvement in mental health services and his needs.

**6.52** The trust's relationship with Surrey Police has developed significantly in the past two years. The trust has set up a clinical referral unit at Surrey Police headquarters in Guildford. The trust has two members of staff based at police headquarters with full access to RiO. It allows them to see the care plan of anyone known to the trust and enables them to advise police of the best course of action. This helps to prevent automatically making someone subject to a section 136.

**6.53** This might have helped to manage Mr H better in the community. He was taken several times to the Abraham Cowley Unit on a Section 136 and discharged either later that day or the following day.

**6.54** The trust has also introduced monthly multi-disciplinary risk panels attended by expert clinicians in the area of risk. Clinical teams are encouraged to bring cases to the risk panel where they are struggling with the long-term management and risk of a particular client. The purpose is for the risk panel to provide a comprehensive view on the case and make suggestions and recommendations on managing it. This would have given the team an opportunity to reflect on Mr H's care and treatment and his diagnosis and helped formulate a risk management plan and allowed clinicians not involved in the case, to provide an independent view on his treatment and management.

**6.55** The trust has also taken steps to improve arrangements for follow-up when patients fail to attend appointments. The CPA risk assessment and management procedure in December 2007 says:

*“Patients who present risk to themselves or others and do not attend appointments (DNA) must be followed up. Any significant change of risk requires a review of the risk documentation. Care co-coordinators must make every attempt to contact service user (i.e. visit). Any significant change of risk to the service user or others must be discussed with the care team. The risk documentation and agreed care plan to address and minimize the identified risks must be shared with all members of the care team and others deemed necessary.”*

**6.56** A senior trust manager told us that they are much better equipped to recognise the needs of patients who repeatedly present at A&E. She told us that the development of the liaison service and the introduction of RiO means that A&E staff are quickly able to identify the needs of patients and signpost them to the appropriate service in a timely manner. She also told us that the trust is in the process of agreeing a new care pathway for service users who present at A&E but do not need the services of the A&E department. We were told that the trust is working to implement the RAID<sup>1</sup> service model (Rapid Assessment Interface and Discharge).

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<sup>1</sup> RAID, a new approach in mental health, delivers an in-reach service across the hospital. As well as psychiatric liaison, it brings together practitioners from other mental health specialties, including substance misuse and old age psychiatry in one team so that all patients over the age of 16 can be assessed and treated or referred appropriately much earlier.

**6.57** A senior trust manager told us that drug and alcohol services are commissioned by Surrey Drug and Alcohol Action Team who manage the collective budget. The funding is received from NHS Surrey, the Home Office and the Department of Health.

**6.58** Locally, the teams ensure that they work in conjunction with mental health services through nominated link workers. The link workers in the Drug and Alcohol Services are registered mental health trained workers. They attend meetings with mental health services to ensure that joint working is standard practice for dual diagnosed clients. They work to one CPA document with clearly defined roles for workers from each service. CPA's are reviewed jointly. A dual diagnosis list is reviewed regularly at local drug/alcohol services meetings and clients are only discharged with the agreement of both services.

#### Finding

*The trust has taken significant steps to improve communication between teams and external agencies. The improved relationship with Surrey Police has been one of the most notable changes. This relationship has had a significant impact on the care of patients in the community who come to the attention of the police. The introduction of RiO has also helped staff share patient information in much more timely way.*

*The introduction of monthly multidisciplinary risk panels has given multidisciplinary staff working with a patient the opportunity to gather the views of other clinical staff in the management of difficult cases.*

*The trust has also taken steps to ensure that patients with dual diagnosis are managed in a more holistic way with regular multi agency meetings and one jointly reviewed care plan.*

#### Learning point

**L7** The trust should continue to encourage risk panel meetings. In circumstances where there is significant uncertainty about an individual patient's diagnosis and/or treatment plan, these cases should automatically be discussed in an appropriate forum,

with other clinical colleagues, to assist in developing an appropriate care and risk management plan.

#### *Current staff training arrangements*

**6.59** Risk training now forms part of the trust's mandatory training programme. We learnt that 96 per cent of staff had now undertaken it.

**6.60** Two personality disorder services (discussed later in this section) have now been introduced, delivered by suitably trained staff.

#### Finding

***Staff training needs in relation to risk and personality disorder have been recognised and acted upon. The trust, however, must ensure that all staff who conduct risk assessments receive risk training and are declared competent before assessing risk.***

#### *Current CPA arrangements*

**6.61** The trust now operates under the 'Care Planning and Assessment Procedure' introduced in September 2010.

**6.62** If Mr H were involved with trust services today, he would still have been managed under CPA arrangements. Some of the qualifying factors outlined in the trust's policy include:

- severe mental health concern (including personality disorder) with a high degree of clinical complexity
- current or potential risk(s), including:
  - suicide, self harm, harm to others (including history of offending)
  - relapse history requiring urgent response
  - presence of non-physical co-morbidity including substance/alcohol/prescription drugs misuse, learning disability

- multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies
- currently/recently detained under Mental Health Act, on Supervised Community Treatment or Guardianship, and most people subject to S.117 MHA or referred to crisis/home treatment teams
- unsettled accommodation/housing issues
- employment issues when experiencing a mental health problem.

**6.63** The trust's current policy states that CPA review meetings must be held:

*"a) no later than 12 weeks after referral for all new people who use services*

*b) no later than one month after discharge from inpatient facilities*

*c) at least every 12 months*

*d) if there is a significant change in the person who uses services circumstances*

*e) before discharge from CPA or secondary mental health services*

*f) before transfer of care to another mental health service or team*

*h) if it is necessary to bring the care team together for any other reason"*

**6.64** We asked the trust how it assures itself about the quality of the engagement between care coordinators and service users and how they monitor the appropriateness of the supervision arrangements. A senior trust manager told us that all staff's supervision is monitored through the trust's quality assurance periodic service reviews. There is also a record keeping system whereby 10 sets of case notes are randomly reviewed each month. This is done as part of the supervision process. We were told that this auditing process is being reviewed to continue to make improvements to data collection and review.

Finding

***The trust's policy for managing patients under CPA arrangements is clear and robust and is in line with guidance set out by the Department of Health.***

### *Personality disorder service*

**6.65** Staff had the option at the time Mr H was involved with services to refer patients to the Henderson Hospital to provide support and therapeutic services for those with personality disorder.

**6.66** Mr H was not referred to Henderson Hospital, despite having been diagnosed with personality disorder, because he needed to get his drinking under control first. Staff involved in Mr H's care agreed that the clinical psychologist would see him for three sessions, but the sessions did not take place.

**6.67** The trust reports that at the time Mr H was known to their services the provision of services for people with personality disorder was patchy. It lacked a consistent approach to engagement, assessment and management and there was no clear pathway of care according to severity of need and complexity. There was inconsistent use of out of area placements and limited access to specific personality disorder focused interventions. There was no clear step down process to enable people to move into more mainstream services.

**6.68** The trust has already taken a number of steps to improve the provision of personality disorder services.

- 1) Over recent years trust staff have undertaken comprehensive training on treatment approaches to personality disorder to enable them to work more effectively with this client group.
- 2) In April 2011 the community services were reorganised. The new system enables staff to more readily identify the needs of people presenting with complex conditions including personality disorder.
- 3) People with personality disorder, who are engaged with working age adults services in the trust, are now able to access focused treatments including systems training for emotional predictability and problem solving (STEPPS) and dialectical behavior therapy (DBT).

- 4) Ongoing use of the local risk panels has allowed clinicians to share assessments, risks and formulations with senior colleagues to help in the effective care and treatment of people with personality disorder.

**6.58** The trust also has a number of plans to further develop the services for people with personality disorder<sup>1</sup>.

- 1) The ‘improving services for people with personality disorder’ strategy was passed at the trust’s executive meeting in July 2012. The strategy aims to help all staff and people using services to be clear about the pathway of care for people with personality disorder and to work from shared principles. There is a tiered approach across services to assist those with highest need to be robustly assessed, engaged and treated if appropriate.
  - One initiative is a tiered model of care with a virtual team working across a number of teams in a specific locality. This model enables the referral process to be more streamlined, with a single point of access into the personality disorder services.
  - The other initiative is the establishment of the Oasis TransitionService in North West Surrey (the area where Mr H lived during his engagement with trust services) which provides a step-up/step-down service within the trust’s personality disorder service and offers therapeutic group work to clients.
- 2) There is a bigger emphasis on consultation for staff in community mental health recovery teams and the acute care pathway to be able to access expert advice and support in a timely way to assist the care and management of people with personality disorder
- 3) Specialist psychotherapy services are focusing on the needs of people with personality disorder

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<sup>1</sup> A full copy of the trust’s implementation plan can be found at appendix B

## Comment

*Trust managers told us that Mr H would have been eligible for, and referred to, either of the trust's current personality disorder services if they had been in place at the time. He also lived in the appropriate catchment area for the Oasis Transition Service.*

*Given Mr H's inability to control his drinking, we cannot be sure he would have been deemed ready for such intervention. But referral to such a service (or working towards it with a clear plan) would have been a positive move in the long-term management of his care and treatment.*

## Finding

*The introduction of two new personality disorder services has had a fundamental impact on how the trust manages service users with personality disorder. Personality disorder training for staff should help to ensure that patients suitable for the new services are quickly identified and referred. Staff can now ensure that patients, such as Mr H, who need help to get them in a position to be ready for such intervention, receive the appropriate level of support and this is clearly documented in their care plan.*

## 7. The internal investigation

7.1 The terms of reference for this investigation include assessing the quality of the trust's internal review and the trust's progress in implementing the action plan.

7.2 In this section we examine the trust's incident policy and whether the trust's investigation into the care and treatment of Mr H met the requirements set out in the policy.

### Reporting of serious incidents

7.3 We have not seen the incident management policy that was in place at the time Mr H was involved with trust services. We have reviewed the trust's current incident reporting policy (August 2011). It is a thorough document in line with national policy. The document is easy to navigate and the process for identifying and reporting incidents is clear.

7.4 The policy says:

*“Serious Incidents are to be reported by the Clinical Risk and Safety Team to the relevant commissioner as soon as it is practicable to do so and within 24 hours of the incident where possible. All details of the incident are to be recorded on the Trust's Incident...The SI notification form must also be completed by the senior manager and sent to the Head of Clinical Risk & Safety within 24 hours”*

7.5 The facts are:

- the police contacted the Runnymede community mental health team on 27 March 2006 to tell them Mr H had been arrested
- the manager of West Elmbridge community mental health team completed an interim investigation of the incident
- a report was produced at the end of April 2006
- an internal review was commissioned to consider the care and treatment of Mr H in accordance with the trust's incident management policy and standard terms of reference.

**7.6** The purpose of the trust's internal review was to:

1. Examine all the circumstances surrounding the treatment and care of Mr H by the mental health services and social services.
  - The quality and scope of his health, social care and risk assessment .
  - Suitability of his treatment, care and supervision in the context of:
    - his actual and assessed social care needs
    - the actual and assessed risk of potential harm to himself and others
    - his actual or assessed vulnerability
    - the history of his medication and compliance with that medication
    - any previous psychiatric history, including alcohol and drug misuse
    - any previous forensic history.
  - The extent to which Mr H's care complied with statutory obligations, the Mental Health Act, Code of Practice and Local Operational interagency policies.
  - The extent to which prescribed treatment and care plans were:
    - adequate
    - documented
    - agreed with him
    - carried out
    - monitored
    - complied with by Mr H.
2. To consider the adequacy of the training of all staff involved in Mr H's care both during his admission and prior to his admission.
3. To examine the adequacy of the collaboration and communication between the agencies involved in the care of Mr H.
4. To consider the adequacy of the support given to Mr H's family and friends by the services involved.

5. To consider the adequacy of response to untoward incidents involving Mr H during his care and treatment.
6. To consider the outcome of the multi-professional clinical critical incident review.
7. To consider the adequacy of internal systems to support performance management and maintain quality standards with Runnymede CMHT.
8. To consider the trust 'vulnerable adults' arrangements and response to vulnerable adult concerns.

**7.7** The trust internal review panel reviewed Mr H's case notes, received statements from and interviewed three professionals involved in Mr H's care and contacted the police regarding the circumstances of the arrest. The panel also examined the manager's report prepared at the time of the arrest and compiled a detailed chronology from Mr H's clinical records.

**7.8** A non-executive director lead was identified to ensure independent input.

**7.9** The investigation team consisted of:

- a non-executive director, Surrey and Borders Partnership Trust (chair)
- head of nursing practice
- general manager, older people mental health services
- carer representative
- nurse director, Tavistock and Portman
- consultant psychiatrist, department of psychiatry
- consultant clinical psychologist, psychological therapies
- administrative coordinator (provided support to the panel).

**7.10** The internal review was commissioned in July 2006. The terms of reference say the report and recommendations were to be presented to Surrey & Borders Partnership Trust Board in September 2006. The report was presented to the board in November 2006.

**7.11** The current policy states that Grade 1 incidents (e.g. unexpected deaths involving people using community services) should be investigated and the findings submitted and approved by the associate director of quality, risk and safety within 30 working days (six weeks) of notification of the incident.

**7.12** The investigators and the operations directorate associate director will then present the report and action plan to the trust scrutiny panel within 40 working days (eight weeks) of notification of the incident.

**7.13** The investigation report and action plan are to be submitted and presented to the relevant commissioner within 45 working days (nine weeks) of notification of the incident.

**7.14** The policy also says:

*“It...has a duty to ensure that incidents are not only identified and reported, but that appropriate investigations are carried out to ensure that any actions arising or lessons to be learnt are transposed into the organisational culture to improve practice.”*

## **Implementation of the recommendations**

**7.15** In this section we look at the trust’s progress in implementing the action plan that resulted from its internal review.

**7.16** The report identified several areas that needed improvement and made 16 recommendations.

**7.17** The trust developed an action plan to take forward the recommendations. The table below shows the trust’s progress against the recommendations.

Recommendation	Progress made
1. Once a risk assessment has been completed an appropriate risk management plan must be developed clearly identifying the people responsible for carrying out that plan. The risk assessment and the risk management plan should be clearly recorded in the case notes.	<ul style="list-style-type: none"> <li>• Risk assessment and management processes agreed as part of CPA policy, March 2007. Risk assessment and management training introduced out as part of CPA training</li> </ul>
2. A summary of previous risk assessments, risk management plans and serious incidents should be recorded at the front of the case file.	<ul style="list-style-type: none"> <li>• Introduction of RiO</li> <li>• Priority clinical audit and effectiveness plan 2006/2007</li> <li>• CPA policy and procedural documents</li> </ul>
3. The trust needs to ensure that record keeping of individual service users is standardised and that all teams involved have access to joint case notes.	<ul style="list-style-type: none"> <li>• Record-keeping standards audit tool introduced</li> <li>• Development of integrated health and social services records of care, treatment and support</li> </ul>
4. The trust should review services currently provided for people with personality disorder. Staff should be trained to recognise the needs of this service user group, to accurately interpret the immediate presenting needs, to be alert to changes in the clinical picture and so provide appropriate long term management.	<ul style="list-style-type: none"> <li>• The work of the personality disorder working group taken to the service planning group</li> <li>• Development of Oasis personality disorder service</li> <li>• Introducing of step-up, step-down personality disorder service</li> </ul>
5. The trust should ensure that network meetings are instituted in cases where more than one agency is involved.	<ul style="list-style-type: none"> <li>• Network protocol incorporated into CPA policy</li> </ul>
6. The trust needs to re-examine the process of internal referrals to other services within the trust ensuring the process is both formal and simplified.	<ul style="list-style-type: none"> <li>• Completion of a trust-wide CMHT audit</li> <li>• Clarification of clinical supervision arrangements and subsequent changes made to Runnymede CMHT arrangements</li> </ul>
7. Multi-disciplinary teams should have systematic team reviews of cases that have long term needs to consider the effectiveness of care being provided. Reviews should be held at a minimum every two years.	<ul style="list-style-type: none"> <li>• Trust-wide audit complete</li> <li>• 95 per cent target introduced for systematic reviews of care plans, in line with CPA policy</li> </ul>

<p>8. The trust should ensure that staff in community teams are adequately trained in risk management as part of the overall process of assessing risk and ensuring it is properly managed.</p>	<ul style="list-style-type: none"> <li>• Training programme in place</li> <li>• CPA risk assessment and management procedure reviewed/updated</li> </ul>
<p>9. Staff training in the area of personality disorder and other complex issues need to be reviewed.</p>	<ul style="list-style-type: none"> <li>• Training undertaken</li> <li>• Progress reviewed in personality disorder working group and strategy group</li> </ul>
<p>10. The trust should establish a performance framework for all community mental health teams ensuring consistency across the organisation.</p>	<ul style="list-style-type: none"> <li>• Development of standardised performance targets</li> <li>• Performance monitored by monthly CPA audit</li> </ul>
<p>11. The trust should carry out an annual audit of supervision and appraisal for all professionals in community mental health teams.</p>	<ul style="list-style-type: none"> <li>• Performance monitored by monthly CPA audit and balanced scorecard information</li> </ul>
<p>12. The practice of social workers presenting cases to a clinician outside the team should be extended to all staff working within multi-disciplinary teams.</p>	<ul style="list-style-type: none"> <li>• Runnymede now has a multidisciplinary team group supervision arrangements in place</li> </ul>
<p>13. The trust should develop a strategy that ensures all staff are trained and are familiar with the adult protection procedure and that the procedure is appropriately applied.</p>	<ul style="list-style-type: none"> <li>• Links established with local representatives from safeguarding adults teams</li> <li>• Review of adherence to adult protection procedures</li> </ul>
<p>14. The trust must ensure that the critical incident management policy is properly followed at all times.</p>	<ul style="list-style-type: none"> <li>• Review of adherence to incident management policy procedures</li> </ul>
<p>15. The trust should provide training for critical incident management to ensure appropriate reviews and reports are undertaken in time.</p>	<ul style="list-style-type: none"> <li>• Review of adherence to incident management policy procedures</li> <li>• Root cause analysis training held</li> </ul>
<p>16. The trust should provide more formal guidance to internal review panels.</p>	<ul style="list-style-type: none"> <li>• Development of guidance</li> </ul>

## **8. Overall conclusions**

**8.1** Aspects of the way trust services managed Mr H could have been improved but there is nothing in his history or previous presentations to suggest that he was a risk to others.

**8.2** Mr H had been known to mental health services since 1991. His diagnoses between then and the incident in 2006 included alcohol dependency syndrome, emotional unstable personality disorder and depressive disorder. He had frequent contact with the CMHT, crisis team and some inpatient episodes at the Abraham Cowley Unit over these 15 years. The consultant psychiatrist and the care coordinator regularly reviewed him in the last four years of his engagement with trust services.

**8.3** Mr H did not have a long-term management plan despite his long engagement with trust services and regular CPA reviews. He was not deemed ready to be referred to Henderson Hospital because of his heavy drinking but there was no clear plan to try to work towards making him ready for such intervention.

**8.4** There was a plan at one point for Mr H to be referred to the clinical psychologist for one-on-one psychological sessions to explore personality disorder issues. This was good practice and a good example of the benefits of multidisciplinary attendance at CPA review meetings. However, it does not appear that Mr H was ever referred to the clinical psychologist.

**8.5** CPA meetings were held regularly and the meetings were well attended and provided a good forum for Mr H's risk, care planning and treatment to be regularly reviewed. Risk indicators for deterioration were identified during these meetings, yet no one intervened when Mr H's behaviour indicated his mental health was deteriorating.

**8.6** Mr H's risk was regularly reviewed but appears not to have been the subject of a risk management plan to provide clear advice about what to do if his risk escalated or if he displayed signs of behaviour associated with deteriorating mental health. Irrespective of diagnosis, Mr H's risk should have been continually assessed and his care planned on his presenting symptoms.

**8.7** Trust services recognised in 1991 that Mr H needed help to manage his drinking. Staff involved in Mr H's care and treatment also recognised that his drinking had a direct impact on his mental health. Attempts were made, early in his care and treatment, to try to engage Mr H with alcohol services. On one occasion this included a referral to a detoxification unit.

**8.8** A nurse specialist from the Windmill drug and alcohol service reviewed Mr H seven times between 23 May 2002 and 12 March 2003. However, despite alcohol having been a constant feature in Mr H's deteriorating mental health and despite plans to refer him to the alcohol service, no one from the alcohol team saw him between 12 March 2003 and the offence in March 2006. Mr H's clinical records do not make clear what attempts were made to engage him with alcohol services during these three years. There was a disconnection between mental health and alcohol services which meant that his care was not managed in a holistic way.

**8.9** Mr H attended A&E departments of acute hospitals many times - 17 in one year. At that time, there was no facility to offer patients, with repeated A&E presentations, the option of direct access to mental health services. He was, on occasion transferred to the Abraham Cowley Unit where he remained for a short period. Mr H does not appear to have spent more than four days as an inpatient on any one occasion. Trust staff often saw his inpatient episodes as a cooling-off period after a suicide attempt, rather than as an opportunity to reassess his care and treatment needs.

**8.10** Mr H had a long history of self-harming and he frequently returned to heavy drinking after brief periods of stability or abstinence. The likelihood that his mental health would deteriorate on these occasions and that he would require input from mental health services was high. It might have been possible to manage Mr H better in the community if these triggers had been acted upon sooner. Instead, he deteriorated to the point where he felt the need to go to A&E and on some occasions needed an inpatient admission.

**8.11** There were occasions when Mr H was clearly not coping in the community, even with the support of the care coordinator and the consultant psychiatrist. This resulted in him continually going in and out of inpatient services. A more long-term view of Mr H's treatment needs might have helped staff to understand and manage him better.

**8.12** Agencies sometimes shared information appropriately but on occasion they could have worked together better to provide a more holistic approach to Mr H's care and treatment, particularly when he was in the community. This included communicating effectively to ensure that Mr H was managed as a vulnerable person when appropriate.

**8.13** Mr H was difficult to engage when his mental health deteriorated, but when he did engage, trust staff involved in Mr H's care could have done more to formulate a long-term care management plan, which included long-term management of his personality disorder.

## **Lessons**

**L1** The trust should continue to ensure, through personal development plans and supervision, that all staff in direct contact with patients receive training in the assessment, planning and management of risk. The trust should ensure that staff receive risk assessment training and are declared competent before conducting any risk assessments. The clinical governance team should audit training records at least every three months and report findings to the trust board at appropriate times, as defined by the trust's governance processes.

**L2** The trust should assure itself that the current process for Care Programme Approach (including care planning, risk assessment, risk management planning) is robust. The clinical governance team should audit compliance at least every six months and report its findings to the board.

**L3** The trust should ensure that all staff adhere to its policy and procedure for managing formal and informal service users' non-compliance with treatment and managing DNA (did not attend) or cancelled appointments.

**L4** The trust should ensure that staff have received training in the trust's latest adult protection policy. Compliance should be monitored through a regular audit programme.

**L5** The trust should continue to develop relationships with partnership agencies. This should include reviewing the protocols with partnership agencies to ensure effective communication and information sharing. This should take place within the next three months.

**L6** The trust should assure itself that appropriate arrangements are in place to ensure that a service user's CPA requirements are fulfilled in a team member's absence.

**L7** The trust should continue to encourage risk panel meetings. In circumstances where there is significant uncertainty about an individual patient's diagnosis and/or treatment plan, these cases should automatically be discussed in an appropriate forum, with other clinical colleagues, to assist in developing an appropriate care and risk management plan.

### Documents reviewed

- Absent without leave/missing person policy, September 2011
- Care planning and assessment procedure, September 2010
- Care programme approach policy, January 2007
- Care programme approach policy, October 2008
- Discharge from in-patient services, October 2007
- Dual diagnosis policy and procedure, October 2009
- Incident management policy, August 2011
- Integrated paper/electronic health records, September 2011
- Management of alcohol and drug use by service users/visitors on trust premises, March 2006
- Management of people with a dual diagnosis of mental health and learning disability, February 2007
- Medicines procedure: discharge notification and prescription sheet, November 2009
- Partnership policy on confidentiality and information recording & sharing, September 2007
- Policy and procedure for nonattendance of patients at appointments (DNA), February 2006
- Record management policy, October 2011
- Records management, November 2007
- Retention of records policy, March 2006
- Risk management strategy, October 2011
- The records management: NHS code of practice, April 2007

## Appendix B

### Surrey and Borders NHS Foundation Trust personality disorder implementation plan

Action	Date	Lead
Period of consultation on the proposal	August - October 2012	AL, HW and VB
Workshops to establish the Tier 3 teams - staffing and pathways	August - October 2012	Ads, psychology leads, medical consultant in psychotherapy, representatives from CMRS
Professional groups to audit their specific training needs and prioritise this training in collaboration with learning and development	August - September 2012	Professional leads for each of the professional groups
CMHRS review engagement, assessment and review process to ensure local alignment with strategy	August 2012	Operational Ads. CMHRS managers, CMHRS psychiatrists, multidisciplinary staff and QAG chairs
New pathways set up specifying the approaches and interventions provided by Tiers 2 and 3	September - October 2012	Ads, psychology leads, medical consultant in psychotherapy, representatives from CMHRS
Training programme developed and cascaded for CMHRs and 24/7 services	August - November 2012	Operational Ads, learning and development, psychology and psychotherapy clinicians
Communication plans	In progress	SC, AL, operational and professional Ads
Workshop to include practitioners from all SABP care groups to promote best practice across services	November 2013	Tier 3 leads, Ads older adults, CYPs and learning disability
Local audits of pathways and access to interventions	March 2013	Lead psychologist supported by an assistant-reports to QAGs
SABP workshop to celebrate progress on improving services for people with personality disorder	September 2013	Tier 3 leads in collaboration with Tier 2 and people who use services and carers
Review the strategy and update with improvements in access for all care groups	October 2013	Tier 3 in collaboration with Tier 2 and people who use services and carers

### Team biographies

#### *Amber Sargent*

Amber joined Verita as a senior investigator in 2009. Previously she worked at the Care Quality Commission (CQC) where she led on several major investigations into patient safety, governance and concerns around performance.

In addition to carrying out reviews and investigations Amber leads Verita's work on reducing sickness absence within NHS trusts and improving medical devices safety. Amber is also involved with helping a foundation trust develop its care pathway for cardiology services and benchmarking the service both nationally and internationally.

#### *Ed Marsden*

Ed has a clinical background in general and psychiatric nursing and NHS management. He has worked for the National Audit Office, the Department of Health and the West Kent Health Authority where he was director of performance management before founding Verita in 2002. He combines his responsibilities as Verita's managing partner with an active role in leading complex investigations and advising clients on the political repercussions of high-profile investigations. He is an expert in investigative techniques and procedures. Ed is an associate of the Prime Minister's Delivery Unit where he has carried out three assignments on immigration.