INDEPENDENT INVESTIGATION

INTO THE CARE AND TREATMENT PROVIDED TO MR AND MRS X BY 5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST & WIGAN LOCAL AUTHORITY

THE HEALTH AND SOCIAL CARE ADVISORY SERVICE

MARCH 2013

NHS
North of England

Independent Investigation

into the

Care and Treatment Provided to Mr. and Mrs. X

by the

5 Boroughs Partnership NHS Foundation Trust

and

Wigan Local Authority

Commissioned by
NHS North West
Strategic Health Authority

Report Prepared by the Health and Social Care Advisory Service
Report Authored by Dr. Androulla Johnstone

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1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. and Mrs. X was commissioned by NHS North West Strategic Health Authority pursuant to *HSG (94)27*[1]. This Investigation was asked to examine a set of circumstances associated with the death of Mr. and Mrs. X who were found dead at their home on the 10 September 2009, both of whom were service users with a secondary care mental health provider. The primary focus of this Investigation is to examine the effectiveness of the care and treatment that Mr. X received from the 5 Boroughs Partnership NHS Foundation Trust and Wigan Local Authority. It will also examine the effectiveness of the care and treatment provided by these same statutory bodies to Mrs. X.

Mr. and Mrs. X received care and treatment for their mental health conditions from the 5 Boroughs Partnership NHS Foundation Trust. At the Inquest held into the deaths of Mr. and Mrs. X between the 10 and 17 October 2011 Her Majesty's Coroner found that Mrs. X had died from ligature strangulation and had been unlawfully killed and that Mr. X had died from the act of hanging himself. The conclusion subsequently reached was that Mrs. X had been killed by her husband and that Mr. X went on to kill himself whilst the balance of his mind was disturbed by mental illness.

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

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust and Local Authority Senior Management Teams which granted access to facilities and individuals throughout this process. The Trust and Local Authority Senior Management Teams have acted at all times in

1. Health Service Guidance (94) 27

an exceptionally professional manner during the course of this Investigation and have engaged fully with the root cause analysis ethos of this Investigation.

2. Condolences to the Family and Friends of Mr. and Mrs. X

The Independent Investigation Team would like to extend their condolences to the family and friends of Mr. and Mrs. X. It is hoped that this report will provide a narrative to the events that occurred and address any of the outstanding questions that they may still have.

At the time of writing this report it had not been possible meet with either the family or friends of Mr. and Mrs. X.

3. Incident Description and Consequences

The following information has been taken from the clinical records of both Mr. and Mrs. X.

Background for Mr. X (deceased)

Mr. X was a white British gentleman who was 70-years old at the time of his death. He had been married to his wife, Mrs. X, for fifty years and the couple had two grown-up sons. Mr. X worked as a coal miner until 1989 when he retired on the grounds of ill health. Clinical records show that Mr. X suffered with mental health problems from his early adulthood onwards. He suffered from depression and anxiety, which at times were accompanied by delusional beliefs, exacerbated by alcohol abuse. This led to his becoming socially isolated.

Mr. X had only intermittent contact with secondary care services until the autumn of 2008. At this time his mental state rapidly deteriorated following an alleged assault on his wife which resulted in her temporarily leaving the marital home. Mr. X underwent an inpatient admission on an informal basis between 12 November 2008 and the 25 March 2009. Mr. X returned to live at the marital home with his wife following his discharge. He was discharged on Enhanced CPA (Care Programme Approach) and received community-based care until the time of his death on the 10 September 2009. It would appear that for a considerable period of time, between his discharge and the time of his death, Mr. X had no allocated Care Coordinator, and that he received very little contact and support within his home from his allocated team. Mr. X received his care and treatment from services provided by the Hindley and Ince Adult Community Mental Health Team.

Background for Mrs. X (deceased)

Mrs. X was a white British lady who was 69-years old at the time of her death. Mrs. X had been treated by her GP for depression and anxiety over a period of many years.[2] In March 2006 Mrs. X was referred to secondary care mental health services by her GP as her memory appeared to be in decline and her mood low. Following the secondary care assessment at this time it was concluded that Mrs. X had a mild cognitive impairment and possible dementia of the Alzheimer type. It was also considered that Mrs. X might be suffering from severe anxiety and depression. It was decided that further assessment was required and arrangements

2 . Mrs. X GP Records PP5-35

were made to follow Mrs. X up at an Outpatient Clinic. Mrs. X did not however engage with the Outpatient Clinic and did not have any further contact with secondary care services until the autumn of 2008 when she left the marital home following an alleged assault by her husband and went to live with her eldest son.

Mrs. X was placed in respite care between October 2008 and March 2009. During this period it was decided that Mrs. X would not pursue Police involvement regarding the alleged attack that her husband had made upon her. Whilst in respite care Social Services initiated a Protection of Vulnerable Adults (POVA) investigation. This investigation was closed during an initial stage as it was thought that Mrs. X would not be returning to the marital home and would not be living with Mr. X again, thus ensuring her continued safety.

However during February 2009 it became clear that Mr. and Mrs. X wished to be reunited and plans were made for their respective discharges to take place. Both Mr. and Mrs. X returned to the marital home at the end of March 2009. Mrs. X was discharged from her respite care on the 17 March 2009 and was placed on Enhanced CPA. A Care Coordinator was allocated to Mrs. X from the Golborne Older Persons' Community Mental Health Team (CMHT) and a social care package was also put into place to provide ongoing support for her in the community. Mr. and Mrs. X were to cancel this care package shortly after their return home, preferring to depend solely upon the Care Coordinator and the support they could receive from the CMHT.

On the 13 July 2009 Mrs. X was admitted into hospital as her physical health had broken down. She had become very dehydrated and had a severe urinary tract infection resulting in systemic sepsis. On the 21 July 2009 Mrs. X was discharged from the hospital back to her home. A new care package had been put in place. It was noted within the clinical record that from this time onwards Mr. X's anxiety grew and Mrs. X became concerned about her husband's behaviour.

Following the input from mental health services in the autumn of 2008, and up until the period immediately prior to their deaths, Mr. and Mrs. X were receiving their care and treatment from two different community mental health teams, both provided by the 5 Boroughs Partnership NHS Foundation Trust and Wigan Local Authority.

Incident Description and Consequences

On the 10 September 2009 a review worker with the Golborne Older Persons' CMHT tried to undertake a visit to Mrs. X at her home. No one came to the door in response to her knocking. Later that day at 16.30 hours the Review Worker returned to Mr. and Mrs. X's house with the CMHT Manager. Attempts were made to rouse the occupants but with no success. The CMHT Manager decided that the situation was potentially serious and the Police were telephoned at 17.00 hours. At approximately 17.30 hours the CMHT Manager telephoned Mr. and Mrs. X's eldest son. In response to this call the son arrived at his parents' home. After a discussion the son agreed to force entry through the back door. Once access was gained the bodies of Mr. and Mrs. X were discovered, they were both dead. The Police arrived in response to the call made at 17.00 hours whilst the CMHT Manager was attempting to call them again, this time to report the discovery of the bodies.[3]

At the Coroner's Inquest that was held between the 10 - 17 October 2011 it was concluded that Mr. X had died from hanging and that *"He took his own life whilst the balance of his mind was disturbed by a diagnosed mental illness".* It was also concluded that Mrs. X had died as a result of ligature strangulation and had been unlawfully killed.[4] No third party was implicated in the deaths of Mr. and Mrs. X, the assumption being that Mr. X killed his wife and then killed himself.

3. Mrs. X Vol. 1 P.9
4. Trust Inquest Documentation

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

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

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

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

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

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

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

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

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

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

5. Terms of Reference

The Terms of Reference for this Investigation were set by NHS North West Strategic Health Authority. The 5 Boroughs Partnership NHS Foundation Trust and Wigan Local Authority did not wish to make any additions. The Terms of Reference were as follows:

1. To examine:

- the care and treatment provided to the service user and his wife, at the time of the incident (including that from non NHS providers e.g. voluntary/private sector, if appropriate);
- the suitability of that care and treatment in view of the service users' history and assessed health and social care needs;
- the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies;
- the adequacy of risk assessments to support care planning and use of the Care Programme Approach in practice;
- the exercise of professional judgement and clinical decision making;
- the interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical needs;
- the extent of services' engagement with carers; use of carer's assessments and the impact of this upon the incident in question;
- the quality of the internal investigation and review conducted by the Trust.

2. To identify:

- learning points for improving systems and services;
- development in services since the user's engagement with mental health services and any action taken by services since the incident occurred.

3. To make:

- realistic recommendations for action to address the learning points to improve systems and services.

4. To report:

- findings and recommendations to the NHS North West Strategic Health Authority Board as required by the SHA.

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of the 5 Borough Partnership Mental Health Services and Wigan Local Authority. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in investigation and inquiry work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Team Leader

Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service. Chair, and Report Author

Investigation Team Members

Dr. Carlo Berti	Consultant Psychiatrist Member of the Team
Mr. Alan Watson	Social Worker Member of the Team
Ms. Catherine Gaskell	Nurse Member of the Team
Mrs. Jane Duncan	Local Authority and Safeguarding Member of the Team

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service
Mrs. Fiona Shipley	Stenography services

Additional Independent Advice to the Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks
Ms. Nicola Davey	Pharmacy advice

7. Investigation Methodology

On the 18 April 2011 NHS North West (the Strategic Health Authority) commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in section five of this report. The Investigation methodology is set out below. It was the decision of the Strategic Health Authority that full anonymity be given to Mr. and Mrs. X and all witnesses to this Investigation.

Communications with the Family of Mr. and Mrs. X

The two sons of Mr. and Mrs. X were written to by NHS North West on the 7 December 2011. They were informed that an Investigation had been commissioned under the auspices of HSG (94) 27 and invited them to make contact with the Strategic Health Authority so that they could become involved fully in the process. At the time of writing this report further communication with the family was ongoing.

Communications with the 5 Boroughs Partnership NHS Foundation Trust

On 19 April 2011 NHS North West wrote to the 5 Boroughs Partnership NHS Foundation Trust Director of Nursing, Governance and Performance. This letter served to notify the Trust that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. and Mrs. X. This correspondence also formally requested that Mr. and Mrs. X's clinical records be released to the Independent Investigation Team. Following this correspondence the Independent Investigation Team Chair made direct contact with the Trust *via* telephone on the 18 July 2011.

On the 16 August 2011 the Chair of the Independent Investigation Team met with the 5 Boroughs Partnership NHS Foundation Trust Executive Team which included representation from both the Trust and the Wigan Local Authority. On this occasion senior Trust and Local Authority Officers were identified as being the Liaison Personnel for the Investigation. On this occasion the Investigation process was discussed and an invitation from HASCAS was made for a workshop to take place to provide a briefing opportunity for all those who would be involved with the Investigation.

A workshop was held on the 1 November 2011 for all those Trust-based witnesses who had been identified as needing to be called for interviews by the Independent Investigation Team. The workshop provided an opportunity for witnesses to have the process explained to them in full. Advice was given regarding the writing of witness statements and the interview process was discussed in detail. On the 7 November 2011 a workshop was also held for all Local Authority-based witnesses identified as needing to be called for interview.

Between the first meeting stage (September) and the formal witness interviews (November) the Independent Investigation Team Chair worked with the Trust and Local Authority liaison personnel to ensure:

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

On the 14 March 2012 the Investigation Team Chair met with the 5 Boroughs Partnership NHS Foundation Trust and Local Authority senior management to discuss the Investigation headline findings. This meeting provided an opportunity for the early learning of lessons and ensured that each statutory agency could develop appropriate and fit for purpose recommendations in conjunction with the Independent Investigation Team prior to the completion of the report.

The draft report was sent to the Trust and Local Authority for factual accuracy checking on the 26 March 2012. All clinical witnesses were also sent key sections of the report for factual accuracy checking. Throughout the Investigation process communications were maintained on a regular basis and took place in the form of telephone conversations and email correspondence. The Independent Investigation Team would like to note that both the Trust and the Local Authority worked with the Independent Investigation Team in a timely and professional manner throughout the entire process.

Communication with NHS Ashton, Leigh and Wigan Primary Care Trust (PCT)

On the 19 April 2011 NHS North West wrote to the Ashton, Leigh and Wigan Primary Care Trust Chief Executive. This letter served to notify the PCT that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. and Mrs. X. This correspondence also formally requested that Mr. and Mrs. X's GP clinical records be released to the Independent Investigation Team. Following this correspondence the Independent Investigation Team Chair made direct contact with the Primary Care Trust (PCT) *via* telephone on the 7 October 2011. Delays ensued due to PCT organisational change.

On the 24 May 2012 the Investigation Team Chair met with the Ashton, Leigh and Wigan Primary Care Trust to discuss the Investigation headline findings. This meeting provided an opportunity for the early learning of lessons and ensured that the commissioner could develop appropriate and fit for purpose recommendations in conjunction with the Independent Investigation Team prior to the completion of the report.

Completion of the Process

It was agreed that a formal workshop would be held with the 5 Boroughs Partnership NHS Foundation Trust and key stakeholders directly prior to the publication of this report to provide feedback and ensure that an opportunity existed for lessons to be learned. This event was held on the 23 May 2012.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon compliant processes. A total of 40 witnesses were interviewed formally. Table one lists the witnesses who were interviewed and the interviewees that were present.

Table One

Witnesses Interviewed by the Independent Investigation Team

(11 November 2011 - 16 December 2011)

Date	**Witnesses**	**Interviewers**
11 November 2011	Consultant Psychiatrist 2 (Mr. X) SUI Reviewer (1) RMN 1 Holdenbrook Ward (Mr. X) RMN 2 Holdenbrook Ward (Mr. X) RMN 3 Holdenbrook Ward (Mr. X)	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse Investigation Team Social Worker Investigation Team Safeguarding Lead In attendance: Stenographer
14 November 2011	Crisis Team Worker 1 (Mr. X) Crisis Team Worker 2 (Mr. X) Crisis Team Worker 3 (Mr. X) Older Persons' CMHT Worker 1 (Mrs. X) Older Persons' CMHT Worker 2 (Mrs. X) Older Persons' CMHT Worker 3 (Mrs. X) Older Persons' CMHT Manager (Mrs. X) Duty Worker Adult Team (Mr. X) Manager Adult CMHT (Mr. X) Duty Officer Adult CMHT (Mr. X) Support Worker Adult CMHT (Mr. X) Former Head of Service Former Assistant Director of Adults Wigan	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse Investigation Team Social Worker In attendance: Stenographer
15 November 2011	Deputy Ward Manager Holdenbrook Ward (Mr. X) Ward Manager Holdenbrook Ward (Mr. X) Care Coordinator 2 (Mrs. X) RMN 4 Holdenbrook Ward (Mr. X)	Investigation Team Chair Investigation Team Nurse Investigation Team Social Worker In attendance: Stenographer
16 November 2011	Review Officer Older Persons' CMHT (Mrs. X) Occupational Therapist Older Persons' CMHT (Mrs. X) SUI Reviewer 1 SUI Reviewer 2 Trust Director of Nursing Trust Medical Director Assistant Director of Adult Services	Investigation Team Chair Investigation Team Nurse Investigation Team Social Worker In attendance: Stenographer HASCAS Director of Service Improvement

	Assistant Director of Nursing Head of Risk and Safety	
21 November 2011	Older Persons' CMHT Manager (Mrs. X) Social Worker 1 (Mrs. X) Crisis Team Manager (Mr. X) Local Authority Adult Protection Coordinator Local Authority Service Manager People's Directorate Local Authority Head of Service Support and Assessment Service	Investigation Team Chair Investigation Team Social Worker Investigation Team Safeguarding Lead In attendance: Stenographer
16 December 2011	Consultant Psychiatrist 1 (Mrs. X) RMN 5 Holdenbrook Ward (Mr. X) Support Worker Older Persons' CMHT (Mrs. X)	Investigation Team Chair Investigation Team Psychiatrist In attendance: Stenographer

Salmon/Scott Compliant Procedures

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

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

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

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

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

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

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

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

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

(h) that they will be given the opportunity to review clinical records prior to and during the interview;

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

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

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

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

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

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

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

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

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

Independent Investigation Team Meetings and Communication

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

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

The Team Met on the Following Occasions:

28 October 2011. On this occasion the Team examined the timeline based on what could be ascertained from analysing the documentary evidence. The witness list was confirmed and emerging issues were identified prior to the interviews.

10 November 2011. A second meeting took place to discuss further issues raised from the secondary literature in preparation for the witness interviews.

11 November 2011 - 16 December 2011. Between these dates witness interviews took place. During this period the Investigation Team took regular opportunities to re-examine the timeline, re-evaluate emerging issues and to discuss additional evidence as it arose. On the 23 November 2011, using the Terms of Reference and the timeline as guidance, the Team developed subject headings that required further examination.

Between the 23 November 2011 and the 13 December 2011 each Team Member prepared an analytical synopsis of identified subject headings (in compliance with the Investigation Terms of Reference) in order to conduct an-in-depth Root Cause Analysis (RCA) process.

14 December 2011. On this day the Team met to work through each previously identified subject heading utilising the 'Fishbone' process advocated by the National Patient Safety

Agency (NPSA).[5] This process was facilitated greatly by each Team Member having already reflected upon the evidence prior to the 14 December 2011 and being able to present written, referenced briefings at the meeting. The 'Five Whys' process was also used.

Following this meeting the report was drafted. The Independent Investigation Team Members contributed individually to the report and all Team Members read and made revisions to the final draft.

Other Meetings and Communications

The Independent Investigation Team Chair met on a regular basis with NHS North West throughout the process. Communications were maintained in-between meetings by email, letter and telephone.

Root Cause Analysis

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

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

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

5 National Patient Safety Agency (2008) *Root Cause Analysis Tools: Guide to Investigation Report Writing following Root Cause Analysis of Patient Safety Incidents*

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed.
2. **Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the 'Decision Tree', the 'Five Whys' and the 'Fish Bone'.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

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

8. Information and Evidence Gathered (Documents)

During the course of this investigation 1,447 pages of clinical records were read and some 2,000 pages of other documentary evidence were gathered and considered. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Local Authority records for Mr. and Mrs X
2. GP records for Mr. and Mrs. X
3. Trust clinical records for Mr. and Mrs. X
4. Trust/Local Authority Internal Investigation Report and Investigation Archive
5. Trust assurance and governance documentation
6. Inquest and Pathology documentation
7. Secondary literature review of media documentation reporting the death of Mr. and Mrs. X
8. Independent Investigation Witness Transcriptions
9. Trust Clinical Risk Assessment Clinical Policies, past and present
10. Trust Care programme Approach Policies, past and present
11. Trust and Local Authority Safeguarding and Vulnerable Adult Policies, past and present
12. Trust and Local Authority Operational Policies, past and present
13. Trust Incident Reporting Policies
14. Trust Clinical Supervision Policy
15. Trust Being Open Policy
16. Trust Operational Policies
17. Healthcare Commission/Care Quality Commission Reports for …Trust services
18. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006
19. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005

9. Profile of the 5 Boroughs Partnership NHS Foundation Trust Services (Past, Present and Transition) and Wigan Local Authority

Profile of the Trust

The following information has been taken from the Trust Annual General Meeting Report.

The Trust Profile

Formed in 2002, 5 Boroughs Partnership NHS Trust achieved Foundation Trust status on 1 March 2010 to become 5 Boroughs Partnership NHS Foundation Trust. Based in the north west of England, the Trust delivers a range of person and family-centred services that promote recovery, wellbeing and health. The Trust provides services for children and young people, adults and older people in a variety of settings including in-patient wards, people's own homes and within a wider-community setting. The Trust has an annual budget of around £100million serving a population of almost one million people living in the boroughs of Halton, Knowsley, St Helens, Warrington and Wigan.[6]

The Trust Vision

The Trust works with many partners including primary care trusts, local authorities, social services and the voluntary sector to help turn its vision of becoming *"a leading provider of world-class mental health, learning disability and community services, with a reputation for quality, innovation and excellence"* into a reality.[7]

Trust Services

Children and Young Peoples' Services

The Trust provides community-based child and adolescent mental health services in each of its five boroughs for young people up to the age of 18, their carers and families. In addition the Trust sees young people in schools and other premises to facilitate collaborative working

6. Trust 2011 AGM Report P. 8
7. Trust 2011 AGM Report P. 8

and care closer to home. The Trust also provides in-patient services within Fairhaven Young People's Unit which is an eight-bedded unit based in Warrington.[8]

Adult Services

The Trust provides acute psychiatric community and in-patient assessment, treatment and support services for adults who develop severe functional mental health disorders such as Bipolar Disorder. The Trust provides many community services in partnership with local authorities and the voluntary sector. The Trust also operates one Psychiatric Intensive Care Unit (PICU) at Leigh Infirmary. This is a highly specialised unit which provides in-patient services to people requiring an intensive period of support in a safe environment, typically for up to 28 days. Services are focused on providing support for people to recover from episodes of mental ill health.[9]

Older Peoples' Services

The Trust provides acute community and in-patient assessment and treatment services for older people. There is also the provision of specialist services to people of all ages who develop organic conditions such as Alzheimer's Disease. The Trust provides services for older people at assessment and treatment centres, acute psychiatric in-patient facilities and in continuing care settings.[10]

Learning Disability Services

The Trust provides community and specialist acute in-patient services for people with a learning disability. The provision offers people choice about when and where they access services to fit in best with their daily lives. The Trust is actively involved in Learning Disability Partnership Boards working with people who have a learning disability to ensure that their health needs continue to be supported in community settings. Services are delivered with local authority and primary care trust partners.[11]

Forensic Services

The Trust provides care and treatment in secure settings for those people who the Courts and/or clinicians identify as not being best cared for in an open environment. Such service

8. Trust 2011 AGM Report P. 9
9. Trust 2011 AGM Report P. 9
10. Trust 2011 AGM Report P. 9
11. Trust 2011 AGM Report P. 9

users often have multiple and complex care needs. The Trust provides low-secure services in two separate male and female units at Hollins Park for adults with mental health disorders, a low secure step-down unit for those ready to move back into community settings and one unit for people with a learning disability.[12]

Profile of Wigan Local Authority

About the Borough

With a population of about 300,000 across an area of 77 square miles, Wigan is one of the largest metropolitan districts in England. The borough is based around the two main towns of Wigan and Leigh, and several smaller towns and villages of the former Lancashire coalfield. Wigan is the most westerly district of the county of Greater Manchester.[13]

Safeguarding Vulnerable Adults

Joint procedures for the recognition, reporting and investigation of the abuse of vulnerable adults in Wigan have been drawn up by a working group representing:

- Wigan Council
- Ashton, Leigh and Wigan Primary Care Trust
- Wrightington, Wigan and Leigh NHS Trust
- Greater Manchester Police
- Age UK
- Wigan and Leigh Housing

The procedures have been drawn up because of concerns that vulnerable people in society may be abused or taken advantage of by those in a position of power over them.

12. Trust 2011 AGM Report P. 9
13.http://www.wigan.gov.uk/Services/CommunityLiving/AboutBorough/

10. Chronology of Events

This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the lives of Mr. and Mrs. X and on their care and treatment from mental health and social care services.

There are three issues regarding the clinical records that were made available to the Independent Investigation Team which need to be noted prior to reading the chronology.

First: paucity of records. There was a distinct paucity in the clinical records relating to the histories of both Mr. and Mrs. X. This has limited to a large extent what is known about the couple prior to their last episode of contact with secondary care services between October 2008 and September 2009.

Second: co-mingling of clinical records pertaining to Mr. X. A significant degree of co-mingling has occurred with the clinical records of Mr. X leading to misinformation being present. This co-mingling was impossible to 'unravel' beyond a certain point as at least three service users of the same name had over the years inadvertently been given the same address, date of birth and NHS identifying numbers. This misinformation also found its way into the clinical records of Mrs. X. As a consequence the Independent Investigation Team could not commence the chronology pertaining to the care and treatment of either service user with any degree of confidence prior to 2006. The fact co-mingling had occurred was made evident by identifying separate clinical entries which had been created by different Consultant Psychiatrists, citing different diagnoses, medication, and events histories (e.g. individuals being in different places on the same day). The misinformation contained in the clinical record did affect the quality of the psychiatric history taken for Mr. X between September 2008 and September 2009. The consequences of this are examined in the main body of the report.

Third: missing records. The Independent Investigation Team is also aware that the internal investigation appeared to have information about certain events that was not presented to this Investigation. The information set out below, and throughout the report, has been included following an exhaustive examination of, and search for, the clinical records by both the Independent Investigation Team and the Trust. The Independent Investigation Team could not include as fact events based on 'hearsay', and could only include events with verifiable documentary evidence.

Background Information for Mr. and Mrs. X

Mr. and Mrs. X were both born in 1939, and were 70 and 69 years of age respectively at the time of their deaths. The couple had been married for 50 years and had two grown up sons.

Mr. X had been a coal miner up until 1989 when he was retired due to ill health. There is a brief mention in his GP clinical record that he had been involved in a mining accident in the late 1960s which had affected his health and wellbeing in some unspecified way. Prior to her retirement Mrs. X had been a factory and shop worker.

It is evident from reading through the GP records that both Mr. and Mrs. X had been treated recurrently for depression and anxiety throughout their adult lives. It is also evident from the GP record that both Mr. and Mrs. X had experienced problems with their physical health during the years directly preceding their deaths. At the time they received their care and treatment with the 5 Boroughs Partnership NHS Foundation Trust and Wigan Local Authority Mr. and Mrs. X had been living in the Wigan area for several years.

It should be noted that the clinical and social care histories of both Mr. and Mrs. X are closely intertwined. In order to present the information in a coherent narrative the information for both individuals is set out below in chronological order.

Clinical and Social Care History for both Mr. and Mrs. X

23 February 2006. It was recorded that Mrs. X visited her GP and the decision was taken to refer her to the Memory Clinic.[14] The GP clinical documentation recorded that Mrs. X had been experiencing memory loss for a period of some 12 months. It was thought that this was possibly due to the stress of looking after her husband as he had been unwell. Prior to this time Mrs. X had not wanted to proceed with a referral.

20 April 2006. Mrs. X was seen in the Memory Clinic by Consultant Psychiatrist 1 who referred Mrs. X for a neuro-psychological assessment. It was noted that Mrs. X had been anxious and depressed due to her husband's poor health. It was recorded that Mr. X had been diagnosed with a Bipolar Disorder. Consultant Psychiatrist 1 wanted to understand whether the memory problems and cognitive impairment Mrs. X presented with were due to Alzheimer's Disease or anxiety and depression exacerbated by her husband's condition.[15]

12 May 2006. Consultant Psychiatrist 1 wrote to Mrs. X's GP. He had reviewed Mrs. X in the Memory Clinic with her friend in attendance on the 20 April. Mrs. X explained that her memory was poor and that her husband irritated her. Mrs. X reported that she had a bad memory, but that she always had been *"scatterbrained".* Mrs. X said that her husband's condition stressed her and that he had a Bipolar Disorder and had not been well for some time. The opinion was that Mrs. X had a mild cognitive impairment and that she should be monitored to see how things developed.

The diagnosis was *"?early dementia ?anxiety and depression".* The Consultant encouraged Mrs. X to take Sertraline (100mg) on a regular basis. The Consultant asked the GP to conduct a physical examination and wrote that he would be referring Mrs. X for a computerised tomography (CT) scan. The plan was to follow her up in four-months time in the Outpatient Clinic. It was noted that historically Mrs. X had not been compliant with anti-depressant medication but that the Sertraline should be trialled for *"several months"* to see if it would be effective.[16]

14. Mrs. X GP Record P. 178
15. Mrs. X Vol. 5 P. 257
16.Mrs. X Vol. 5 PP. 258-261

23 August 2006. The Senior House Officer on Consultant Psychiatrist 1's team wrote to the GP to say that Mrs. X had been reviewed in the Outpatient Clinic. She was once again accompanied by her friend. The diagnosis remained *"?anxiety and depression ?early dementia".* The management plan was to increase her Sertraline from 100mg to 150mg once daily. The GP was asked to forward on the blood results that had been requested the previous May. Consultant Psychiatrist 1 planned to follow Mrs. X up in the Outpatient Clinic in three-months time.

Mrs. X appeared to have improved a little since May. She continued to be distressed caring for her husband. During the consultation she became *"weepy and was very tearful"* She denied any thoughts of suicide or self harm.[17]

5 June 2007. Consultant Psychiatrist 1 wrote to the GP to say that Mrs. X had not been attending the Psychiatric Outpatient Clinic as previously planned and that another appointment would be sent.[18]

August 2007. An 'Essential Data Form' was completed by a Community Psychiatric Nurse (CPN) with the Older Persons' Community Mental Health Team (CMHT). Mrs. X was designated as requiring the Care Programme Approach (CPA), although her needs were assessed to be low.[19]

Once again it was recorded that Mrs. X had not attended her Outpatient appointment with Consultant Psychiatrist 1. He wrote to the GP that her husband had rung to say his wife did not need any further appointments as she was fine. The GP was asked to re-refer Mrs. X in the future if it became necessary.[20]

January and February 2008. Mrs. X visited her GP twice during this period. In the January it was recorded that that there were marital problems. Mrs. X reported that her husband was depressed and verbally abusive, not physically violent, but that he shouted at her and broke her things. In the February it was recorded that the GP had a chat with Mrs. X about her

17. Mrs. X GP Record PP.147-148
18.Mrs. X GP Record P. 146
19. Mrs. X Vol. 1 P. 1
20. Mrs. X GP Record P. 163

husband's controlling attitude. She was encouraged to stay in contact with her female friends and get out more.[21]

August 2008. Mrs. X visited her GP on two occasions. The first time the GP described Mrs. X as having a blunted affect and difficult home circumstances due to her husband's Bipolar Disorder. She was less able to cope and was forgetful. The second time the GP wrote that Mrs. X was upset because her husband *"still had a bad temper not physically violent, but breaking things & shouts and swears".*[22]

3 September 2008. Mrs. X was reviewed by the GP. Mrs. X was shaky and wanted something to calm her down. She was referred for guided self help.

28 September 2008. Mr. X was referred to secondary care mental health services by his GP. This referral went to the Crisis Team. The Crisis Team forwarded the FAX referral to the Central Duty Team. Checks were made on SWIFT (the Local Authority electronic record system). It was noted that Mr. X was known to the service and that his case had been closed previously in November 2006.

The FAX narrative (from the GP) stated that Mrs. X had left her husband one week earlier to go and live with her son. Mr. X had stated that he intended to commit suicide as he could not cope without her. Mr. X had answered the door to the GP in his underwear. It was noted that Mr. X presented a risk to himself and had thoughts of suicide. The GP did not feel, however, that a Mental Health Act (2007) assessment was required at this stage. The GP had spoken to Mr. X's son who had said that his father had taken the break up with Mrs. X badly.

Mr. X's case was processed by the Gateway Service who referred Mr. X to the Golborne Older Persons' CMHT. The electronic record shows that the case was opened but not allocated. A note was made *"CONCLUSION: URGENT TO OPCMHT AT Claire House".*[23]

21. Mrs. X GP Record P.178
22. Mrs. XGP Record P. 177
23. Mr. X Vol. 7 P. 390 - 391

29-30 September 2008. An 'Initial Core Assessment' was conducted by a Triage Nurse at the Golborne Older Persons' CMHT (OPCMHT), who visited Mr. X at his home with a Social Worker. It was recorded that Mr. X had been placed on Enhanced CPA.

It was also recorded that:

- Mr. X had been referred as an urgent case by his GP;
- Mr. X's wife had left him and he was distraught, expressing paranoid ideas, neglecting himself and not eating;
- Mr. X had not expressed any suicidal ideas (which was in contrast to an earlier presentation);
- Mr. X had a long history of mental health problems;
- Mr. X had been seen by a Consultant Psychiatrist at the Trust a few years earlier.

Mr. X reported that his wife of fifty years had left him. He explained that she had become neglectful of the house and no longer cooked meals, neither could she switch on the fire nor use the remote control for the television. Mr. X also said that his wife blamed him and accused him of being responsible for everything going wrong. Mr. X expressed the belief that his neighbours wanted him to leave his house. He said that he *"knew"* they were talking about him and this had led him to stop going to the local shops in order to avoid them. Mr. X described himself as *"feeling worse"* over the past three to four months.

Mr. X said that his wife had previously had a brain scan, but that she had not allowed him to accompany her. She told him the scan had been *"clear".* Mr. X described a poor relationship with one of his sons and that no one in the family was talking to him at the present time. Mr. X felt isolated.

As part of the initial assessment Mr. X's eldest son was contacted. He told the CPN that the family were finding it difficult to cope with his father and that his mother found the situation distressing. Mr. X was assessed as having "*severe paranoid ideas".* He was also described as being tearful and dishevelled and was identified as neglecting himself. He did not want to be admitted to hospital. Mr. X agreed to be seen again the following week and to comply with his medication. He said he had thoughts of suicide but no plans; this was in contrast to other documented information (see above).

It was noted that Mrs. X had seen Consultant Psychiatrist 1 in 2006 who suggested she be treated for anxiety and that she may have early dementia. Mrs. X had not attended for any further follow up.

The plan was to:

- discuss the case with the OPCMHT Team Manager;
- get the case allocated *"asap";*
- *"to speak to Consultant and get meds PX";*
- *"to visit this week to give support and medication".*[24]

1 October 2008. The OPCMHT Social Worker faxed the GP and asked him to *"commence Risperidone 2 mg at nocte [at night]*. The OPCMHT Triage Nurse and the Social Worker made a domiciliary visit to Mr. X at the request of the GP. It was recorded that they were both worried about Mr. X as he was paranoid and found coping with his wife's angry outbursts difficult. It was noted that Mr. X needed to be seen by a Consultant Psychiatrist *"as a matter of extreme urgency".* A significant risk of Mr. X committing suicide was recorded.[25]

2 October 2008. The Central Duty Team received a report that Mr. X had been alleged to have assaulted his wife. Mrs. X had told Police that since she retired eight years ago Mr. X hit her from *"time to time"*. On the 17 September 2008 Mrs. X claimed Mr. X had *"shoved"* her to the floor and punched her more than once to the chest. On this occasion she had left the house and gone to stay with her son. Mr. X was arrested for assault and bailed with the condition that he did not attempt to contact his wife. This information was forwarded to the Older Persons' CMHT.[26]

The Central Duty Team screened a referral for Mrs. X. The Central Duty Team contact form stated that an incident had occurred on the 1 October at 15.03 hours. There had also been a report of domestic harassment by Mr. X over the telephone towards his son. Since Mrs. X left the marital home on the 17 September Mr. X had been apparently been telephoning his son and was reported to have been making a nuisance of himself.[27]

24. Mr. X Vol. 2 PP. 23-26
25. Mr. X Vol. 8 P. 488 and Mr. X Vol. 9 P. 525
26. Mr. X Vol. 7 P. 392
27. Mrs. X Vol. 2 PP. 92-94

3 October 2008. The Older Persons' CMHT Manager recorded the difficulty experienced by staff in locating a Consultant Psychiatrist that could make a home visit to Mr. X. It was decided that Mr. X's case needed to be referred to the Adult CMHT due to the functional nature of his presentation. The Crisis Team was to be on standby over the weekend with medical support if required.[28]

A 'Summary of Intervention' form was completed by an Adult CMHT Social Worker. The CMHT was recorded as being the Hindley and Ince CMHT (adult team). It was recorded that Mr. X was on Enhanced CPA. At this stage the Care Coordinator was listed as being the Consultant Psychiatrist (this would have been an initial default position until a proper allocation was made). It was recorded that Mr. X had been diagnosed many years before as having a Paranoid Psychosis. Previously it had also been recorded that Mr. X was suffering from a Bipolar Disorder (this was probably an erroneous entry). Two Social Workers from the Older Persons' CMHT conducted a joint visit to the home and noted that Mr. X was paranoid and drinking alcohol, both whiskey and lager. Mr. X continued to drink throughout the interview. It was recorded that Mr. X's fixed paranoid ideas were affecting his ability to look after himself as he was not leaving the house. It was thought Mr. X's mental health was deteriorating but that the risks he presented with were low and that he presented no risk to others and he denied any intent of harming himself. It was decided that Mr. X would require monitoring from the Crisis Team over the weekend.[29] **NB. At this time Mr. X was receiving input from the Older Persons' CMHT, the Adult CMHT and the Crisis Team whilst the handover was facilitated.**

It was recorded that workers from the Crisis Team visited Mr. X. Mr. X expressed the view that he did not want people coming to the house as he did not want any fuss. Mr. X agreed to Home Treatment Team intervention (part of the Crisis Team) at the weekend and for his case to be reviewed by his Care Coordinator (who was as yet unallocated) the following Monday.[30]

4 and 5 October 2008. On the 4 October a telephone call was made by a worker from the Crisis Team to Mr. X to arrange a home visit. Mr. X declined the offer. Mr. X said he would

28. Mr. X Vol. 9 P. 528
29. Mr. X Vol. 2 PP. 27-28
30. Mr. X Vol. 9 P. 529

contact his Care Coordinator on Monday (it remains unclear who he thought this was).[31] The next day a member of the Crisis Team telephoned Mr. X to arrange another visit. He declined this and also the offer for a telephone call later that same day. The plan was to pass this information on to the Care Coordinator.[32]

6 October 2008. The Consultant Psychiatrist from the Adult CMHT assigned to Mr. X, Consultant Psychiatrist 2, and a Social Worker from the Adult CMHT, visited him at his home. He seemed calm, although tearful, and refused to come into hospital. The Psychiatrist did not think Mr. X was detainable under the Mental Health Act (2007) at this time. Mr. X agreed to engage with regular support. It was noted during the visit that the allocation of a Care Coordinator was required in order to provide further assessment and that this had not yet been done.[33]

7 October 2008. The Adult CMHT received a telephone call from Mr. X. It was recorded that he said *"[they] want him out and he knows what [they are] doing".* Mr. X had interpreted the home visit the previous day as implying that the Adult CMHT workers had wanted him to pack his bags and leave his home. The person receiving the call tried to reassure Mr. X. Following the telephone call Consultant Psychiatrist 2 spoke to the Social Worker who had made the visit with her the previous day. It was agreed that the Social Worker would undertake a joint home visit with another colleague. The visit took place and Crisis Team input was offered again. Mr. X said that he did not want to accept this kind of service.

Later that day Mr. X telephoned the Adult CMHT to say that someone from the Crisis Team had contacted him and that he did not want their support. It was agreed that Mr. X needed continuity of care and that it was important for a Care Coordinator to be allocated. Discussions took place between the Adult CMHT and the Crisis Team to ensure a safe handover.[34]

Eventually Mr. X decided that he would receive daily visits from the Home Treatment Team (part of the Crisis Team) for the next five days until a Care Coordinator was allocated. The

31. Mr. X Vol. 9 P. 530
32. Mr. X Vol. 9 P. 531
33. Mr. X Vol. 7 P. 386 and Mr. X Vol. 9 P. 533
34. Mr. X Vol. 7 PP. 386 - 387

allocation meeting was due on the Friday in five-days time. Mr. X however refused to be visited by any other workers on this day as he had already previously received a home visit from the Adult CMHT.[35]

8 October 2008. Mr. X telephoned the Golborne CMHT (the Older Persons' CMHT) and asked for a hospital admission as he was not coping. The clinical record states: *"[Mr. X] to transfer today".*[36]

A scheduled joint visit was made by the Golborne Older Persons' CMHT and the Adult CMHT. Mr. X was dishevelled and smelt of body odour. Mr. X was ambivalent about going to hospital.

The Social Worker from the Adult CMHT, who had previously visited him at home on the 3 and 6 October, accompanied Mr. X to the hospital for an inpatient admission. Everything was described as going reasonably well until he arrived on the ward. At this point Mr. X said he wanted to go home. Mr. X felt that everyone was against him. There was a considerable delay in the ward doctor arriving to commence the admission. Mr. X became upset and would not accept anything to eat. After a wait of over an hour Mr. X became distressed and refused to stay on the ward. He was told that the bed would be kept for him that night. Mr. X returned home without being seen by any medical staff.

On his return home Mr. X expressed his worry about his pending visit to the Police Station in relation to the alleged assault on his wife. The Social Worker explained that his care was transferring to the Adult CMHT. She advised him of how to contact the Team and what to do if he needed help out of hours. The plan was to discuss Mr. X with Consultant Psychiatrist 2 the following day. The Crisis Team was scheduled to continue daily contact until the end of the week.[37] **N.B. At some point after this date (probably the 10 October) the Social Worker became Mr. X's Care Coordinator. From this point on the Social Worker is referred to in this report as Care Coordinator 1.**

On this same day. A 'Contact Assessment' form was completed for Mrs. X. Mrs. X's son had contacted the Central Duty Office on the advice of Claire House who had told him

35. Mr. X Vol. 9 PP. 534-536
36. Mr. X Vol. 7 P. 387
37. Mr. X Vol. 9 PP. 537-539

someone would come and *"see his mum within two days".* The son had not been able to go to work for three weeks since his mother had come to live with him because she could not be left on her own. It was recorded that he was worried about losing his home if he could not work.[38]

9 October 2008. The Crisis Team attempted a home visit but Mr. X refused them entry. The Adult CMHT was informed.[39] Mr. X was found to be under the influence of alcohol. Whiskey and strong lager were found in his lounge despite Consultant Psychiatrist 2's previous advice about not drinking. It was noted that Mr. X looked unkempt (it is not clear who wrote the clinical record relating to this information, but it would appear a visit was made by the Adult CMHT).[40]

Consultant Psychiatrist 2 was asked to visit Mr. X at his home. She recorded in a letter to the GP that Mr. X was miserable and crying and believing that people were talking about him. He was drinking alcohol to help him sleep. It was noted that he had been married for 50 years and had two grown up sons and that his wife had left him two weeks previously. It was also noted that Mr. X had a long mental health history of depression going back some 30 years. The GP was asked to prescribe Risperidone 2 mg twice daily and to increase Mr. X's current Paroxetine (Seroxat) to 40 mg a day.[41]

On this same day. A Worker from the OPCMHT received an immediate referral from the Central Duty Team regarding Mrs. X. Mrs. X's son had telephoned to say that he could no longer cope with his mother. A call was made to Lakelands Residential Care Home to see if a bed was available.[42] An 'Initial Core Assessment' was conducted by the OPCMHT worker. It was recorded that Mrs. X had been an immediate referral due to an incident of abuse and the fact that her son could not continue to cope as her carer. Mrs. X was too frightened to return home as her husband was there. The son refused a care package to be brought into his home to care for his mother as he did not want to be her carer or for her to continue to live with him. The son was however prepared to keep his mother at his home until a suitable place could be found for her.[43] A risk screen was conducted. The following was recorded:

38. Mrs. X Vol. 2 PP. 98-100
39. Mr. X Vol. 9 P. 545
40. Mr. X Vol. 7 P. 387
41. Mr. X Vol. 9 PP. 502-503
42. Mrs. X Vol. 2 P. 82
43. Mrs. X Vol. 3. PP. 146-153

- *"risk to self - no;*
- *risk to others - no;*
- *risk of vulnerability - yes;*
- *risk of neglect - no."*

Mrs. X was designated Enhanced Level CPA.[44]

10, 11 and 13 October. Care Coordinator 1 telephoned Mr. X who said that he did not want a visit made to his home and that he had not changed his mind about going to hospital. He said he had eaten and taken his medication. The Care Coordinator contacted Consultant Psychiatrist 2. It was agreed that they would visit Mr. X the following Monday. If his condition remained unchanged a Mental Health Act (2007) assessment would be arranged. The GP surgery was informed. The Crisis Team agreed to remain in contact over the forthcoming weekend.[45] The next day the Crisis Team telephoned Mr. X, he declined their input.[46] On the 13 October Care Coordinator 1 spoke to the GP. He was informed of the current situation and was agreeable to take part in a Mental Health Act (2007) assessment if it was deemed to be necessary.[47]

14 October 2008. Mrs. X's case was allocated to a Community Psychiatric Nurse (CPN), Care Coordinator 2, at the Golborne OPCMHT. She recorded that a first contact would be made the following day and that Mrs. X was designated as a new client.[48] The case was allocated to Care Coordinator 2 with an assigned Social Worker as co-worker to conduct the Protection of Vulnerable Adults Investigation (POVA) in relation to the alleged assault that had taken place.[49]

15 October 2008. A visit to Mrs. X took place on this day. Care Coordinator 2, Consultant Psychiatrist 1 and an OPCMHT CPN were present. It was recorded that Mrs. X was too anxious to discuss a care plan.[50] She was described as being afraid and agreed to go into Lakelands Residential Home for respite care for a period of two weeks. Her son was struggling to cope with her and he did not want her to continue to live with him. The

44. Mrs. X Vol. 4. PP. 154-156
45. Mr. X Vol. 9 P. 547-549
46. Mr. X Vol. 9 P. 550
47. Mr. X Vol. 10 P. 553
48. Mrs. X Vol. 1 P. 3
49. Mrs. X Vol. 2 P. 77
50. Mrs. X Vol. 1 P. 5

Psychiatrist conducted a Mini Mental State Examination. The score was 14/30. Mrs. X was disorientated and her memory was poor. A CT brain scan was indicated and "*medication for dementia"* was prescribed. A FAX was sent to Lakelands.[51]

A CPA assessment was commenced on this day by Care Coordinator 2. The assessment stated that Mrs. X had been living with her son for the past three weeks and that he could no longer cope as he needed to get back to work. It was noted that Mrs. X had cognitive problems and short-term memory impairment. Mrs. X was frightened of her husband and did not want to return home. The plan was for Mrs. X to go to Lakelands Residential Care Home for a period of respite. A bilateral tremor was noted in her arms and a referral for a neurology appointment was made. The medication was Duloxetine 60 mg once daily and Donepezil 5 mg once daily. Mrs. X was recorded as having two sons neither of whom maintained regular contact with her due to their father's behaviour.[52] Care plans were developed to address Mrs. X's memory problems, tremors, anxiety and social isolation. A crisis plan was also developed.[53]

22 October 2008. Consultant Psychiatrist 1 wrote to Mrs. X's GP. He had been asked to see Mrs. X by the OPCMHT. Mrs. X had been gradually developing cognitive problems which included short-term memory impairment. Mrs. X's activities of daily living abilities had also declined. Mrs. X had grown increasingly frightened of her husband and was living with her son who was finding it difficult to look after her because she got confused and did not always know who he was. The opinion was that Mrs. X probably had *"a dementia syndrome, suggestive of underlying Alzheimer's Disease".* The plan was to refer Mrs. X for a neurological assessment and to commence her on a cholinesterase inhibitor. Consultant Psychiatrist 1 was to follow her up in three-months time and the OPCMHT was to maintain contact with her via Care Coordinator 2.[54]

23 and 29 October 2008. On these dates the Care Coordinator visited Mrs. X in the presence of her son to discuss the future.[55]

51. Mrs. X Vol. 2 P. 80
52. Mrs. X Vol. 3 PP. 111-117
53. Mrs. X Vol. 3. PP. 136-145
54. Mrs. X Vol. 5. PP. 242-243
55. Mrs. X Vol. 2 PP. 78-79

30 October 2008. A Multi Disciplinary Team meeting was held for Mr. X. The meeting recorded his diagnosis as being *"Psychotic Depression Paranoid".* At this time Mr. X denied experiencing hallucinations or having thoughts of killing himself. It was noted that Mr. X drank heavily and he was advised to cut down. The GP was written to. It was noted in this letter that Mr. X was drinking about one and a half bottles of whiskey a week and that he was having to attend the Police Station as part of his bail conditions.[56]

7 November 2008. Care Coordinator 2 visited Mrs. X at Lakelands with her son present. Plans for the future were discussed.[57] An Occupational Therapy referral was requested.[58] (It is unclear exactly when Mrs. X was admitted to Lakelands).

12 and 13 November 2008. Mr. X was referred for a psychiatric assessment by the Hindley and Ince CMHT Duty Worker due to Mr. X having *"agitation/anxiety".* A psychiatric interview and clinical examination was conducted by a Psychiatrist (grade and designation not recorded).[59] It was recorded that Mr. X was *"well known"* to Consultant Psychiatrist 2's team. It was recorded that:

- Mr. X had a long history of mental health problems;
- his wife had left him in October 2008 since which time he had become depressed with feelings of anxiety and not being able to cope, she was no longer talking to him;
- his wife had contacted the Police and claimed that Mr. X had assaulted her;
- a referral had been made to Consultant Psychiatrist 2 for a hospital admission and had Mental Health Act (2007) assessment *"a few weeks ago";* (it is unclear whether the mental Health Act assessment occurred or not)
- Mr. X had thoughts about harming himself but *"doesn't want to die and won't do anything on the ward";*
- the psychiatric history noted *"anxiety, depression, ...no admissions? has been under Section 117, ?paranoid psychotic";* (this was in fact erroneous information)
- (current listed medication illegible in the clinical record);
- Mr. X lived in his own house;
- no forensic history was noted;

56. Mr. X Vol. 9 PP. 508-509
57. Mrs. X Vol. 2 P. 76
58. Mrs. X Vol. 2 PP. 95-96
59. Mr. X Vol. 1 PP. 14-21

- Mr. X had paranoid thoughts about people talking about him;
- Mr. X denied hearing voices or having visual hallucinations.

The diagnosis given at this stage was Agitated Depression. Mr. X was admitted as an inpatient to the Holdenbrook Unit at the Leigh Infirmary and was prescribed Level 2-15 minute observations.[60]

Following admission to the ward. Mr. X was assessed. It was recorded that a referral had been made to secondary care services by the GP on the 29 September 2008. An 'Initial Core Assessment' was completed and it was noted Mr. X was nervous and agitated. Mr. X had been neglecting himself and had paranoid ideas. An 'Enhanced Assessment Form' was completed.

The assessment recorded that Mr. X had been admitted onto the Holdenbrook Unit for a period of assessment as an informal patient. The actions required were identified as:

- admit to the ward;
- allocate to a Named Nurse;
- nurse on appropriate observations 2-15;
- monitor mood and document changes;
- liaise with Multi Disciplinary Team and administer prescribed medication;
- facilitate ventilation/exploration of feelings.

It was also noted that Mr. X was well known to the CMHT and that he had recently telephoned Claire House *"10+"* times asking for help. He had previously been seen by Consultant Psychiatrist 2 when he had refused admission.

Medication on admission was listed as: Risperidone 3 mg twice daily, Paroxetine 20mg once daily, Esomeprazole 40mg once daily, Finasteride 5mg once daily, Tamsolusin 400mcg once daily, Ezetimibe 10mg once daily, Perphenazine 2mg twice daily, Diazepam 2mg as required (maximum three times a day), Zopiclone 7.5mg as required at night. Senne two tablets as

60. Mr. X Vol. 3 P. 118

required at night. It was recorded that Mr. X was compliant with his medication regimen. In addition Mr. X admitted drinking alcohol (whiskey and lager) to help him cope.[61]

A Risk Screen was completed by the Duty Officer. The following was recorded:

- *"risk to self - no;*
- *risk to others - yes;*
- *risk of vulnerability - yes;*
- *risk of neglect - yes."*[62]

The admitting Doctor wrote that when Mr. X had been asked about suicide he had replied *"thought about using dressing gown tie."*[63] This information was not used to inform the Risk Screen.

14 and 15 November 2008. A ward round was held on the 14 November. Mr. X was described as being pleasant and cooperative.[64] A care plan was developed on the 15 November. It was noted that Mr. X had been admitted to the ward due to high levels of anxiety and *"increasing depression after his wife left him several weeks ago."* Mr. X had reported that he *"was no longer able to cope and that he had been drinking alcohol (whiskey) to excess."* The plan was to *"give 1:1 time with Named Nurse and other staff to facilitate ventilation of feelings and to explore ways of coping with them."* Mr. X's mental state was to be monitored by utilising assessments as appropriate. Mr. X was also to have medication administered as prescribed. The ward was to liaise with the CMHT and Care Coordinator1.[65]

A Risk Screen was completed. The following was recorded:

- *"risk to self - no;*
- *risk to others - yes;*
- *risk of vulnerability - yes;*
- *risk of neglect - yes."*

Mr. X was noted as having been on Police bail for assaulting his wife, an offence which he denied. Mr. X was placed on Level 2-30 minute observations. Mr. X was not overtly paranoid; however he remained anxious, fearful and hopeless.[66]

61. Mr. X Vol. 2 PP.37-40 and Mr. X Vol. 2 PP. 32-36
62. Mr. X Vol. 3 PP. 91-94
63. Mr. X Vol. 1 PP. 14 and 17
64. Mr. X Vol. 7 P. 426
65. Mr. X Vol. 1 P. 6
66. Mr. X Vol. 3 PP. 82-85

17 and 18 November 2008. On the 17 November the Social Worker assigned to conduct the POVA visited Mrs. X with an Occupational Therapist. Mrs. X's son was due to visit and also to provide information about the attack and physical abuse. The Police had finished their investigation and Mrs. X was not going to pursue the case.[67] The following day a Vulnerable Adult Monitoring Form was commenced.[68]

22 November 2008. An Effective Care Coordination Summary of Intervention Form was completed for Mr. X. It was noted that Mr. X was on Enhanced CPA. It was recorded that Mr. X was anxious with regard to the security of his home and property. The Care Coordinator *"remained unavailable"* therefore the advocacy service had come to the ward to support Mr. X in liaising with his family. At this time Mr. X did not know his wife's plans and his family were not communicating with him. He felt *"in limbo and his future [was] uncertain".* Mr. X maintained that he did not hit his wife, he admitted to a *"tussle"* whilst attempting to get her to stay in the house when she was leaving him.[69]

26 November 2008. A 'Summary of Intervention' form was completed by Mr. X's Named Nurse. Mr. X had been seen by Consultant Psychiatrist 2. He was depressed. The plan was for him to get engaged in ward activities and to go on home leave visits. Occupational Therapy inputs were agreed to facilitate his eventual return home and his medication was increased to Risperidone 4mg twice daily and Paroxetine (Seroxat) 50mg once daily.[70]

On this same day. Care Coordinator 2 visited Lakelands with the Social Worker leading the POVA. Mrs. X was clear that she did not want to see her husband again or to return home. Mrs. X said she was happy at Lakelands but did not wish to remain there for the rest of her life. Sheltered accommodation was discussed with her.[71]

4 December 2008. A referral was submitted for Mr. X to Liaison Occupational Therapy for assessment. At this stage Mr. X had been recorded as being diagnosed with a Bipolar Disorder. The referral was made because Mr. X was anxious, low in mood and lacking in motivation. Mr. X needed support with personal care and domestic activities.[72]

67. Mrs. X Vol. 2 P. 75
68. Mrs. X Vol. 5. PP. 245-250
69. Mr. X Vol. 1 P.3
70. Mr. X Vol. 3 PP. 670-673
71. Mrs. X Vol. 2 P. 74
72. Mr. X Vol. 4 P. 236-237

10 December 2008. A 'Summary of Intervention' form was completed following a review meeting. Mr. X complained of feeling depressed and anxious, lacking in energy and motivation. It was agreed that the Paroxetine would be decreased gradually over the next week.[73]

On this same day. The POVA investigation was completed. The Social Worker leading this process was due to hold a planning meeting with the OPCMHT Manager. Mrs. X was not to return home and would be looking for alternative accommodation. Mrs. X had dropped the charges against her husband. It was decided to close the POVA and not to have a conference as it was thought it would not achieve anything in addition to the protection plan which was in place. Mrs. X was to remain in 24 hour residential support until an alternative could be found.[74]

11 December 2008. A telephone call was received by Care Coordinator 2 from Mrs. X's son to say that he did not want to deal with his mother's finances. The son was very stressed and appeared to be angry during the telephone call. It was decided that the matter needed to be discussed with the OPCMHT Team Manager.[75]

17 December 2008. Mr. X had a 'Summary of Intervention' form completed following a ward round. The Consultant Psychiatrist was present. Mr. X told them that he was still low, anxious and *"on the edge".* He had no thoughts of self harm and had visited his home with Care Coordinator 1 to pay his gas and electricity bills.[76]

19 December 2008. The Review Officer from the OPCMHT visited Lakelands to complete the sheltered accommodation application with Mrs. X and her son.[77]

27 December 2008. A Risk Screen form was completed for Mr. X. The following was recorded:

- *"risk to self - no;*
- *risk to others - yes;*
- *risk of vulnerability - yes;*

73. Mr. X Vol. 4 P. 248
74. Mrs. X Vol. 2 P. 73 see also P. 254
75. Mrs. X Vol. 2 P. 67
76. Mr. X Vol. 4 P. 246
77. Mrs. X Vol. 2 P. 66

- *risk of neglect - yes."*

Mr. X was recorded as having been on Police bail for assaulting his wife, which he denied. Mr. X's mental state was described as fragile as he tried to adjust to the current circumstances of his life. Care Plans were developed to support Mr. X's social isolation, lack of familial support, and anxiety.[78]

29 December 2008. A 'Summary of Intervention' form was completed for Mr. X. Mr. X stated that he felt *"terrible"* and *"ill"*. Mr. X felt his home situation was what was affecting him. He agreed to his Named Nurse discussing his feelings with Consultant Psychiatrist 2. The possibility of Electro-Convulsive Therapy (ECT) was discussed.[79]

6 and 8 January 2009. On the 6 January an application was made for Sheltered Accommodation for Mrs. X.[80] On the 8 January Care Coordinator 2 visited Mrs. X at Lakelands. Mrs. X was happy to remain where she was for the present and said that she did not want sheltered accommodation.[81]

14 January 2009. A 'Summary of Intervention' form was completed by a student nurse. Mr. X was unhappy and wanted to discharge himself. It was decided that he would have some escorted leave. Mr. X was to be prescribed Procylidine for the side effects of the Risperidone, and his Propranolol (which had been prescribed for anxiety) was to be increased to 20mg three times a day.[82]

16 and 19 January 2009. On the 16 January a 'Summary of Intervention' form was completed by Care Coordinator 1. Mr. X was designated as being *"NonCPA"*. The Consultant Psychiatrist had suggested that Mr. X would benefit from psychological therapy. Mr. X was still having difficulties dealing with his estrangement from both of his sons and his wife.

Care Coordinator 1 was to arrange for a Support Worker to begin visiting Mr. X on the ward in order to establish a rapport. It was noted that Mrs. X had dementia and that Mr. X had not

78. Mr. X Vol. 3 PP. 78-81 and Mr. X Vol. 11 PP. 661-664
79. Mr. X Vol. 4 P. 244
80. Mrs. X Vol. 2 P. 65
81. Mrs. X Vol. 2 P. 64
82. Mr. X Vol. 3 PP. 675-676

yet been informed of this. At this time Mrs. X was living in respite care and being followed up by the Golborne Older Persons' CMHT.

Risks were noted regarding Mr. X's alcohol misuse and paranoid, persecutory thoughts. Mr. X was advised that once he returned home staff would visit him in pairs if he continued to drink.[83]

On the 19 of January a Risk Screening form was completed. The following was recorded:

- *"risk to self - no;*
- *risk to others - yes;*
- *risk of vulnerability - yes;*
- *risk of neglect - yes."* [84]

It was noted that Mr. X was in a confused state and was reacting to his paranoid thoughts. Mr. X was placed on "*Level 2-15 for further assessment".* Mr. X's mental state was described as fragile and he was also unsteady when mobilising. Mr. X was prescribed Level 2-15 minute observations because he was paranoid, was low in mood and psychotic.[85]

20 January 2009. A review took place for Mrs. X. The package was to remain the same (no details were given). Mrs. X was designated as requiring Enhanced CPA. Her needs level/eligibility criteria were described as *"Critical".* The care plan did not appear to require any change.[86] Care Coordinator 2 escorted Mrs. X to attend the review with Consultant Psychiatrist 1. Mrs. X's son did not wish to attend. It was understood that Mr. X remained unwell and that Mrs. X wished to remain at Lakelands.[87]

It was noted that Mr. X was currently an inpatient on Holdenbrook Ward at Leigh Infirmary and had a Bipolar Disorder. Mrs. X's Magnetic Resonance Imaging scan to her brain (MRI scan) showed *"deep white matter changes, probably related to small vessel disease".* Her cognitive deficits remained unaltered. She had been started on Galantamine, and had initially experienced side effects. It was decided, however, to increase the Galantamine as she had been stable on it for some time with no further side effects detected. The referral to a

83. Mr. X Vol. 4 PP. 242-243
84. Mr. X Vol. 3 PP. 74-76
85. Mr. X Vol. 4 P. 177 and Mr. X Vol. 5 P. 294
86. Mrs. X Vol. 1 P. 6
87. Mrs. X Vol. 2 P. 63

neurologist was yet to take place to investigate her tremor. The plan was to review her at the Outpatient Clinic in six-months time.[88]

21 January 2009. Mr. X thought everyone on the ward wanted to hurt him, or even kill him. At this time Mr. X was being treated for Psychotic Depression. There had been a change in his mental state since his medication had been reviewed. Mr. X continued to refuse Electro-Convulsive Therapy (ECT). Mr. X's behaviour was bizarre and he was hallucinating. The plan was for Haloperidol PRN (*pro re nata*/as required) to be given.[89]

27 and 28 January 2009. On the 27 January a ward round was held, it was not recorded who attended. Mr. X denied experiencing persecutory delusions. However Mr. X expressed paranoid ideas about the Police and described auditory hallucinations in which people were talking about him. Mr. X was also experiencing dizzy spells. It was decided to discontinue the Aripiprazole and the Propranolol.[90] The following day a Mini Mental State Examination was conducted, it is unclear by whom. Mr. X received a score of *"26/30"* which placed him just outside the 'normal range' for his age.[91]

2 February 2009. Mrs. X's son telephoned Care Coordinator 2 to say his mother wanted to return home. The son was stressed. He had not visited his father and could not cope with visiting his mother. A 'Summary of Assessment' form was completed by Care Coordinator 2. Mrs. X was noted to be very anxious and wanted to return home to live, but did not wish to live there on her own. Mrs. X realised that she would need support.[92]

3 February 2009. A 'Risk Screen' form was completed for Mr. X by the Deputy Ward Manager. The following was recorded:

- *"risk to self - no;*
- *risk to others - no;*
- *risk of vulnerability - no;*
- *risk of neglect - no."*

88. GP Records P. 154
89. Mr. X Vol. 7 PP. 422 – 423
90. Mr. X Vol. 7 P. 418
91. Mr. X Vol. 1 P. 11
92. Mrs. X Vol. 2 P. 62 and Mrs. X Vol. 3. PP. 127-128

It was recorded that Mr. X was at no risk whilst in supervised 24 hour care. However the Risk Screen went on to say that Mr. X had been granted leave between the 17 March (noted as being *"today"* (on the form) to the 20 March 2009. The date of completion of the Risk Screen was given as being the 3 February 2009. This information is confusing and contradictory.[93]

17 February 2009. A ward round was held for Mr. X on this day. Both Consultant Psychiatrist 2 and Care Coordinator 1 were present. The outcome of the ward round was written up the following day.[94]

On this same day. Mrs. X was assessed at her home by an Occupational Therapist and Care Coordinator 2. Mrs. X did not want to go home on her own.[95]

18 February 2009. An 'Effective Care Coordination Summary of Intervention' form was completed for Mr. X (ward round summary). It was noted that Mr. X was *"NonCPA".* It was recorded that Consultant Psychiatrist 2 had increased Mr. X's medication from 2mg to 5mg Diazepam because of his continued anxiety. Mr. X was advised to go for walks and use relaxation techniques to control his anxiety. It was also recorded that Mr. X was agreeable to seeing a Psychologist for further help in order to wean him off his medication and the alcohol that he had used previously to help him cope. Mr. X was to receive help from a Support Worker to help with his coping skills. Leave of *"4-6 hours three times and two overnight stays"* was agreed. No signature was appended to the Summary of Intervention Form, therefore it remains unclear who wrote it.[96]

19 February 2009. An *"OPCMHT Res/Nursing Care Application Panel"* form was completed. On the 20 January 2009 Mrs. X had been assessed by Consultant Psychiatrist 1. On this occasion she had expressed the desire to remain at Lakelands. However she was now saying that she wished to return home. It was stated that Mrs. X had *"the capacity to make her own decisions."* A joint meeting was to be held between Consultant Psychiatrist 1 and

93. Mr. X Vol. 11 PP. 609-611
94. Mr. X Vol. 8 P. 450
95. Mrs. X Vol. 2 P. 59
96. Mr. X Vol. 1 P. 5

Consultant Psychiatrist 2 on 25 February to discuss the way forward for both Mr. and Mrs. X as a couple.[97]

25 February 2009. A Multidisciplinary Team meeting was held for Mr. X and a 'Summary of Intervention' form was completed. Mr. X was recorded as being *"NonCPA"*. Mr. X was present at this meeting. At this meeting it was agreed that Mr. X was eating well and interacting with others. He refused to consider ECT. Mr. X's Haloperidol and Diazepam were stopped and Pericyazine 2.5mg twice daily commenced. It was thought by the Team that Mr. X's main issue was anxiety.[98]

On this same day. Care Coordinator 2 escorted Mrs. X to Holdenbrook Ward to visit her husband. Mr. and Mrs. X said they wanted to be together and acknowledged the need for support. Mr. X was briefed about Mrs. X's illness. Planned home leave was discussed and arranged.[99] **There is no extant record for the joint meeting between the two treating teams of both Mr. and Mrs. X that was due to take place on this day.**

27 February 2009. A letter was sent to Mrs. X stating that an Outpatient appointment had been arranged at the Thomas Linacre Centre for the 28 April 2009 with a Consultant in Neurology.[100]

2 March 2009. The 'Hospital Anxiety and Depression Scale' form was completed. Mr. X was scored as being 'borderline' for depression and one point over 'borderline' for anxiety. It was not recorded who completed the assessment as there was no place on the form for a signature.[101]

On this same day. A Risk Screen was completed for Mrs. X. The issues of abuse were recorded. It was also noted that Mrs. X had been struggling to look after herself prior to her admission to Lakelands. It was stated that Mrs. X would require *"intense"* support once she returned home. The following was recorded:

- *"risk to self - no;*
- *risk to others - no;*

97. Mrs. X Vol. 2 PP. 89-91
98. Mr. X Vol. 4 PP. 240-241
99. Mrs. X Vol. 2 P. 58
100. Mrs. X Vol. 1 P. 8
101. Mr. X Vol. 1 PP. 8-10

- *risk of vulnerability - yes;*
- *risk of neglect - no."*

Mrs. X was recorded as being on Enhanced level CPA.[102]

5 and 6 March 2009. On the 5 March Mr. X went home for the day with a CMHT Support Worker. The visit went well.[103] Care Coordinator 2 escorted Mrs. X between her home and Lakelands for a home visit.[104] The following day Mrs. X's Care Coordinator telephoned Holdenbrook Ward to arrange an overnight leave period for Mr. X and his wife at their home.[105]

9 and 11 March 2009. On the 9 March Care Coordinator 2 escorted Mrs. X on a home visit. Mrs. X enjoyed her visit home during which time her husband was not reported to have been aggressive. Communications were in train between Care Coordinator 2 and Care Coordinator 1 (Mr. X's Care Coordinator).[106] On the 11 March Care Coordinator 2 left a message on Mr. and Mrs. X's son's answer machine to say that his parents would be at home on overnight leave and that he may wish to visit them. No message was returned.[107]

12 March 2009. Mr. X was placed on a one-day leave period from the ward. He was collected by a CMHT Worker. The leave went well and he requested overnight leave. Mr. X appeared to be well with no suicidal thoughts. The Multidisciplinary Team plan was to agree to the overnight leave and if this went well to give Mr. X a one-week period of leave. Mr. X's family were informed.[108]

13, 17, 18 and 24 March 2009. On the 13 March Care Coordinator 2 escorted Mrs. X home for an overnight leave. This went well. There was no evidence to suggest that Mr. X was being aggressive.[109] Mrs. X was discharged from Lakelands on the 17 March. Care

102. Mrs. X Vol. 3 PP. 120-123
103. Mr. X Vol. 7 P. 414
104. Mrs. X Vol. 2 P. 56
105. Mr. X Vol. 7 P. 414
106. Mrs. X Vol. 2 P. 54-55
107. Mrs. X Vol. 2 P. 53
108. Mr. X Vol. 7 P. 410
109. Mrs. X Vol. 1 PP. 49-51

Coordinator 2 escorted Mrs. X home. Mrs. X had not been aware she was due to return home on a permanent basis, but when told was *"ecstatic"* to do so.[110]

On the 18 March Care Coordinator 2 visited Mrs. X at home. Mrs. X appeared to be stable and pleased to be home. Mr. X was glad to be home also. Anchor (a social care provider) was due to deliver the agreed care package the following day (support with activities of daily living). The Occupational Therapist was due to carry out an assessment of Mrs. X. Mr. and Mrs. X's son was contacted to inform him that his mother was now back at home.[111] On the 24 March an Occupational Therapy (OT) assessment was conducted in the home. It was noted that the couple may struggle to look after themselves.[112]

25, 26 and 27 March 2009. On the 25 March a prescription review took place for Mr. X. Mr. X's medication was: Esomeprazole 40mg once daily, Finasteride 5mg once daily, Tamsolusin 400mcg once daily, Ezetimibe 10mg once daily, Diazepam 2.5mg twice daily, Zopiclone 7.5mg at night, Lofepramine 70mg three times daily, Ibuprofen 400 mg three times a day, Pericyazine 2.5mg twice daily, Procylidine 5mg once daily. The admission drugs that were discontinued were Risperidone and Paroxetine. The given diagnosis on the prescription sheet was Depressive Disorder with Psychosis.[113] A ward round for Mr. X was also held on this day. It was noted that Mr. X was *"doing fine in community"*. The plan was to discharge him in his absence with Care Coordinator 1 supporting him. His medication was to be supplied in blister packs and his Procylidine was to be reduced to 5mg once daily. Mr. X was to be followed up in the community in four-weeks time. Mr. X was duly discharged on Enhanced CPA.[114]

On the 26 March a FAX was sent to the GP informing the practice that Mr. X had been discharged and that he would require blister pack medication. A discharge prescription was also provided.[115] On the 27 March a letter was sent to the GP to say that Mr. X had been discharged on Enhanced CPA on the 25 March under the care of Consultant Psychiatrist 2.

110. Mrs. X Vol. 1 P. 48
111. Mrs. X Vol. 1 P. 47
112. Mrs. X Vol. 3 PP. 118-119
113. Mr. X Vol. 5 P. 312
114. Mr. X Vol. 7 P. 406
115. Mr. X Vol. 9 P. 506

The plan was for Mr. X to be followed up in the Outpatient Clinic in six-to-eight weeks time.[116]

30 and 31 March 2009. Care Coordinator 2 telephoned Mr. X following a conversation with his Care Coordinator. Mr. X was told that Mrs. X must not drive.[117] On the 31 March the Occupational Therapist (OT) made a home visit to Mrs. X. Mrs. X was reluctant to follow the OT's advice and refused any help with the shopping. The OT planned to visit again within the next couple of weeks.[118] Later the same day Care Coordinator 2 visited Mrs. X. Mrs. X was told that under no circumstances she should drive because of her cognition problems. Support was to be provided with shopping.[119]

N.B. the Trust internal investigation stated a seven-day follow up took place on this day. The Independent Investigation Team could find no clinical record to support this event having occurred.

2 and 6 April 2009. A 'Central Duty Team Contact' form was sent to Care Coordinator 2 from Anchor Care to say that Mr. X had cancelled the care package because he thought he could manage alone.[120] On the 6 April Care Coordinator 2 visited Mrs. X at her home, she seemed to be well. Mrs. X said that her husband was not so well. He however denied this saying that he only had bowel problems.[121]

8 April 2009. A 'Risk Screening' form was completed for Mr. X. The following was recorded:

- *"risk to self - no;*
- *risk to others - yes;*
- *risk of vulnerability - yes;*
- *risk of neglect - yes."*

It was noted that Mr. X could frequently disengage and that he was on Enhanced CPA. Care Plan One noted that he was still waiting for a diagnosis. The plan was for the Consultant to

116. Mr. X Vol. 7 P. 441
117. Mrs. X Vol. 1 P. 46
118. Mrs. X Vol. 1 P. 44
119. Mrs. X Vol. 1 P. 45
120. Mrs. X Vol. 2 PP. 84- 88
121. Mrs. X Vol. 1 P. 43

assess him and for the CMHT to continue to provide him with support. Care Plan Two addressed prostate issues. Care Plan Three addressed accommodation and social support issues. It was noted that his wife had dementia and he would require ongoing support. Care Plan Four addressed his social isolation. There was a Contingency and Crisis Plan; there were, however, no links made between this plan and those of the Golborne OPCMHT caring for Mrs. X.[122]

9, 17 and 21 April 2009. On the 9 April Care Coordinator 2 telephoned Mrs. X who said she did not feel too well. Mrs. X denied that her husband was causing any problems stating he was not well either. It was noted that the incorrect amount of Donepezil had been prescribed, (20 mg twice daily instead of 5 mg once daily). The GP was contacted who corrected the error. Mrs. X was advised to take only half a tablet a day until the correct medication was made available in a blister pack.[123]

On the 17 April Mrs. X's allocated Support Worker visited her. Mrs. X was noted to be less shaky. Mr. X was still in bed (it was 10.35 hours). It was noted that Mrs. X was not taking her night medication. Mrs. X said that Mr. X had to go into hospital for an operation.[124] On the 21 April the Support Worker visited Mrs. X again. Mr. and Mrs. X were finding it difficult to cope without their car. Their son was coming to take them out occasionally.[125]

21 April 2009. Care Coordinator 1 visited Mr. X at his home. He was agitated and did not want to see members of the CMHT. He was recorded as not being happy with the Care Coordinator visits and said that he wanted to see Consultant Psychiatrist 2.[126]

22 April 2009. Care Coordinator 2 visited Mrs. X at home. Mr. X was angry and agitated about his driving license and blamed mental health services for the DVLA involvement. Mr. and Mrs. X had an altercation. However, after Care Coordinator 2 intervened, Mr. X said he would never hurt his wife. Mrs. X was certain that she wished to remain in her own home. Care Coordinator 2 discussed Mr. X's presentation with Care Coordinator 1 who planned to discuss Mr. X with the Senior House Officer.[127]

122. Mr. X Vol. 8 PP. 466-470 and Mr. X Vol. 8 PP. 471-475
123. Mrs. X Vol. 1 P. 41
124. Mrs. X Vol. 1 P. 42
125. Mrs. X Vol. 1 P. 33
126. Mr. X Vol. 10 P. 595
127. Mrs. X Vol. 1 P. 40

On this same day. A home visit was made to Mr. X. by the Senior House Officer and Care Coordinator 1. Mr. X was noted to be non-compliant with his medication and was drinking alcohol. His medication was reviewed. (No details were recorded).[128]

23 and 28 April 2009. Mrs. X's Support Worker visited her at home and ensured that all of Mrs. X's belongings had been transferred from the Lakelands Residential Care Home.[129] On the 28 April the Support Worker visited Mrs. X again. Mr. X was saying that his bowels were causing him problems.

Mrs. X was taken to see the Consultant Neurologist by her Support Worker, he queried Parkinson's Disease. It was decided that a review with Consultant Psychiatrist 1 was required.[130] Unfortunately the Support Worker did not bring Mrs. X's medication with her to the appointment and it was not possible for the Consultant Neurologist to know whether she had commenced her cholinesterase inhibitors. He agreed that she had *"dementia syndrome"*. Due to her reported visual hallucinations he wrote to the GP and Consultant Psychiatrist 1 that he thought she may have Lewy Body Dementia, he also queried Parkinson's Disease.[131]

30 April 2009. A home visit was made to Mr. X by Care Coordinator 1. Mr. X appeared to be well. Mrs. X said that she was not taking some of her medication (this was reported to the Golborne Older Persons' Team). Mr. X said that he did not want the Support Worker from the Adult CMHT to visit him again as he could not see a role for her. The Support Worker was advised of this.[132]

7, 8 and 12 May 2009. On the 7 May the OPCMHT Review Officer made a home visit to Mrs. X. Mrs. X had not been taking some her medication and was advised to do so. The couple did not appear to be getting along. Mr. X said that Mrs. X hid her handbag and then could not remember where she had put it. Mrs. X said her husband was a bully. Mrs. X agreed to visit the Day Centre.[133] On the 8 May the Review Officer returned to the house to take Mrs. X to the Day Centre. Mrs. X did not want to go and have a look around as planned.

128. Mr. X Vol. 11 P. 601
129. Mrs. X Vol. 1 P. 39
130. Mrs. X Vol. 1 P. 37
131. GP Records P. 164
132. Mr. X Vol. 9 P. 510
133. Mrs. X Vol. 1 P. 36

She described her husband as being like a *"mad man".*[134] On the 12 May the Review Officer made another home visit to Mrs. X. It was reported that Mrs. X did not want to attend the Day Centre as *"it was not for her".* Mrs. X had been compliant with her medication. It was noted that Mr. X was very concerned about his bowels.[135]

13 May 2009. A discharge summary was sent by Mr. X's Senior House Officer on behalf of Consultant Psychiatrist 2 to the GP. Mr. X was designated as being on CPA (please note: by this stage being on CPA was equivalent to the former (Enhanced CPA level). The management plan was:

- for Mr. X to be followed up by Care Coordinator 1 within seven days of discharge;
- for an Outpatient review to take place in four-weeks time (this differed from the ward-held notes that said 6-8 weeks);
- for Mr. X to continue on Enhanced CPA;
- for blister pack medication to be prescribed.

The GP was also sent a list of the medication.[136]

14 and 18 May 2009. On the 14 May Care Coordinator 2 visited Mrs. X at her home. Mrs. X appeared to be well and was taking her medication. Mr. X was worried about his health. A review was to be planned with Consultant Psychiatrist 1.[137] On the 18 May the Occupational Therapist made a home visit. She recorded she would visit again in two-weeks time. Mrs. X said she wished to go out more as she was struggling with Mr. X and his difficulties with the DVLA.[138]

2 June 2009. A Staff Grade Psychiatrist and a Worker from the Adult CMHT met to conduct a CPA Review for Mr. X. By this stage Care Coordinator 1 had left the Trust. In a letter to the GP it was noted that Mr. X was eating and sleeping well. He was not feeling depressed and had no symptoms of anxiety. He was described as being settled in presentation and *"very happy".* The plan was to review him again in six-months time.[139] The Mental State Examination showed Mr. X to be pleasant and cooperative. He was eating and sleeping well.

134. Mrs. X Vol. 1 P. 35
135. Mrs. X Vol. 1 P. 34
136. Mr. X Vol. 10 P. 557-561
137. Mrs. X Vol. 1 P. 32
138. Mrs. X Vol. 1 P. 23
139. Mr. X Vol. 11 P. 601 and GP Record P. 220

He was neither depressed nor anxious and had no psychotic symptoms. Mr. X had no thoughts of self harm. The medication was Lofepramine 70mg three times a day and Pericyazine 2.5mg twice daily. It was recorded that Mr. X had not taken any Diazepam since leaving hospital and that he had settled well back into the community and was happy with his wife living at home. The plan was to discontinue the Diazepam and to review in the Outpatient Clinic in six-months time. The GP was written to advising him of this.[140]

3 June 2009. The Occupational Therapist visited Mrs. X at home to assess her washing and dressing. Mrs. X was worried about her husband as he had not been eating and did not feel very well. Mrs. X was advised to keep herself active as this would prevent further memory loss. She said she did not feel like doing anything when her husband was not well.[141]

12 June 2009. Consultant Psychiatrist 2 retired on this date. Care Coordinator 1 had left her employment in May and Mr. X's case had not been reallocated to another Care Coordinator.

24 June 2009. Care Coordinator 2 visited Mrs. X at her home. Her husband was present. Mrs. X looked unkempt. It appeared that Mr. and Mrs. X were doing well although Mr. X was worried about his driving license. The plan was to discuss Mrs. X with Care Coordinator 1 (who had left the Trust at least one month previously).[142]

6, 8, 9 and 11 July 2009. On the 6 July a home visit was made by Mrs. X's Support Worker. Mrs. X seemed *"edgy"* and could not move. Mr. X also said he was not well as he had trouble with his *"waterworks*" and was going to contact his former Support Worker with the Adult CMHT about it.[143] The DVLA had written to the GP to say that Mrs. X's driving license had been revoked due to cognitive impairment.[144]

On the 8, 9 and 11 of July home visits were made to Mrs. X by her Support worker. On the 11 July it was noted that Mrs. X was a *"little on edge".*[145]

13 July 2009. Mr. X made an urgent request for Care Coordinator 2 to contact him as his wife was unwell. Care Coordinator 2 was out of the office so the Review Officer visited Mrs.

140. Mr. X Vol. 8 PP. 456-458
141. Mrs. X Vol. 1 P. 31
142. Mrs. X Vol. 1 P. 29
143. Mrs. X Vol. 1 P. 18
144. GP Record P. 176
145. Mrs. X Vol. 1 P. 28 and Mrs. X Vol. 1 P. 17 and Mrs. X Vol. 1 P. 19

X and then called for an ambulance. Mrs. X was admitted to Orrell Ward where she was treated for a urinary tract infection and dehydration.[146]

20 and 21 July 2009. On the 20 July a telephone call was taken by Care Coordinator 2 from Orrell Ward to say that Mrs. X was ready for discharge. Care Coordinator 2 informed the ward staff that she would arrange a package of care for Mrs. X. The package was to commence on the 22 July and Mrs. X was to be discharged on the 21.[147] On the 21 July a telephone call was taken by the Commissioning Team. A care package was to be provided to Mrs. X from Anchor Care commencing the following day.[148] Mrs. X was duly discharged back to her home.

23 July 2009. A home visit was made by Care Coordinator 2. The discharge report from the hospital showed that Mrs. X had systemic sepsis as a result of a urine infection. Both Mr. and Mrs. X said that they accepted they needed support.[149] A home visit was also made by Mrs. X's Support Worker.[150]

27, 29 and 31 July 2009. On the 27 July a home visit was made by Mrs. X's Support Worker. Mrs. X was just waking up. The Support Worker asked if the agency staff were attending to Mrs. X's needs appropriately and said that she would discuss the case with Care Coordinator 2 when she returned back to the office. Nothing untoward was recorded.[151] On the 29 July Care Coordinator 2 made a home visit. Mrs. X looked a little dishevelled. There had been issues regarding the care package. Mr. X said he was struggling to come to terms with his wife's illness.[152] On the 31 July another home visit was made and nothing untoward was recorded.[153]

4 August 2009. Care Coordinator 2 telephoned Mr. X to say that she had received an email from the Commissioning Team to say that he had cancelled Mrs. X's care package. Mr. X said he was able to give his wife her medication and that the Support Worker would bath his wife. He was told that this could only be a temporary measure.[154]

146. Mrs. X Vol. 1 P. 27
147. Mrs. X Vol. 1 P. 26
148. Mrs. X Vol. 1 P. 25
149. Mrs. X Vol. 1 P. 24
150. Mrs. X Vol. 1 P. 24
151. Mrs. X Vol. 1 P. 15
152. Mrs. X Vol. 1 P. 22
153. Mrs. X Vol. 1 P. 13
154. Mrs. X Vol. 1 P. 21

11 August 2009. Mr. and Mrs. X were seen at the Outpatient clinic by Consultant Psychiatrist 1, this was for a CPA Review meeting. The Support Worker was also present. It was agreed that the Older Persons' CMHT would continue to be involved as ongoing support was needed for Mrs. X as Mr. X's mental health could fluctuate.[155]

17 August 2009. Mr. X telephoned the Hindley and Ince Adult CMHT and spoke to his former Support Worker. Mr. X was *"really upset and crying"* saying that everyone was against him and that the DVLA were going to take his license from him. Mr. X could hardly talk for crying and said he could not cope. The Support Worker said she would visit him at home later that day after talking to her Manager.

The Support Worker spoke to the Adult CMHT Manager. The Worker was asked to observe the condition of Mr. X's home and to ascertain whether or not he was taking his medication. During the home visit it was evident that Mr. X was paranoid about his driving license. Otherwise it was recorded that Mr. X *"looked OK"* and was taking his medication.[156]

Mrs. X's Support Worker received a telephone call from Mr. X who was in a *"distraught state"*. He was worried about his driving license. It was agreed that the Support Workers from both CMHTs would liaise together.[157]

19 August 2009. A message was left in the Adult CMHT office from Mr. X requesting that someone contact him. When Mr. X was contacted by the Support Worker he said that the service was conspiring against him. Mr. X would not listen to the Support Worker when she tried to reassure him.[158]

20 August 2009. Care Coordinator 2 telephoned the Adult CMHT Manager. An Older Persons' CMHT Support Worker had gone to the home to take Mrs. X out and noted that Mr. X was anxious and agitated stating that people were against him. The Care Coordinator was concerned that Mr. X's deteriorating mental state would impact upon his wife's health. The Manager said that the Adult CMHT would follow Mr. X up.

155. Mrs. X Vol. 1 P. 12
156. Mr. X Vol. 8 PP. 459-461
157. Mrs. X Vol. 1 P. 20
158. Mr. X Vol. 8 P. 462

The Adult CMHT Manager spoke to the OPCMHT Review Officer who had visited the couple previously. The Review Officer had met Mr. X at his home following a recent visit to his wife. The Reviewing Officer did not have any concerns about Mr. X's mental health.[159]

On the same day. A home visit was made by Mrs. X's Support Worker. It was apparent that Mr. X was paranoid. Mrs. X was reported as *"feeling terrified and nervous when he's angry".* The Support Worker then took Mrs. X to the hairdressers. On returning to the house she told the couple she would visit them a week later as she was going on holiday.[160]

25 August 2009. Care Coordinator 2 visited Mrs. X at her home. She appeared stable in mood although she had recently had a urine infection. Mr. X said that he did not want his wife to go back to Lakelands and would prefer her care to continue with the Older Persons' CMHT. Mrs. X said she was happy at home and agreed with her husband. It was explained that Care Coordinator 2 was going on annual leave and that the Support Worker and another member of the OPCMHT would support them whilst she was away.[161]

28 August 2009. A CPA Review Document was completed by Care Coordinator 2. The review was completed with Mr. and Mrs. X and the need for Mrs. X to receive her medication and plenty of fluids was made clear.[162]

2 September 2009. Mrs. X's Support Worker made a home visit to her with another member of the OPCMHT. On this occasion it was noted that Mrs. X had what was described as a cold sore on her lip. Mrs. X said that her husband had *"done it".* On returning to the office the OPCMHT Manager was informed. It was decided that Care Coordinator 2 would be informed on her return from annual leave on the 16 September and the plan was for the Support Worker to visit again on the 23 September.[163]

159. Mr. X Vol. 8 PP. 463-464
160. Mrs. X Vol. 1 P. 14
161. Mrs. X Vol. 1 P. 11
162. Mrs. X Vol. 1 P. 11
163. Mrs. X Vol. 1 P. 10

Account of the Incident

10 September 2009. The Manager of the Adult CMHT was approached by the Manager of the Golborne Older Persons' CMHT. The Older Persons' CMHT Manager wanted to know if the adult service had had any contact with Mr. X. The Manager was concerned as they could not gain access to the house and Mrs. X's prescription had not been picked up. Earlier that day the Older Persons' CMHT Review Officer had not been able to get any response when she had knocked at the door of the couple's house. The Older Persons' CMHT Manager explained his plan to contact the Police.

Later on the same day. The Older Persons' CMHT Manager attended the premises of Mr. and Mrs. X at 16.30 hours accompanied by the Review Officer. With the help of a neighbour they were able to gain access to the back of the house. They could not gain entry to the house and the Police were called at 17.00 hours. At 17.30 hours the Older Persons' CMHT Manager contacted Mr. and Mrs. X's eldest son. The son arrived and agreed to force the back door. The son and the Older Persons' CMHT Manager entered the premises where the bodies of Mr. and Mrs. X were found. The Police were called again and arrived in response to the first call made at 17.00 hours whilst this call was in progress.[164]

Cause of Death

Mr. X was found to have died by hanging, the conclusion being made by the Coroner that this was self inflicted. Mrs. X was found to have died by ligature strangulation, the conclusion being made by the Coroner that she had been unlawfully killed. No third party was considered to have been involved in the deaths of either Mr. or Mrs. X. It was thought, following post mortem examination, that Mr. and Mrs. X had died somewhere between the 5 and 6 September 2009, several days before their bodies were discovered.

164. Mrs. X Vol. 1 P. 9

11. Identification of the Thematic Issues

11.1. Thematic Issues

The Independent Investigation Team identified 15 thematic issues that arose directly from analysing the care and treatment that Mr. and Mrs. X received from the 5 Boroughs Partnership NHS Foundation Trust and the Wigan Local Authority. These thematic issues are set out below. The issues pertaining to Mr. X are the principle ones pertaining to this Investigation and are numbered 1-12.

1. **Diagnosis.** Mr. X did not receive a clear diagnosis. This was for two principle reasons. First: at some point in time, prior to the GP referral being made in September 2008, Mr. X's clinical record was co-mingled with those of two other service users. This meant that three diagnoses were extant in his record, namely: Bipolar Disorder, Paranoid Psychosis, and Depression and Anxiety. Whilst it might be possible that all three diagnoses had been correctly attributed to Mr. X at some stage, examination of the clinical record suggests that this was unlikely. Therefore Mr. X re-entered secondary care mental health services in September 2008 with an incorrect set of information in his clinical record. This was to serve as a persistent point of confusion. Second: this point of confusion was exacerbated by Mr. X's case never being subjected to an appropriate level of diagnostic formulation. His diagnosis remained unclear until the time of his death.

2. **Medication and Treatment.** Medication and treatment choices did not follow those recommended by the National Institute of Health and Clinical Excellence (NICE) guidance, neither did the medication regimen follow the basic best practice British National Formulary guidance. Mr. X was prescribed a medication regimen that was at times detrimental to his health and had not been selected in a coherent manner following a robust diagnostic formulation. Mr. X had distinct medication adherence issues and these were not taken into account as part of an ongoing medicines management approach. Psychological therapy treatments were indicated but were not provided.

3. **Use of the Mental Health Act (1983 and 2007).** The Mental Health Act (2007) does not play a significant part in the care and treatment that Mr. X received from the 5 Boroughs Partnership NHS Foundation Trust. However there would appear to have been a lack of understanding on the part of Trust and Local Authority workers as to when the Mental Health Act could have been considered. On the 8 October 2008 Mr. X had reached the stage where he was no longer looking after himself and his mental health was deteriorating rapidly. The Independent Investigation Team concluded that when Mr. X refused to be admitted onto Holdenbrook Ward a Mental Health assessment should have been arranged on this occasion as he was at significant risk of self neglect.

   By the 13 October 2008 Consultant Psychiatrist 2, Care Coordinator 1 and the GP were prepared to arrange a Mental Health Act (2007) assessment. It is evident that Mr. X's mental health continued to deteriorate but that no further action was taken. It is probable that the treating team thought that Mr. X did not require such an intervention, however it is unusual for the rationale not to have been recorded. The extant clinical record and the information provided by clinical witnesses to this Investigation give the impression that Mr. X's mental health was allowed to deteriorate without intervention until he reached a point of crisis.

4. **Care Programme Approach (CPA).** The Care Programme Approach (CPA) failed to operate in a coherent manner in the case of Mr. X. It was evident from examining the clinical record that a rudimentary approach to CPA was taken. Assessment and care planning were minimal and Care Coordination was largely absent. From May 2009 Mr. X, even though he had been designated as requiring 'Enhanced' CPA, had no designated Care Coordinator. This situation continued until the time of his death in September 2009. The minimum level of care that could and should have been expected from Mr. X's CMHT was not delivered to him. The treating team had the knowledge (of both his condition and his situation), the opportunity, and the means to intervene. Mr. X was asking for help and was not seeking to avoid engagement. Had the treating team assessed Mr. X's condition on an ongoing basis in accordance with CPA guidance, and had the treating team ensured that his care plans were both developed and implemented, it is entirely possible that he would not have reached the state of crisis that led to the deaths of both himself and his wife.

5. **Risk Assessment.** It would appear that Mr. X did not receive a formal risk assessment. On several occasions a Trust Risk Screen was conducted, but a full assessment did not take place in accordance with Trust policy requirements. This meant that Mr. X was never understood in the context of his full risk profile and that no risk management plans were either developed or implemented in order to mitigate against it. HM Coroner said the following about Mr. X. *"At the time of his death he was under the care of a Community Mental Health Team. He was not appropriately monitored and his risk of harm to himself and others was not appropriately assessed. He took his own life whilst the balance of his mind was disturbed by a diagnosed mental illness."*[165]

6. **Referral, Admission and Discharge Planning.** Referral, admission and discharge planning processes lacked coordination in the autumn of 2008. Prolonged referral and admission processes left Mr. X subject to delays in receiving appropriate levels of assessment and also in being given the care and treatment interventions that he required. Poorly managed discharge processes in March 2009 left Mr. X and his wife in a vulnerable position which meant that their continued health and wellbeing could not be maintained once the couple were living back in the community.

7. **Safeguarding Vulnerable Adults and Mental Capacity.** Mr. X's needs regarding safeguarding were never identified either in relation to himself or his wife. Mr. X was an individual with significant mental health problems and poor activities of daily living skills. Mr. X was socially isolated and had physical health problems and impaired mobility. He drank, was non compliant with his prescribed medication, and was the main carer to his wife who had dementia. There was an assumption made by services that the input they gave to Mrs. X was sufficient to maintain her in the community and to ensure both her health, social care and safety needs were met. However it was evident from entries in the clinical records that she was frequently unkempt and that she had difficulties shopping, cooking and looking after the house. It was also evident that Mr. X struggled to make up the short fall in the care package provided and that he himself had been identified as being vulnerable and prone to self neglect. The couple were maintained in the community in a situation that was far from

165.Trust Inquest Documentation

ideal and which required a more coherent care plan that was shared and jointly implemented between the treating teams of both Mr. and Mrs. X.

8. **Service User Involvement in Care Planning and Treatment.** Mr. X did not receive person-centred care and treatment. It was evident that he was neither known well nor understood by his treating team. He was seen as being a stubborn person who could at times reject the care that was offered to him. However Mr. X never disengaged from services and frequently sought intervention when in crisis. Had a therapeutic relationship been built up with Mr. X over time then it may have been possible for services to have constructed a care plan that was both effective and acceptable to him. It is a sad fact that most of the health and social care practitioners that provided care and treatment to Mr. X directly, and were interviewed as part of this Investigation, could not remember him at all. This illustrates well how superficial levels of engagement with this gentleman were.

9. **Carer Assessment and Involvement.** Mr. X was the main 24 hour carer for his wife who had dementia. It was evident that he struggled to support his wife and to maintain their activities of daily living. Mr. X had physical and mental health problems of a long-standing nature. It was recorded by his Care Coordinator at the point of his discharge in March 2009 that he would require a care plan to support him in his carer role. This was never provided for him. In the summer of 2009 it was recorded that Mr. X was experiencing difficulties in coping with his wife's condition. In August 2009 it became apparent to members of his wife's treating team that Mr. X's mental health was deteriorating. It was recorded that the team had concerns that this could impact negatively upon the continued health and wellbeing of his wife. However despite documenting the difficulties that he was experiencing no interventions were made and Mr. X continued to care for his wife. At this stage both of the CMHTs engaged in the care and treatment of Mr. and Mrs. X should have ensured that the couple were reassessed with immediate effect. This did not occur and Mr. X eventually reached a state of crisis.

10. **Documentation and Professional Communication.** Two major issues were identified regarding documentation and professional communication. First: Mr. X's historic clinical record had been subject to a significant degree of co-mingling with

other service users of the same name. This led to ongoing confusion exacerbated by poor clinical diagnostic formulation. That this co-mingling occurred signifies that the Trust and Local Authority record management systems were not robust enough to ensure patient identification protocols were fit for purpose. Second: Trust and Local Authority staff of all grades and disciplines worked to poor levels of clinical practice regarding maintenance of the clinical record. Risk assessment, safeguarding, and CPA documentation was maintained in the most rudimentary manner, and was not in keeping with extant policy and procedure guidelines. Clinical meetings, ward rounds and general clinical discussions were not recorded making it impossible to understand what was talked about and what clinical decisions were made. Witnesses who gave evidence to this Investigation had poor levels of recollection leaving the Independent Investigation Team no option but to conclude that, in the absence of any documentation detailing the required clinical activities, these activities did not in fact take place.

11. **Adherence to Local and National Policy, Procedure and Clinical Guidelines.** Trust and Local Authority Policies were of an excellent standard. However there was a prevailing culture amongst Trust and Local Authority staff of all grades and disciplines which led to the view being taken that it was somehow not their responsibility to know what these policies contained. Consequently policies were not adhered to and this had a detrimental effect on the care and treatment that Mr. X received. Trust audit processes did not appear sophisticated enough at the time to either detect or address policy non-adherence issues.

12. **Management of the Care and Treatment of Mr. X.** The Independent Investigation Team concluded that there were serious failures regarding the way in which care and treatment was provided to Mr. X. These failures were both significant and comprehensive in nature to the extent that the management of the case was severely compromised to the ultimate detriment of Mr. X's health, safety and wellbeing. Clinical decisions were not made based upon the best information available to the treating team at any one time. Mr. X was never understood as an individual and he had poor levels of assessment, care planning and treatment throughout the last 12 months of his life. It is the conclusion of the Independent Investigation Team that

significant omissions in the management of his care and treatment allowed his mental health to deteriorate to the stage where he reached crisis point.

The Independent Investigation Team concluded that the treating teams involved had the knowledge, the opportunity, and the means to intervene in August 2009. Had they done so it is highly probable that the events of September 2009 that led to the deaths of Mr. and Mrs. X would not have occurred.

13. **Clinical Governance and Performance (Trust and Local Authority)**. The Trust has robust clinical governance structures and systems in place in 2012. The Trust has recently been developing its work as a learning organisation to ensure that Serious Untoward Incident processes have additional safeguards built into them. A significant amount of work has occurred to ensure that Trust audit processes are sensitive enough to detect non compliance in areas such as the Care Programme Approach. Audit standards are now very specific and are monitored on a regular basis. Care Pathways have been developed to ensure that a robust structure is provided when providing services to service users. The Local Authority was not able to supply any information to this investigation.

14. **The Care and Treatment of Mrs. X.** The Independent Investigation Team concluded that there were serious failures regarding the way in which care and treatment was provided to Mrs. X. These failures were both significant and comprehensive in nature to the extent that the management of the case was severely compromised to the ultimate detriment of Mrs. X's health, safety and wellbeing. Clinical decisions were not made based upon the best information available to the treating team at any one time. It is the conclusion of the Independent Investigation Team that significant omissions in the management of her care and treatment placed this vulnerable adult in a situation where she was at risk of both abuse and neglect.

15. **Summary of the Way in Which the Couple were Treated Jointly.** The care and treatment that the couple received was not managed in a coherent manner which took into account their joint needs as a couple. The involvement of two separate teams served to fragment care and prevented a full assessment of both need and risk from taking place. Although the two teams working with Mr. and Mrs. X were located in

the same building there was a failure to coordinate assessment and care planning for the couple. Staff relied too much on anecdotal and informal discussion and did not make full use of professional skills. This was to the ultimate detriment of the health, safety and wellbeing of the couple.

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

In the simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the 'Five Whys' could look like this:

- serious incident reported = serious injury to limb
- immediate cause = wrong limb operated upon (ask why?)
- wrong limb marked (ask why?)
- notes had an error in them (ask why?)
- clinical notes were temporary and incomplete (ask why?)
- original notes had been mislaid (ask why?)
- (Because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. If it was applied to Mr. X it would look like this:

- Mr. X killed Mrs. X (ask why?)
- because he had a mental illness which caused a significant abnormality of mind = root cause.

It is important to note that a root cause may be something that cannot always be assigned to a service or to a system. In the cases of Mr. X and Mrs. X other inquiry processes can lend additional focus to an HSG (94) 27 Independent Investigation process. However it is possible to assign causality to acts or omissions on the part of statutory services when these can be shown to have impacted upon the failure to have managed a service user's mental health appropriately. This Investigation has found causal links between the care and treatment provided to both Mr. and Mrs. X and the circumstances leading up to their deaths. These findings are supported by those of the Coroner's Inquest.

A Coroner's Inquest was held between the 10 and 17 October 2011. Her Majesty's Coroner returned the verdict that *"On 10 September 2009 … [Mr. X], known as …, was found deceased at his home address. At the time of his death he was under the care of a Community Mental Health Team. He was not appropriately monitored and his risk of harm to himself and*

others was not appropriately assessed. He took his own life whilst the balance of his mind was disturbed by a diagnosed mental illness."[166]

The verdict continued:
"On 10 September 2009 … [Mrs. X] was found deceased at her home address. At the time of her death she was under the care of a Community Mental Health Team. Her risk of suffering harm was not appropriately assessed. [Mrs. X] was unlawfully killed."[167]

RCA Third Stage

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

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

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

Contributory factors can be identified as either being 'influencing' or 'causal'.

Causal Factors. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term 'causal factor' is used in this report to describe an act or omission that the Independent Investigation Team have concluded had a direct causal bearing upon the failure to manage either Mr. and Mrs. X effectively and that this as a consequence impacted directly upon the events leading up to the deaths of Mr. and Mrs. X in September 2009.

166. Trust Inquest Documentation
167. Trust Inquest Documentation

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

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

12.1. Findings Relating to the Care and Treatment of Mr. and Mrs. X

The findings in this chapter analyse principally the care and treatment given to Mr. X by the 5 Boroughs NHS Foundation Trust and the Wigan Local Authority between the 29 September 2008 and September 2009.

This chapter is presented in a total of 15 subsections. Subsections 12.1.1. - 12.1.12. examine the quality of the care and treatment given to Mr. X. Subsection 12.1.13. addresses key Trust governance systems and processes. Subsection 12.2. examines the care and treatment given to Mrs. X. Subsection 2.3 examines the Care Pathway that the couple undertook jointly.

12.1.1. Diagnosis

The Independent Investigation Team would like to note that the diagnoses that are considered below are based on what the treating clinical team knew, or thought they knew, about Mr. X between the 29 September 2008 and September 2009.

12.1.1.1. Context

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

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

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

Mr. and Mrs. X Investigation Report

Background Information

Mr. X was diagnosed as having the following disorders.

F31 Bipolar Affective Disorder (ICD 10)

"This disorder is characterized by repeated (i.e. at least two) episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (mania or hypomania), and on others of a lowering of mood and decreased energy and activity (depression). Characteristically, recovery is usually complete between episodes, and the incidence in the two sexes is more nearly equal than in other mood disorders. As patients who suffer only from repeated episodes of mania are comparatively rare, and resemble (in their family history, premorbid personality, age of onset, and long-term prognosis) those who also have at least occasional episodes of depression, such patients are classified as bipolar.

Manic episodes usually begin abruptly and last for between 2 weeks and 4-5 months (median duration about 4 months). Depressions tend to last longer (median length about 6 months), though rarely for more than a year, except in the elderly. Episodes of both kinds often follow stressful life events or other mental trauma, but the presence of such stress is not essential for the diagnosis. The first episode may occur at any age from childhood to old age. The frequency of episodes and the pattern of remissions and relapses are both very variable, though remissions tend to get shorter as time goes on and depressions to become commoner and longer lasting after middle age.

Although the original concept of "manic-depressive psychosis" also included patients who suffered only from depression, the term "manic-depressive disorder or psychosis" is now used mainly as a synonym for bipolar disorder."[168]

Paranoid Psychoses (ICD 10)

The definition of a Paranoid Psychosis is described under F22.0 in ICD 10, as a Delusional Disorder. This is a disorder characterised by the development either of a single delusion or of a set of related delusions that are usually persistent and sometimes lifelong. The content of the delusion or delusions is very variable. Clear and persistent auditory hallucinations

168. ICD-10 Classification of Mental and Behavioural Disorders, by the World Health Organization, CH-1211, Geneva 27, Switzerland, 1992. (http://www.who.ch)

(voices), schizophrenic symptoms such as delusions of control and marked blunting of affect, and definite evidence of brain disease are all incompatible with this diagnosis. However, the presence of occasional or transitory auditory hallucinations, particularly in elderly patients, does not rule out this diagnosis, provided that they are not typically Schizophrenic and form only a small part of the overall clinical picture.

Agitated Depression (ICD 10)

This definition refers to an episode of depression in which several of the symptoms are marked and distressing, typically loss of self-esteem and ideas of worthlessness or guilt. Suicidal thoughts and acts are common and a number of 'somatic' symptoms are usually present (medically unexplained physical symptoms). It is classified under the Severe Depressive Episode without psychotic symptoms, ICD 10 F32.2.

Anxiety Disorders (ICD 10)

These disorders should be classified under Neurotic Stress related Disorders ICD 10 F40-48. Anxiety disorder is a blanket term covering several different forms of a type of mental illness of abnormal and pathological fear and anxiety. The term anxiety covers four aspects of experiences an individual may have: mental apprehension, physical tension, physical symptoms and dissociative anxiety. Anxiety disorder is divided into generalised anxiety disorder, phobic disorder, and panic disorder; each has its own characteristics and symptoms and they require different treatment (Gelder et al. 2005). The emotions present in anxiety disorders range from simple nervousness to bouts of terror (Barker 2003).

Delirium

This is described in ICD 10 under F05 either as not superimposed F05 or on dementia F05.1. This is described as an aetiologically nonspecific organic cerebral syndrome characterised by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behaviour, emotion, and the sleep-wake schedule. The duration is variable and the degree of severity ranges from mild to very severe.

12.1.1.2. Findings

Clinical Record Anomalies

When Mr. X was referred to secondary care mental health services by his GP in September 2008 initial Summary Intervention forms recorded that he had historically received diagnoses

of both Paranoid Psychosis and Bipolar Disorder. It had also been recorded in his previous CMHT records that he had suffered from anxiety and depression.

The notion that Mr. X may have suffered from a Paranoid Psychosis initially came from a rudimentary examination of what was supposed to be Mr. X's previous clinical records. It is evident that once Mr. X's referral had been received from his GP, the Golborne Older Persons' CMHT accessed Mr. X's old CMHT paper clinical records. Unfortunately these records contained a co-mingled set of clinical information and on the balance of probabilities it is possible that this diagnosis did not belong to Mr. X. A letter contained within Mr. X's previous clinical records stated that *"I reviewed this patient… today (20 November 2006) and note that he had a past history of Paranoid Psychosis…The last report is known from his mother two years ago…I understand my predecessor…considered him appropriate for discharge from his Section 117."*[169] **It must be noted that this letter gave Mr. X's address and date of birth. However it must also be noted that the Mr. X, who is the subject of this report, mother died when he was a baby, and that he had never been subject to a Section 117. This is the first factoid about Mr. X that he probably suffered from a Paranoid Psychosis.**

Following Mr. X's referral in the autumn of 2008, the diagnosis of Bipolar Disorder was arrived at following a discussion that was held between personnel at the Golborne Older Persons' CMHT and Consultant Psychiatrist 1 (Mrs. X's Psychiatrist). Consultant Psychiatrist 1 had probably been told, either by the GP or Mrs. X, that Mr. X suffered from a Bipolar Disorder. Consultant Psychiatrist 1 would probably not have been able to ascertain this by accessing the Trust Electronic record alone as the former CMHT record makes no mention of this diagnosis. The diagnosis of Bipolar Disorder entering Mr. X's clinical record probably occurred when erroneous information was sent to the GP, throughout the preceding decade, which muddled several different service users with the same name. **It must be noted that a careful examination of the GP clinical record yielded a significant number of letters which detailed information probably belonging to at least three service users of the name, all of whom had been assigned the same address, date of birth and NHS number at some point over the years. It was made evident to the Independent Investigation Team by the careful reading of these letters that the social circumstances**

169.Mr. X CMHT Records P. 36

of the service user mentioned in them (with the Bipolar Disorder) were very different to those of the Mr. X who is the subject of this report and was most likely not the same person.

The diagnosis of Anxiety and Depression is most likely to have been the correct historical diagnosis for Mr. X. This appears in his Trust-held former CMHT record in 2003. It was noted *"you have a history of depression and anxiety problems, occasionally experiencing mild paranoid thoughts. You also have difficulty sleeping."*[170]

N.B. The issues raised by clinical record anomalies are addressed in full in subsection 12.1.10 below.

Diagnostic Decision Processes

Following the GP referral in September 2008 a 'Summary of Intervention' form was completed. This form noted that Mr. X had been diagnosed many years previously as having a Paranoid Psychosis and that Consultant Psychiatrist 1 had suggested he may be suffering from a Bipolar Disorder.[171] It was also noted that Mr. X was paranoid and drinking alcohol. At this stage Mr. X had yet to be assessed by a psychiatrist.

Over the following weeks it was observed that Mr. X appeared to be drinking alcohol to excess in an attempt to self medicate. Consultant Psychiatrist 2 assessed Mr. X on the 9 October and recorded that he had a 30-year history of depression. This information was gained by discussing Mr. X's history with him directly.[172]

On the 20 October 2008 at a multidisciplinary meeting the diagnosis was recorded as being *"Psychotic Depression Paranoid."* At this time Mr. X denied experiencing hallucinations or of having thoughts of killing himself. It was noted that Mr. X drank heavily and he was advised to cut down.[173]

When Mr. X was admitted onto Holdenbrook Ward on the 12 November 2008 it was recorded that the reason his referral had been made to inpatient services was due to

170. Mr. X CMHT Records P. 17
171. Mr. X Vol. 2 PP. 27-28
172. Mr. X Vol. 7 P. 387 and Mr. X Vol. 9 PP. 502-503
173. Mr. X Vol. 9 PP. 508-509

"agitation/anxiety".[174] It was also recorded: *"anxiety, depression, …no admissions? has been under Section 117, ?paranoid psychotic."*[175] It must be noted that the information about Mr. X having been on a previous Section 117 and suffering from Paranoid Psychosis was probably incorrect. At this stage the given diagnosis was Agitated Depression.

Between the 18 and 27 January 2009 Mr. X was recorded as having a delirium-type episode. On the 25 January he had an unsettled night when he was *"confused and disorientated up every hour from 01.00 wanting to get dressed into his day attire."* It was recorded that staff thought he was responding to external stimuli. During the day Mr. X continued to be agitated, demanding to leave the ward. He refused lunch due to *"extreme anxiety".* It was observed that Mr. X appeared to be reacting to visual hallucinations in that he was trying to pick things up that were not there.[176] Mr. X expressed paranoid thoughts and believed that someone wanted to murder him. Mr. X was discussed in the ward round on the 27 January 2009 and his medication was regimen was reviewed. The change in medication appeared to have settled him back down. No considerations were recorded as to how this episode contributed to Mr. X's diagnostic formulation. It would appear that, in actual fact, Mr. X had had an adverse reaction to his medication. This was the eventual explanation set out in the clinical record, however it is not clear what exactly what evidence this conclusion was derived from.

On the 24 February 2009 a referral was made for an Occupational Therapy assessment. The diagnosis given on the form was Bipolar Disorder.[177] It is entirely unclear why this diagnosis was recorded at this stage. It would appear that the person making the referral either did not know Mr. X very well, that his diagnosis had not been explicitly recorded in the documentation that the worker had access to, or he had not yet been diagnosed.

Throughout Mr. X's stay on Holdenbrook Ward the diagnosis appears to have centered upon anxiety and depression. Mr. X himself described feelings of anxiety and depression, stating that he felt low in mood and had little energy or motivation. During the first weeks of his admission Mr. X's significant issues with alcohol were also recorded, but never used as part of a diagnostic formulation.

174.Mr. X Vol. 1 PP. 14-21
175. Mr. X Vol. 3 P. 118
176. Mr. X Vol. 10 P. 419
177. Mr. X Vol. 4 P. 236-237

Mr. X had a medication review conducted on the 25 March 2009 which was the day of his discharge. It was recorded on the prescription sheet that Mr. X had a Depressive Disorder with Psychosis. However on the 13 May 2009 *"depression and anxiety symptoms"* was written on the Discharge Summary sent to the GP in the narrative text, the diagnoses sections on the form were left blank.[178] On the 8 April 2009 following Mr. X's discharge Care Coordinator 1 recorded on the care plan that Mr. X was still waiting for a diagnosis.[179]

12.1.1.3. Conclusions

It appears to the Independent Investigation Team that the information available to the treating teams at the point of referral in September 2008 was probably flawed and misleading. It is also obvious that this information was repeated in the clinical record erroneously throughout the time that Mr. X spent on Holdenbrook Ward. After a careful examination of the clinical record it would appear that these historical diagnoses were taken at face value and accepted by the treating team. At no time were these diagnoses tested or re-evaluated in the light of Mr. X's current presentation.

It would seem, judging from Mr. X's presentation between September 2008 and September 2009, that he had significant feelings of depression and anxiety. At times he had paranoid ideas about the people around him and on one occasion, in January 2009, he appeared to have an episode of delirium, which is recorded in the clinical record as having possibly been due to an adverse reaction to his medication regimen at the time.[180] It was also known that Mr. X drank alcohol to an extreme level at times. A coherent diagnostic formulation was required in order to understand the aetiology of Mr. X's problems. The aetiology needed to be understood in order to understand what was happening to Mr. X and why in order to provide the most clinically effective means of treating him.

Diagnostic Formulation

There is no evidence to suggest that any robust diagnostic formulation was undertaken. A formulation should have defined how the treating team thought Mr. X was presenting and why. Mr. X's social history, physical conditions and mental health problems and symptomology should all have been identified and brought together. Consideration should have been taken with regards to his age, social isolation and alcohol consumption. The

178. Mr. X Vol. 10 P. 557-561
179. Mr. X Vol. 8 PP. 466-470
180. Mr. X Vol. 11 P. 644

formulation should also have considered a prognostic statement and included clinical risk assessment and management planning.

It is not always possible to provide a clear diagnosis with immediate effect, however every effort should be made to ensure that a diagnosis is given. In a case like that of Mr. X, when several different diagnoses appear to have been recorded historically, differential diagnoses should always be considered. This diagnostic method should be used when multiple diagnostic possibilities are present. Basically the most obvious or reasonable diagnosis should be examined first and tested utilising known patient history and current presentation. The most common explanation should be considered in the first instance. Each and every factor should be examined until an evidence-based diagnosis can be made.

In the case of Mr. X there is no evidence in the clinical record to suggest that an appropriate diagnostic approach was utilised. Clinical witnesses interviewed by this Investigation could not remember the case in enough detail to add any additional information not present in the clinical documentation. The fact that Mr. X was discharged, after a five-month inpatient admission on Holdenbrook Ward, with no diagnosis identified is strongly suggestive that diagnostic practice within the treating team was poorly developed.

Consequences for Mr. X's Care and Treatment

In the long term it would be reasonable to state that if a patient's condition is not clearly diagnosed then it may not be possible to understand what any prescribed care and treatment is trying to affect. In the short term it is not unreasonable for a patient to have their symptoms treated prior to a diagnosis being made, as was the case for Mr. X, this is good practice. However unless the underlying condition is understood eventually then there may be severe limitations regarding the clinical effectiveness of any long-term care and treatment programme. There are three important factors that need to be highlighted.

First: Mr. X was never understood in the context of his correct psychiatric history. A great deal of the information that the treating teams thought they knew about him was probably incorrect. Mr. X was not a very sociable person and did not volunteer information about himself readily. Whilst he was an inpatient on Holdenbrook Ward it was evident that, despite care plans to increase his social interaction, very little time was actually spent with Mr. X. It is remarkable that after a five-month stay on the ward, which could be considered a

significant period of time for such an episode, none of the ward-based clinical witnesses interviewed by the Independent Investigation Team could remember Mr. X with any degree of clarity. Mr. X killed both himself and his wife within a six-month interval of being discharged from the ward. This has to be considered as being a traumatic and noteworthy event. It is extraordinary that clinical witnesses could not remember an individual with whom they had worked intensively for such a prolonged period of time, especially in view of the fact that he and his wife died in such unusual circumstances. The nature of the contact witnesses had with Mr. X, coupled with the unusual circumstances regarding his death, could reasonably have been expected to have 'fixed' him in the memory of those who had worked with him within such a relatively short time of the incident occurring. The conclusion that the Independent Investigation Team reached was that no one on the ward had actually got beyond a very superficial therapeutic relationship with Mr. X, and that the five months he spent there represented a missed opportunity in relation to understanding this very anxious and troubled individual.

Second: Mr. X was noted to have had a problem with alcohol consumption. This was both a historic factor and one which was also still present at the time he was first referred by his GP to secondary care mental health services in September 2008. Once an inpatient on Holdenbrook Ward the assumption was made that this behaviour was no longer current, presumably because he was no longer able to access alcohol, and therefore of no further relevance. This was a naïve assumption at best, and a professionally inappropriate dismissal of an important diagnostic factor at worst. It was evident that following his discharge from Holdenbrook Ward on 25 March 2009 Mr. X resumed drinking alcohol because he was attempting to self medicate in order to alleviate the worst of his symptoms of anxiety that persisted. It was never considered whether or not Mr. X's alcohol consumption could have caused some kind of alcoholic paranoia (F10.5, ICD 10), this is a type of alcohol-induced psychotic disorder in which delusions of a self-referential or persecutory nature are prominent. It was never considered whether or not Mr. X required some specialist support from Alcohol Services with his drinking which was recorded as being a problem of long standing. Neither was Mr. X's alcohol habit considered as being part of his risk profile, especially in relation to his wife who often appeared to have become the focus of his aggression in the past.

Third: Mr. X should have received a care and treatment plan that was developed in an evidence-based manner in accordance with the National Institute for Health and Clinical Excellence (NICE) guidance. However in order to ensure this was achieved a diagnosis would have been required.

Summary

The Independent Investigation Team concluded that the clinical practice of Mr. X's treating team fell below that to be expected in relation to diagnosis. Based upon what was known, and what was thought to have been known about Mr. X, a more robust diagnostic formulation should have been developed, one which used a differential diagnosis model and examined his presentation with regards to his social and psychiatric history, physical conditions, and current mental health problems and symptomology. After a twelve-month interval of care and treatment with the Trust, between September 2008 and September 2009, no thorough psychiatric examination of Mr. X's case was undertaken and no conclusive diagnosis was reached. There appears to have been a significant lack of professional curiosity shown in relation to Mr. X by his treating team. The examination of his case appears to have been documented poorly and was superficial in the extreme.

In subsection 12.1.2. below the medication and treatment provided for Mr. X is examined in full as set against national best practice expectation and the relevance of the absence of a robust diagnosis is clarified.

- ***Contributory Factor One. The failure to provide a robust diagnostic formulation for Mr. X ensured that his care and treatment programme was not developed to its full potential. This contributed to the poor overall management of Mr. X's health and social care management.***

12.1.2. Medication and Treatment

12.1.2.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling),

psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

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

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

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

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

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

The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they

remember to take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly/monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and / or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

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

12.1.2.2. Findings

Mental and Physical Health of Mr. X

As has been seen from subsection 12.1.1. above, Mr. X had significant feelings of depression and anxiety. At times he had paranoid ideas about the people around him and on one occasion, in January 2009, he appeared to have an episode of delirium, which is recorded in the clinical record as having possibly been due to an adverse reaction to his medication regimen at the time.[181] It was also known that Mr. X drank alcohol to an extreme level at times.

It was recorded in Mr. X's clinical record that his physical health was poor. He had prostate problems, cardiac problems, high cholesterol, and arthritis of the wrist, knees and hips.[182] Mr. X had undergone a knee replacement several years prior to his admission onto Holdenbrook Ward, he walked with a stick and was often unsteady on his feet.

Medication

The difficulties in ascertaining the precise medication regimen that Mr. X was prescribed prior to September 2008 were the same as those in ascertaining his diagnosis. The clinical record anomalies ensured that this was a difficult task. The medication regimen as recorded in Mr. X's clinical record is listed below in chronological order, unless identified specifically

181.Mr. X Vol. 11 P. 644
182. Mr. X Vol. 1 P. 2

with an*, there is no guarantee that any of these entries actually relate to Mr. X as they may have been included in error. The reader is referred to the report glossary for definitions of the medications listed.

- **16 November 1998. Paroxetine (**Seroxat) 40mg at night and Olanzapine 5mg three times a day. Mr. X's mental health problems were documented as being *"paranoid psychosis ?Depressive illness."*[183]
- **25 October 2001.** Olanzapine 40mg once daily and Paroxetine 5mg once daily.[184]
- **4 April 2004.** Olanzapine 10mg once daily (it is unclear whether other medication was also prescribed at this time).[185]
- **24 December 2004.** The CPN wrote to the GP suggesting that Mr. X be prescribed Diazepam 2mg twice daily for 14 days following an episode of anxiety.[186]
- **9 October 2008*.** Risperidone (not specified) mg twice daily and Paroxetine (Seroxat) to 40mg once daily.[187]
- **12 November 2008*(on admission to Holdenbrook Ward)*.** Risperidone 3mg twice daily, Paroxetine 20mg once daily, Esomeprazole 40mg, Finasteride 5mg once daily, Tamsulosin 400mcg once daily and Ezetimibe 10mg once daily.[188]
- **13 November 2008*(following admission to Holdenbrook Ward)*.** Risperidone 3mg twice daily, Paroxetine 20mg once daily, Esomeprazole 40 mg, Finasteride 5mg once daily, Tamulosin 400 mcg once daily and Ezetimibe 10mg once daily, Perphenazine 2mg twice daily, Diazepam 2mg PRN (as required but a maximum of three times daily), Zopiclone 7.5mg PRN at night, Senna two tablets PRN at night.[189]
- **26 November 2008*.** Medication was increased to Risperidone 4mg twice daily and Paroxetine (Seroxat) 50mg once daily.[190]
- **27 November 2008.** Lithium Carbonate 600mg at night, Venlafaxine 37.5mg morning and 75mg at night (although this appears in Mr. X's GP records this prescription most definitely does not belong to him).[191]
- **3 December 2008*.** Propranolol 10mg three times a day.[192]
- **17 December 2008*.** Lofepramine 70mg twice daily was commenced.[193]

183.CMHT Record PP.27 and 49-50
184.CMHT Records P. 25
185.GP Record P. 72
186.GP Record P.78 and CMHT Record P. 30
187.Mr. X Vol. 9 PP. 502-503
188.Mr. X Vol. 2 P.33
189.Mr. X Vol. 2 P.33
190.Mr. X Vol. 3 PP. 670-673
191.GP Record P. 236
192.Mr. X Vol. 11 P.628

- **21 January 2009*.** Haloperidol 5mg PRN (prescribed following an episode of confusion and with accompanying hallucinations).[194]
- **27 January 2009*.** Aripiprazole and the Propranolol were discontinued.[195]
- **6 February 2009*.** Ibuprofen (Brufen) was prescribed for rheumatoid arthritis in knee.[196]
- **18 February 2009*.** Diazepam was increased from 2mg to 5mg twice daily for anxiety.[197]
- **25 February 2009*.** Haloperidol was stopped and Pericyazine 2.5mg twice daily commenced.[198]
- **25 March 2009* (at the point of discharge from Holdenbrook Ward).** A prescription review took place. The medication was Esomeprazole 40mg once daily, Finasteride 5mg once daily, Tamsolusin 400mcg once daily, Ezetimide 10mg once daily, Diazepam 2.5mg twice daily, Zopiclone 7.5mg at night, Lofepramine 70mg three times daily, Ibuprofen 400mg three times a day, Pericyazine 2.5mg twice daily, Procylidine 5mg once daily. The admission drugs that were discontinued were Risperidone and Paroxetine (Seroxat). The given diagnosis on the prescription sheet was Depressive Disorder with Psychosis.[199]
- **22 April 2009*.** Mr. X was noted as not being compliant with his medication and that he was drinking alcohol again. His medication was reviewed and changed (details could not be found in the clinical records but are probably included in the list directly below).
- **13 May 2009*.** The Discharge Summary sent to the GP on this date listed Mr. X's medication as being Esomeprazole 40mg once daily in the morning, Finasteride 5mg once daily in the morning, Azetamide 10mg once daily in the morning, Tamsolusin once daily in the morning, Zopiclone 7.5mg at night, Lofepramine 70mg three times a day, Ibuprofen 400mg three time a day, Periciazine 2.5mg twice daily, Diazepam 2.5.mg twice daily, Procylidine 5mg twice daily.[200]

193. Mr. X Vol. 11 P. 631
194. Mr. X Vol. 7 P. 422
195. Mr. X Vol. 7 P. 418
196. Mr. X Vol. 11 P. 648
197. Mr. X Vol. 1 P. 5
198. Mr. X Vol. 4 PP. 240-241
199. Mr. X Vol. 5 P. 312
200. Mr. X Vol. 10 PP. 560-561

- **2 June 2009*.** Lofepramine 70mg three times and Pericyazine 2.5mg twice a day. It is apparent that Mr. X stopped taking Diazepam at the point of his discharge.[201]

Antidepressants

National Institute of Health and Clinical Excellence (NICE) guidance recommends the use of antidepressants for the treatment of depression and anxiety. Mr. X was first treated with Paroxetine (Seroxat) in 2008. A decision was made at the end of 2008 to stop the Paroxetine and it was noted that this was to occur gradually until it was stopped in January 2009. Lofepramine 70mg twice a day was prescribed in December 2008 concurrently with Paroxetine for up to seven weeks. At the point of Mr. X's discharge on the 25th March 2009 it appears that the dosage of Lofepramine was raised to 70mg three times a day which is the maximum recommended dose. The choice of drug and the dosage were justified in accordance with Mr. X's presentation and meet British National Formulary (BNF) guidance.

However there are issues relating to the use of Lofepramine in that it can worsen clinical symptoms and promote suicidal feelings. Close supervision of patients, and in particular those at high risk, should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregivers of patients) should be alerted about the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present. Immediately prior to Mr. X being discharged the Lofepramine dose was increased. No monitoring plan appears to have been put into place.

Anxiolytics/Benzodiazepines

Benzodiazepines (such as Diazepam) are not recommended unless they are provided on a temporary basis to manage a short-term crisis period. NICE guidance states that:

"One of the key concerns about the use of benzodiazepines is that many people develop tolerance to their effects, gain little therapeutic benefit from chronic consumption, become dependent on them (both physically and psychologically), and suffer a withdrawal syndrome when they stop taking them. The withdrawal syndrome may be prolonged and can develop at any time up to 3 weeks after cessation of a long-acting benzodiazepine, or a few hours after

201. Mr. X Vol. 8 PP. 456-458

cessation of a short-acting one. The syndrome includes anxiety, depression, nausea and perceptual changes."[202]

It would appear that from the 13 November 2008 until the 2 June 2009, Mr. X was prescribed Diazepam on a routine basis. The recommended dosage for anxiety falls between 2mg and 10mg two-four times daily. The Royal College of Psychiatry recommends that Diazepam should be used for a period of a few weeks only (less than four weeks) and that very few people have been shown to benefit from long-term usage.[203] The fact that Mr. X was known to have periods of non compliance with his medication regimen is of particular concern as a sudden cessation in Diazepam could have caused an abrupt worsening of his symptoms. This did not appear to have been a consideration in the long-term medication management of Mr. X. It is reported that shortly after his discharge on the 22 April 2009 Mr. X had stopped taking his medication and had commenced drinking alcohol.[204] On the 2 June 2009 it was recorded, following an Outpatient appointment, that Mr. X had decided to stop taking his Diazepam following his discharge. The GP was written to on the 18 June 2009 to ask him to stop prescribing this particular medication.[205] There is no evidence that any advice was given to Mr. X about the effects of a sudden withdrawal from Diazepam, or that the treating team considered monitoring his condition following the 22 April 2009 once it was known he may have stopped this medication. As no one was meeting with, or monitoring, Mr. X it cannot be known whether or not this affected his mental state. It was however recorded by the Golborne Older Persons' CMHT when making visits to his wife that Mr. X had occasionally been *"angry and agitated"* and that he felt generally unwell with various gastro-intestinal complaints. These symptoms could have been manifestations of Diazepam withdrawal.

Propranolol

Propranolol can be prescribed to alleviate physical symptoms of anxiety such as palpitations and tremor rather psychological symptoms. The usual dose is 40mg once a day increasing to 40mg three times a day. The initial dose of 10mg three times a day is below the therapeutic dose range. A dosage increase to 20mg three times a day was recorded to treat anxiety, although the drug was stopped two weeks later following an episode of confusion.

202.http://www.nice.org.uk/usingguidance/optimalpracticereviewrecommendationreminders/optimal_practice_review_recommendation_reminders_detail.jsp?o=92
203.http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/benzodiazepines.aspx?theme=print
204. Mr. X Vol. 11 P.601
205. Mr. X Vol. 8 PP. 456-458

Antipsychotics

Mr. X was treated with Aripiprazole, Risperidone, Haloperidol, Pericyazine, and Perphenazine at varying stages between September 2008 and September 2009. Aripiprazole and Risperidone are both atypical antipsychotic drugs. The British National Formulary recommends that this class of drugs is *"used with great caution in the elderly"*. It is not clear when Aripiprazole was prescribed or at what dose. The drug is only mentioned once in the notes. The recorded stop date for Aripiprazole is three months after the initial prescription for Risperidone. If Aripiprazole were prescribed, then plans to reduce the dose incrementally before stopping it should have been documented in order to avoid the risk of acute withdrawal syndrome, or rapid relapse. Risperidone was first prescribed in October 2008 at a dose of 2mg twice a day (4mg in total). This is above the recommended starting dose of 1mg twice a day, and four times higher than the recommended dose for the elderly (0.5mg twice a day). Mr. X was 69 years old at this time, so dosage advice for prescribing in the elderly should have been taken into account. The total daily dose of Risperidone was increased over the first month to 8mg, this is above the 'usual dose range' of 4-6mg and twice the recommended dose for the elderly.

Pericyazine 2.5mg twice daily was commenced on 25 February, when the Diazepam and Haloperidol were apparently stopped. This was also the dosage that Mr. X was discharged from Holdenbrook Ward on. This dose is in line with the British National Formulary (BNF) guidance recommended 'starter' dose for an elderly patient as a short term adjunct for the treatment of severe anxiety and impulsive and dangerous behaviour.

Perphanazine 2mg twice a day was listed on the medication record when Mr X was admitted to Holdenbrook Unit on 12/13 November 2008. There is no other reference to the indication of this medication being prescribed at any other point. The dose is within the recommended limit for treating elderly patients for violent or dangerously impulsive behaviour.

Haloperidol 5mg prn (*pro re nata* or as required) was first prescribed on 21 January 2009 following an episode of confusion and with accompanying hallucinations. It was stopped a month later. There is no indication of maximum frequency, but if this were given three times a day, the dose would be at the upper end of the dosage range indicated in the BNF, with half the adult dose being recommended in the elderly.

Other medication

Finasteride is indicated for benign prostatic hyperplasia. It is an alternative to alpha-blockers such as Tamsulosin which are also indicated for this condition (BNF). There are no clinical notes to suggest that Mr. X was under the care of a urologist, and it is not unusual for these medicines to be initiated by the GP. The fact that Mr. X was receiving both these medicines suggests that his routine medicines may not have been adequately reviewed in primary care.

There is no indication that Mr. X was receiving anti-inflammatory or other medicines to relive pain associated with arthritis until February 2009. He was however prescribed an acid suppression medicine (Esomeprazole) from November 2008 (and possibly before this). Esomeprazole offers gastric protection, but there is no indication as to why this may have been required. For all patients, but particularly in the elderly and those where there are concerns regarding medication compliance, it is considered good practice to suspend or stop medicines that are not clearly indicated.

Mr. X is reported to have had high cholesterol. Ezetimibe is used to reduce cholesterol. Again, this balance of risk and benefit should be considered where patients are known to have difficulties adhering to their prescribed medication.

Zopiclone

It is unclear whether or not Mr. X had been prescribed Zopiclone prior to admission. Zopiclone is licensed for short term use for insomnia (up to four weeks), although it is frequently prescribed for longer than this. It should be used with caution in the elderly and in those with a history of drug abuse. Mr. X continued to be prescribed Zopiclone throughout his time as an inpatient, and was still prescribed it on discharge four months later.

Procyclidine

Procyclidine, probably at dose of 5mg twice daily was prescribed to alleviate the side effects of Risperidone. At discharge it was determined that the dose should be reduced to 5mg once daily despite the fact that the Risperidone (this being the rationale for prescribing Procyclidine in January) had been discontinued. The discharge summary indicated that a dose of 5mg twice daily should be continued.

General Medication Management

In view of the fact that no conclusive psychiatric diagnosis was reached or formulation was developed, it is difficult to understand the rationale behind the medication regimen that Mr. X followed. This lack of clarity is not helped by the fact that clinical documentation is lacking in detail and clinical witnesses called by the Investigation had a poor recall of the case. The consistent use of antipsychotic medication would suggest that a psychosis was being treated, however it is not certain whether the prescription choice was made because of the way Mr. X presented or because of his historic diagnoses (which may have been incorrect). At the point of his discharge on the Discharge Summary documentation the phrase *"depression and anxiety symptoms"* was written.

Adherence to the Medication Regimen

In December 2008 Mr. X commented that when he took Lofepramine he felt as though he was *"walking around like a zombie".*[206] Mr. X had an unsteady gait, often felt 'wobbly' and also had a history of cardiac problems. Mr. X stumbled on the ward on several occasions which he put down to the Lofepramine.[207] Mr. X stated on many occasions that he had little faith in his medication regimen making him better.

On the 19 January 2009 Mr. X appeared to have a reaction to the Propranolol that he was taking. He presented as being confused, disorientated, unable to sleep, and had some psychotic thoughts and visual disturbance.[208] On the 21 January it was thought that he was having a reaction to his Aripiprazole. However Haloperidol was prescribed for his 'psychotic' symptoms.[209] This period of confusion continued for eight days. The Ariprazole and Propranolol were discontinued as a result. No further 'psychotic' episodes were recorded.

Both prior to his admission to Holdenbrook Ward in November 2008 and following his discharge in March 2009, it was recorded that Mr. X was not compliant with his medication regime, this practice usually coincided with his drinking alcohol. At the point of his discharge the GP was written to requesting that Mr. X's medication be supplied to him in blister packs in order to encourage his compliance.[210] Bearing in mind that Mr. X had little confidence in his medication, often refused to take it, was on Diazepam which should not be discontinued

206. Mr. X Vol. 11 P. 632
207. Mr. X Vol. 11 P.636
208. Mr. X Vol. 11 P. 644
209. Mr. X Vol.7 P. 422
210. Mr. X Vol. 9 P. 506

without medical supervision, and had been prescribed an increased dose of Lofepramine, it would have been reasonable to have expected a care plan to have been developed with regards to this particular aspect of his treatment. This was not done.

Prescribing

Risperidone is a powerful antipsychotic and should be initiated by a consultant psychiatrist. It is therefore of concern that a Social Worker made the request to a GP to prescribe the medicine. Since a GP is legally responsible for the affects of medicines that they prescribe, such a request should be made within the context of a shared care agreement between them and the Consultant Psychiatrist.

Recording prescribing indications

Some of the medicines prescribed for Mr. X can be prescribed for more than one condition. In most cases the treatment goals are absent, and so any attempt to assess whether or not the medicine has had the desired effect would have been compromised.

Medicines review

Medicines reviews should be undertaken by the GP on a regular (at least six monthly) basis for all elderly patients receiving repeat medication, and more frequently when a patient is taking medicines that require more intensive monitoring. Medicine reviews should also be undertaken following initiation of a medicine or a change of dose in order to assess whether or not the patient is experiencing any benefit, and also when drugs need to be stopped gradually. Recorded instances of medicine review are extremely rare in the case of Mr. X, and do not appear to have been conducted at all following the increase in his dose of Loperamide on discharge from hospital and the time of his death.

Whilst an inpatient, and in addition to the clinical review undertaken by the Consultant Psychiatrist, patients should receive a medication review from a clinical pharmacist. Clinical pharmacy services may be provided within the hospital or be provided by a neighbouring hospital. Even where medicines are supplied by a community pharmacy provider, clinical checks and advice should be evident. A planned outpatient review by the Consultant Psychiatrist six-eight weeks after discharge is unlikely to constitute an appropriate medication review for this patient.

There is no evidence of any clinical reviews by the GP or by a clinical pharmacist, and those undertaken by the hospital are poorly documented with regard to indication, review and outcome. Except when a crisis arose there is no evidence to suggest that any attempts were made to undertake a holistic review of Mr. X's medicines whilst he was an inpatient and discontinue ones that might no longer be indicated, or may be exacerbating his condition and/or symptoms.

Use of blister packs

Blister packs are likely to have been supplied by the local community pharmacist. In any event, this person would have been in a position to verify whether or not medicine remained in the packs returned after use. Although removal of medicines does not in itself mean that they have been taken, pharmacists should contact the prescriber if they have concerns regarding the taking of medicines by vulnerable patients.

Reliance on self reporting of non-adherence with medication

Mr. X was reported to be non-compliant with his medicines at various times. The term compliance tends to reflect medicine taking from the prescriber perspective, whereas the term non-adherence recognises the patients perspective and autonomy in the decision about taking or not taking their medicines. It is estimated that non-adherence with prescribed medicines is between 30–50% and that this may be higher amongst patients with mental health problems.

There is no obvious written evidence that any assessment or enquiry was undertaken into Mr. X's views and beliefs about his medicines, although he is reported to have held strong views about the effects of the Lofepramine on his mobility, and very little faith in his medicines in general.

There appears to be an underlying assumption in this case that self reporting of medicines taking, without enquiry is sufficient, and yet it is also known that patients may not disclose their failure to comply when asked a simple question about compliance by a doctor. Disposing of medicines, or even giving them to another person, is not unheard of. Given the nature of his relationship with his wife, this should have been taken into consideration.

Medicines adherence can be increased through discussion between the prescriber and the patient in order to establish shared understanding of realistic treatment goals.

Medicines and driving

Mr. X expressed significant anxiety about driving. Many of the medicines he was prescribed can affect motor skills and this impairment is exacerbated by alcohol. For this reason there is a public safety concern to be considered as well as an interest in facilitating his ability to manage the house and care for his wife. A detailed medication review and exploration of his medicines may have generated a more balanced discussion around the lifestyle choices he might make.

Other Evidence-Based Treatment Options

Occupational Therapy

Occupational Therapy is described as being the assessment and treatment of physical and psychiatric conditions using specific, purposeful activity to prevent disability and promote independent function in all aspects of daily life. On several occasions throughout the time that Mr. X was an inpatient on Holdenbrook Ward the decision to refer him for an Occupational Therapy assessment was recorded. A referral appears to have been made on the 4 December 2008, the referral was to request inputs with regards to Mr. X's low mood, anxiety, social isolation and poor daily living skills. Whilst an assessment took place it would seem that no long-term treatment occurred as a result of this.

Occupational Therapy could have provided specific interventions to work on Mr. X's social isolation and could also have supported him in developing daily living skills in preparation for his discharge and his ongoing role as main carer for his wife. Had this kind of intervention been made available it could have made a positive contribution to his health and wellbeing.

Electroconvulsive Therapy (ECT)

ECT is used for the treatment of severe and/or resistant depression. On 28 December 2008 the treating team suggested to Mr. X that he consider a course of ECT. Mr. X approached the ward staff for an information leaflet which was given to him.[211] After reading through the information leaflet Mr. X was adamant that he did not want to pursue the idea of ECT and refused to consider it further as was his right to do.

211. Mr. X Vol. 11 P. 637

Psychology

A clinical review took place on the 18 February 2009. Consultant Psychiatrist 2 had advised Mr. X to try relaxation techniques and to go for walks as an alternative method for controlling his anxiety. It may have been unreasonable to have suggested that Mr. X 'walked off' his anxiety as he was also reported as having a swollen and painful left knee (due to rheumatoid arthritis) for which anti-inflammatory medication and rest had been prescribed.[212] At this juncture the Psychiatrist had just raised the dose of Mr. X's Diazepam from to 2mg to 5mg twice daily in order to manage his anxiety. It would appear that the plan was to refer Mr. X to a Psychologist *"for coping skills"* to which Mr. X was in agreement. This approach was also suggested so that on discharge Mr. X would no longer depend upon alcohol as an attempt to self medicate.[213]

This was a sensible plan. However it was being advised without ensuring that Mr. X's depression and alcohol problems were managed first. NICE guidance advises that when a person has anxiety with an accompanying depression and/or alcohol misuse problem it is advisable to ensure that the treating team understands the aetiology of the condition so that treatment can be offered in an effective and systematic manner.

Psychological treatments for anxiety usually consist of Cognitive Behaviour Therapy (CBT) and applied relaxation techniques. To be effective, these would usually involve weekly meetings with a healthcare professional for a period of some three to four months. It would appear from reading Mr. X's clinical record that Psychological Therapy, whilst having been considered, was never provided.[214]

Alcohol Misuse

The fact that Mr. X misused alcohol as a method of coping was well documented. The only help and support he received with this was to be advised to cut down. No aspect of this behaviour was examined in the light of his diagnosis, past behaviour, presentation, medication regimen, risk, role as a carer to his wife, or recovery. At no time was a referral considered to specialist alcohol services even though alcohol had been identified as being a potential trigger for aggressive behaviour and that staff considered he may present a risk to

212. Mr. X Vol. 11 P. 622
213.Mr. X Vol. 1 P.5
214. http://www.nice.org.uk/nicemedia/live/13314/52602/52602.pdf

them when visiting him in the home unless they did so in pairs. The only action recorded prior to his discharge to address Mr. X's alcohol consumption was as follows *"advise [Mr. X] to reduce alcohol intake. Advise [Mr. X] that staff will visit in pairs if he presents as drinking to excess/under the influence".*[215]

Multidisciplinary Inputs

Whilst Mr. X was an inpatient there would appear to have been a minimal degree of therapeutic interaction between him and the ward-based staff. The recorded interactions were either reactive responses to difficulties that Mr. X encountered or routine interventions in relation to Mr. X's eating, drinking and personal care. Mr. X was on the ward for a five-month period which provided an ample opportunity for staff to get to know him and work with him on a therapeutic basis. Whilst care plans were developed there were no documented interventions recorded. The clinical witnesses who were interviewed by this Investigation could not cast any additional light onto this topic as they struggled to remember Mr. X with any degree of clarity.

12.1.2.3. Conclusion

Medication

There is a difficulty when assessing the appropriateness and effectiveness of Mr. X's medication regimen. This is due to the fact that it remains uncertain what diagnostic formulation had been reached and whether or not it had been developed with an incorrect psychiatric history. It was evident that at times Mr. X expressed thoughts that appeared to be paranoid in nature, however the degree of severity was never ascertained. In January 2009 Mr. X had what appeared to be his only truly 'psychotic-type' episode, however the treating team ultimately decided that this was as a result of side effects from his Propranolol. Once this drug had been stopped Mr. X's mental state rapidly improved.

It is often recorded, especially by unqualified staff, that every time Mr. X expressed any worries or anxieties, that he was voicing paranoid ideas. The main focus of his so-called paranoid ideas centered on the loss of his driving license. It is apparent that the Support Workers who visited him and his wife between March and September 2009 could not understand why he was so seemingly troubled and 'obsessed' by this. However it could be

215. Mr. X Vol. 4 P. 242

seen as a perfectly legitimate concern for a man with poor mobility who was the main carer for a wife with dementia to require transport. It is entirely possible that the label of psychosis clouded the treating team's understanding of his presentation, and that this label may have been given without a true understanding of the aetiology. It would appear that the treating team decided to treat the 'paranoid' thoughts with medication. It is quite probable that Mr. X did suffer from what his former Psychiatrist, had in 2003, described as occasional mild paranoid thoughts.[216] This is however quite different from being diagnosed as having a Paranoid Psychosis, unfortunately Mr. X did not have this diagnosis either confirmed or ruled out between September 2008 and the time of his death on September 2009. It will have to remain an area of conjecture and speculation as to whether or not Mr. X's antipsychotic medication was given as a result of an incorrect former diagnosis, or whether it was prescribed based solely on his presentation in September 2008.

It was evident that Mr. X had significant reasons to feel depressed and anxious. He was lonely, worried about his future and estranged from his wife and family. It is naïve in the extreme to have supposed that a pharmaceutical approach alone could have raised his mood and solved his problems. The reliance upon Diazepam to relieve Mr. X's anxiety goes beyond naivety and borders upon unacceptable medical practice, especially as no medication management plan was in place to supervise the abrupt cessation that took place at Mr. X's volition.

The approach taken to Mr. X's medication often appeared to have made him feel ill and did not take into account his frail physical health. There is evidence to suggest that both the Propranolol and Lofepramine compromised both Mr. X's mental and physical wellbeing.

The absence of a structured, significant and holistic review of Mr. X's medicines at any point is a cause for concern. Such a review could have resulted in a reduction in the number of medicines that Mr. X was prescribed (for all conditions) and possibly any side effects that he was experiencing. Any dependency and any adverse effects due to abrupt cessation of medicines may have been avoided. Discussion might have revealed more about his beliefs of the benefits, or lack of benefits, of his medicines and created an opportunity to discuss the effect of alcohol in relation to his ability to drive and create a treatment plan to minimise

216. Mr. X CMHT Notes P.17

these in the future or come to terms with a necessary compromise. The lack of evidence of pharmaceutical oversight of the prescribing in hospital is also of concern.

It remains unclear to the Independent Investigation Team, as it must have been to the treating team, exactly what set of problems the medication was trying to affect as the aetiology of Mr. X's condition had not been explored and no robust diagnostic formulation had taken place. Mr. X was on a significant amount of medication, the monitoring of which did not appear to be managed in a coherent manner.

Other Evidence-based Interventions

Occupational Therapy and Psychological Therapy were considered appropriately. Neither were actually provided. This has to be seen as a missed opportunity as it was evident that Mr. X's medication regimen made no significant improvement to his mental state. The lack of therapeutic intervention that took place on Holdenbrook Ward also has to be seen as a missed opportunity.

Summary

Between September 2008 and September 2009 Mr. X received medication for his depression and anxiety. He also received medication for a supposed psychotic disorder of some kind. Whilst it is entirely possible that the medication prescribed was the most appropriate and effective treatment of choice, the lack of a robust diagnostic formulation could leave this open to debate. It is a fact that other evidence-based treatment interventions were not provided which, in the light of Mr. X's condition appearing to be resistant to pharmaceutical intervention, were most definitely indicated. This is of particular significance as Mr. X had expressed a readiness to engage with a Psychologist whilst expressing his lack of confidence and belief in his medication regimen.

Following his discharge in March 2009 Mr. X received only sporadic follow up in the community. It was evident that he was not being compliant with his medication and had returned to his alcohol misuse habit. Mr. X was not offered a referral to a specialist service to address his alcohol consumption.

It is the conclusion of the Independent Investigation Team that the treatment plan constructed for Mr. X lacked coherence, coordination and monitoring to the detriment of his health and wellbeing.

- ***Contributory Factor Two. The failure to provide a comprehensive care and treatment programme contributed to the poor overall management of Mr. X's health and social care management.***

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

12.1.3.1. Context

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

At any one time there are up to 15,000 people detained by the Mental Health Act in England. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.[217]

Section 131 of the Mental Health Act (1983 and 2007) allows for people to be admitted into a psychiatric hospital on either a voluntary or informal basis, this means they can be treated without a compulsory detention order. Following the Bournewood findings in 2004 at the European Court of Human Rights a distinction was made between 'voluntary' and 'informal'.

217. Mental Health Act Commission 12th Biennial Report 2005-2007

'Voluntary' patients are people who are judged to have full capacity to consent or refuse consent to treatment; this means that they have the right to refuse all treatment and to discharge themselves from hospital at any time they wish. An 'informal' patient is a person who is judged as not having the capacity to give consent. This means that whilst they may raise no objection to being admitted and receiving treatment additional measures have to be taken to ensure their continued risk is contained and that their human rights are safeguarded. Many mental health Trusts in effect treat 'voluntary' and 'informal' patients in the same way. It is not clear whether Mr. X was judged as having capacity or not during his admission on Holdenbrook Ward.

12.1.3.2. Findings

Historic Mention of the Mental Health Act (1983) in Mr. X's Clinical Record

As has already been mentioned there has been a co-mingling of at least two other service users' clinical records into the historic clinical records of Mr. X. There is mention of a Mr. X being discharged from a Section 117 on the 21 November 2006 (Section 117 is a requirement for aftercare which usually follows a Section 3 of the Mental Health Act). After a careful examination of the clinical record it is evident that this entry does not relate to the Mr. X who is the subject of this report. All other references to Section 117 are included, and referred to, within Mr. X's clinical record in error.

The Events of 8 October 2008 and the Failure to Admit Mr. X onto Holdenbrook Ward

Between the 28 September and the 7 October 2008 Mr. X was not considered to require a Mental Health Act (2007) assessment. Consultant Psychiatrist 2 tried to persuade Mr. X to accept an inpatient admission in order to expedite his treatment, but he refused.

On the 8 October 2008 Mr. X, whose mental health had begun to steadily decline, asked to be admitted into hospital. He was accompanied to Holdenbrook Ward at the Leigh Infirmary by a Social Worker from the Hindley and Ince Adult CMHT who was in due course to become his Care Coordinator. Mr. X had been anxious and low in mood in preceding days and had also been thought to have paranoid ideas. It was evident that his mental health was deteriorating and that he was no longer able to look after himself properly as he was unkempt, smelt strongly of body odour, and was drinking alcohol to excess.[218]

218. Mr. X Vol. 7 PP. 386-387

Mr. X retained a degree of ambivalence about being admitted onto the ward. Once he arrived there was a considerable delay as the ward doctor was not able to come onto the ward to commence the admission and there was no other doctor available. During the wait to be seen by an admitting doctor Mr. X grew increasingly distressed and ultimately he demanded to leave. The Social Worker drove Mr. X back home.[219] During Investigation interviews clinical witnesses said that a doctor should have admitted the patient immediately on arrival, but that delays could often take place, sometimes for up to four hours.

Clinical witnesses also told the Independent Investigation Team that the Social Worker had not thought Mr. X was detainable under the Mental Health Act (2007) at this time because he was not considered to be at risk of suicide and that he could go home. Clerking in systems and understanding of the Mental Health Act appear to have been confused as Mr. X was allowed to leave the ward without an assessment taking place. Staff did not appear to recognise that risk of self neglect and vulnerability could also trigger a Mental Health Act (2007) assessment if deemed to be appropriate in the presence of a severe mental illness.

The Events of October 2008 Prior to Mr. X's Admission onto Holdenbrook Ward

The following day (9 October) Mr. X refused to let members of the Hindley and Ince Adult CMHT into his home. When they finally gained access it was noted that he was drinking heavily.[220]

On the 10 October (a Friday) Mr. X refused to receive a home visit. It was recorded that if this situation continued a Mental Health Act (2007) assessment would be arranged. The plan was to review Mr. X the following Monday and for the Crisis Team to monitor the situation over the weekend. Within 36 hours of the failed attempt to admit Mr. X onto Holdenbrook Ward his mental state had deteriorated to the point where a Mental Health Act (2007) assessment was being considered.[221]

Mr. X refused input from the Crisis Team over the weekend.[222]

219. Mr. X Vol. 9 PP. 537-539
220. Mr. X Vol. 9 P. 545 and Mr. X Vol. 7 P. 387 and Mr. X Vol. 9 PP. 502-503
221. Mr. X Vol. 9 P. 547-549
222. Mr. X Vol. 9 P. 550

On Monday the 13 October the Social Worker (Care Coordinator 1) spoke to the GP over the telephone in order to inform him of the situation. The GP was agreeable to take part in a Mental Health Act (2007) assessment if it was deemed to be necessary.[223]

There would appear to have been visits to Mr. X's home on the 23 and 29 October 2008. This activity has been logged by the Trust electronic data system, unfortunately what occurred during these visits does not appear to have been recorded.[224]

On the 30 October a Multidisciplinary Team meeting took place which recorded Mr. X's diagnosis as being *"Psychotic Depression Paranoid".* At this time he denied experiencing hallucinations or of having thoughts of killing himself. It was noted that Mr. X drank heavily and he was advised to cut down. The GP was written to. It was noted in this letter that Mr. X was drinking about one and a half bottles of whiskey a week and that he was having to attend the Police Station as part of his bail conditions following the alleged assault on his wife.[225]

The Trust Internal Investigation Team had access to information that suggested Mr. X was accompanied to the GP by Care Coordinator 1 on the 31 October. Mr. X no longer appeared to be paranoid but he was not eating or sleeping and his personal care was described as being poor. The Internal Investigation report also cites that Care Coordinator 1 contacted Mr. X by telephone on the 5 November and arranged to visit him on the 7 November. No record could be found by the Independent Investigation of this meeting.[226]

There was no evidence of any further face-to-face meetings with Mr. X given to the Independent Investigation Team until the 12 November when he sought help by making *"10 plus calls"* to Claire House. This led to his assessment and admission onto Holdenbrook Ward at the Leigh Infirmary.[227]

Nowhere in the clinical record is there any mention of what actually occurred with the Mental Health Act (2007) assessment that the Hindley and Ince Adult CMHT were planning to conduct. It would appear that Mr. X's mental state continued to deteriorate until he reached a

223. Mr. X Vol. 10 P. 553
224. Mr. X Vol. 10 PP. 595-599
225. Mr. X Vol. 9 PP. 508-509
226. Trust Internal Investigation Report P. 12
227. Mr. X Vol. 2 PP.32-40

point of crisis on the 12 November and instigated his own admission onto Holdenbrook Ward.

12. 1.3.3. Conclusions

The Mental Health Act (2007) does not play a significant part in the care and treatment that Mr. X received from the 5 Boroughs Partnership NHS Foundation Trust and Wigan Local Authority. However there would appear to have been a lack of understanding on the part of Trust workers as to when the Mental Health Act could have been considered. On the 8 October 2008 Mr. X had reached the stage where he was no longer looking after himself and his mental health was deteriorating rapidly. The Independent Investigation Team concluded that when Mr. X refused to be admitted onto Holdenbrook Ward a Mental Health Act (2007) assessment should have been arranged on this occasion as he was at significant risk of self neglect.

By the 13 October 2008 Consultant Psychiatrist 2, Care Coordinator 1 and the GP were prepared to arrange a Mental Health Act (2007) assessment. It is evident that Mr. X's mental health continued to deteriorate but that no further action was taken. It is probable that the treating team thought that Mr. X did not require such an intervention, however it is unusual for the rationale not to have been recorded. The extant clinical record and the information provided by clinical witnesses to this Investigation give the impression that Mr. X's mental health was allowed to deteriorate without intervention until he reached a point of crisis.

- ***Contributory Factor Three. The opportunities to use the Mental Health Act (2007) were not considered in a timely manner. This contributed to the poor overall management of Mr. X's health and social care management.***

12.1.4. The Care Programme Approach

12.1.4.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.[228] Since its

228. The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990

introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach*.[229]

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

The purpose of CPA is to ensure the support of mentally ill people in the community, its primary function is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.
The essential elements of any care programme include:

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

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

229. Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

5 Boroughs Partnership NHS Foundation Trust CPA Policy (Effective Care Coordination Policy and Procedures 2008)

The Trust 2008 policy stipulated the main focus of Effective Care Coordination was to ensure:

- the promotion and maintenance of recovery;
- prioritisation of the needs of people with severe mental illness;
- the assessment of needs of service users and carers;
- the development and delivery of a care plan and the allocation of a Care Coordinator;
- the assessment and management of risk.[230]

Trust criteria for service users being placed on Enhanced CPA were as follows.

- *"They have multiple care needs such as physical health or disability, lifestyle and diet, housing, finance, employment, carer responsibilities, parenting capacity, pregnancy etc., which may require support from other statutory or voluntary sector agencies together with inter-agency care coordination.*
- *They are only willing to cooperate with one professional or agency but they have multiple care needs.*
- *They may be in contact with a number of care agencies (including the criminal justice system or childrens' services).*
- *They are likely to require more frequent and intensive interventions perhaps with medication management.*
- *They are more likely to have mental health problems co-existing with other problems such as substance misuse or learning disability.*
- *They are more likely to be at risk, of harming themselves or others, and /or at risk of self-neglect or domestic abuse.*
- *They are more likely to disengage with services."*[231]

The 2008 Trust policy stated that all service users who had undertaken a hospital admission would automatically qualify for Enhanced CPA.[232]

230. Trust Effective Care Coordination Policy and Procedures 2008. P.10
231.Trust Effective Care Coordination Policy and Procedures 2008. P.18
232. Trust Effective Care Coordination Policy and Procedures 2008. P. 19

The Role of the Care Coordinator was as follows.

- *"The Care Coordinator will have responsibility for coordinating care, ensuring the care plan is delivered, and ensuring the care plan is reviewed and that any other additional assessment is undertaken where required.*
- *The Care Coordinator is a named professional within the multidisciplinary team who is assigned responsibility for coordinating the package of care offered to the service user and where appropriate his/her carer.*
- *They are responsible for keeping in close contact with the service user, and for advising the other members of the care team of changes in the circumstances of the service user, which may require review, or modification, of the care plan."*[233]

The Trust policy stated that each Care Coordinator should have knowledge about the principles of Effective Care Coordination, safeguarding children and domestic abuse. The Care Coordinator was also expected to understand the roles and functions of other agencies and to be able to coordinate care and network appropriately on behalf of the service user. There was a responsibility stipulated that Care Coordinators were expected to conduct a review when there was a change in circumstance or cause for concern.[234] Care Coordinators were also responsible for ensuring local Vulnerable Adults procedures were complied with, that documentation was maintained, and that carer support needs were assessed and managed.

Individual service users on Enhanced CPA could expect:

- a holistic assessment of their health and social care needs;
- care and treatment to be coordinated between agencies;
- carer needs to be assessed and addressed;
- care plans to be developed with them, and reviewed on a regular basis according to need and change of circumstance;
- a Care Coordinator to be allocated within 72 hours of being accepted onto Enhanced CPA.[235]

Carers were instructed to receive:

- a carers' leaflet and information about services provided and available for relatives;

233. Trust Effective Care Coordination Policy and Procedures 2008. P. 19
234. Trust Effective Care Coordination Policy and Procedures 2008. P. 20
235. Trust Effective Care Coordination Policy and Procedures 2008. PP.23-25

- a review of their needs every 12 months;
- their own written care plan.[236]

N.B. All issues relating to policy adherence are addressed in subsection 12.1.11. below.

12.1.4.2. Findings

Trust Policy and Procedure

At the time Mr. and Mrs. X were receiving their care and treatment from the 5 Boroughs Partnership NHS Foundation Trust and Wigan Local Authority, a robust and fit for purpose CPA policy was in place. However the Independent Investigation Team found the language in the policy to be distracting as the Trust maintained the use of 'Enhanced' and 'Standard' CPA levels *after* these terms had been superseded nationally by 'CPA' and NonCPA'. For that reason this report also uses the same language as that used by the Trust, but the Independent Investigation Team recognises that these terms are outmoded.

CPA Status

Mr. X was assessed as requiring Enhanced CPA during his initial assessment with secondary care mental health services in September 2008. At this time he was managed in the community.[237] This Enhanced CPA status continued on his admission to Holdenbrook Ward, however it is noted that whilst a patient on the ward his status was described as being *"NonCPA"* on the 16 January and the 18 and 25 February 2009 during reviews and ward rounds.[238] On his discharge on the 25 March 2009 he was once again given the status of being on *"Enhanced CPA".*[239] He was to continue as being designated Enhanced CPA until the time of his death in September 2009.

In accordance with the Trust policy and national best practice guidance, Mr. X met the criteria for Enhanced CPA throughout the entire duration of his last episode of care and treatment with the Trust (September 2008 - September 2009). There is no rationale provided as to why for a period of some six weeks, whilst on Holdenbrook Ward, Mr. X was designated as being *"NonCPA"*. It is evident from the Trust policy criteria that he would

236. Trust Effective Care Coordination Policy and Procedures 2008. PP.29-30
237. Mr. X Vol. 2 PP. 23-26
238. Mr. X Vol. 4 PP. 242-243 and Mr. X Vol. 1 P. 5 and Mr. X Vol. 4 PP. 240-241
239. Mr. X Vol. 5 P. 312

automatically have met the Enhanced CPA threshold as he was an inpatient. The Independent Investigation Team observed that this temporary designation was inappropriate.

Care Coordinator Allocation

Following the GP Referral in September 2008

The Trust CPA Policy is quite clear that for those service users designated as being on Enhanced CPA a Care Coordinator should be allocated within 72 Hours. It was recorded in the clinical record on the 29 September 2008 that Mr. X was placed on Enhanced CPA. On this day it was recognised and recorded that Mr. X required allocation *"asap"*.[240]

On the 3 October it was written that Mr. X's condition was deteriorating. The Care Coordinator was recorded as being Consultant Psychiatrist 2, which was a default position. In effect Mr. X's case had still not been allocated.[241] The situation appeared to have been exacerbated by two CMHTs being involved with Mr. X at the same time, the Hindley and Ince Adult CMHT, and the Golborne Older Persons' CMHT. There is mention in the clinical record on the 3 October 2008 that the case would be reviewed on Monday (6 October 2008) by the Care Coordinator, presumably Consultant Psychiatrist 2.

On the 6 October 2008 Consultant Psychiatrist 2 visited Mr. X at his home with a Social Worker from the Adult CMHT. It was noted on this occasion that a Care Coordinator needed to be allocated in order to provide further assessment. On this occasion it was recorded that Mr. X was tearful and refusing a hospital admission, but that he would accept regular support if it was offered to him in his home. This made the allocation of a Care Coordinator of immediate importance.[242]

On the 7 October 2008 it was evident that Mr. X's mental state was deteriorating. He was paranoid and required a joint home visit to be made. Mr. X was offered the services of the Crisis Team, he initially refused this. It was noted that Mr. X required continuity of care and that it was important a Care Coordinator was allocated. It was finally decided, with Mr. X's agreement, that the Crisis Team would be involved for the *"next five days"* until a Care Coordinator could be found. No reason was recorded in the clinical record as to why nine

240. Mr. X Vol. 2 PP. 23-26
241. Mr. X Vol. 2 PP. 27-28
242. Mr. X Vol. 7 P. 386 and Mr. X Vol. 9 P. 533

days after Mr. X had been placed on Enhanced CPA no Care Coordinator could be provided for him.[243]

On the 8 October 2008 Mr. X reached crisis point and he was taken to Holdenbrook Ward at the Leigh Infirmary for an emergency admission by the Social Worker from the Adult CMHT who had visited him on the 6 October 2008. Once there Mr. X refused admission and was taken back to his house. He expressed his worries about being on Police bail on his return home. The Social Worker explained to Mr. X that his care was going to be transferred from the Golborne Older Persons' CMHT, to her team, the Hindley and Ince Adult CMHT. At some stage thereafter this Social Worker became Mr. X's Care Coordinator. This would appear to have occurred by the 10 October as the Social Worker signs herself as being the 'Care Coordinator' from this date (the Social Worker is referred to from this point on in this report as Care Coordinator 1).[244]

Between the 9 October and the 12 November 2008 Mr. X continued to live at his home. It was evident that he was drinking heavily and that his mental health had deteriorated to the point that a Mental Health Act (2007) assessment was being considered. On the 12 November Mr. X was admitted to Holdenbrook Ward, informally, in a state of crisis. It was recorded that his Care Coordinator was Care Coordinator 1. Nowhere in the clinical record, between the 8 October and the 12 November 2008, was there any evidence to suggest precisely *when* the Care Coordinator had been allocated (it would appear to have been sometime following the 8 October 2008), or whether any kind of CPA process had been instigated.[245] Mr. X's admission on the 12 November would appear not to have been as result of Care Coordinator 1's intervention, but because Mr. X had himself made *"10+"* telephone calls to Claire House asking for help.[246]

Care Coordinator Allocation Following Mr. X's Discharge in March 2009

Care Coordinator 1 remained the allocated Care Coordinator during Mr. X's inpatient stay on Holdenbrook Ward between 12 November 2008 and the 25 March 2009. She also remained the Care Coordinator at the point of his discharge. On the 8 and 22 April it was recorded that

243. Mr. X Vol. 7 PP. 386 - 387 and Mr. X Vol. 9 PP. 534-536
244. Mr. X Vol. 7 P. 387 and Mr. X Vol. 9 PP. 537-539
245. Mr. X Vol. 1 PP. 14-21 and Mr. X Vol. 2 PP.37-40 and Mr. X Vol. 2 PP. 32-36
246. Mr. X Vol. 2 PP. 32-40

Care Coordinator 1 was still involved in Mr. X's care.[247] It was also recorded that she was still acting as the Care Coordinator on the 1 May 2009.[248] There is no further mention of Care Coordinator 1 who apparently left the employ of the Local Authority sometime in May 2009 at which point Mr. X's care was said to have *"transferred"* to Consultant Psychiatrist 2. In a Trust chronology of the care and treatment received by Mr. X following his death it is recorded that Mr. X had regular contact with both his Care Coordinator and a Support Worker from the Adult CMHT between 25 March and the middle of May 2009. Unfortunately not all of these contacts appear to have been recorded and the Independent Investigation Team could not verify exactly what took place during this period.[249]

On the 2 June 2009 Mr. X was reviewed at Outpatient Clinic by a Staff Grade Psychiatrist and a Duty Worker at the Hindley and Ince Adult CMHT. It would appear that the Staff Grade Psychiatrist was designated, by default, as being the Care Coordinator. Clinical witnesses when interviewed by the Independent Investigation Team said that at this time Mr. X had not been reallocated a Care Coordinator and that this was why the Duty Worker was present at the meeting.[250] Mr. X was not seen by the Hindley and Ince Adult CMHT between the 2 June and the 17 August 2009. By the 17 August Mr. X's mental health had begun to cause the Golborne Older Persons' CMHT cause for concern when visiting Mrs. X. On the 17 August it would appear that Mr. X still had no allocated Care Coordinator and an unqualified Support Worker was sent to his home to assess him.[251]

Assessment and Review of Needs

Prior to Admission

Between the 29 September and the 12 November 2008, whilst a certain degree of activity was recorded on behalf of the Golborne Older Persons' CMHT, the Hindley and Ince Adult CMHT and the Crisis Team, little in-depth assessment appears to have occurred. Based on the clinical documentation made available to the Independent Investigation Team the only kind of formal assessment to have been recorded was an Effective Care Coordination 'Initial Core Assessment' (29 September 2008) and a basic Risk Screen and 'Summary of

247. Mr. X Vol. 8 PP. 466-475 and Mr. X Vol. 11 P. 601
248. Mr. X Vol. 9 P. 510 and Mr. X Vol. 10 P. 557-561
249. Mr. X Vol. 11 P. 601
250. Mr. X Vol. 11 P. 601 and witness transcriptions
251. Mr. X Vol. 8 PP. 459-461

Intervention' conducted sometime early in October 2008 (this assessment was not dated but it was probably written on the 3 October 2008).[252]

The 'Initial Core Assessment' was completed by a member of the Golborne Older Persons' CMHT and provided a robust clinical review at the point of Mr. X's GP referral, albeit that some important fields on the form were left blank. Mr. X related his psychiatric history to the CMHT Worker. It would appear from his account that he had suffered from anxiety for a number of years. A very compelling account was recorded about how Mr. X described coping with his wife's change in behaviour, her rages and inability to manage simple tasks around the house. It was noted that Mr. X had *"severe paranoid ideas"* and that this was affecting his ability to cope. The CMHT Worker checked on the OTTER system (Trust electronic record) and found that Mrs. X had been seen previously by Consultant Psychiatrist 1 and that Mr. X may have been trying to cope with this situation and that further intervention should be explored.[253] On the 3 October the documentation was updated following a conversation with Consultant Psychiatrist 1 (Mrs. X's Psychiatrist) who had stated Mr. X had a history of Bipolar Disorder.[254]

Other entries in the clinical documentation for this period were limited to initial impressions and rudimentary plans, these certainly did not conform to the requirements of the Trust CPA Policy documentation.

A fundamental flaw in the care and treatment that Mr. X received at this stage, and which was to continue to affect his care and treatment outcomes in a negative manner from this point forward, was the fact that no psychiatric history was either taken or verified about him. A 'notion' was floated from the outset that Mr. X had a psychiatric history and was known well by certain members of the treating team.

This 'notion' did not prompt any assertive attempt by the treating team to recall his past mental health clinical records in order to understand Mr. X in the context of his full psychiatric history. This should have been a fundamental part of his initial assessment. This was never achieved. Preconceived 'factoids' were recorded, for instance, that Mr. X suffered from a Bipolar Disorder, this diagnosis in fact belonged to another service user with the same

252. Mr. X Vol. 2 PP. 29-31
253. Mr. X Vol. 2 PP. 23-26
254.Mr. X Vol. 2 PP. 27-28

name. The point being made here is that little was known about Mr. X. Members of his treating team expressed a poor degree of professional curiosity about him, and this trend continued from the time of his referral in September 2008 to the time of his death on the 10 September 2009. This ensured that the assessment conducted on behalf of Mr. X was both superficial in nature and lacking in a holistic approach to ascertain his full set of health and social care needs. At this stage the assessment conducted did not lead to a coherent set of care plans.

During Admission

Whilst an inpatient on the Holdenbrook Unit Mr. X's assessments and reviews were formally conducted on the dates set out below.

- **12 November 2008:** a Senior House Officer conducted a psychiatric interview and clinical examination. This assessment stated that Mr. X was *"well known"* to Consultant Psychiatrist 2. It was noted that Mr. X felt depressed and anxious and that he thought people were talking about him. The clinical record stated *"mental health problems since 26 years old, anxiety, depression, no previous admissions? Has been under Section 117, Paranoid Psychosis?"*[255] **N.B. at interview with the Independent Investigation Team Consultant Psychiatrist 2 did not state that Mr. X had been well known to her. It would appear that on admission the previous clinical history that was accessed belonged to another patient of the same name, and a significant percentage of what was recorded about Mr. X was erroneous.**
- **12-13 November 2008:** admission assessment was conducted ('Initial Core Assessment', 'Enhanced Core Assessment' and a 'Risk Screen').[256]
- **13-14 November 2008:** a Mini Mental State Examination, Waterlow Pressure Score, personal handling assessment, General Health Questionnaire, weight, falls, and nutritional risk assessments were conducted.[257] An Enhanced CPA Assessment form was also completed.
- **15 November 2008:** a Risk Screen and 'Summary of Intervention' form was completed.[258]
- **20 November 2008:** a Mini Mental State Examination gave Mr. X a below 'borderline normal' score for his age.[259]

255. Mr. X Vol. 1 PP. 14-21
256. Mr. X Vol. 2 PP. 32-40 and Mr. X Vol. 3 PP. 91-94
257. Mr. X Vol. 3 PP. 46-66
258. Mr. X Vol. 3 PP. 82-85

- **22 November 2008:** an Effective Care Coordination 'Summary of Intervention' form was competed by the named Nurse. It was noted that the *"Care Coordinator was still unavailable"* and that the Advocacy Service had been called to come onto the ward (the Independent Investigation Team noted this as being good practice).[260]
- **26 November 2008:** an Effective Care Coordination 'Summary of Intervention' form was completed by the Named Nurse.[261]
- **3 December 2008:** a 'Summary of Intervention Form' was completed. On this occasion Mr. X said that he felt depressed and anxious.[262]
- **4 December 2008:** a referral was made for an Occupational Therapy assessment.[263]
- **10 December 2008:** a 'Summary of Intervention' form was completed following a review meeting. Mr. X complained of feeling depressed and anxious, lacking in energy and motivation.[264]
- **17 December 2008:** a 'Summary of Intervention' form was completed following a ward round. Consultant Psychiatrist 2 was present. Mr. X said that he was still low, anxious and *"on the edge".* He had no thoughts of self harm and had visited his home with Care Coordinator 1 to pay his gas and electricity bills.[265]
- **27 December 2008:** a Risk Screen was completed.[266]
- **29 December 2008:** a 'Summary of Intervention' form was completed. Mr. X stated that he felt *"terrible"* and *"ill".* Mr. X felt his home situation was what was affecting him. He agreed to his feelings being discussed with Consultant Psychiatrist 2.[267]
- **14 January 2009:** a 'Summary of Intervention' form was completed by a Student Nurse. Mr. X was unhappy and wanted to discharge himself.[268]
- **16 January 2009:** a 'Summary of Intervention' form was completed by Care Coordinator 1. Mr. X was designated as being *"NonCPA".*[269]
- **19 January 2009:** a Risk Screening form was completed.[270] It was noted that Mr. X was in a confused state and was reacting to his paranoid thoughts. Mr. X was placed on "*Level 2-15 for further assessment".*[271]

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259. Mr. X Vol. 3 PP. 46-47
260 .Mr. X Vol.1 P.3
261. Mr. X Vol. 3 PP. 670-673
262. Mr. X Vol. 3 P. 68
263. Mr. X Vol. 4 P. 236-237
264. Mr. X Vol. 4 P. 248
265. Mr. X Vol. 4 P. 246
266. Mr. X Vol. 3 PP. 78-81
267. Mr. X Vol. 4 P. 244
268. Mr. X Vol. 3 PP. 675-676
269. Mr. X Vol. 4 PP. 242-243
270. Mr. X Vol. 3 PP. 74-76

- **28 January 2009:** a Mini Mental State Examination was conducted.[272]
- **3 February 2008:** a Risk Screen was completed by the Deputy Ward Manager.[273]
- **19 February 2009:** an Effective Care Coordination 'Summary of Intervention' form was completed. It was noted that Mr. X was *"NonCPA".* No signature was appended to the Summary of Intervention Form, therefore it remains unclear who wrote it.[274]
- **25 February 2009:** a Multidisciplinary Team meeting was held and a 'Summary of Intervention' form was completed. Mr. X was recorded as being *"NonCPA".*[275]
- **2 March 2009:** the 'Hospital Anxiety and Depression Scale' form was completed. Mr. X was scored as being 'borderline' for depression and one point over 'borderline' for anxiety. It was not recorded who completed the assessment as there appears to be no place on the form for a signature.[276]
- **25 March 2009:** a ward round and prescription review took place on this day. This was the day that Mr. X was discharged from Holdenbrook Ward. It was noted that Mr. X was to be discharged on Enhanced CPA. ***There was no indication in the clinical record that a formal discharge CPA had taken place. If the ward round was intended to provide this opportunity significant assessment and planning documentation was not completed.***[277]

Post Discharge

Post discharge the quality of the assessment and review that Mr. X received has to be examined not only in the context of his considerable mental health problems, but also in the context of his role as a carer to his wife who had a dementia of either an Alzheimer or Lewy Body type. At interview clinical witnesses were asked by the Independent Investigation Team whether or not Mr. X had been offered a carer assessment in recognition of the fact that he was going to have to undertake the role of carer once he and his wife returned home. We were told that he refused this opportunity and no further assessment was offered to him. This issue is examined in full in subsection 12.9 below.

271. Mr. X Vol. 4 P. 177
272. Mr. X Vol. 1 P. 11
273. Mr. X Vol. 11 PP. 609-611
274. Mr. X Vol. 1 P. 5
275. Mr. X Vol. 4 PP. 240-241
276. Mr. X Vol. 1 PP. 8-10
277. Mr. X Vol. 5 P. 312 and Mr. X Vol. 7 P. 406

Mr. X was discharged with a plan that stated he was to be followed up in the Outpatient Clinic within six to eight weeks following his discharge.[278] Care Coordinator 1 also developed care plans on the day of Mr. X's discharge; it is unclear whether or not these were developed with him.

On the 8 April a Risk Screen was completed by Care Coordinator 1 during a follow up meeting with Mr. X. However it should be noted that this follow up appears to have taken place 15 days after Mr. X's discharge, and not within the required seven days as stipulated in the Trust CPA policy.[279] **N.B. the Trust internal investigation process stated a seven-day follow up took place on the 30 March 2009. The Independent Investigation Team could find no clinical record to support this having occurred.** (Trusts across the country set this seven-day post discharge review based upon a recommendation of the National Confidential Inquiry into Suicides and Homicides. The recommendation was developed resulting from the finding that individuals discharged from hospital were at particular risk of committing, or attempting to commit, suicide in the immediate post discharge period. Given Mr X's symptomatology and his social circumstances he was in a particularly vulnerable group and this immediate post discharge monitoring was of particular relevance).

On the 22 April a home visit was undertaken by Care Coordinator 1 and a Senior House Officer (Junior Grade Psychiatrist). It was recorded that Mr. X was not compliant with his medication and that he was drinking alcohol. His medication was reviewed, but no details were recorded.[280]

Care Coordinator 1 made a home visit to Mr. X on the 30 April (recorded on 1 May). On this occasion Mr. X said he did not want any more appointments to be made by the Hindley and Ince Adult CMHT Support Worker, who had apparently been visiting him. The Independent Investigation Team could not find the record of interventions made by this person prior to this date or what these visits had consisted of.[281] From this date onwards it can be concluded that Mr. X did not have a Care Coordinator.

278. Mr. X Vol. 7 P. 441
279. Mr. X Vol. 8 PP. 466-470
280. Mr. X Vol. 11 P. 601
281. Mr. X Vol. 9 P. 510

It is evident from the clinical record that there were no further interventions made with Mr. X until he was seen in the Outpatient Clinic on the 2 June 2009. This meeting was intended to serve as a CPA review, however the documentation completed was minimal, there was no evidence that the care, contingency or crisis plans were reviewed at this point.[282]

Mr. X continued with no Care Coordinator. On the 17 August it was decided that he needed to be assessed as it had been reported by the Golborne Older Persons' CMHT when visiting his wife that he appeared to be distressed. Mr. X had also been telephoning asking for help. The Hindley and Ince Adult CMHT Support Worker was sent to his home. She did not find there to be any indication that Mr. X required any further input. This individual was not qualified, and in the view of the Independent Investigation Team, should not have been sent out to conduct this task at this juncture as it was evident Mr. X needed an assessment by a professionally qualified staff member as his mental health was deteriorating.[283]

In summarising the assessment and review processes undertaken for Mr. X it can be seen that they were deficient for the periods of time that he spent in a community care and treatment context. The Trust CPA Policy stated that *"the relevant ECC assessment document must be reviewed at ECC review/meetings and amended accordingly…An ECC review document must be completed at every review."*[284] Whilst it was evident that the front ECC cover form was utilised, there was no evidence to suggest that assessment and care planning was being considered and reviewed in full keeping with the Trust policy expectation.

Care Planning, Monitoring and Promotion of Recovery

Care planning for Mr. X was non existent prior to his admission onto Holdenbrook Ward between the 28 September and the 12 November 2008 regardless of the fact that he had been on Enhanced CPA for a period of six weeks prior to this time. The Trust CPA policy extant in 2008 and 2009 stipulated that service users on CPA should have received the allocation of a Care Coordinator within 72 hours of being designated Enhanced CPA status and that an initial Enhanced Care Coordination meeting should have been held within 28 days.[285] This was not achieved and no care planning ensued.

282. Mr. X Vol. 11 P. 601 and GP Record P. 220
283. Mr. X Vol. 8 PP. 459-461
284. Trust Effective Care Coordination Policy and Procedures 2008. P.31
285. Trust Effective Care Coordination Policy and Procedures 2008. PP.25-27

Whilst on Holdenbrook Ward Mr. X had care plans developed on the dates set out below.

- **15-22 November 2008:** care plans were developed to address some physical ailments that Mr. X suffered from together with his social isolation. It was noted that he had prostate problems, high cholesterol and arthritis in his knee. There was also a care plan to address Mr. X's high levels of anxiety and depression, the fact that Mr. X also drank whiskey to help him cope was mentioned. These care plans were not signed. The author's identity is unknown.[286] The care plan was dated as having been reviewed on the 26 November and 6 December 2008 *"without change."*[287]
- **27 December 2008:** care plans were developed to support Mr. X's mental health, physical health, social isolation, finances, lack of familial support, and anxiety.[288]
- **29 December 2008:** the care plans were signed off by the Ward Manager on this day.[289]
- **18 February 2009:** a care plan review took place. Mr. X's Diazepam had been increased from 2mg to 5mg twice daily. Mr. X's anxiety continued to be a problem, he was advised to try relaxation techniques and going out for a walk. Mr. X had agreed to meet with a Psychologist for coping skills rather than having a reliance on medication and alcohol. The care plan review did not appear to review the actual care plans themselves. The form, whilst dated, was not signed.[290]

The plans developed on Holdenbrook Ward on the 27 December were dated as having been reviewed on the 20 February 2009. It was difficult for the Independent Investigation Team to understand how the care plans were monitored and reviewed from the examination of the clinical record, this is because the clinical record did not contain a detailed review of Mr. X's progress against his assessed need. It was evident that Mr. X left Holdenbrook Ward with all of his identified needs and problems unresolved.

Prior to Mr. X being discharged back into the community on the 25 March 2009, there was a recorded review of his care plans which included the development of a contingency and crisis plan which was conducted by Care Coordinator 1. Care Coordinator 1 developed a series of care plans for Mr. X. Care Plan One noted that Mr. X was still waiting for a diagnosis. This first plan was for Consultant Psychiatrist 2 to assess Mr. X and for the CMHT to continue to

286. Mr. X Vol. 1 PP.2-7
287. Mr. X Vol. 11 P. 670
288. Mr. X Vol. 11 PP. 661-664
289. Mr. X Vol. 11 PP. 677-682
290. Mr. X Vol. 1 P. 5

provide him with support. Care Plan Two addressed Mr. X's prostate issues. Care Plan Three addressed his accommodation and social support issues (it was noted that his wife had dementia and Mr. X would require ongoing support). Care Plan Four addressed Mr. X's social isolation. A Contingency and Crisis Plan was developed, however there were no links made between this plan and the Golborne Older Persons' CMHT who were caring for Mrs. X.[291] There is no extant clinical record to show that these plans were ever implemented, monitored or reviewed. Mr. X's role as carer for his wife was neither examined nor addressed in an appropriate manner.

Liaison and Care Coordination

The role of a Care Coordinator is primarily one of coordinating care and ensuring that plans of care are developed, delivered and reviewed. In a case such as the one Mr. X's represented, the Care Coordinator could reasonably have been expected to liaise on a regular basis with both Mr. X's treating team and also with that of Mrs. X. It was noted by the Independent Investigation Team that unqualified Support Workers were used to ensure regular contact was made with, and support given to, both Mr. and Mrs. X. This in itself was entirely appropriate. However in the case of Mr. X there may have been an over reliance on the Support Worker role to the extent that when Mr. X wished his Support Worker to be withdrawn from visiting him at his home, Care Coordination was in effect also withdrawn.

A Care Coordinator for a service user on Enhanced CPA should always be a professionally qualified member of the treating team. This individual should be mindful that they are not necessarily being asked to act as a 'community psychiatric nurse' or a 'social worker' but as a coordinator of care and as such should be a proactive agent in the management of the care and treatment programme indentified for the individual service users allocated to them. In the case of Mr. X, in effect, he had no care coordination following his discharge from the Holdenbrook Unit on the 25 March 2009.

Crisis and Contingency Planning

All service users on Enhanced CPA require a contingency and crisis plan. MIND provides the following definition:

291. Mr. X Vol. 8 PP. 466-475

"Every CPA should include a crisis and contingency plan which gives clear details of who is responsible for addressing elements of care and support, and who to contact. Copies of the plans should be provided to the service user, his or her GP and any other significant care provider, if this is appropriate and agreed by the service user. The plan should cover what action needs to be taken when the person's mental health is deteriorating, the services that have worked well in the past, and the name of an individual who the service user responds to well in times of crisis. It will also cover contingency plans if the first choice of treatment or intervention is not available. This should ensure that any crisis is tackled in a way that is both acceptable to the service user and most likely to be effective."[292]

Mr. X had a contingency and crisis plan developed for him by Care Coordinator 1 at the point of his discharge on the 25 March 2009. In a crisis Mr. X was advised not to drink alcohol, to remember to take his medication, and to distract his thoughts by gardening. The people identified that he could contact in crisis for support were:

- Care Coordinator 1;
- Consultant Psychiatrist 2;
- the Adult CMHT Support Worker;
- the GP.

Unfortunately following the development of this plan, the key individuals identified as being able to support Mr. X had left the Trust (Consultant Psychiatrist 2 and Care Coordinator 1). Whilst the GP remained a constant figure in Mr. X's life, and was mentioned in the plan, there is no evidence to support the fact that this contingency and crisis plan had been shared with the GP Practice. The Support Worker was still available, but it has to be noted that Mr. X had previously requested that she took no further part in his care.

On the 17 August 2009 Mr. X telephoned the Hindley and Ince Adult CHMT and spoke to the Support Worker. It was recorded that Mr. X was *"really upset and crying"* saying that everyone was against him and that the DVLA were going to take his license from him. Mr. X could *"hardly talk for crying"* and said he could not cope.[293] A home visit was made later that day. During the home visit it was evident that Mr. X was 'paranoid' about his driving license. Otherwise it was reported that Mr. X *"looked OK"* and was taking his medication.

292. http://www.mind.org.uk/help/medical_and_alternative_care/crisis_services#CPA
293. Mr. X Vol. 8 PP. 459-461

Mr. X telephoned the CMHT office again on the 19 August and spoke once again to his Support Worker. It was recorded that he believed the service was conspiring against him and he would not listen when the Support Worker tried to reassure him.[294]

On the 20 August Care Coordinator 2 telephoned the Hindley and Ince Adult CMHT because she was concerned about Mr. X's deteriorating mental state. The Hindley and Ince Adult CMHT Manager took a verbal report from the Review Officer who had visited the couple some weeks previously and who made a visit to the home on the 20 August. The Review Officer talked to Mr. X who was extremely worried and anxious about his driving licence, he was advised not to worry. A glass of whiskey was observed and Mr. X was advised against drinking.[295] No further assessments or interventions were made with Mr. X until the time of his death on the 10 September 2009.

12.1.4.3. Conclusions

From the time of Mr. X's referral on the 28 September 2008 the assessment process was compromised by the fact that erroneous information had been inserted into his clinical records. This was caused by other service users' records having been co-mingled in with those of Mr. X some years previously. At interview few of the clinical witnesses, apart from those who continued with his care and treatment in the community following his discharge on the 25 March 2009, could actually remember Mr. X at all and this Independent Investigation found it impossible to disaggregate 'fact' from 'factoid' even with the benefit of direct clinical witness contact. The assessment process for Mr. X was jumbled, lacking in coordination and on many occasions factually inaccurate. The contradictory information in Mr X's clinical notes was not detected or corrected by a thorough analysis of the available case material. The contradictory information in Mr X's clinical notes was not detected or corrected by a thorough analysis of the available case material. It is impossible to know how exactly this may have impacted upon on the subsequent care and treatment that was offered to him. However, regardless of what the impact was, this must be noted as being unacceptable both in relation to the underlying clinical records system in use at the time and the practice of individual practitioners involved.

294. Mr. X Vol. 8 P. 462
295. Mr. X. Vol. 8 P. 464

CPA was the crucial missing aspect in relation to the care and treatment that Mr. X received. Mr. X was mentally ill and on Enhanced CPA and needed more support than he was offered. Following the discharge of both Mr. and Mrs. X in March 2009, most of the health and social care activity was focused around Mrs. X. Mr. X's needs were neither assessed nor monitored. As a consequence he received no viable care and treatment between 25 March and the 10 September 2009, the date of his death.

There is no evidence to demonstrate how Care Coordinators actually coordinated care within the CMHTs. It would seem that Care Coordinators were acting as either Community Psychiatric Nurses or Social Workers, and subsequently failed to understand the core function and purpose of care coordination. The Care Coordinators should have been taking a more proactive role in the management of both Mr. and Mrs. X as a couple and mobilising the services and inputs required.

Care Coordination and the lack of suitable arrangements in the winter of 2008 and the summer of 2009 led to a major disruption in the delivery of appropriate and safe care and treatment to Mr. X. Witnesses at interview were clear that the service that took the initial referral should have provided Care Coordination. This was not done in the first instance. In the spring and summer of 2009 Mr. X was on Enhanced CPA but no longer had a Care Coordinator allocated to him, by default this became the Staff Grade Psychiatrist.

Mr. X had serious mental health issues and between the 25 March and the time of his death in September 2009 he was also a 24 hour a day, seven-day-a week carer for his wife who had dementia. His needs were not assessed, his mental health was not monitored, and his care and treatment plans were not implemented.

Mr. X was by all accounts a gentleman who needed 'sensitive handling'. The Independent Investigation Team heard from witnesses that he could be "*stubborn and difficult.*"[296] These personality traits of Mr. X appear to have alienated his treating team to some extent and they regarded his outbursts and refusals of help and support as being a final stance. However it was evident that he did want help and support and in times of distress and crisis he would seek interventions. It is not uncommon for mental health service users to be ambivalent about

296.Witness Transcriptions

receiving care and treatment. A skilled and experienced team should have been able to look beyond his "*stubborn and difficult"* façade and to have maintained a viable working relationship with him. It must be stressed, that whilst Mr. X may have been 'difficult' he was compliant and sought out actively help for his mental illness. It is a fact that Trust personnel had the knowledge, the opportunity and the means to provide assessment, care and treatment to Mr. X in the form of care coordination. This was not achieved to the detriment of Mr. X's health and wellbeing and also to that of his wife.

This view was shared by Her Majesty's Coroner who said *"At the time of his death he was under the care of a Community Mental Health Team. He was not appropriately monitored and his risk of harm to himself and others was not appropriately assessed. He took his own life whilst the balance of his mind was disturbed by a diagnosed mental illness."*[297]

It is the conclusion of the Independent Investigation Team that the Hindley and Ince Adult CMHT failed to provide the appropriate assessment, monitoring, care and treatment to Mr. X. Mr. X had been assessed as requiring Enhanced CPA. He suffered from a mental illness, was distressed and anxious, and had the responsibility of being the fulltime carer for his wife who was suffering from dementia. Mr. X's mental health was clearly in decline for several weeks prior to both his death and that of his wife. This deterioration was noted, but did not lead to an appropriate assessment of his mental state.

It was evident that Mr. X had poor mental health, poor physical health, mobility problems and worries about losing his driving licence, and thereby, what remained of his limited independence. He was also the fulltime carer for his wife who had dementia, which is a degenerative disease that affects an individual's behaviour, cognition, function and personality. Mr. X had become extremely anxious and paranoid, which had been recognised in the past as being a key part of his relapse signature. Mr. X was worried about both his health and that of his wife. He was actively seeking out help from the mental health teams he had contact with, but received inputs from unqualified staff, who with the best intentions tried to offer Mr. X reassurance, when in fact he required skilled psychiatric assessment and intervention.

297.Trust Inquest Documentation

The minimum level of care that could and should have been expected from Mr. X's CMHT was not delivered to him. The treating team had the knowledge (of both his condition and his situation), the opportunity and the means to intervene. Mr. X was asking for help and was not seeking to avoid engagement. Had the treating team assessed Mr. X's condition on an ongoing basis in accordance with CPA guidance, and had the treating team ensured that his care plans were implemented, it is entirely possible that he would not have reached the state of crisis that led to the deaths of both himself and his wife.

- ***Contributory Factor Four. The failure to provide a robust CPA for Mr. X ensured that his needs were not assessed appropriately and that his care and treatment programme was not delivered. This made a significant contribution to the poor overall management of Mr. X's health and social care management.***

12.1.5. Risk Assessment

12.1.5.1. Context

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

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

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

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service user's past and current clinical presentation to allow an informed professional opinion about assisting the service user's recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

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

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed'*[298].

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

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

298. Best Practice in Managing Risk; DoH; 2007

Research Data Regarding Husband/Wife Homicide/Suicide Incidents

Suicidality in the Elderly

The Royal College of Psychiatry recognises that *"Suicidal behaviour in the elderly is undertaken with greater intent and with greater lethality than in younger age groups, and health care staff play a vital role in the recognition and prevention of suicide in this age group…Males aged 75 and over have the highest rates of suicide in nearly all industrialised countries, and among many of these nations suicide rates rise with age".*[299]

Homicide in the Elderly

A national survey published by the Journal of Forensic Psychiatry and Psychology (2010) stated that *"...perpetrators aged 65 and over were most likely to use strangulation/suffocation and the victim was more often a female and a family member or spouse. In younger perpetrators, drug and alcohol misuse and previous violence were more common. Older perpetrators had high rates of affective disorder and were more likely to be mentally ill at the time of the offence. Targeting substance and alcohol misuse and street violence may reduce homicide risk in younger people. Preventing homicide among the elderly might be best achieved through more specialised GP training to improve recognition and treatment of depression."*[300]

Combined Incidents of Homicide and Suicide

Combined incidents of homicide and suicide whilst not common are far from unique with the likelihood increasing slightly in populations aged 55 years and over. The incidence rate is so low that few studies have been conducted. However studies conducted to date in the United States of America suggest that the perpetrator is likely to be male and the homicide victim is likely to be a female member of his family, most often the spouse.[301]

5 Boroughs Partnership NHS Foundation Trust Policy (2008)

The Purpose of the Clinical Risk Assessment Policy was given as:

- *"To provide an agreed trust-wide structure for assessing clinical risks*
- *To develop agreed tools to assist in clinical risk assessment*

299.http://apt.rcpsych.org/cgi/content/full/6/2/102
300.Homicide convictions in different age-groups: a national clinical survey Journal of Forensic Psychiatry & Psychology Volume 21, Issue 3, First published 2010, PP 321 - 335
301.http://ajp.psychiatryonline.org/cgi/content/full/155/3/390

- *To embed risk management in day-to-day practice, in particular as part of the Care Programme Approach (CPA)*
- *To enable staff to feel that risks can be identified and reduced by intervention and that tragedies are not always inevitable*
- *To enable staff to feel that the clinical management of risk can be strengthened"*[302]

The Trust risk screening process was a two-part process. The first being the 'Risk Screening Tool', the second being the 'Main Risk Assessment Tool'. The Trust expectation was that they would be used as follows:

"Risk Screening Tool (Otter Form 3a)

- *At every initial contact*
- *At the start of each episode of care*
- *If presenting in an emergency situation where there are no previous notes available*

Main Risk Assessment Tool (Otter Form 3b)

- *At initial contact*
- *As clinically required eg at CPA meetings, ward rounds*
- *Prior to hospital admission and on discharge*
- *Prior to leave and on return from leave*
- *After an incident, SUI or period of seclusion*
- *At Review*
- *On Discharge"*[303]

N.B. All issues relating to policy adherence are addressed in subsection 12.1.11 below.

12.1.5.2. Findings

Trust Policy and Procedure

At the time Mr. X was receiving his care and treatment from the Trust a robust and fit for purpose Clinical Risk Assessment policy (2008) was in place which was in keeping with national best practice guidance. This policy made the appropriate cross referencing to other related clinical policies such as:

- the Effective Care Co-ordination Policy;

302. Trust Clinical Risk Assessment Policy (2008) P.4
303. Trust Clinical Risk Assessment Policy (2008) P.54

- Mental Health Act Procedures;
- the Medicines Management Code;
- Management and Prevention of Violence at Work;
- the Safeguarding Children Policy;
- the Vulnerable Adults Policy;
- the Child Admitted to Adult Wards Policy;
- the Children Visiting Adult Wards and Other Trust Premises Policy;
- the Domestic Abuse Policy for Service Users.[304]

Events History

Mr. X was referred to secondary care mental health services in Wigan by his GP on the 28 September 2008. Mrs. X had left her husband one week previously to go and live with her son. Mr. X had stated that he intended to commit suicide as he could not cope. The GP did not feel, however, that a Mental Health Act (2007) assessment was required at this stage. The GP had spoken to Mr. X's son who had said that his father had taken the break up with Mrs. X badly. It was known shortly after Mr. X's referral to secondary care mental health services that he was alleged to have perpetrated an assault against his wife and that there were indications that domestic violence and abuse had been a feature of his marital life for several years.

Clinical Assessment

Mr. X was diagnosed at the point of his admission onto Holdenbrook Ward as possibly suffering from Paranoid Psychosis. It was noted that Mr. X had poor physical health as he had both prostate and cardiac problems. Mr. X also had arthritis in the wrist, knees and hips and often found his gait to be unsteady. Mr. X was observed to be anxious, and he was assessed as having delusional and paranoid ideas. Mr. X was known to have self medicated with alcohol, the practice of which he was still undertaking at the point of admission to Holdenbrook Ward on the 12 November 2008. At the time of his admission it was known that Mr. X had allegedly assaulted his wife and that their relationship had broken down, together with those of other family members. Mr. X was assessed as being isolated and unsupported in the community and that his anxiety and depression, which had been life-long, were being exacerbated by this situation. The treating team also knew that Mr. X's wife had dementia

304. Trust Clinical Risk Assessment Policy (2008) P.3

and that her behaviour had become difficult for Mr. X to manage in recent months. The situation in which Mr. X found himself prior to his inpatient admission in November 2008 had led to him having suicidal thoughts and neglecting himself.

Risk Assessments and Management Plans - Process and Procedure

3 October 2008 (Pre-first admission): an Enhanced Care Coordination (ECC) Risk Screening form was completed by a Worker from the Golborne Older Persons' CMHT. It was quite evident that some of the information on the form was incorrect. For example, Mr. X had mentioned that he had a history of drinking heavily, but the risk form stated this was not an issue. Mr. X was assessed as not being a risk to either himself or to others, but he was assessed as being vulnerable and at risk of neglect.[305] Mr. X was on Enhanced CPA and the Risk Screening process should have led to the completion of the HoNOS Form/Form 3b and care planning. This did not appear to have occurred.

12 November 2008 (on Holdenbrook Ward): a (ECC) Risk Screening form was completed. Alcohol was listed as *not* being a problem, despite the information given about Mr. X at the time of his admission and that the fact that the risk assessment went on to state that two people should visit Mr. X when discharged due to the risks posed by his drinking. The information about Mr. X having previously been subject to a Section 117 was erroneous, as it referred to a different service user with the same name. It was noted that previous diagnoses included depression and paranoid psychosis. The details of the alleged assault by Mr. X upon his wife were recorded. Mr. X was listed as suffering from delusions and paranoid thinking. The section relating to the Criminal Justice System was filled in with a *"No"* but the narrative stated that Mr. X was on *"conditional Police bail".* It was considered at this stage that Mr. X had himself been subject to abuse as his wife shouted at him and accused of a sundry misdemeanours. Mr. X was assessed as being no risk to himself, a risk to others, at risk of vulnerability and also of self neglect. No HoNOS form/form 3b was completed or risk-based care plans developed as a result of this Risk Screen. This was counter to the requirements of the extant Trust Clinical Risk Assessment policy for a service user on Enhanced CPA.[306]

305. Mr. X Vol. 2 PP. 29-31
306. Mr. X Vol. 3 PP. 91-94

It is important to note that the admitting Doctor recorded Mr. X had thoughts of committing suicide and had also mentioned his plans of using his dressing gown tie as a ligature. It is unclear from reading the clinical record to establish whether or not these thoughts were considered to have been a serious declaration of intent or not. No mention of these plans, rudimentary or otherwise, were recorded in Mr. X's risk screening examination. The Risk Screen identified Mr. X as not being a risk to himself. It would appear that the Risk Screen process was not multidisciplinary in nature and that the ward-based Named Nurse who conducted it did not discuss the case with the admitting Doctor.[307] This served to minimise the perception of Mr. X's risk to himself.

15 November 2008 (on Holdenbrook Ward): a (ECC) Risk Screening form was completed. This risk assessment was identical to the one compiled on the 12 November 2008.[308]

27 December 2008 (on Holdenbrook Ward): a (ECC) Risk Screening form was completed. It was noted that Mr. X had previously had a problem with drinking, however this so called 'historic' problem had still been an issue for him when was admitted to the ward only five weeks earlier. Mr. X's alcohol consumption should have been considered a present-day risk. The information about Mr. X having previously been subject to a Section 117 was erroneous. It was noted that Mr. X had allegedly assaulted his wife and that the Golborne Older Persons' CMHT thought he may have assaulted his wife in the past. Earlier clinical records accessed about Mr. X suggest that he had been in the habit of pushing his wife around. It was noted that Mr. X had problems with his heart, wrists, hips and knees and that he had difficulty mobilising. It was considered at this stage that Mr. X had himself been subject to abuse as his wife shouted at him and accused of a sundry misdemeanours. Mr. X was assessed as being no risk to himself, a risk to others, at risk of vulnerability and also of self neglect. No HoNOS form/form 3b was completed or risk-based care plans developed as a result of this Risk Screen. This was counter to the requirements of the extant Trust Clinical Risk Assessment policy for a service user on Enhanced CPA.[309]

19 January 2009 (on Holdenbrook Ward): a (ECC) Risk Screening form was completed. The assessor put a *"No"* in the box for alcohol problems, which was not correct and contradicted the 'Summary of Intervention' form that had been completed on the 16 January

307. Mr. X Vol. 1 PP. 14 and 17
308. Mr. X Vol.3 PP. 82-86
309. Mr. X Vol.3 PP. 78-81

2009 in which alcohol was raised as a potential risk. The section relating to past admissions was completed with a 'Yes', however there is no evidence to suggest Mr. X had ever had a previous inpatient admission, this information was probably taken from the erroneous information in Mr. X's old clinical records. Mr. X was described as *not* feeling helpless or hopeless, however on the 16 January in a 'Summary of Intervention' assessment, three days earlier, he was described as being depressed and unhappy.[310] The risk assessment also affirmed in the negative that Mr. X suffered from either hallucinations or delusions whilst stating that he *was* reacting to paranoid symptoms. Mr. X was assessed as being no risk to himself, a risk to others, at risk of vulnerability and also of self neglect. No HoNOS form/form 3b was completed or risk-based care plans developed as a result of this Risk Screen. This was counter to the requirements of the extant Trust Clinical Risk Assessment policy for a service user on enhanced CPA.[311]

3 February 2009 (on Holdenbrook Ward): a (ECC) Risk Screening form was completed by the Deputy Ward Manager, the date given is the 3 February. This form documented that Mr. X currently had a degree of insight, had undergone several previous admissions, that he had no issues with drinking alcohol, had no previous charges or conviction of assault, that no people had been identified as potentially being at risk from Mr. X, that there were no issues regarding physical illness or pain, and that there were no concerns that would merit a CPA approach. Mr. X was assessed as presenting no risks to either himself or to others, and of having no risks regarding vulnerability or neglect. The problem with this Risk Screen is that a great deal of the information on it was not correct. No HoNOS form/form 3b was completed or risk-based care plans developed as a result of this Risk Screen.[312] This was counter to the requirements of the extant Trust Clinical Risk Assessment policy for a service user on enhanced CPA.

8 April 2009 (following Mr. X's discharge): a (ECC) Risk Screening form was completed by Care Coordinator 1. Alcohol was listed as being a historic problem. It was noted that previous records had stated Mr. X had been on a Section 117, but that Mr. X was adamant he had never been on a Section 3 (the usual route for patients being placed on a section 117). Care Coordinator 1 described his relationship with his wife as being unsupportive, but that Mr. X's sister had been visiting the home. Most of the information on the Risk Screening

310. Mr. X Vol. 4 PP. 242-243
311. Mr. X Vol. 3 PP. 74-77
312. Mr. X Vol. 11 PP. 609-611

form was historic in nature and did not address the current risks that Mr. X faced in the community. Mr. X was assessed as being no risk to himself, a risk to others, at risk of vulnerability and also of self neglect. No HoNOS form/form 3b was completed or risk-based care plans developed as a result of this Risk Screen. This was counter to the requirements of the extant Trust Clinical Risk Assessment policy for a service user on enhanced CPA.[313]

In conjunction with the Risk Screening forms information was also recorded in the 'Summary of Intervention' forms. These recorded as a matter of fact that Mr. X had a significant history of domestic abuse and violence.

Difficulties with the Process

It is a fact that Mr. X had seven Risk Screening forms completed on his behalf between the 3 October 2008 and the 8 April 2009. However despite this activity it can be stated with a high degree of confidence that Mr. X never received an actual Risk Assessment between the time of his referral to secondary care mental health services on the 28 September 2008 and the time of his death in September 2009.

The Trust Clinical Risk Assessment Policy (2008) provided clear instruction as to how professionals should proceed with regard to service users on Enhanced CPA. The Risk Screening tool (form 3a in the policy) was a single stage in what should have been a multi-stage process. Clinicians did not progress on from form 3a to form 3b which provided the 'Risk Assessment and Summary' part of the process. As a result the Risk Screening tool did not lead to a multidisciplinary assessment of risk and neither did it lead to the development of risk related care and treatment management plans.

The Risk Screens examined by the Independent Investigation Team were found to contain both incorrect and contradictory statements on a regular basis. It would appear that the process was a 'tick box' process rather than a reflective multidisciplinary analysis regarding the management of Mr. X and the risks that he presented. A significant percentage of the information included in the Risk Screening process was incorrect and a result of incorrect clinical information being made available to Mr. X's current treating team. However a significant proportion of the history about the unhappy marital status of the couple was

313. Mr. X Vol. 8 PP. 446-470

probably true. Whilst Mrs. X may not have been able to corroborate the history it was recorded that Mr. X's sister was in contact with services and her views could have been sought.

Potential Risks to Mrs. X

Regardless of what was true or not, it is a fact that Mr. X had been arrested for allegedly assaulting his wife in October 2008. It is also a fact that the treating team both recorded and thought that Mr. X had a significant history of perpetrating domestic violence and abuse. It seemed quite extraordinary to the Independent Investigation Team that once discharge back to the marital home was being considered for both Mr. and Mrs. X no aspect of this risk was ever considered or recorded by either Mr. or Mrs. X's treating teams. There were significant prompts in the clinical records to indicate that this was an area of concern. It had been recorded for example *"records (1998) indicate history of being verbally abusive and pushing wife around"* and *"wife reported that [Mr. X] more paranoid and aggressive"* and (Mrs. X was reported as saying) *"when she retired about eight years ago…her husband started to hit her from time to time when he lost his temper. She has never reported it because she was terrified of him."* [314]

The treating teams of both Mr. and Mrs. X knew the following at the point of the couple's return to the marital home in March 2009:

- Mr. X had a history of depression and anxiety with paranoid features;
- Mrs. X had dementia and she was in the habit of shouting at her husband and accusing him of doing things he had not done;
- there were significant indications that domestic violence/abuse had been occurring in the marital home on a regular basis over a period of several years;
- a POVA had been instigated following an allegation of assault against Mr. X by his wife in October 2008, this had only been dropped because it was thought the couple would not be returning to the marital home again and that in the future they would be living separately;
- Mr. and Mrs. X were socially isolated;
- Mrs. X was becoming very dependent upon Mr. X and he had difficulties with mobilising which caused him a great deal of additional anxiety;

314 . Mr. X Vol. 3 PP.83-87 and Mr. X Vol. 7 P. 392

- Mr. X used alcohol to self medicate in order to help him cope with his stress and depression, and also to help him sleep.

Clinical witnesses told the Independent Investigation Team at interview that a meeting was held between Consultant Psychiatrists 1 and 2, and Care Coordinators 1 and 2 on the 25 February 2009. This meeting was apparently called in order to arrange the discharge process and follow up care and treatment package that both Mr. and Mr. X would require following their joint discharge back into the community. Unfortunately this meeting was not recorded and none of the clinical witnesses could recall exactly what was discussed on this day. Regardless of what was discussed it is evident that risk assessment and risk management issues were not addressed in accordance with minimum best practice expectations. The Independent Investigation Team can state this with a high degree of confidence as all risk assessment and risk management decisions have to be recorded and then implemented, in the case of Mr. and Mrs. X neither was achieved.

In the weeks leading up to the couple's death it was evident that Mr. X's mental health was deteriorating and that he could not cope with the stress of his role as fulltime carer to his wife. This was recognised as presenting an ongoing risk to his wife's continued health and wellbeing, however no risk assessment of the situation was undertaken.

In the weeks leading up to the couple's death it was evident that the Golborne Older Persons' CMHT thought it possible that Mr. X had hit his wife causing an injury to her lip. Mrs. X was reported as being *"terrified and nervous"* on the 20 August and on the 2 September when asked about the injury to her lip stated that Mr. X had *"done it".*[315] These concerns did not prompt any action to be taken. Please see subsection 12.2. below for a further examination of the risks presented to Mrs. X.

Potential Risks to Mr. X

Assessment of Mood

When Mr. X was referred by his GP to secondary care mental health services in September 2009 his risk of suicide was a major concern. Mr. X had described himself as being without hope and very depressed. As the weeks went by Mr. X stated that he did not intend to take his

315. Mrs. X Vol. 1 PP.10- 14

own life, but he continued to feel anxious and depressed. It is evident that Mr. X's anxiety and depression remained a constant factor between September 2008 and the time of his death in September 2009. It is far from certain how members of treating team continued to assess his mood. When Mr. X was seen at the Outpatient Clinic on the 2 June 2009 he described himself as being *"very happy."* He was described as eating and sleeping well. He was neither depressed nor anxious and had no psychotic symptoms. Mr. X expressed no thoughts of self harm. The plan was for him to be followed up in six-months time.[316] However the following day concerns regarding Mr. X were identified by the Golborne Older Persons' CMHT in that he had not been eating and had not been feeling very well.[317] It is not uncommon for individuals with mental health problems to present in widely differing ways within a short period of time, however it has to be noted that robust assessment requires continuity of care, and should where possible, be conducted by professionals who know the patient. It should also be noted that service users on Enhanced CPA, especially with the kinds of health and social care needs that Mr. X had, require more than a six-monthly follow up. At the very least the correct CPA risk assessment and care planning processes should have been followed at this CPA meeting and the required documentation completed. This was not done.

Risks of Vulnerability

Most of the risk screens recorded that Mr. X had been subject to abuse from his wife in that she routinely accused him of things he had not done and shouted at him.[318] This had led to Mr. X being considered at risk of being vulnerable. Another factor that the risk screens recorded was Mr. X's tendency to self neglect when his mental state declined. It would appear that neither treating team involved with the couple understood the kind of stress a carer can be subject to when looking after the needs of a person with dementia. Individuals with dementia can at times be abusive, deluded, hostile and violent.

It was recorded in Mr. X's clinical record that Mrs. X had previously taken on the traditional role of a housewife and before her illness had done all of the cooking and cleaning in the home. It was evident that Mr. X found performing these tasks very difficult. During his stay on Holdenbrook Ward an Occupational Therapy assessment had been mentioned as being something that he required, however it was not recorded what the outcome of this was. It is

316. Mr. X Vol. 11 P. 601
317. Mrs. X Vol. 1 P. 31
318. Mr. X Vol. 3 P.80

recorded that Mrs. X had Occupational Therapy assessment and inputs, but this in itself did not support Mr. X in the running of the home.

Mr. X cancelled his wife's care support package on two occasions following their discharge back into the community. Neither Mr. nor Mrs. X liked strangers coming into their home. The risk of neglect, assessed specifically in the light of the couple's desire for privacy, should have been more explicitly undertaken as it was evident that the couple struggled to cope once back in their own home.

In the final weeks of his life it was evident that Mr. X's mental health was deteriorating. The Golborne Older Persons' CMHT reported this to the Manager of the Hindley and Ince Adult CMHT. The response of the Adult CMHT was to send out unqualified workers who were not appropriately trained to asses Mr. X. These individuals appeared to try and persuade Mr. X that his negative thoughts and feelings were without foundation and any potential issues and risks were both minimised and dismissed. At this juncture, a service user who was on Enhanced CPA, and who was referred for an assessment by a member of another treating team who had concerns about them, should have received a timely assessment from a suitably qualified health or social care professional. This did not happen.

Staff Risk Assessment Training

Trust Managers told the Independent Investigation Team that risk assessment training forms part of a mandatory continuing professional development programme. However several clinical witnesses interviewed by the Independent Investigation Team stated that they had not received any recent risk assessment training and that this may have compromised the quality of the care and treatment they delivered to Mr. and Mrs X. It must be noted that most clinical witnesses interviewed by this Investigation found it difficult to articulate the clinical risk assessment processes that they are required to follow and had not read the policy.

12.1.5.3. Conclusions

Research Data Regarding Husband/Wife Homicide/Suicide Incidents

The Profile of Mr. X

It is important to reflect that the profile of Mr. X fitted that of high risk individuals as identified by current research data. The Independent Investigation Team have to assess the reasonableness of the care and treatment given based upon what was known and what should

have been known by the treating team at the time Mr. X was with the Trust. Bearing this in mind the Independent Investigation Team concluded that it would not be reasonable to have expected the treating team to have either predicted the killing of Mrs. X or to have been *au fait* with the literature regarding older people and homicide (however the Older Persons Team should have known about the literature on violence associated with dementia, both perpetrated by and suffered by the dementia sufferer. Given that there should have been joint planning especially at the point of discharge from hospital the Older Persons' Team should have ensured that this was considered as part of the joint risk assessment).

Homicide, whether by a mental health service user or not, is a relatively rare occurrence in the United Kingdom. Community Mental Health Teams, whilst they should be mindful of the potential for acts of violence on the part of service users, will rarely, if ever, encounter such an event.

Completed acts of suicide however are more regular phenomena than those of homicide, especially in the elderly. The Royal College of Psychiatry has identified that the depressed elderly are more likely to plan an act of suicide with lethal consequences. In short an elderly person who wants to end their own life will take every measure to ensure they are successful, are not seeking to be 'found in time,' and are not putting out a 'cry for help.' Depression, feelings of hopelessness, and a growing dependence on alcohol are all factors of significance that should alert both primary and secondary care services. It is the conclusion of the Independent Investigation Team that had Mr. X received an appropriate level of risk assessment the treating team would have identified that the profile of Mr. X merited ongoing monitoring. It is entirely probable that had Mr. X continued to recieve the levels of support his situation merited that his mental health could have been improved, his challenges as a carer supported, and his social isolation ameliorated with the consequent lessening of suicidal ideation. Community Mental Health teams should as a matter of course be familiar with the research literature pertaining to suicide and should be able to assess the risk of service users such as Mr. X.

The main focus of Investigations of this kind is to ensure that lessons are learned. It is acknowledged that staff could not reasonably have been expected to be aware of all of the literature available regarding elderly people and homicide, and also of dual homicide/suicide events. However as a point of learning it is known that the population of the United Kingdom

is aging. Couples such as Mr. and Mrs. X are not unique where mental illness can affect both partners and the stresses of carer obligations can weigh heavily. Couples with a complex presentation, such as Mr. and Mrs. X, merit an in-depth assessment, care planning, and monitoring process for the duration of time that they receive their care and treatment from secondary care services. Need and risk require mapping against an evidence-based schema to ensure that care and treatment is both effectively and safely delivered.

Summary of the Other Factors

It was inconceivable to the Independent Investigation Team, based on what the treating teams knew and thought they knew at the time, that no detailed risk assessment and management plan was developed to ensure the continued safety and wellbeing of both Mr. and Mrs. X at the time of their discharge in March 2009. It would appear obvious to most people, professional and lay alike, that if a couple had lived several years in an abusive relationship within the marital home that this pattern of behaviour was likely to continue. The likelihood of the pattern continuing was made more probable by virtue of the difficult situation that the couple found themselves in and that the situation was bound to become more challenging and more difficult as Mrs. X's dementia progressed and her cognition declined.

The risks to the couple were not simply those of safety, but also of wellbeing. The risks posed by the couple, and to the couple should have been rigorously assessed prior to their discharge back to the marital home in March 2009. The responsibility for this rested jointly with both treating teams and the Care Coordinators should have worked together to ensure that a suitable management plan was developed, implemented, monitored and reviewed.

Risk assessment cannot be examined without considering the effectiveness of the Care Programme Approach (CPA) as delivered to Mr. X. Subsection 12.1.4. above addresses the shortfalls that occurred in the care and treatment provided to Mr. X as a result of a deficient CPA process. In short:

- all of the information about Mr. and Mrs. X that was known, and should have been known, was not brought together to inform a coherent risk assessment and risk management plan;
- the two separate CMHTs that provided care and treatment to Mr. and Mrs. X did not work together effectively to ensure the couple's safety;

- the absence of a Care Coordinator for Mr. X between May and September 2009 ensured that his deteriorating mental state was not monitored and his risk assessment was not conducted appropriately.

It is evident from an examination of Mr. X's case that neither Trust policy nor national best practice guidance was adhered to with regard to clinical risk management. This lack of adherence was evident between September 2008 and September 2009.

It must be noted that in the weeks leading up to his death Mr. X had not disengaged with services and actively sought help which was not provided to him in either a timely or appropriate manner. Services had the knowledge, opportunity and the means to intervene to help Mr. X. Even though Mr. X had no contact from members of his own treating team, members from his wife's treating team, the Golborne Older Persons' CMHT were visiting the home several times a week. Both teams had the knowledge about Mr. X's problems. The Golborne Older Persons' CMHT and the Hindley and Ince Adult CMHT had the opportunity to assess his deteriorating condition, and more assertive action should have been taken by the Hindley and Ince Adult CMHT to assess Mr. X when concerns were raised about his deteriorating mental health. The means were available to intervene as Mr. X was actively seeking help and did not wish to disengage from services.

This view was shared by Her Majesty's Coroner who said the following about Mr. X *"At the time of his death he was under the care of a Community Mental Health Team. He was not appropriately monitored and his risk of harm to himself and others was not appropriately assessed. He took his own life whilst the balance of his mind was disturbed by a diagnosed mental illness."*[319]

- ***Contributory Factor Five. The failure to provide multidisciplinary risk assessment for Mr. X ensured that his risk profile was not properly understood and that consequently no fit for purpose risk management plans were put into place. This made a significant contribution to the poor overall management of Mr. X's health and social care management to the detriment of his continued safety and wellbeing, and also to that of his wife.***

319.Trust Inquest Documentation

12.1.6. Referral, Transfer and Discharge Planning

12.1.6.1. Context

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

Trust Services

Gateway and Advice Service Operational Policy

"The Team role is to provide access & assessments, for people who may need treatment with secondary care mental health services. Gateway and Advice practitioners will support access to services on both an urgent and routine basis, as well as to ensure smooth pathways between primary care and secondary care services. Referrals that meet the emergency criteria will be managed by the Crisis Resolution Home Treatment Service where GPs can refer directly.

The Gateway and Advice Team will provide a mental health assessment service for adults with moderate to severe symptoms of mental illness / disorder. In addition to mental health and risk assessments, clients who do not meet the referral criteria may be given advice and / or signposted to alternative services most suited to their needs. It is therefore important to foster and maintain effective partnerships with services in the non-statutory sector, to ensure effective care for people with less severe conditions.

The Team will support primary care services to provide a service for clients with common mental health problems who require specialist psychiatric advice or psychotherapeutic treatment and further assessment and management of people who have more moderate to severe mental illness who cannot be supported in primary care alone.

This Service will operate in the context of screening clients in order to determine the need for acceptance to service and further assessment & treatment in conjunction with the Effective Care Co-ordination Policies and Procedure, and all other Policies of the Trust and Local Authorities.''[320]

Crisis Resolution Home Treatment Team Operational Policy

''Crisis Resolution/ Home Treatment refers to a system for the rapid response and assessment of mental health crisis in the community with the possibility of offering comprehensive acute psychiatric care at home until the crisis is resolved, and usually without hospital admission. Acute care is delivered by a specialist team so as to provide an alternative to hospital admission for individuals with serious mental illness who are experiencing acute difficulties.''[321]

This service is provided 24 hours each day, seven days each week. The service is required to provide assessment, planning, intervention and support with activities of daily living. All potential hospital admissions should be routed through this service for appropriate screening and assessment, including Mental Health Act assessments. The Operational Policy states the following:

''Obviously Crisis resolution/ Home treatment teams strive to maintain individuals in crisis in the community. Consideration of hospital admission is a clear indication for referral to assessment by the team, and the issue of whether hospital treatment still needs to be considered in the best interests of the individual and their family, is a question that teams will address after every assessment.

Circumstances may change, such as the clinical condition, an inadequate response to treatment and intervention, access to the home, the wishes of the service user, concern about risk behaviours, burden on relatives, or the need for more intensive monitoring.''[322]

Trust Adult CMHT Operational Guidance

The policy states that regarding the referral process:

320. Gateway and Advice Team Operation al Policy P. 5
321. INTEGRATED ACUTE CARE PATHWAY OPERATIONAL PROCEDURE INCORPORATING CRISIS RESOLUTION/HOME TREATMENT, AND INPATIENT CARE. 2009 P. 9
322. INTEGRATED ACUTE CARE PATHWAY OPERATIONAL PROCEDURE INCORPORATING CRISIS RESOLUTION/HOME TREATMENT, AND INPATIENT CARE. 2009 P. 29

- referrals will be accepted in writing, by telephone or by electronic means on the OTTER system;
- all urgent referrals will be seen in five working days;
- all routine referrals will be seen within 10 working days;
- referrals will be entered onto the OTTER IT system in accordance with Trust Guidance.[323]

It has to be noted that the CMHT Operational Policy contained contradictory information to that to be found in the Trust Effective Care Coordination Policy (ECC) extant at the same time. The ECC policy stated that a service user could expect a *"Care Coordinator to be allocated within 72 hours of being accepted onto Enhanced CPA*".[324] The Operational Policy stated that *"where possible the [initial] assessor will become the Care Co-ordinator. Where this is not possible a Care Co-ordinator will be identified at the next team meeting."* [325] It should be noted that whilst handover meetings were held on a daily basis, CMHT team meetings were held on a weekly basis.

It should also be noted that the assessment timescales (as set out above) differ from those to be found in Appendix One of the policy which states that the Local Authority required assessment to commence within 48 hours of the referral being received.

The Wigan and Leigh CMHT Care Pathway routed service users through the referral process as follows:

1. All referrals in hours (Monday to Friday 9.00-17.00 hours) would be routed through the 'Gateway' service. Out of hours all referrals would be routed through the Crisis and Home Treatment Team.
2. The referral would be screened and sent to the relevant CMHT.
3. An assessment would take place and the case would then be allocated for Care Coordination as deemed appropriate.[326]

323.Trust Adult CMHT Operational Guidance P.9
324. Trust Effective Care Coordination Policy and Procedures 2008. PP.23-25
325.Trust Adult CMHT Operational Guidance P.9
326. Trust Adult CMHT Operational Guidance Appendix One

Trust Integrated Acute Care Pathway Operational Procedure Incorporating Crisis Resolution/Home treatment and Inpatient Care Policy (October 2008)

"This combined and Integrated Operational Policy is an acknowledgement that Crisis Resolution/Home Treatment Teams and In-Patient Services should operate as a 'Whole System' and seamless Service, located within the Resource and Recovery Centres."[327]

The Care Pathway stated *"While use of the term "Recovery" amongst Mental Health Services influences attitudes towards an optimistic view of the prospects of people experiencing mental distress, it should be understood that "recovery" is a process that is unique to each person. It is not just a state of personal "well being" but is the actual development of each individual coping strategy in order that they can assume the fullest control of their own life – the rate of recovery is therefore unique to each individual. To recover is a verb, in the same sense as 'improvement' or 'being' in recovery.*

The process of recovery is the goal of all treatment which must enhance each individual's personal strengths, abilities and the support they receive from their family and peer networks. Each person's control of their life will be maximised by promoting availability of choice, including the type and intensity of service they require for successful living and supporting each person's ability to make choices."[328]

The policy stated that admission to an inpatient unit would be considered when a person could not be adequately or safely assessed and/or it was not possible to intervene in the home with the treatment phase.

12.1.6.2. Findings

Initial Referral (28 September 2008)

Mr. X was referred to secondary care mental health services on the 29 September 2008 by his GP. The referral was initially received by the Crisis Team who passed it onto the Central Duty Team. An initial screening took place and it was noted, following a check on the SWIFT system (the Social Services electronic record), that Mr. X's case had been closed previously in November 2008 (it remains unclear whether or not these records related to the

327. Trust Integrated Acute Care Pathway Operational Procedure Incorporating Crisis Resolution/Home treatment and Inpatient Care Policy (October 2008) P. 2
328. Trust Integrated Acute Care Pathway Operational Procedure Incorporating Crisis Resolution/Home treatment and Inpatient Care Policy (October 2008) P. 13

Mr. X who is the subject of this report or to a different service user of the same name).[329] The case was identified as being an 'Urgent' referral.

The case was referred to 'Gateway' who said that they would look at the case but could not guarantee that they would accept it onto their caseload. The GP was advised by the Central Duty Team to contact 'Gateway' directly to process the referral. The GP was concerned about Mr. X and had made it clear that he considered Mr. X to be a risk to himself, albeit that at this stage he did not appear to meet a Mental Health Act (2007) assessment threshold. The GP was told that 'Gateway' would process the referral and would contact him to report on the progress made before the 'Gateway' service closed for the day at 17.00 hours. The 'Gateway' service did not contact the GP as promised before closing hours and this meant that the GP had to make several more telephone calls in order to ensure that the referral had been processed. 'Gateway' did in fact refer the case to the Golborne Older Persons' CMHT. It was recorded that the case had been opened although not allocated.[330]

Mr. X was seen on either the 29 or the 30 September 2008 by the Golborne Older Persons' CMHT (the assessment form did not specify the date the assessment commenced). A robust initial assessment into Mr. X's situation was conducted by a Triage Nurse. This was good practice as the service was required to see all urgent referrals within five days; Mr. X was seen within 24 hours.

By the 3 October 2008 the Hindley and Ince Adult CMHT were also involved in the case. It was recorded by the Golborne Older Persons' CMHT that there were difficulties in finding a Consultant Psychiatrist to make a home visit to Mr. X. It was decided to hand the case over to the Hindley and Ince Adult CMHT due to the functional nature of Mr. X's presentation. The 3 October 2008 was a Friday and so it was decided that Mr. X would receive monitoring and support from the Crisis Team over the weekend and that medical support could be provided from this source if needed.[331]

It was recorded that Mr. X had not wished to have input from the Crisis Team over the weekend. He declined both home visits and telephone calls.[332]

329. Mr. X Vol. 7 P. 390 - 391
330. Mr. X Vol. 7 P. 390 - 391
331. Mr. X Vol. 2 PP. 27-28
332. Mr. X Vol. 9 PP. 530-531

By the 6 October Mr. X's case appears to have been accepted by the Hindley and Ince Adult CMHT and Consultant Psychiatrist 2 and a Social Worker (later to be Care Coordinator 1) made a home visit. However the arrangements still appear to have been unclear as communications were ongoing between the Adult CMHT and the Older Persons' CMHT as to how the 'handover' was to be managed. It was decided that until a Care Coordinator was allocated the Home Treatment and Crisis Team would continue to provide assessment and support for Mr. X. In order to provide a safe handover it was agreed that this arrangement would be required for a further five days.[333]

Mr. X was reluctant to engage with the Home Treatment and Crisis Team. On the 8 October Mr. X telephoned the Golborne Older Persons' CMHT and asked for an inpatient admission. A joint visit was made to Mr. X at his home by staff from both the Hindley and Ince Adult CMHT and the Golborne Older Persons' CMHT. The Social Worker (later to be Care Coordinator 1) accompanied Mr. X to Holdenbrook Ward at the Leigh Infirmary where a bed had been made available to him.[334]

Up until this point Mr. X was being seen routinely by three different teams, the Hindley and Ince Adult CMHT, the Golborne Older Persons' CMHT and the Home Treatment and Crisis Team. The status of Mr. X's referral of the 29 September 2008 could be described as remaining in some kind of allocation and handover 'limbo'.

Initial Referral to Holdenbrook Ward on the 8 October 2008

During the planned admission to Holdenbrook Ward everything was described as going reasonably well until arrival on the ward. There was a considerable delay in the Ward Doctor arriving to commence the admission. In the meantime Mr. X became upset and would not accept anything to eat. After a wait of over an hour Mr. X became distressed and refused to stay on the ward. He was told that the bed would be kept for him that night. Mr. X returned home without being seen by any medical staff.[335]

Mr. X was referred for an inpatient admission because he had reached a state of crisis. Due to a lack of timely medical intervention Mr. X's admission was not commenced and Mr. X

333. Mr. X Vol. 7 PP. 386 - 387 and Mr. X Vol. 9 PP. 534-536
334. Mr. X Vol. 7 P. 387 and Mr. X Vol. 9 PP. 537-539
335. Mr. X Vol. 9 PP. 537-539

decided to return home. Little was recorded about this event. However at interview clinical witnesses told the Independent Investigation Team that patients should have been seen straight away on arrival at the ward and admission processes should have been commenced with immediate effect. However witnesses also said that in practice delays in the admission process could sometimes be for up to four hours due to a lack of medical staffing availability.

In the case of Mr. X significant delays to the admission process on Holdenbrook Ward led to him returning home where his mental state continued to decline. The clinical staff present during the abortive admission on the 8 October did not appear to know how to proceed and this resulted in Mr. X's referral being terminated due to a service system malfunction.

Referral to Holdenbrook Ward 12 November 2008

In November 2008 Holdenbrook Ward was an acute admission ward for older patients (over 65) with functional disorders. During this period the Independent Investigation Team heard that accessing medical cover on the ward could be difficult. All medical cover for this ward came from the Older Persons' CMHTs. Consultant Psychiatrist 2, who was Mr. X's doctor working with the Hindley and Ince Adult CMHT, had no beds on this ward. This situation was to create an additional barrier to Mr. X's care and treatment receiving an appropriate medical overview on a day-to-day basis.

Clinical witnesses at interview could not remember why Mr. X had been admitted to this particular ward, but were of the view that it would probably have been due to the pressure on the adult acute admissions ward where Consultant Psychiatrist 2 would have managed her own beds.

Discharge from Holdenbrook Ward on the 25 March 2009

Mr. X was discharged from Holdenbrook Ward on the 25 March 2009. At the point of discharge the plan was for Mr. X to receive follow up. The clinical record provides a confusing account as the initial medical follow up meeting is described as being due four weeks, four-six weeks and eight weeks after discharge.

Following his discharge Mr. X should have received a seven-day follow up from his Care Coordinator. It is unclear whether or not the seven-day follow up for Mr. X occurred as there is no clinical record detailing this event. On the 8 April 2009 Care Coordinator 1 conducted a

Risk Screen and developed care plans. Two more visits were made to Mr. X, on the 22 April and the 1 May 2009. Mr. X had no further contact with a Care Coordinator from this time forward. The care plans that were developed were rudimentary and did not address his issues and needs as a carer. There is no evidence to suggest that the care package that was put into place, for both Mr. X and his wife at the point of their mutual discharge, was discussed in detail with either Mr. X or his sons.

The GP received a request to amend Mr. X's prescription at the point of his discharge on the 25 March 2009. However the discharge summary was not sent out until the 13 May 2009, some seven weeks after the discharge had taken place.

In short Mr. X was discharged from a five-month inpatient stay with a rudimentary care plan in place to address his own particular mental health care needs. It would also appear that the care plans put into place for Mrs. X, which required her husband's full cooperation, did not take into account the possible physical and emotional impact it could make upon Mr. X's continued health and wellbeing.

12.1.6.3. Conclusions

Initial Referral (28 September 2008)

The Trust Internal Investigation Report describes how the Golborne Older Persons' CMHT was under *"considerable pressure"* at this time. Shortages of staff meant that caseloads were perceived to be high throughout 2008 and 2009.[336] The Independent Investigation Team remains unclear as to the extent to which this was the deciding factor in allocating Mr. X to the Hindley and Ince Adult CMHT. The clinical record suggests that the allocation decision was made because Mr. X's presentation was functional in nature. However clinical witnesses at interview gave widely varying accounts of how and why the case was managed as it was in September 2008.

Whilst the Independent Investigation Team accepts that the decision to finally allocate Mr. X to the Hindley and Ince Adult CMHT on the 3 October was sound, based on his functional presentation, pressures on the service continued to have a negative impact upon the way his care and treatment was managed over time.

336.Trust Internal Investigation Report P. 22

It took a period of 13 days, from the point of the GP referral on the 29 September 2008, before Mr. X's case was allocated to a single team and to Care Coordinator 1. During this period Mr. X was seen/contacted by a total of eight health and social care professionals. There are three issues to be considered.

First: continuity of care. It was evident that Mr. X did not like strangers coming into his home and this dislike appeared to have been exacerbated by his feelings of confusion and paranoia. He ultimately refused to allow Crisis Team workers into his home, during this period his mental state continued decline. Mr. X needed to have been allocated in more a timely manner in order to ensure the continuity of care that he required.

Second: role of the Crisis Team. The presence of the Crisis and Home Treatment Team may have fostered a false sense of security. Mr. X was assigned to the Crisis Team over the weekend commencing 4 October. Mr. X refused to engage. During the week that followed Mr. X's case remained unallocated, on the 7 October 2008 the decision was made yet again to utilise the Crisis Team despite the fact that the Crisis Team had not been able to engage with Mr. X. The Crisis and Home Treatment Team Operational Policy states that the primary function of the service is to prevent unnecessary hospital admission by providing intensive home treatment. However the policy goes on to say that one of the key indicators that a hospital admission is required is when a service user refuses access to their home (see context section above). Mr. X was refusing access to his home and neither the Golborne Older Persons' CMHT or the Hindley and Ince Adult CMHT had been able to complete an assessment. It was evident that Mr. X was talking about suicide, drinking heavily and neglecting his self care.

It is not certain whether or not Mr. X required a hospital admission at this stage, or whether he actually met the referral criteria for the Crisis and Home Treatment Team. However what was certain was that his mental state was deteriorating and no assertive plan had been put into place for managing Mr. X's case.

Third: timely assessment and risk management. It was identified at an early stage that Mr. X needed to have a Care Coordinator allocated to him as quickly as possible in order for an in-depth assessment to be conducted. A degree of urgency had been identified due to the fact that Mr. X had suicidal thoughts, was neglecting himself and was drinking alcohol.

It remains unclear whether or not Mr. X was referred to the adult team because of his clinical presentation or because of the workforce issues that were impacting negatively upon the Golborne Older Persons' CMHT. It was evident that the older persons' team could not access a doctor to visit Mr. X. However, once the decision had been made on the 3 October 2008 to refer Mr. X to the Adult CMHT, delays continued to occur. The Independent Investigation Team could not find a satisfactory answer as to why Mr. X continued to be seen by three different teams until the 10 October. This situation served to confuse Mr. X and delayed the in-depth assessment that he required.

Initial Referral to Holdenbrook Ward on the 8 October and 12 November 2008

8 October 2008

It is the conclusion of the Independent Investigation Team that the referral to the Holdenbrook Ward on the 8 October 2008 was managed poorly. It is uncertain why Mr. X was referred to the older persons' acute admission ward and not the adult acute admission ward which would have been under the *aegis* of Consultant Psychiatrist 2. On arrival poor medical staffing levels ensured that Mr. X was not able to be admitted in a timely manner ultimately leading to his return home. At this juncture it was thought that he was not actively at risk of suicide and that he could safely leave the ward. However Mr. X had already reached a point of crisis, had no Care Coordinator, and had not yet received a full assessment of his mental state, health needs and risk profile. Mr. X was allowed to return home to a situation which was not being assertively managed and as a consequence Mr. X's mental health continued to deteriorate.

12 November 2008

Once again Mr. X was referred to Holdenbrook Ward in a state of crisis. This time he was admitted. Once again it remains uncertain as to why Mr. X was sent to a ward that was not part of the adult service. Clinical witnesses suggested that this occurred due to the pressure on beds in the unit overseen by Consultant Psychiatrist 2 requiring Mr. X to be admitted elsewhere. Clinical witnesses explained that if a patient was admitted in an emergency to the 'wrong' ward then a transfer would normally occur at the soonest possible opportunity. In Mr. X's case this did not occur as he was left on Holdenbrook Ward for five months. No explanation for this was given to the Independent Investigation Team. The Independent Investigation Team asked clinical witnesses whether or not the quality of the care and treatment of patients allocated to wards outside of their treating team's area/care group was

affected negatively. Witnesses answered in the affirmative. Patients who were allocated in this manner frequently suffered from a lack of medical continuity of care and review. CMHT and Care Coordinator inputs were often compromised due to the fact that ward rounds and team meetings had to be arranged on a bespoke basis placing additional pressures on both the ward and CMHT time resources.

Discharge from Holdenbrook Ward on the 25 March 2009

Mr. X was discharged from Holdenbrook Ward after a five-month inpatient stay with a rudimentary set of care plans and a basic Risk Screen. Communications with primary care were not timely and communications with carers and family members were inadequate. Mr. X was not followed up in the community in any meaningful sense following his discharge and this is largely due to the paucity of the discharge planning process developed for him. Had the discharge planning been conducted in a more robust manner then it is probable that a new Care Coordinator would have been allocated to Mr. X when Care Coordinator 1 left the Trust. Due to the poor quality of the discharge plan Mr. X's needs were minimised and as a consequence, despite being on Enhanced CPA, ceased to be seen as a priority by his treating team.

Summary

Mr. X was seen promptly for an initial assessment between the 29 and 30 September 2008, this was good practice. However, apart from this, referral, transfer and discharge processes for Mr. X were managed poorly. There were three major issues identified by the Independent Investigation Team.

First: on the whole Trust policies and procedures were robust, evidence-based and in keeping with national policy expectation. However policy documentation, on occasion, contained contradictory advice regarding timescales. The policies did not specifically address how service users who refused to engage with services should be managed. Trust policies stated that the aim was to provide a seamless service with a single point of entry. Whilst the policies set out Trust expectation in a clear and concise manner, it would appear that significant problems occurred with implementation in the case of Mr. X.

Second: referral, transfer and discharge practice in the case of Mr. X was seen to run counter to Trust policy and procedure. Whilst this may be due in part to the workforce issues

identified above, it must also be noted that the clinical witnesses interviewed by the Independent Investigation Team had a very poor understanding of Trust requirements and did not appear to have read the policy documentation.

Third: it would appear that workforce issues, namely staff vacancies and medical staffing availability, impacted upon the quality of the care and treatment that Mr. X received over time. The Independent Investigation Team noted that the 5 Boroughs Partnership NHS Foundation Trust now offers an 'ageless service' namely one that allocates service users to teams according to mental health presentation rather than age. However this system will still leave service users vulnerable to delays in allocation and inappropriate inpatient placement if workforce capacity problems continue to occur.

- ***Contributory Factor Six. Referral and transfer processes did not operate in a seamless and timely manner. This contributed to Mr. X's mental health being allowed to deteriorate on at least two occasions. Discharge processes did not conform to Trust policy expectations and did not provide for the assessment and management of Mr. X's needs once he had returned to the community in March 2009. This went on to make a significant contribution to the subsequent breakdown of his mental health.***

12.1.7. Safeguarding Vulnerable Adults and Mental Capacity

N.B. The context section directly below has been developed to facilitate the understanding of how Mr. X's case was managed in relation to Safeguarding and Mental Capacity. This context section has also been developed to facilitate the understanding of how Mrs. X's case was managed in relation to Safeguarding and Mental Capacity (see subsection 12.2.).

12.1.7.1. Context

National

Safeguarding Adults is a responsibility placed on social care through the *No Secrets* guidance which is issued under Section 7 of the Local Authority and Social Services Act 1970.

Through this legislation, statutory social care organisations have a duty of partnership to work with other statutory bodies to put in place services which act to prevent abuse of vulnerable adults, provide assessment and investigation of abuse and ensure people are given an opportunity to access justice.

The *No Secrets* statutory guidance was developed in response to several serious incidents, and states that: [337]

"The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety." (Paragraph 1.2)

This document was supported by a further document produced by the Association of Directors of Social Services which describes a framework for good practice and outcomes in adult protection.[338]

By 2008, based on the content of both of these documents, Local Authorities would have been expected to have a Safeguarding Board/Committee and a safeguarding framework/procedures in place. Social care staff would be expected to be trained in this area of work and to be familiar with adult safeguarding policies and procedures and should have been clear as to how to respond to issues as they arose.

There was a clear expectation from the Department of Health that *No Secrets* would apply to all statutory agencies, however this is statutory *guidance*; it therefore took some time before it was fully implemented in the NHS.

In October 2008, the Department of Health carried out a large national consultation on the *No Secrets* guidance.[339] The aim of this consultation was to understand how far *No Secrets* had progressed across agencies and to find out how it could be improved. Over 12,000 people took part in the consultation including 3,000 citizens. There were around 500 responses in total but only 67 of these were from NHS organisations.

337. Department of Health (2000) No secrets: *Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, DH, London
338.Association of Directors of Social Services (2005) Safeguarding Adults *A National Framework of Standards for Good practice and outcomes in adult protection work,* ADSS, London
339. Department of Health (2008) *Safeguarding Adult', the review of the No secrets guidance,* DH, London

One of the key findings was the absence of adult safeguarding systems within the NHS to ensure that healthcare incidents that raise safeguarding concerns are considered in the wider safeguarding arena.

In response, the Department of Health published a document which tied existing systems of Clinical Governance into adult safeguarding in order to clarify responsibilities and expectations of NHS staff in relation to this issue. [340]

The Department also funded an adult safeguarding campaign, run by the Nursing and Midwifery Council in 2010, to raise awareness of adult safeguarding amongst nurses and midwives.

It would therefore not have been common practice for health staff to have been fully aware of, and using, adult safeguarding procedures in 2008/09.

At the current time GP's are not yet engaged nationally with adult safeguarding. Recently, the British Medical Association published a toolkit to support Practices in dealing with this issue but, as yet, it has not been implemented in the majority of Practices.[341]

Safeguarding Process

When safeguarding is working effectively the following things are in place:

- all staff have a basic understanding of safeguarding and can make a prompt referral to the right place in order to elicit a response;
- staff who deal directly with safeguarding will pick up the referral and respond to it (within a short agreed timescale eg. 24 hours) in order to ensure the safety of the individual;
- immediate action/referral to the Police if necessary should take place when a crime has been committed. The Police may well lead the process if this is required;
- a strategy planning meeting will be called involving all those who have knowledge of the case to agree what is known and what further investigation should happen (this

340. Department of Health (2010) Clinical Governance and Adult Safeguarding *An integrated approach* DH, London
341. British Medical Association (2011) Safeguarding Vulnerable Adults *A Toolkit for General Practitioners,* BMA London

would usually happen within seven days) and a protection plan should be put in place, after discussion with the individual;

- investigation should occur;
- Case Conferences will take place at specific intervals both to hear the outcomes of the investigation and to monitor the protection plan. Again the views of the individual should be sought throughout the process;
- the case should be closed once the issue had been resolved and ongoing safety assured.

5 Boroughs Partnerships NHS Foundation Trust Safeguarding Adults Vulnerable Adults Policy (2008)

N.B. The language in the policy refers to 'Adult Protection' rather than 'Safeguarding'.

The Policy stated that *"all staff in contact with adults must read and be aware of the local multi agency Safeguarding Adults Policy for their local area in conjunction with this policy…Staff must take into account their professional Code of conduct and duty of Care."*[342]

The Policy stated that the Trust had a duty to safeguard adults from abuse. *"any adult at risk of abuse or neglect should be able to access public organisations for appropriate interventions which enable them to live a life free from violence and abuse. All citizens should have access to relevant services for addressing issues of abuse and neglect, including the civil and criminal justice system and victim support services. Remedies available should also include measures that achieve behaviour change by those who have perpetrated abuse or neglect."*[343]

The Trust Policy listed the different forms that abuse could take:

- **physical:** including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;
- **sexual:** including rape and sexual assault or sexual acts to which the adult has not consented, could not consent to, or was pressured into consenting;
- **psychological:** including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or support networks;
- **financial or material:** including theft, fraud and exploitation;

342. Safeguarding Adults Vulnerable Adults Policy (2008) P. 3
343. Safeguarding Adults Vulnerable Adults Policy (2008) P. 4

- **neglect and acts of omission:** including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or education services;
- **discriminatory abuse:** including racist, sexist and disability related slurs;
- **domestic abuse:** being any aspect of threatening behaviour, violence (psychological, physical etc.) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. It is a pattern of abusive and controlling behaviour by which the perpetrator seeks to exert power over the victim;
- **institutional abuse:** can be any of the above and also include poor or unsatisfactory professional practice, or pervasive ill treatment or gross misconduct;
- **bullying behaviour:** is a form of abuse, defined as the *"the unjustified display or verbal or physical aggression on the part of one individual or group towards another".*[344]

The Trust policy recognised that abuse could be *"staff to staff; staff to service user; service user to service user; carer to service user; service user to carer".*[345]

The Trust policy made the following statement regarding Mental Capacity:
"One of the overriding principles in safeguarding adults is capacity and consent. Whenever possible every effort must be made to obtain the consent of an adult to report abuse taking into consideration the definitions of the Mental Capacity Act (2005). However when there is a duty of care and the adult does not have the capacity to protect him/herself the matter must be discussed with the Trust senior manager or nominated deputy…on how best to proceed.

Any patient affected by abuse who has capacity, should be consulted as to whether or not they wish any action to be taken in relation to their own situation…If the individual does not wish to report the abuse discussion must take place with the trust senior manager or nominated deputy…as to the appropriate course of action.

Experience has shown that, on occasion, vulnerable adults are placed in situations, which leave them seriously at risk of abuse. Sometimes attempts to justify this are made on the grounds of a person's right to make choices about their lifestyle, which may involve risk.

344. Safeguarding Adults Vulnerable Adults Policy (2008) P. 6
345. Safeguarding Adults Vulnerable Adults Policy (2008) PP. 6-7

Decisions about risk at this level should never be made by individual staff but through a properly constituted professionals meetings and involving risk assessments."[346]

The Trust policy stated that Heads of Service were responsible for:

- ensuring all managers were aware of their responsibilities regarding adult protection in keeping with all policies and procedures;
- reporting all serious incidents and reporting all alerts in keeping with policy and procedure;
- liaising with all partner agencies;
- deciding on the level of investigation required and coordinating it;
- maintaining all documentation.

Managers of services providing direct care to patients were responsible for:

- ensuring all staff were aware of the Trust Adult Protection Policy and multi-agency procedures;
- ensuring that all staff were aware of how to raise an alert;
- ensuring that all new staff received training and induction;
- ensuring that all adult protection incidents were reported;
- using the supervision process to reflect on adult protection incidents;
- ensuring all incidents were recorded on the correct documentation.

All staff providing direct care to patients were responsible for:

- attending mandatory adult protection training;
- treating all service users with dignity and respect;
- being aware of how to raise an alert;
- participating in adult protection meetings as required;
- keeping accurate records.

The policy also stated that all staff had to attend mandatory training at the level commensurate with their roles and responsibilities. The specific Wigan and Leigh protocol was not included in the overarching Trust policy. However there was a separate Adult Safeguarding Policy for Wigan (November 2008).

346. Safeguarding Adults Vulnerable Adults Policy (2008) P. 7

Safeguarding Vulnerable Adults in Wigan Policy (November 2008)

The content of the Wigan policy was similar to that of the Trust-wide policy. In addition the Wigan policy highlighted certain aspects that should be considered when assessing the seriousness of any given situation. They were as follows:

- the vulnerability of the adult;
- the extent of the abuse;
- the length of time it had been occurring;
- the impact upon the individual;
- the risk of repeated or escalating acts, involving either the named individual, and/or others.[347]

Additional risk factors were identified as being:

- living in the same house as the abuser;
- a history of abuse;
- when a adult is dependent upon the abuser;
- when there has been a change in lifestyle e.g. financial or illness;
- when a member of the household experiences emotional of social isolation;
- strained family relationships;
- carer stress: especially when the carer drinks heavily, is depressed and has health problems.

The policy placed an emphasis upon risk, and sought practitioners to ask in particular *"does the vulnerable adult appreciate and understand the nature and consequences of any risk they may be subject to and do they willingly accept such risk?"*[348] The policy recognised the individual's right to make choices, even when this involved a degree of risk taking. However the policy also recognised the need to assess the individual's ability to make those choices. It was stipulated that a person's capacity was key in determining the degree of intervention that statutory services could take.

The policy stated *"In every situation it will be assumed that a person can make their own decisions unless it is proved that they are unable to do so. This means that there will be a*

347. Safeguarding Vulnerable Adults in Wigan Policy (November 2008) PP. 9-10

348. Safeguarding Vulnerable Adults in Wigan Policy (November 2008) P. 11

*presumption **against** lack of capacity… During the investigation process, it is essential that there is a certainty that the alleged victim fully understands the nature of the concerns and the choices facing them. In cases where it is felt that the adult is unable to give informed consent a multi-agency assessment should be undertaken. Capacity should be assessed in relation to the specific activity or issue that is being considered. It should not be assumed that a capacity or lack of capacity in respect to one area equates directly to another situation. For example, consent to medical treatment may not mean that an adult is able to give consent to sexual activity."*[349]

The policy stated that an assessment in relation to capacity should:

- *"relate to the timing and nature of a particular situation, i.e. a particular treatment or a particular decision;*
- *be undertaken by a person with expertise relevant to the adult's situation;*
- *consider whether the person is able to understand or retain the information relevant to the decision to be made;*
- *consider whether the person is able to make a decision based on that information;*
- *be fully recorded on the case file.*

Circumstances where an individual is considered to lack capacity might include those:

- *where the individual does not know that they have a decision to make;*
- *where the individual does not understand the choices available or the consequences of those choices;*
- *where the individual cannot communicate their decision. However, in these and other circumstances they can only be deemed incapable in making a decision where every reasonable effort has been made to assist their understanding of the situation and the communication of the wishes. This will include arranging an advocate and/or interpreter where necessary and possible. It is important to start from the assumption that the individual is trying to find some way of communicating their wishes rather than that they cannot do so."* [350]

"If it is decided that the person does have capacity, has taken an informed decision and by that action, is placing him or herself at risk, the worker should consult with:

- *The person themselves*

349. Safeguarding Vulnerable Adults in Wigan Policy (November 2008) P. 61
350. Safeguarding Vulnerable Adults in Wigan Policy (November 2008) PP. 61-62

- *Their carer – with the person's consent, unless the carer is suspected of the abuse*
- *Their community support network*
- *Any other relevant agency, service or individual*

To ensure that the person understands the risk that they are taking and the choices available to them to remove or reduce the risk."[351]

The Wigan policy clarified that any Vulnerable Adult Safeguarding investigation was the responsibility of the Local Authority Department of Adult Services Team.

Mental Capacity (National)

Adult safeguarding is not set in primary legislation in the same way as in children's safeguarding. The statutory guidance provides a framework for organisations to use in order to work with individuals who are vulnerable to, or experiencing, abuse. At the heart of this process is the consent of the individual to work with the agencies to find ways to protect themselves. One of the most important considerations, therefore, is the mental capacity of the vulnerable person to give this consent.

In the case of an individual without mental capacity, the decision making is clearly defined in line with the Mental Capacity Act (2005).[352] This Act came into force in October 2007, in order to give time for organisations to train their personnel to understand and use it effectively.

Under the Mental Capacity Act a person is presumed to make their own decisions *"unless all practical steps to help him (or her) to make a decision have been taken without success."* Incapacity is not based on the ability to make a wise or sensible decision.

In the case of an individual who lacks capacity to keep themselves safe, a best interest's decision can be made which may enable staff, in an extreme situation, to facilitate removal of the individual from harm.

351. Safeguarding Vulnerable Adults in Wigan Policy (November 2008) P. 62
352. Mental Capacity Act (2005) Chapter 9, Part One: *Persons Who Lack Capacity*, HMSO, 4/2005 305602 19585

It is much more problematic when the vulnerable individual has capacity to make decisions but refuses to take action to keep themselves safe.

There is no formal action that public sector staff can take in these circumstances other than to maintain structured contact in order to leave open the option for the individual to change their mind. If a crime has been committed, the Police can pursue an investigation of the alleged perpetrator but often, this does not progress into the criminal justice system due to the unwillingness of the victim to participate.

The additional law that must always be considered in these circumstances is the Human Rights Act.[353] Article 8, in essence, states:

1. Everyone has the right to his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

This Article means that public authorities cannot intervene in the lives of individuals where they have capacity and are making unwise choices, unless there is a crime being committed or the issue is impacting on the lives of others.

12.1.7.2. Findings

The Safeguarding Vulnerable Adults in Wigan Policy (November 2008) was a robust and evidence-based document in keeping with national policy best practice expectation.

Event Background

It has been difficult for the Independent Investigation Team to ascertain beyond any reasonable doubt that all of the historic clinical information within Mr. X's clinical record actually pertains to him and not to other service users. However it can be reliably ascertained

353. Human Rights Act (2000) Article 8, The right to respect for private and family life

that the following occurred (N.B. the following account addresses the safeguarding issues pertaining principally to the health and wellbeing of Mr. X. Whilst it is recognised that there is a high degree of overlap, the specific issues pertaining to Mrs. X are examined in subsection 12.2.5. below):

- **1998:** Mrs. X visited her GP and stated that her husband's mental health was poor and that as a result she was tense and not able to sleep.[354]
- **6 November 1998:** Mr. X was seen at an emergency outpatient clinic. It was noted that according to Mrs. X she sometimes became afraid of him because he "*becomes verbally aggressive and has pushed her around frequently.*"[355]
- **20 April 2006:** Mrs. X was seen at the Memory Clinic by Consultant Psychiatrist 1 who referred Mrs. X for a neuro-psychological assessment. It was noted that Mrs. X had been very stressed by her husband and Consultant Psychiatrist 1 wanted to understand whether the memory problems and cognitive impairment were due to Alzheimer's Disease or anxiety and depression exacerbated by her husband's condition.[356]
- **29 August 2007:** Mrs. X did not attend her Outpatient appointment with Consultant Psychiatrist 1. He wrote to the GP to say that her husband had rung to say his wife did not need any further appointments as she was fine. The GP was asked to re-refer in the future if it became necessary.[357]
- **17 January 2008:** The GP wrote that there were marital problems. Mrs. X reported that her husband was depressed and verbally abusive, not physically violent, but he shouted at her and broke her things.[358]
- **11 February 2008:** The GP had a chat with Mrs. X about her husband's controlling attitude. She was encouraged to stay in contact with her female friends and get out more.[359]
- **18 August 2008:** Mrs. X visited her GP who wrote that Mrs. X was upset because her husband *"still had a bad temper not physically violent, but breaking things & shouts and swears."*[360]

354.Mrs. X GP Record P. 28
355. Mr. X CMHT Record PP.27 and 49-50
356. Mrs. X Vol. 5 P. 257
357. Mrs. X GP Record P. 163
358. Mrs. X GP Record P. 178
359. Mrs. X GP Record P.178
360. Mrs. X GP Record P. 177

- **17 September 2008:** Mr. X allegedly assaulted his wife. It remains unclear what occurred. Mrs. X claimed that her husband pushed her to the ground and punched her in the chest. Mr. X claimed that there was a tussle and she fell to the ground. He denied punching her. Mr. X was arrested by the Police on the 2 October 2008. The charges were dropped by Mrs. X at a later date, however no further clarification of what actually happened was established.
- **29-30 September 2008:** Mr. X was referred to secondary care services by his GP. During the initial assessment he said that his wife had always been very supportive of him but that in recent years Mrs. X had become less tolerant of his mental health problems. She would get angry and shout at him. She would accuse him of stealing her things, blaming him when she could not get things to work (such as the television remote control and new electric fire) and deriding him in front of her friends. Mr. X was finding the situation *"intolerable."* Mr. X was depressed about his wife leaving him and felt abandoned and socially isolated as his family would have nothing to do with him.[361]
- **3 October 2008:** a Risk Screen was conducted. It was recorded that Mr. X was vulnerable and had been subject to domestic abuse in the form of his wife accusing him of sundry things he had not done and *"having shouting outbursts at him."* Mr. X was also identified as being at risk of self neglect.[362]
- **8 October - 12 November 2008:** it was routinely recorded in the clinical notes that Mr. X was unkempt, had a strong body odour and was drinking heavily.
- **14 October 2008:** a Protection of Vulnerable Adults (POVA) investigation was commenced for Mrs. X regarding the alleged assault Mr. X had made on her.[363]
- **12-13 November 2008:** Mr. X was admitted onto Holdenbrook Ward. The Risk screen that was conducted assessed him as being a risk to others (his wife, and health and social care professionals if he drank alcohol), at risk as a vulnerable adult (from his wife's verbal abuse), and at risk of self neglect.[364]
- **10 December 2008:** it was decided that the POVA would be closed and that no case conference was required as a Protection Plan had been developed. The central premise of the plan was that Mr. and Mrs. X would never be living together again.[365]

361. Mr. X Vol. 2 PP. 23-26
362. Mr. X Vol. 2 PP. 29-31
363. Mrs. X Vol. 2 P. 77
364. Mr. X Vol. 3 PP. 90-94
365. Mrs. X Vol. 2 P. 73 see also P. 254

- **27 December 2008:** the Risk Screen that was conducted assessed him as being a risk to others (his wife, and health and social care professionals if he drank alcohol), at risk as a vulnerable adult (from his wife's verbal abuse), and at risk of self neglect.[366]
- **19 January 2009:** the Risk Screen that was conducted assessed him as being a risk to others (his wife, and health and social care professionals if he drank alcohol), at risk as a vulnerable adult (from his wife's verbal abuse), and at risk of self neglect.[367]
- **3 February 2009:** a Risk Screen was conducted and Mr. X was assessed as presenting no risks to either others or to himself. Mr. X was not assessed as being at risk from vulnerability or from neglect.[368]
- **19 February 2009:** it was recorded that Mrs. X was expressing a desire to return back to her own home. It was also recorded that she had the capacity to make her own decisions.[369]
- **25 February 2009:** the treating teams of both Mr. and Mrs. X understood that the couple wanted to return home together.[370]
- **2 March 2009:** it was recorded in Mrs. X's clinical record that she remained vulnerable and that she would require an *"intense"* level of support on her return home.[371]
- **24 March 2009:** at the time of couple's discharge an Occupational Therapy (OT) assessment was conducted in the home. It was noted that the couple may struggle to look after themselves.[372]
- **2 April 2009:** Mr. X cancelled the social care package because he thought he could manage alone.[373]
- **8 April 2009:** a Risk Screen was conducted for Mr. X he was assessed as being a risk to others, at risk of vulnerability and also at risk of neglect.[374]
- **22 April 2009:** Care Coordinator 1 visited Mr. X and it was recorded that he was non compliant with his medication and that he was drinking alcohol again. On the same day Care Coordinator 2 witnessed an altercation between Mr. and Mrs. X. However

366. Mr. X Vol. 3 PP. 78-81
367. Mr. X Vol. 3 PP. 74-76
368. Mr. X Vol. 11 PP. 609-611
369. Mrs. X Vol. 2 PP. 89-91
370. Mrs. X Vol. 2 P. 58
371. Mrs. X Vol. 3 PP. 120-123
372. Mrs. X Vol. 3 PP. 118-119
373. Mrs. X Vol. 2 PP. 84- 88
374. Mr. X Vol. 8 PP. 466-470

Mr. X gave the assurance that he would never hurt his wife, and Mrs. X said that she wished to stay in her own home with her husband.[375] [376]

- **28 April 2009:** Mrs. X was seen by a Consultant Neurologist who agreed that she had *"dementia syndrome."* Due to her reported visual hallucinations the Doctor thought she may have Lewy Body Dementia.[377]
- **8 May 2009:** it was recorded that Mrs. X described her husband as being like a *"mad man."*[378]
- **2 June 2009:** Mr. X was seen at the Outpatient Clinic, he appeared to be well and was described as being *"very happy."*[379]
- **24 June 2009:** Care Coordinator 2 recorded Mrs. X as looking unkempt, although she also recorded that the couple appeared to be doing well.[380]
- **6 July 2009:** it was recorded by the Support Worker that Mrs. X seemed to be *"edgy"* and that Mr. X did not appear to be well as he had trouble with his *"water works".*[381]
- **11 July 2009:** Mrs. X was described as being a *"little on edge."*[382]
- **13 July 2009:** Mr. X contacted Care Coordinator 2 urgently as Mrs. X was ill. An ambulance was called. Mrs. X was admitted to Orrell Ward where she was treated for a Urinary tract Infection and dehydration.[383]
- **21-23July 2009:** Mrs. X was discharged from hospital back to her home. A new social care package was to be provided to Mrs. X from Anchor Care, commencing on this day.[384] Mr. and Mrs. X were recorded as now accepting the need for support in the home. Mrs. X had been seriously ill with a systemic sepsis as a result of a urine infection.[385]
- **29 July 2009:** it was recorded that Mrs. X looked dishevelled and that Mr. X was struggling to come to terms with his wife's illness.[386]
- **4 August 2009:** Mr. X cancelled his wife's package of social care. He felt that he could give his wife her medication and that the CMHT Support Worker could bathe

375. Mr. X Vol. 11 P. 601
376. Mrs. X Vol. 1 P. 40
377. Mrs. X GP Records P. 164
378. Mrs. X Vol. 1 P. 35
379. Mr. X Vol. 11 P. 601 and GP Record P. 220
380. Mrs. X Vol. 1 P. 29
381. Mrs. X Vol. 1 P. 18
382. Mrs. X Vol. 1 P. 19
383. Mrs. X Vol. 1 P. 27
384. Mrs. X Vol. 1 P. 25
385. Mrs. X Vol. 1 P. 24
386. Mrs. X Vol. 1 P. 22

his wife. He was informed that this could be a temporary measure only. Apparently Mrs. X had not liked strangers providing personal care to her.[387]

- **11 August 2009:** Mr. and Mrs. X were seen at the Outpatient clinic by Consultant Psychiatrist 1. It was agreed that the Golborne Older Persons' CMHT would continue to be involved as ongoing support was needed as Mr. X's mental health could fluctuate.[388]
- **17-20 August 2009:** on the 17 August Mr. X telephoned the Hindley and Ince Adult CMHT he was reported to have been *"really upset and crying"* saying that everyone was against him and that the DVLA were going to take his license from him. Mr. X could hardly talk for crying and said he could not cope. The plan was to discuss his case with the CMHT Manager. The Worker was asked to observe the condition of Mr. X's home to ascertain whether or not he was taking his medication. During the home visit it was evident that Mr. X was paranoid about his driving license. Otherwise Mr. X was deemed to have *"looked OK"* and to be taking his medication.[389] During the 19 and 20 August Mr. X continued to be agitated and Care Coordinator 2 was concerned about the effect this would have upon Mrs. X's wellbeing.[390] Mrs. X was described as *"feeling terrified and nervous when he's angry."*[391]
- **25 August 2009:** Mrs. X appeared stable in mood although she had recently had a urine infection. Mr. X said that he did not want his wife to go back to Lakelands Residential Home and would prefer her care to continue with the Older Peoples' CMHT. Mrs. X said she was happy at home. The Care Coordinator explained that she would be going on annual leave and what the support arrangements would be while she was away.[392]
- **28 August 2009:** a CPA review was conducted.
- **2 September 2009:** the Support Worker made a home visit to Mrs. X accompanied by another CMHT colleague. On this occasion it was noted that Mrs. X had what was described as a cold sore on her lip. Mrs. X said that her husband had *"done it."* On returning to the office the CMHT Manager was informed. It was decided that the Care Coordinator would be informed on her return from annual leave on the 16

387. Mrs. X Vol. 1 P. 21
388. Mrs. X Vol. 1 P. 12
389. Mr. X Vol. 8 PP. 459-461
390. Mr. X Vol. 8 PP. 463-464
391. Mrs. X Vol. 1 P. 14
392. Mrs. X Vol. 1 P. 11

September and the plan was for the Support Worker to visit again on the 23 September.[393]

- **10 September 2009:** workers from the Golborne Older Persons' CMHT had become anxious about Mrs. X as her prescription had not been picked up and the team had not been able to access to the house. Mr. and Mrs. X were found dead in their home later that day.

Additional Factors

In order to understand whether adult safeguarding procedures were utilised appropriately in the case of Mr. X (and by default Mrs. X) it is necessary to understand:

1. the couple's history as it would relate to safeguarding risks;
   and
2. the range of health and social care challenges the couple faced in September 2008;
   and
3. what changes had taken place regarding the health and social situation of the couple prior to their discharge home in March 2009;
   and
4. what discharge planning had been put into place to ensure the continued health, safety and wellbeing of the couple.

1. The couple's history. As can be seen from the events background Mr. X had been recorded over a period of many years as having a history of aggression towards his wife which was exacerbated by his mental illness. It would appear that when his mental health broke down his episodes of aggression would increase. Whilst it cannot be proved with any degree of certainty, it would appear that these bouts of aggression took the form of verbal outbursts rather than direct physical assaults. It was recorded that Mrs. X found these outbursts difficult to live with and that they had a negative impact upon both her health and wellbeing over the years.

Mr. X's history of aggression towards his wife would appear to have been of long standing accompanied by bouts of heavy drinking. Whilst this information was known to the treating teams between September 2008 and September 2009 it did not inform either the POVA or

393. Mrs. X Vol. 1 P. 10

any subsequent risk assessment or management plan that was developed for the couple. This is of particular note as the Wigan Adult Safeguarding Policy (November 2008) considered any kind of abuse to have a raised level of risk when the abuse was historic and of long standing.

2. The range of health and social care challenges pertinent to safeguarding that the couple faced in September 2008. At the time Mr. X was referred to secondary care mental health services in September-October 2008 the following factors were either known, or should have been known, had all clinical records been accessed:

- alcohol misuse was present;
- domestic abuse was historic and of long standing;
- Mr. X had depression accompanied by other kinds of long standing physical and mental health problems;
- Mrs. X had dementia which had resulted in both functional and behavioural changes;
- Mrs. X had been verbally abusing her husband;
- Mr. X had been arrested following allegations of him assaulting his wife;
- Mrs. X was too frightened to continue living with her husband;
- Mr. X was neglecting himself and appeared to be unable to meet his own daily living needs independently.

The Wigan Adult Safeguarding Policy (November 2008) identified the factors listed above as being of particular significance when identifying the level of risk in situations of abuse. Whilst this information was known to the treating teams between September 2008 and September 2009 it did not inform either the POVA or any subsequent risk assessment or management plan that was developed for the couple.

3. Changes to the couple's health and social care situation prior to their discharge in March 2009. At the point of discharge the couple's health and social care situation remained unaltered to that at the time of their referral into secondary care mental health services the preceding autumn. The only difference was that Mr. and Mrs. X were now service users and both had been placed on Enhanced CPA.

It must be noted that Mrs. X's mental health condition**,** by virtue of her diagnosis, could not have been expected to have improved. In fact it would be reasonable to assume that her condition would have continued to deteriorate. Mr. X's mental health condition appeared to have been largely resistant to treatment whilst he was an inpatient on Holdenbrook Ward. The main factor in any observable improvement appeared to be due to his wife agreeing to return to both him and the marital home. In short, all of the health and social care challenges that existed in the autumn of 2008 remained. These challenges remained those of particular significance to the safeguarding of vulnerable adults. However these challenges were not brought together and examined in any meaningful way in order to inform a risk assessment and management plan.

In December 2008 the POVA investigation into the alleged assault of Mrs. X by Mr. X was closed. It was decided that a Case Conference was not required as a Protection Plan had been developed, the plan being that the couple would not be returning to live together again. The Independent Investigation Team asked clinical witnesses whether or not they had re-considered safeguarding issues in light of the fact that the POVA Protection Plan was not going to be followed. The view of the clinical witnesses was that as the POVA had been closed no other considerations would have been necessary unless another incident had taken place. This was the reason given for no further safeguarding risk assessments or care planning having taken place at the point of their discharge home together.

4. Planning at the point of discharge. Mr. X was discharged with a Risk Screen and a rudimentary set of care plans. The Risk Screen and care plans did not take into account the factors pertinent to safeguarding (as listed above). Mr. X was on Enhanced CPA and had undergone a five-month interval of inpatient care. At the point of his discharge the Risk Screen had identified Mr. X as presenting an ongoing risk to his wife, and of being both vulnerable and prone to self neglect. Even though these factors had been identified no specific consideration had been taken regarding either Mr. X's needs as a vulnerable adult or those of Mrs. X.

From May 2009 Mr. X had no ongoing support offered to him. His case had not been reallocated when Care Coordinator 1 left the employ of the Local Authority. This meant that his needs were no longer being assessed or his progress monitored. A general notion existed that Mr. X was doing well. The Trust Internal Investigation Review Team was given this as

being the main reason why Mr. X was considered not to be a priority for Care Coordinator reallocation. The needs of Mr. X were also considered to be 'covered off' in that the Golborne Older Persons' CMHT was making regular visits to the home and that they would be able to 'keep an eye' on Mr. X. It is not certain why this notion prevailed. The facts of the case were that Mr. X was:

- still on Enhanced CPA (had his mental health situation improved significantly it would have been reasonable to have expected his CPA level to have been formally downgraded);
- not adherent to his medication regimen;
- beginning to misuse alcohol again;
- suffering from a variety of physical ailments;
- frequently agitated, anxious and preoccupied;
- the main carer for his wife who was suffering from dementia;
- had poor coping and activities of daily living skills;
- identified as being vulnerable and prone to self neglect.

The accounts in the clinical records of both Mr. and Mrs. X place a great deal of emphasis upon the negative effects of Mr. X's behaviour and mental illness upon the health and wellbeing of Mrs. X. On several occasions it was recorded that Mr. X had been advised that he should modify his behaviour and his alcohol consumption otherwise he would not be able to look after his wife. In August 2009 when it was evident that Mr. X's mental health was beginning to deteriorate concern was recorded, not in relation to his continued health and wellbeing, but in relation as to how this would affect Mrs. X.

The health and social care focus of the Golborne Older Persons' CMHT was placed entirely upon the needs of Mrs. X. At interview clinical witnesses from the Older Persons' services were adamant that Mr. X was not their responsibility and that their presence in the home was solely to look after his wife. Mr. X's needs as a service user, a carer and a vulnerable adult in his own right went unassessed, unaddressed and unmonitored.

Mental Capacity

Mr. X's mental capacity was never in question during the time that he received his care and treatment from both the Trust and the Local Authority. The Independent Investigation Team

found this to be a reasonable assumption. However it should be noted that in order for Mr. X to have been able to make an informed decision about returning to the marital home with his wife, the precise nature of her condition should have been explained to him, together with the long-term care and treatment implications of being her carer. Care Coordinator 2 attempted to explain to Mr. X what dementia was and gave him a leaflet. It is not certain how much additional information was provided to him as it was evident that a joint discharge plan was neither developed nor discussed with Mr. X.

12.1.7.3. Conclusions

Mr. X came to the attention of secondary care mental health services in September 2008. At this time it was ascertained that he had a long mental health history, even though the exact nature of this was neither verified nor understood. However it was known that Mr. X and his wife had a significant history of marital disharmony exacerbated by his mental health problems and her advancing dementia. The couple came to the attention of secondary care services in the autumn of 2008 as a result of the aftermath of an alleged assault on Mrs. X by Mr. X.

It was evident at this stage that Mr. X did not understand why his wife's behaviour had changed so dramatically. She had become verbally abusive, accusative and argumentative. Mrs. X had always been the family home maker and had always looked after the household affairs; she had also always been patient, and supportive of, Mr. X's mental health problems Mr. X reported that in recent months she was unable to look after the house and found the most simple things, like using the television remote control, impossible. His wife also no longer seemed to be sympathetic to Mr. X's fragile mental health.

On the 14 October 2008 a POVA investigation was instigated. This should have provided the opportunity to examine all aspects of safeguarding risk regarding the couple. However the situation at the time led both health and social care professionals to suppose that the couple would never live together again and that any issues of significance were of relevance only if Mr. and Mrs. X were still domiciled together. Whilst this may have been a reasonable assumption to make at the time, safeguarding issues should have been revisited once the decision had been made to discharge the couple back to the marital home. It was misguided for the treating teams to believe that another safeguarding incident would be needed before the issues could be revisited. At this stage a comprehensive needs and risk assessment for the

couple should have been completed, paying attention not only to the risks posed to Mrs. X by her husband, but also to the risks posed by her to Mr. X.

Mr. X's needs regarding safeguarding were never identified either in relation to himself or those of his wife. Mr. X was an individual with significant mental health problems and poor activities of daily living skills. Mr. X was socially isolated and had physical health problems and impaired mobility. He drank, was non compliant with his prescribed medication, and was the main carer to his wife who had dementia. There was an assumption made by services that the input they gave to Mrs. X was sufficient to maintain her in the community and to ensure both her health and social care needs were met. However it was evident from entries in the clinical records that she was frequently unkempt and that she had difficulties shopping, cooking and looking after the house. It was also evident that Mr. X struggled to make up the short fall. Mr. X apparently cancelled the care package that was put into the house on two occasions. Clinical witnesses to this investigation suggested that the reason for this was in part financial and in part due to the fact that Mrs. X did not like strangers attending to her personal care needs. Whatever the reason, the couple were left having to manage their own daily social care needs to the detriment of both their health and wellbeing.

Mrs. X's admission to hospital in July 2009 was a direct result of dehydration which had resulted in a urine infection and systemic sepsis. This was a potentially life threatening condition. It is unclear how Mrs. X was able to become so unwell and whether a lack of appropriate care contributed to this. Mr. X recognised that his wife was becoming seriously ill and made an emergency telephone call to seek assistance, this intervention probably saved Mrs. X's life. On her return from hospital a new social care package was put into place and it was recorded that the couple understood the need to accept support, however when the couple cancelled the care package once again two weeks later no assessment was undertaken to ascertain how this decision could impact upon the health and wellbeing of the couple, and more importantly what could be done to manage the situation.

By August 2009 it was evident that Mr. X's mental health had started to break down. This instigated two home visits from unqualified Support Workers who decided that Mr. X's condition did not merit any interventions to be made. At this time it was known that Mr. X was:

- struggling to look after his wife;

- finding it difficult to come to terms with her illness;
- drinking alcohol;
- distressed and anxious.

It would appear that the treating teams providing care and treatment to the couple had an understanding that safeguarding interventions centered upon acts of violence or other kinds of abuse. Clinical witnesses to this Investigation had a poor understanding of how safeguarding policies and procedures could be utilised to intervene when vulnerability and neglect were in evidence. Mr. X was a vulnerable adult who found himself in the role of carer to his wife, another vulnerable adult. The Independent Investigation Team concluded that the couple needed a joint risk assessment and a joint care plan that addressed all of the risk factors that were present. These risk factors should have included:

- past acts of violence and the likelihood of future acts of violence;
- the couple's mental health conditions and prognosis;
- Mr. X's drinking;
- the couple's social isolation;
- Mr. X's physical health and impaired mobility;
- the couple's vulnerability;
- the couple's difficulties in caring for themselves and undertaking activities of daily living tasks and resultant possible risk of self neglect.

As a minimum the care plan should have addressed:

- Mr. X's needs as both a service user and a carer;
- Mrs. X's needs as a service user;
- the thresholds for intervention.

- ***Contributory Factor Seven. Safeguarding processes were neither understood nor implemented in keeping with either extant local policy or national best practice guidelines in relation to Mr. X and his wife. The failure to do so placed the couple at significant risk and made a significant contribution to the circumstances that led to their deaths.***

12.1.8. Service User Involvement in Care Planning and Treatment

12.1.8.1. Context

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

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

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

12.1.8.2. Findings

The Independent Investigation Team found it very difficult to build up a picture of Mr. X in order to understand the man that he was. This, in part, was due to the fact that the historic clinical record contained very little detail about him, and what was extant was unreliable. Another obstacle to understanding Mr. X was the fact that many of the clinical witnesses interviewed during this Investigation could not remember anything about him.

However a picture of Mr. X gradually emerged. He was described as being a proud and orderly 70-year old gentleman who walked with a stick following knee replacement surgery. It was also known that he could become anxious and agitated when depressed and that his thinking could become paranoid when his mental health deteriorated.

Mr. X had been married to his wife for 50 years and the couple had two grown-up sons from whom he was estranged. It was evident that over the years Mr. X had been perceived by his family as being aggressive, a bully, and a person who required a controlled environment. Throughout the period when Mr. X received his last episode of care with both the Trust and the Local Authority, he was described as being devoted to his wife telling staff that she was the *"love of his life."*[394]

394. Clinical Witness Transcription

Following his referral to secondary care mental health services by his GP in September 2008 Mr. X was ultimately accepted by the Hindley and Ince Adult CMHT and allocated to Care Coordinator 1. It was evident that he was a troubled individual at this stage. Mr. X was agitated and had paranoid ideas. Before his case was finally allocated to Care Coordinator 1 he was seen by (and communicated with) eight different health and social care professionals due to the hiatus in processing his referral. He did not wish to have contact with so many people and consequently refused to engage with services. As a result his mental health continued to deteriorate. Whilst it was acknowledged that Mr. X required a continuity of care approach, services were unable to respond in a timely manner to his needs.

Between 12 November 2008 and the 25 March 2009 Mr. X was an inpatient. This represents a significant period of time. The clinical records illustrate that during his time on the ward staff spent very little time interacting with him. Mr. X was frequently described as *"keeping himself to himself".* It would appear that his desire for isolation was rarely challenged. A care plan was developed to address this, but there is little evidence to suggest that it was ever implemented. In short, Mr. X spent nearly five months on the ward. Few clinical witnesses could remember him, and those who did had a very hazy recollection of who he was. It would appear that Mr. X was not understood well as an invidual. For example: he had an unreliable and unverified psychiatric history; was advised to 'walk off his anxiety' when his knee was swollen and he had been prescribed rest; and was described as having a paranoid episode when he had instead undergone a severe drug reaction.

Mr. X left the ward with an unclear diagnosis and a rudimentary set of care plans. There was no evidence to suggest that he received copies of his care plans or that they were developed or discussed with him. Once back in the community Mr. X had little contact with his own treating team. In the last two months of his life he had to instigate his own access to services and was not able to get the help that he sought. During those final months, instead of trying to understand what lay behind Mr. X's anxiety, unqualified Support Workers attempted to 'jolly him along' and minimised his concerns leaving him both unheard and unsupported.

12.1.8.3. Conclusions

The Independent Investigation Team concluded that Mr. X was poorly understood by his treating team over time. It was evident that he was a proud and private individual who often rejected services and challenged those who provided care to him. The treating team appeared

to take its cue from Mr. X and either withdrew services or only offered support and advice on its own terms. Individual workers from the treating teams appear to have spent a great deal of time arguing with Mr. X or trying to persuade him that his fears were without foundation.

It is not unusual for service users to be ambivalent about the care and treatment they receive. This is an ever-present challenge to mental health services and one that all providers of care should be both familiar and at ease with. Service providers should seek to engage with service users in a manner that is acceptable to the service user. If a person has been assessed as requiring an Enhanced CPA level of input then every effort should be made to build up a therapeutic relationship in order to work with the individual in the most effective manner possible. Ambivalence, and at times rejection, on the part of the service user should not be seen as a valid reason to walk away. Efforts to engage should continue if the assessed clinical need indicates that it should.

Mr. X was not managed in a patient-centric manner. Whilst he was at times ambivalent he was never entirely rejecting of the services that were offered to him, and on many occasions he sought help for himself when in crisis. Mr. X was not understood in the light of any properly formulated psychiatric diagnosis and neither were his needs as a carer considered. The care and treatment provided to Mr. X did not take either his needs or his wishes into account. The effect of this was to increase his isolation and his distress and anxiety were allowed to continue unabated.

- ***Contributory Number Eight. Mr. X remained an unknown quantity. Engagement with him was often on a superficial level and this made a contribution to the poor formulation of his care and treatment needs.***

12.9. Carer Assessment and Involvement

12.1.9.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that '*the individual service user and normally, with his or her agreement, any carers, should be involved throughout the*

assessment and care management process. They should feel that the process is aimed at meeting their wishes.' In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that '*people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care*'. Also that it will '*deliver continuity of care for a long as this is needed'*, '*offer choices which promote independence'* and '*be accessible so that help can be obtained when and where it is needed*'.

Carer involvement

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

Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to them. It also gave carers the right to an assessment independent of the person they care for.

The Carers (Equal Opportunities) Act 2004 placed a duty on Local Authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. Also that it facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health (1999) stated that all individuals who provide regular and substantial care for a person on CPA should:

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

12.1.9.2. Findings

Mr. X's Role as a Carer to his Wife

It was thought by the Consultant Neurologist who assessed Mrs. X on the 28 April 2009 that she had dementia syndrome and that she may have been suffering from a dementia of the Lewy Body type. He also queried Parkinson's Disease.[395] There is a wide body of information available about Lewy Body dementia. *"There is considerable overlap between Lewy body dementia and two other disorders: Alzheimer's disease and Parkinson's disease. In Lewy Body dementia, patients experience a loss of dopamine-producing nerve cells similar to that seen in Parkinson's disease. They also lose acetylcholine-producing nerve cells, similar to what occurs in Alzheimer's disease. Patients with Lewy body dementia often experience cognitive problems associated with Alzheimer's disease, such as memory loss, spatial impairment and language difficulties. They may also develop Parkinsonian symptoms, such as muscle rigidity, a blank facial expression, soft voice, tremor, poor balance and gait disturbances… People with Lewy body dementia also tend to show marked fluctuations in their cognitive functioning, often several times a day. In addition, they tend to fall asleep easily during the day and have restless, disturbed sleep with behavioural acting out."*[396]

Key clinical features of Lewy Body dementia are visual hallucinations and visuospatial difficulties. Sufferers may have difficulty in initiating movement, have a stiffening of the limbs, and may be unsteady on their feet, being prone to falls. Other key features include difficulties with concentration and memory. Sufferers may also become easily confused and distracted, this can fluctuate wildly and they may also experience night waking. Being a carer for a person with Lewy Body dementia becomes a fulltime task that can be both challenging and distressing.

Mr. X was his wife's main carer. He had no carer assessment conducted in order to support him in this challenging role. The Independent Investigation Team was told that no carer assessment was offered to Mr. X because the assumption had been made that he would have been rejecting of it.

A carer assessment should have taken place prior to his discharge from the Holdenbrook Unit in March 2009 as part of a structured discharge care plan for both him and his wife. The

395. GP Records P. 164 and Mrs. X Vol. 1 P. 37
396. johnshopkinshealthalerts

Independent Investigation Team recognised that Mr. X often refused services, however he may have been more likely to engage with this kind of assessment whilst he was still an inpatient.

Prior to his discharge Care Coordinator 2 spent time with Mr. X explaining about Mrs. X's illness. She gave him a leaflet and explained that Mrs. X would no longer be able to care for the home in the way that she once did. Mr. X had not realised until this point that his wife was ill, he had thought she was just *"messing around".* He said that he loved her and staff thought that he really seemed to care about her. He was to later describe his wife to a team worker as the love of his life, and said that he would never do anything to cause her harm.

It was good practice for Care Coordinator 2 to have held this meeting with Mr. X. However the information that she gave to him was of a very serious nature and the implications resulting from it were both momentous and life altering. It would appear that no other meeting was arranged in which these implications were to be worked through, needs assessed and care plans developed. A considerable amount of follow up should have occurred and did not.

It was evident that following discharge the couple struggled to cope. In effect the roles of Mr. and Mrs. X had been reversed. According to Mr. X, Mrs. X had always taken on the home making and carer role in the marriage. Mr. X was now having to take over these roles from his wife.

He should have been assessed and given the support he required in his own right. Instead all of the assessment focus and support concern was focused upon Mrs. X. Occupational Therapy and Support Worker efforts concentrated upon her activities of daily living and encouraging her to shop and cook and take care of the house. It is evident from reading the clinical records that Mrs. X often did not shop, would not cook, and could not take care of the house. Mrs. X had a degenerative disease of the brain, one in which her functioning could be expected to decrease rapidly over time regardless of much therapy and support she received. Whilst it was good practice to ensure that Mrs. X continued to function as independently as possible for as long as possible, it should not have been the sole focus of inputs to the couple.

In the meanwhile Mr. X had to meet the shortfall in the best way that he could. His acute distress at not being to drive was seen as further evidence of paranoid thinking. He was

advised to walk to the shops or to catch a bus to the supermarket. This was far from constructive. Mr. X had undergone knee replacement surgery. Both of his knees were painful at times and would often swell. Consequently he needed to walk with a stick which would have made the carrying of bags of food shopping very difficult, if not impossible.

Mr. X was left in a situation that he found difficult to cope with. By August 2009 he was reported as struggling to come to terms with his wife's condition. It is a fact Mr. X telephoned for help in a distressed state on several occasions. His appeals for help were managed on a superficial basis. Support Staff attempted to 'rally him around' and vigorously challenged his view of the world. Whilst this stance may have been well meaning it was not a professional response to a service user, who was also a carer to another service user, in distress.

Mrs. X's Role as Carer to her Husband

Prior to the time that Mrs. X's dementia had progressed to the point that her functional abilities were significantly impaired, she had acted as carer to her husband. The Independent Investigation Team was told that Mrs. X had historically looked after all of the couple's household affairs. This included managing the finances, cooking, cleaning and all other general household tasks. Mr. X told his treating team that Mrs. X had also provided him with loving support when his mental health became unstable. He described feeling confused and unsupported once his wife's personality and behaviour changed as her dementia progressed. It was evident that once she left the marital home in September 2008 that Mr. X could not cope on his own.

Other Family Member Considerations

Mr. and Mrs. X had two grown up sons. Their eldest son was able to maintain a degree of ongoing support to the couple between September 2008 and September 2009. When Mrs. X left the marital home in September 2008 she went to live with him.

On the 8 October 2008, three weeks after Mrs. X had left her husband, her eldest son telephoned the Central Duty Office seeking urgent help and support. Mrs. X was reported to be highly confused during this period and it was not possible for her to be left alone in her son's home. At this time Mrs. X needed to be supervised at all times and this led to significant problems very quickly. Mrs. X's son needed to be able to go to work which he

could no longer do whilst caring for his mother. By this stage he had not been able to attend work for three weeks. The son was told that someone would *"see his mum within two days."*[397]

The following day, on the 9 October, it was recorded that Mrs. X's case had been treated as an immediate referral due to an incident of reported abuse by her husband and because her son could not continue as her carer. The son refused a care package to be brought into his home for Mrs. X as he did not want her to be permantly domiciled with him. The son was however prepared to keep his mother at his home until a suitable place could be found for her. Consequently enquiries were made to see whether a place could be found for Mrs. X at Lakelands Residential Home.[398] At this time Mrs. X was placed on Enhanced CPA.

On the 15 October Care Coordinator 2 visited Mrs. X at her son's home. The son was reported to be struggling to cope with her and the plan was to admit Mrs. X to Lakelands Residential Home for a two-week period of respite care.[399]

On the 22 October Mrs. X was seen at the Outpatient Clinic by Consultant Psychiatrist 1. She was described as still living with her son who was finding it difficult to look after her because she got confused and did not always know who he was.[400] It is unclear exactly when Mrs. X was finally admitted into Lakelands, however it would appear to have been at least 15 days after the son had telephoned for help in a state of crisis.

Once Mrs. X was in Lakelands Residential Home it is evident that her eldest son was still engaged with services. However the records do not detail exactly how CMHT staff continued to engage with him over time. There is virtually no mention of the son in the lead up to Mrs. X's discharge or following her return home in March 2009, although it is mentioned that he visited the couple on occasion and took them shopping in his car. The Independent Investigation Team acknowledge that the son did not always wish to work with services and appeared to be ambivalent about taking on a role as carer to his parents.

397. Mrs. X Vol. 2 PP. 98-100
398. Mrs. X Vol. 3. PP. 146-153 and Mrs. X Vol. 2 P. 82
399. Mrs. X Vol. 2 P. 80
400. Mrs. X Vol. 5. PP. 242-243

12.1.9.3. Conclusions

The following factors were identified:

- Mr. and Mrs. X were, albeit at different times, *de facto* carers for each other;
- either partner, when operating in the carer role, would have met the threshold to qualify for a carer assessment;
- there was ample evidence to suggest that by September 2008 Mr. X could neither manage nor understand his wife's behaviour and deterioration of cognitive function. Whilst it was recognised that he would require ongoing help and support to care for her, at the point of the couple's joint discharge in March 2009, no care plan had been developed for him by Care Coordinator 1;[401]
- an Occupational Therapy assessment conducted in the home on the 24 March 2009 concluded that the couple *"may struggle to look after themselves;"* [402]
- despite the levels of care provided by statutory agencies, when Mrs. X returned to the marital home in March 2009, her complex needs placed a significant onus upon Mr. X to meet them on a 24 hour basis;
- Mr. X reported that he struggled to meet the demands of caring for his wife;
- there was a failure to see Mr. X as a source of positive contribution to Mrs. X's recovery and support to him in that task: rather he was defined as being a problem;
- Mr. X's needs as a carer were not assessed in the light of his own ongoing needs as a service user;
- the couple's ability to manage their day-to-day affairs and the stresses placed upon them both were neither understood nor addressed.

It is not possible to know with certainty to what the extent the pressures of being a carer contributed to Mr. X's ongoing feelings of depression or distress. Being a fulltime carer is widely acknowledged to be a difficult role, one where a person's mental and physical health can break down under pressure. The Princess Royal Trust for Carers states that *"To care safely and maintain their own physical and mental health and well-being, carers need information, support, respect and recognition from the professionals with whom they are in contact. Improved support for the person being cared for can make the carer's role more manageable."*[403]

401. Mrs. X Vol. 1 P. 27
402. Mrs. X Vol. 3 PP. 118-119
403. http://www.carers.org/why-do-carers-need-support

Whilst care and support were put into place for Mrs. X, Mr. X's needs as both a service user and carer were largely ignored. In March 2009 assumptions were made regarding the couple's ability to manage in their own home. It was good practice to enable the couple to return home, as was their wish. However it was poor practice to both provide and oversee a package of care that was not developed as a result of a robust and dynamic assessment process that took into account the needs of both and Mr. and Mrs. X equally. Mrs. X had complex needs. Mr. X as her main carer was both entitled to and required a carer assessment. Whilst it was assumed that he would reject such an assessment, services should have continued to offer practical support to him. It is a fact that when Mr. X tried actively to access support in the summer of August 2009 this was not forthcoming.

Mr. X had complex needs as a service user which were ongoing but largely unaddressed. No consideration was taken as to how the pressures of caring for a person with dementia, concomitant with having a severe and enduring mental illness of his own, would affect either his own ongoing health and wellbeing or that of his wife. In the summer of 2009 Mr. X's mental health was not being monitored appropriately and the care plans that had been developed to meet his identified mental health needs at the point of his discharge in March 2009 had not been implemented.

Clinical Witnesses described Mr. X as being stubborn, and at times, difficult to help. This was undoubtedly true on occasion. However it was evident from reading the clinical record that Mr. X frequently requested help and intervention for both himself and his wife and that he was not entirely rejecting of services. Had Mr. X been engaged with in a more person-centered manner, and had a therapeutic relationship been developed with him, then he may have been able to work with either his wife's Care Coordinator, or his own, to support his needs better.

Mr. X was not supported in the manner to which it would normally be expected for a carer to be. It is the conclusion of the Independent Investigation Team, that whilst the impact of this cannot be estimated with any degree of accuracy, that this must have made a significant contribution to Mr. X's ongoing distress and anxiety to the detriment of both his and wife's continued health and wellbeing.

- ***Contributory Factor Nine. Mr. X's needs as a carer were neither assessed not addressed. This placed a great deal of stress upon him and made a significant contribution to the circumstances that led to both his death and that of his wife.***

12.1.10. Documentation and Professional Communication

12.1.10.1. Context

Documentation

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

The GMC states that:

'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off[404]*'*

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

"Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised."[405]

Professional Communication

"'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion."[406]

Jenkins *et al* (2002)

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

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

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone[407]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively[408]. The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

12.1.10.2. Findings

Documentation and Professional Communication

Management of Clinical Information

At some stage before September 2008, it is unclear precisely when, the Mr. X who is the subject of this report had his clinical records co-mingled with those of up to two other service users of the same name. It would appear that the same NHS Number, address, and Date of Birth were assigned erroneously to each service user, the data of which belonged to Mr. X. A close examination of the record revealed some confusing information. The Independent Investigation Team noted the following anomalies:

- there appeared to be three distinct diagnoses: Bipolar Disorder; Paranoid Psychosis; and Depression and Anxiety;
- the clinical record appeared to record two entirely different medication regimens being prescribed at the same time;
- there were records that indicated a discharge from a Section 117 had taken place, whilst it was evident that no inpatient admission or Mental Health Act sectioning had ever occurred for Mr. X;
- one entry recorded that the service user had a mother who visited the GP surgery with him frequently, another entry stated that the service user's mother had died when he was a young child;
- one clinical record entry stated that the service user had a supportive wife who had accompanied him to the surgery, whilst another entry made the next day noted that the couple were estranged and had not seen each other for several months;
- one entry describes Mr. X as having mobility problems, whilst another entry shortly afterwards states that he was about to run a marathon;

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

- one entry had the service user living in the community in a stable condition, whilst another entry the following day, in another part of the clinical record, stated that the service user had been an inpatient for several weeks.

It was evident that the notes had been comingled. The anomalies were not easy to ascertain from a 'casual read through'. Due to each record entry bearing identical patient identifiers the anomalies only became apparent through conducting a detailed examination.

The Independent Investigation Team can only speculate as to how this situation occurred. The record mismanagement would appear to have possibly originated as a Medical Secretary error whereupon each service user of the same name (each being treated by the same CMHT and registered at the same GP surgery) were thought to be the same individual. This resulted in Outpatient Clinic letters and other sundry clinical communications being assigned to Mr. X's case regardless of whether or not he was the actual patient in question. If this was the origin of the problem then it is likely that the clinicians creating the records for transcription did not include the basic minimum data set to ensure that each patient was identified correctly by their Medical Secretaries.

As a consequence of the clinical record co-mingling erroneous information was sent to both Mr. X's GP and into the CMHT database. As the years went by certain 'factoids' about Mr. X were therefore assumed by the GP, which were perpetuated by the GP sending the erroneous information back to CMHT when corresponding about either Mr. X or his wife. In short, Mr. X's psychiatric history was recorded in such a manner to foster confusion and erroneous assumptions.

The Independent Investigation Team asked clinical witnesses at interview whether or not they were aware of the clinical record co-mingling. It became evident that whilst they were not aware of this, they were aware that there were three service users of the same name and information about them had become muddled in the past. Clinical witnesses explained that on occasion the wrong clinical folders had been got ready for the wrong patient at Outpatient appointments, and that the OTTER system (the Trust electronic record system) did not always flag up the correct patients when clinicians sought to input fresh data. Clinical witnesses explained that the only way of ensuring these mistakes did not continue was to be vigilant, but that even so, incorrect entries were probably sometimes made. Had a thorough

assessment been completed at key points in the history of Mr X's care and treatment- for example when he became a hospital in-patent, these anomalies might have been discovered and corrected.

Quality of Record Keeping

The overall quality of record keeping was of a poor general standard. Clinical records provided little more than a chronological series of activity reports. Clinical risk assessment and care planning documentation was of a rudimentary nature. It was evident that a 'tick box' approach had been taken. Whilst forms were filled in there was no evidence of any accompanying narrative that recorded with clarity:

- clinical impressions;
- rationales for care and treatment;
- detailed care plans;
- monitoring and review processes.

Ward rounds were recorded in the most basic manner possible and CPA, safeguarding, and risk assessment reviews were not recorded in keeping with Trust policy and procedure requirements. Due to the poor level of clinical record keeping it has not been possible to understand how exactly the care and treatment of Mr. X was assessed, managed, monitored and reviewed. The clinical witnesses that gave evidence to this Investigation found it difficult to remember how the significant junctures on Mr. X's care pathway were managed. Due to the clinical record being so lacking in detail there was nothing upon which they could reflect in order to assist their recollections. The clinical witnesses interviewed were of the general impression that a great deal of positive work was achieved with Mr. X. However actions were not recorded, and few witnesses could remember what exactly occurred. The Independent Investigation Team concluded that there was poor evidence to suggest that Mr. X received his care and treatment in keeping with Trust best practice expectation. Another feature that made interpreting the clinical record difficult was the fact that many clinical entries were neither signed nor dated.

Interagency Liaison and Information Sharing

Trust and Local Authority Systems

The Internal Investigation Review Team that conducted the Trust and Local Authority investigation into the care and treatment that Mr. and Mrs. X received directly following their deaths found that there were inconsistencies in communication systems used. For example, the Manager of the Golborne Older Persons' CMHT did not use the Trust global email system preferring instead to use the Local Authority system. This was identified as causing potential blockages to ensuring communications flowed to all employees, Trust and Local Authority alike.

Communications with Primary Care

The Independent Investigation Team has three observations to make concerning Trust/Local Authority communications with Mr. X's GP:

- **First:** the information sent to the GP for several years, supposedly relating to Mr. X, did not in fact refer to him. This information potentially placed Mr. X at risk from receiving incorrect medication, assessment and management.
- **Second:** Mr. X was referred by his GP to secondary care mental health services on the 29 September 2008. Communication delays occurred on the part of the Gateway Service which meant that the GP was not kept informed regarding the progress the referral was making. This led to a high degree of frustration on the part of the GP who had to persist in making telephone calls to ensure Mr. X's case was being processed through the system.
- **Third:** when Mr. X was discharged from Holdenbrook Ward in March 2009 the GP who was cited in the discharge crisis and contingency plan had not had this information shared with him, and the Discharge Summary was not written until the 13 May 2009, some seven weeks after Mr. X's discharge.

The three examples listed above demonstrate how important information about Mr. X did not 'follow the patient'. Information sent from secondary care to primary care services was often incorrect, misleading or tardy.

12.1.10.3. Conclusions

The Internal Investigation Review Team found that between July 2009 and October 2009 the Trust record keeping audit tool was being revised and was therefore out of commission. The Internal Review Team concluded that had the audit tool been in use then the absence of risk

information may have been brought to Managers' attention and action taken. The Independent Investigation would add that even when the audit tool was in place prior to the summer of 2009 it had not been effective in picking up poor record keeping practice and, that no matter how effective the audit tool may or not have been, it would not have been sophisticated enough to identify the effects of the co-mingling of several patient records into one case record.

The Independent Investigation Team sought to understand the clinical systems and culture that underpinned clinical record keeping systems and practice. There were several issues:

- Trust and Local Authority Workers, whilst working within the same teams, tended to follow the systems and practice of whichever organisation they were employed by. This meant clinical and social care information was not always stored in the same place or made accessible to everyone.
- Underpinning clinical records systems did not operate with sufficient safety checks to ensure that patients with the same name were identified correctly and not confused one with the other.
- Clinical and social care staff had a rudimentary understanding of their professional responsibilities when it came to maintaining a clinical/social care record. Witnesses that gave evidence to this Investigation found it difficult to articulate who in the team was responsible for maintaining the clinical/social care record. Senior team members often delegated the role to more junior colleagues who may not have had the experience necessary to know what was expected of them. Witnesses also demonstrated a lack of awareness of the appropriate forms and levels of documentation that were required in accordance with both Trust and Local Authority policy guidance.

Her Majesty's Coroner who held the Inquest into the deaths of both Mr. and Mrs. X criticised health and social care workers for not maintaining a robust clinical record, the absence of which led to a lack of confidence on the part of the Coroner regarding the quality of the care and treatment provided. The Independent Investigation Team found that the poor standard of record keeping, coupled with the almost total inability of most witnesses to remember Mr. X, led to conclusions being reached that if a required intervention had not been recorded, and could not be recalled by witnesses, then it did not happen. This conclusion holds for most

aspects of safeguarding, risk assessment and management, CPA and care planning processes pertaining to the care and treatment provided to Mr. X. It must be noted that the health and social care professionals involved, and their employing statutory agencies, have left themselves open to criticism about their practice that cannot be defended by not maintaining a robust set of patient records.

It is not possible to know to what degree the poor management of Mr. X's clinical record impacted upon the effectiveness of the care and treatment package that he received over time. However it can be asserted that clinical record management systems and clinical record keeping practice fell below the most basic standard to be expected. It is a fact that erroneous information was carried forward in time about Mr. X which led to incorrect clinical impressions of him being formed. This, when seen in the context of the rudimentary levels of engagement with Mr. X (see subsection 12.1.8), ensured that he remained a relatively unknown quantity.

- ***Contributory Factor Ten. Trust and Local Authority record keeping arrangements failed to provide a fit for purpose system that ensured patient information was maintained correctly. Trust and Local Authority staff failed to adhere to best practice professional record keeping guidance. These two failures in combination contributed to the poor overall management of Mr. X's case.***

12.1.11. Adherence to Local and National Policy and Procedure

12.1.11.1. Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."*[409] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

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

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 12.1.13. below.

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

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

12.1.11.2. Findings

Quality of Local Policies and Procedures

The clinical and practice policies and procedures of both the Trust and the Local Authority were of an excellent standard. They were evidence-based and provided a high degree of clarity setting out explicitly key roles regarding corporate, team and individual responsibilities.

Non Adherence Issues

It was evident that despite a robust mandatory training and development programme, staff from the Trust and the Local Authority had poor levels of understanding regarding:

- policy and procedure content;
- general roles and responsibilities for day-to-day policy implementation;

- personal and professional accountability;
- service user and carer rights;
- specific Trust and practitioner obligations regarding duties of care which have a basis in national best practice and statutory guidance.

The local policies and procedures that most witnesses interviewed by this Investigation struggled to articulate were those pertaining to:

- record keeping;
- the Care Programme Approach (CPA);
- clinical risk assessment;
- carer assessment;
- safeguarding vulnerable adults;
- clinical supervision.

The Independent Investigation Team found that there was an underlying culture that led to staff maintaining a passive stance to their roles and responsibilities regarding policy and protocol adherence. At interview many witnesses appeared to be genuinely surprised that they had a specific duty of care to adhere to Trust policy guidance. When pushed further, few witnesses had any recognition that local best practice guidance related directly to national best policy practice guidance, to which both they and their employing statutory agencies had a duty to comply with.

Adherence to National Best Practice Guidelines

It was evident to the Independent Investigation Team that the best practice guidance produced by the National Institute of Health and Clinical Excellence (NICE) was not routinely incorporated into day-to-day clinical practice and decision making processes for Mr. X. This can be seen clearly when examining the medication and treatment regimen prescribed for Mr. X which did not reflect national best practice extant at the time.

Another observation that can be made is one relating to the use of language. It was evident that terms such as ‘Enhanced’ CPA and Protection of Vulnerable Adults (POVA) had been superseded in the national lexicon some years previously. However the staff of both the Trust

and the Local Authority adhered to an 'old style' vocabulary for day-to-day usage which is illustrative of the fact that many staff were not in step with national policy change.

12.1.11.3. Conclusions

Most staff of all grades and disciplines when interviewed as part of this Investigation could not describe what either their individual or collective roles and responsibilities were in relation to Trust and Local Authority policy and procedure. Neither could most witnesses understand even at this stage, following a Coroner's Inquest and an internal investigation report, that the care and treatment provided to Mr. X did not adhere to the specified care pathway as set out in agreed local policy and procedure documentation and that this constituted poor practice. The Independent Investigation Team was at a loss to understand how such a strong and ingrained lack of understanding could still prevail. This is an issue that both the Trust and the Local Authority must address as a matter of urgency in order to ensure the continued health, wellbeing and safety of other service users.

- ***Contributory Factor Eleven. Failure on the part of the Trust, the Local Authority and each individual practitioner involved to adhere to policy guidance made a significant contribution to the failure to manage Mr. X's case in an evidence-based and professional manner to the detriment of his health, safety and wellbeing.***

12.1.12. Management of the Care and Treatment of Mr. X

This subsection serves to examine the overall impact of the care and treatment Mr. X received upon his mental health and continued wellbeing. This subsection also serves to summarise the clinical findings set out in subsections 12.1.1. -12.1.11. above.

12.1.12.1. Findings

Care and Treatment

Subsections 12.1.1.-12.1.11. set out the main issues that were pertinent to the quality of the care and treatment that Mr. X received from the 5 Boroughs Partnership NHS Foundation Trust and Wigan Local Authority. When examining these issues the Independent Investigation Team had to consider whether or not there was a direct causal link between the

quality of the care and treatment that Mr. X received and the subsequent deaths of Mr. X and his wife.

Patient Factors

Mr. X was not understood in the context of his psychiatric history. This history is still unclear due to the poor quality and reliability of the extant clinical record and the fact that few clinical witnesses could remember anything about Mr. X prior to December 2008.

Mr. X was described by witnesses as being a stubborn person who would reject services if his privacy was being compromised. It would appear however that Mr. X was not actually rejecting of services per se but only in the manner of delivery. It is a fact that Mr. X sought help and support on many occasions and remained engaged with services the majority of the time.

It is not easy to understand why so many witnesses to this Investigation could not remember Mr. X, or why those that could, did not portray any more than a most rudimentary picture of him. It is evident that the treating teams that worked with Mr. X did not build up a therapeutic relationship with him in any meaningful sense. This ensured that Mr. X remained an unknown quantity.

Organisational Factors

Services Involved and Care Pathway

Mr. X was allocated to the Hindley and Ince Adult CMHT on, or around, the 13 October 2008. At the point of referral on the 29 September 2008 Mr. X had been initially allocated to the Golborne Older Persons' CMHT. The clinical record provides, and witnesses to this Investigation gave, two reasons why Mr. X was moved from one team to the other. The first was that the Older Persons' CMHT could not find a doctor to assess him, the second was that Mr. X may have been best placed with the Adult CMHT because his problems appeared to have been functional rather than organic in nature. Whilst the discussion went on as to where Mr. X should be placed the Home Treatment and Crisis Resolution Team was called upon to monitor Mr. X and this team worked alongside both the Older Persons' and Adult CMHTs.

In November 2008 Mr. X was admitted to Holdenbrook Ward which was an inpatient facility for older people with functional disorders. Consultant Psychiatrist 2, who was an adult

psychiatrist, had no beds on this ward and had no routine clinical links with it. Once again witnesses to this investigation gave four different reasons as to why Mr. X was placed there when the continuity of his care would be compromised. They were as follows:

- there were no beds on the adult ward where Consultant Psychiatrist 2 had her beds and that the plan was to transfer him as soon as a bed was available;
- Mr. X was over 65 therefore he would have been routinely admitted to Holdenbrook Ward;
- Mr. X would not have been best placed on an adult acute admission ward because he may have found it too noisy and alarming;
- the service provided was an 'ageless' service and patients would be admitted according to their clinical need and not their chronological age.

Within a six-week period Mr. X had been passed from the Older Persons' CMHT to the Home Treatment and Crisis Resolution Team and then onto the Adult CMHT. Confusingly for the first three weeks following his referral all three teams appeared to be working with Mr. X at the same time. At the point of his admission to Holdenbrook Ward Mr. X found himself back within an Older Persons' service whilst remaining an allocated patient with the Adult CMHT. There were significant issues regarding his continuity of care in that all day-to-day assessment, care and treatment was provided from an entirely different team to that responsible for his ongoing CPA, diagnostic and treatment programme.

During Mr. X's time on Holdenbrook Ward it was recorded that there were difficulties in getting the Care Coordinator onto the ward for ward rounds. There appeared to have been little consistent dialogue between ward nursing staff and Care Coordinator 1 until early 2009, some six weeks following Mr. X's admission.

Care Coordinator 1 completed an Intervention Summary Form on the 16 January 2009. This was the first direct recorded input that she had had with Mr. X regarding any kind of assessment process since the time of his admission. It is interesting to note that the information on the form is different to that previously prepared on the ward by the Named Nurse. For example Mr. X was designated as being "*Non* CPA" instead of Enhanced CPA. Plans were detailed on the form, such as psychological therapy inputs, but there is no evidence to suggest that they were ever pursued.

At the point of Mr. X's discharge a meeting was held on the 25 February 2009 between the treating teams of both Mr. and Mrs. X. It is unfortunate that the discussion that took place at this meeting was not recorded. At no stage was it ever considered that both Mr. and Mrs. X ought to have been treated by the same team, thereby ensuring a seamless package of care. The option of transferring Mr. X to the Older Persons' CMHT should have been an open option and one that should have been considered at:

- the point of the couple's discharge in March 2009;
- when Care Coordinator 1 left and could not be replaced;
- when Mr. X's mental health began to break down in the summer of 2009 and both CMHTs had to decide whether or not an intervention needed to be considered.

It would appear that Mr. X's allocation to any particular team was not as the result of following a set care pathway or through undertaking an assessment of the patient. The care pathway that Mr. X undertook could not be clearly defined by any member of the treating team that was interviewed by this Investigation and appeared to have been followed in an ad hoc manner that may not have always been in the best interests of Mr. X.

Team Working and Staffing Levels

Between 29 September 2008 and September 2009 staffing levels appeared to have been a major factor in determining the care and treatment pathway that Mr. X underwent. Staffing issues were evident on several occasions and are set out below.

- At the point of referral by the GP in September 2008 no Psychiatrist could be found from the Older Person's CMHT to conduct an initial assessment of Mr. X. This may ultimately have led to his referral being passed onto the Adult CMHT. The Internal Investigation Review Team was told by witnesses that the Golborne Older Persons' CMHT was under significant pressure. This pressure was so intense that, for example, there was no capacity left to undertake safeguarding investigations when required. Witnesses also stated that the Older Persons' CMHT Workers had to cover for the Central Duty Team. This practice put more pressure on the workers. The reason put forward by the Internal Review Team was that the Local Authority had not filled staff vacancies. Once again this may have been a contributory factor when placing Mr. X with the Adult CMHT. His placement may have been largely due to team resourcing issues rather than clinical need.

- On the 8 October 2008 Mr. X was supposed to have been admitted onto Holdenbrook Ward. The ward could not find a doctor to process the admission and this caused a significant delay. This delay unsettled Mr. X who demanded to be taken home. The admission did not happen and Mr. X was taken home where his mental health continued to deteriorate for another four weeks until he reached crisis point.
- At the end of January 2009 Mr. X had an adverse reaction to his Propranolol. It was recorded that the ward could not find a doctor to come out and see Mr. X who was confused and acting in a bizarre manner. Mr. X was not managed in an optimum manner at this point.410 It would appear that some five different doctors made inputs over a five day period from both the adult and older persons' teams. Mr. X was alternatively described as having:
    - a reaction to his Propranolol;
    - a reaction to his Aripiprazole;
    - a psychotic episode that required the prescription of Haloperidol.

  Mr. X's medical management appeared to have been fragmented and new medications were prescribed without an understanding being reached of what was causing his 'psychotic episode'.
- In May 2009 Care Coordinator 1 left the employ of the Local Authority. From this point forward Mr. X had no Care Coordinator. As he was still designated as being on Enhanced CPA a new Care Coordinator should have been allocated with immediate effect. It is unclear whether this was not done because it was deemed not to be necessary or because there was no capacity within the team.
- In June 2009 Consultant Psychiatrist 2 left the Trust. It is unclear which Consultant Psychiatrist took over Mr. X's case following this event. When Mr. X was seen in the Outpatient Clinic on the 2 June 2009 it was by a Staff Grade Doctor and a Duty Worker. This particular doctor was not asked to see Mr. X again even once his mental health had begun to deteriorate in August 2009.
- The care and treatment of both Mr. and Mrs. X, following their discharge in March 2009, appears to have been placed largely in the hands of unqualified workers. These workers whilst able to provide ongoing support into the home should not have been deployed to undertake assessments. When concerns were raised about Mr. X's mental health in August 2009 the assessment was in effect conducted by two unqualified

410. Mr. X Vol. 11 P.645

workers, one from the Older Persons' CMHT and one from the Adult Team. It was evident that whilst their inputs may have been well meaning the Workers did not have either the skill or experience to undertake an assessment of Mr. X's mental health.

Clinical Leadership and Supervision

The Internal Investigation Review Team was told by witnesses that clinical supervision was undertaken on an ad hoc basis and was not conducted in keeping with Trust Policy guidance. Caseloads were not examined in supervision on a regular basis and the discussions that did tale place were not documented. It was also noted that during the period between March and September 2009 "the Older Persons' Community Mental Health Team practitioners were covering duties for missing staff for on average one and a half days per week. This could be more during sick/leave period. This was in addition to their [designated] casework."411 It would appear that workforce pressures prevented clinical leadership and supervision processes from being effective.

Clinical Process, Practice and Systems

Report subsections 12.1.1.-12.1.11 have examined in detail the quality and effectiveness of the care and treatment that Mr. X received. At each stage of a service user's progression through a clinical pathway certain interventions are to be expected. These are:

- diagnostic formulation;
- assessment of risk;
- assessment of care and treatment need;
- care and risk management planning;
- care and treatment implementation;
- monitoring and review.

In order to ensure that the interventions listed above are implemented statutory agencies providing secondary mental health care services are expected to ensure that the following processes, protocols, resources and systems are in place. These are:

- clinical records management systems;
- clinical record keeping protocols;
- risk assessment policies and protocols;

411. Trust Internal Investigation Report P. 24

- Care Programme Approach policies and protocols;
- Safeguarding Vulnerable Adult policies and protocols;
- medicines management policies and protocols;
- a workforce with both the capacity and capability to carry out core functions;
- clinical supervision and staff training opportunities.

It is not possible to make generalisations about an organisation when examining systems and functions viewed through the lens of a single case. However it was evident to the Independent Investigation Team that for a twelve-month period of time, regardless of which treating team Mr. X received his care and treatment from, significant departures were made from the care pathway as set out in extant Trust and Local Authority policy and procedure. It was also evident that underpinning protocols and systems failed to either support or ensure the effectiveness of patient care delivery.

12.1.12.2. Conclusions

It would appear that a 'Swiss Cheese Model' of issues lined up in chronological sequence. The 'Swiss Cheese Model' describes a situation when:

"every step in a process has the potential for failure, to varying degrees. The ideal system is analogous to a stack of slices of Swiss cheese. Consider the holes to be opportunities for a process to fail, and each of the slices as 'defensive layers' in the process. An error may allow a problem to pass through a hole in one layer, but in the next layer the holes are in different places, and the problem should be caught. Each layer is a defence against potential error impacting the outcome… For a catastrophic error to occur, the holes need to align for each step in the process allowing all defences to be defeated and resulting in an error."[412]

Care and Treatment

The Independent Investigation Team identified six major failings in the delivery of the care and treatment Mr. X received. Each of these individual failings were sufficient on their own to have made a significant negative impact upon the effectiveness of the care and treatment provided. When these failings are examined together it can be seen that they combined in such a way as to cause an incremental chain of events that led to Mr. X's mental state not

412 . http://patientsafetyed.duhs.duke.edu/module_e/swiss_cheese.html

being assessed, monitored, managed or treated appropriately to the ultimate detriment of the health, safety and wellbeing of both him and his wife.

First. It was the conclusion of the Independent Investigation Team that Mr. X's case was managed poorly from a time that predated the GP referral in September 2008. The co-mingling of his clinical information with that of other service users of the same name brought about an untenable situation whereby Mr. X's psychiatric history was irretrievably muddled. Had any member of the treating team read carefully through the historic clinical information then it would probably have been made obvious to them what had occurred. This was not done. Instead erroneous diagnostic formulations were duplicated in Mr. X's record between September 2008 and September 2009 as assumptions were made based on false information.

Second. It would have been good practice for Consultant Psychiatrist 2 and her team to have assessed Mr. X in the light of his current presentation and to have developed a diagnostic formulation. It would appear that this process was never completed and that Mr. X was repeatedly assessed based on what was thought to have been known about him from previous episodes of care. For example, when Mr. X had an apparent adverse drug reaction in January 2009, the prevailing view was that he had experienced a psychotic episode, rather than a bout of delirium that was drug induced. It is probable that the previous history that was thought to exist may have 'coloured' clinical opinion. Following five months as an inpatient, at the point of Mr. X's discharge in March 2009, several different diagnoses were still being documented within his clinical record and no definitive diagnostic formulation had been developed. At no stage was Mr. X's significant alcohol consumption considered as being the cause for some of his paranoid thinking.

Third. The medication and treatment offered to Mr. X was not optimal. Medication was used to allay his anxiety, treat his paranoia and ameliorate his depression. When one pharmaceutical appeared not to work another appeared to have been prescribed leading to different medications being layered one upon the other. For example, at one stage in January 2009, Mr. X was prescribed Diazepam, Propranolol and sleeping medication, all at the same time, in order to alleviate with his anxiety. It was apparent that this was not considered to be a short-term response in order to manage an acute episode. It is a fact that Mr. X was prescribed Diazepam for a nine-month period, something which would normally be contraindicated. It was evident that Mr. X required other kinds of interventions for his

anxiety, such as those advocated by the NICE guidelines. At one stage Psychology inputs were suggested and Mr. X was recorded as being agreeable to this. Nothing appears to have been done to expedite this and Mr. X did not receive this treatment.

Mr. X was described as being psychotic and paranoid. However the aetiology of this was never ascertained. Mr. X did express views that the world was against him and that people talked about him behind his back. This was most definitely a sign of paranoid thinking, but evidence of a psychosis being present was possibly a little thin. The previous diagnoses in his historical clinical record may have served to have predisposed the interpretation of the thoughts Mr. X expressed. Once again it would have been good practice to have provided a therapeutic intervention such as Cognitive Behaviour Therapy. This kind of approach is also advocated by the NICE guidance. Instead the treatment response was to prescribe Risperidone, and for a period of one month Haloperidol at the same time, to manage Mr. X's condition. It has to be said that as Mr. X was often non adherent to his medication regimen this was a treatment option that was not necessarily going to offer a long-term solution to his problems once he returned to living in the community.

Mr. X self medicated by consuming a significant amount of alcohol as a means of coping. The only intervention offered for his alcohol misuse was to be told to cut back. This was not an appropriate manner in which to address an identified problem which may have ultimately been a major factor in his paranoid thinking.

In short, medication was prescribed without a full understanding of the problems that it was supposed to affect due to the fact that Mr. X's case did not receive a robust diagnostic formation.

Fourth. Mr. X was not considered in the light of his full risk as he was never properly assessed. From examination of the extant clinical record it would appear that Mr. X had Risk Screens conducted (form 3a from the Trust risk policy). However, even though he was designated as being on Enhanced CPA a full risk assessment (form 3b from the Trust risk policy) was never utilised. This ensured that the risk profile generated of Mr. X was generally of a tick box nature. His risk was not assessed in a holistic manner and no risk management plans were developed in order to mitigate against the problems that had been identified. This left both Mr. X and his wife in vulnerable situation.

Fifth. The Care Programme Approach (CPA) failed to work for Mr. X. CPA is intended to ensure that service users are assessed, managed, monitored and reviewed on a regular basis. CPA should also ensure that an individual's care is coordinated by the ever-present interventions of the designated Care Coordinator. From examining the clinical records and interviewing witnesses it became apparent to the Independent Investigation Team that CPA was not implemented in its true sense. Practitioners confused activity with meaningful engagement. Mr. X was designated as being on Enhanced CPA and as such should have received a total package of care in keeping with the extant Trust policy. This was not achieved. It is a fact that for the last three months of his life Mr. X had no Care Coordinator and his CPA had basically ceased to exist.

Mr. X had a series of needs which made his presentation complex. Mr. X had poor physical health. It was assumed that this was largely a somatic presentation, but had the secondary care mental health team contacted the GP it would have been understood that Mr. X had several genuine physical health problems that he was being treated for. Mr. X had a history of depression and anxiety. Care plans were often developed to support his mental health problems, however these plans were weak for two reasons. The first being that the plans focused upon Mr. X trying to remain positive (which was unrealistic), and the second being that the support identified as being required in the plans was never provided (for example Psychology input). Mr. X had difficulties with some basic activities of daily living. He had never had to be independent in this regard as his wife had always looked after the household management. Following the couple's discharge in March 2009 the onus fell upon Mr. X to manage the home which he found extremely difficult to do. Mr. X was the main carer for his wife who suffered from dementia. Whilst it was recognised that he would require a care plan for this, one was never developed.

In short, Mr. X had many problems which required active intervention and support. Frustratingly the problems were identified on a regular basis, but care plans remained rudimentary in nature, and most tellingly were not implemented. This ensured that Mr. X's problems persisted and he was left largely to fall back on his own limited resources to manage them, which he could not do. Mr. X was not assessed, managed, monitored or reviewed in accordance with either Trust policy or national best practice guidance. CPA failed to operate.

Sixth. Mr. X was the main carer for his wife. He met the threshold for a carer assessment. It has long been recognised that both the mental and physical health of long-term carers can be severely compromised. Mr. X had physical and mental health problems of long-standing which pre-dated his wife's dementia. Prior to his wife becoming ill she had in effect been the carer for Mr. X. Mr. X wanted to return home with his wife. It was good practice to support the couple in meeting their wishes in this regard. It was however poor practice not to have provided a robust care plan and ongoing support to Mr. X in order to maintain the couple's health, safety and wellbeing.

Policy, Protocol and System

The Trust had robust policies and protocols in place at the time Mr. X was receiving his care and treatment from the Trust and Local Authority services. It was apparent however that these policies and protocols were not adhered to, to the detriment of the care and treatment Mr. X received. It would appear that the reasons for this were equally divided between cultural and systems factors.

Systems

It was apparent that the Community Mental Health Teams were under significant pressures caused by a depleted workforce. This ensured that essential safety nets of care, such as the Care Programme Approach and clinical supervision were not operating in an optimal manner.

It was also evident that Trust audit programmes were not sensitive enough, and were also being reviewed during the summer of 2009 and thereby out of commission, which meant that failures to adhere to Trust policy and procedure were not detected and consequently could not be addressed. This was of particular note regarding the Trust clinical risk assessment and management policy.

It is a fact that many care and service delivery problems Trusts encounter fall into the 'sub-audit' blind spot. These kinds of things include the basic building blocks of care that are often considered to be so fundamental to practice that they are not a routine part of the audit process. These kinds of things include: taking a psychiatric history; conducting a diagnostic formulation; building up a therapeutic rapport with a service user; ensuring that a person-centric stance is taken. The fact that these basic building blocks of care are not usually the subject of audit underlines the importance of clinical supervision processes which is where

these kinds of things should routinely be discussed. When both audit and clinical supervision fail to be part of clinical practice serious shortfall in care can go undetected. This situation is exacerbated when the workforce is stretched to the point that training and development opportunities are curtailed.

Culture

The witnesses that gave evidence to this Investigation found it difficult to articulate even the most fundamental parts of either Trust and/or Local Authority policy. Some witnesses claimed to have never received any kind of Trust clinical risk assessment training for example, even though the Trust records demonstrate that there is a sound compliance with this kind of event. What was apparent was a complete lack of professional curiosity about either Trust or Local Authority policy. Some of the witnesses had recently been called to the Coroner's Inquest, but had obviously not taken any steps to increase their knowledge and reflect upon their practice in a constructive manner following the feedback from this. Neither was there any evidence to suggest that witnesses had read through the internal investigation report and reflected upon what changes needed to occur at both a team and individual practitioner basis.

It would be usual for practitioners, who have so recently been called to account for the care and treatment they had provided, to be *au fait* with both the case and Trust policy and procedure prior to being interviewed by an Independent Investigation Team. Especially as each witness had been advised prior to the interview to prepare themselves in this manner. At interview not only could most witnesses recall nothing about the case, they could not articulate basic Trust Policy and procedure and did not know what was in the Trust internal investigation report. The Independent Investigation Team found this continued lack of professional curiosity and engagement with the process of serious concern as it was seen as being reflective of a culture where the understanding of individual practitioner accountability was low and would continue to place patient care at risk.

Corporate Learning. Whilst the Trust and Local Authority policies and processes were of an excellent standard, and were in fact amongst the best the Health and Social Care Advisory Service had ever seen, adherence to them was poor. Trusts should be mindful that audits need to ascertain both policy adherence, and also the quality of that adherence, which should also address some of the basic building blocks of care 'sub audit' blind spots.

Trusts should ensure that practitioners are able to attend all mandatory Trust training and development events, and clinical supervision should be a mandatory safety net of care that ensures best practice is both supported and delivered.

Team Learning. Team Managers have a distinct role in the delivery of effective and safe care and treatment. This task can be difficult and the challenges ever present. Whilst it is commendable to attempt to do 'whatever it takes' to ensure services are delivered, shortcuts to essential policy guidance should never be allowed to occur. It is quite usual for teams to become 'embattled' and to take a 'heads down' approach. When this occurs activity is often mistaken for meaningful engagement. Team Managers have a professional accountability to ensure that any serious deficits in the service are reported up with immediate effect and for capacity issues, and any short-term plans to manage them, are documented and agreed. Shortcuts in clinical best practice should never be seen as a means of managing capacity issues, especially when undertaken in an *ad hoc* manner.

Individual Learning. All health and Social Care Workers, qualified or unqualified, have a distinct duty of care which is either covered in their contract of employment, and/or by their registering body. This duty of care is specified in all Trust and Local Authority clinical polices. It is made explicit that Team Managers have a duty to ensure that all staff are aware of the requirements of each policy and procedure, and that all staff have a duty to adhere to them. Staff employed by either the Trust, or the Local , should always take responsibility for their own learning and have an explicit duty of care at all times to act in a knowledgeable manner in the best interests of the health, safety and wellbeing of service users. A passive engagement with the full expectations of an individual practitioner's role can never be condoned and is entirely unacceptable.

Summary

There were serious failures regarding the way in which care and treatment was provided to Mr. X. These failures were both significant and comprehensive in nature to the extent that the management of the case was severely compromised to the ultimate detriment of Mr. X's health, safety and wellbeing. Clinical decisions were not made based upon the best information available to the treating team at any one time. It would appear that Mr. X was never understood as an individual and he had poor levels of assessment, care planning and treatment throughout the last 12 months of his life. It is the conclusion of the Independent

Investigation Team that significant omissions in the management of his care and treatment allowed his mental health to deteriorate to the point where he reached crisis point. Her Majesty's Coroner stated that *"at the time of his death he was under the care of a Community Mental Health Team. He was not appropriately monitored and his risk of harm to himself and other was not appropriately assessed. He took his own life whilst the balance of his mind was disturbed by an undiagnosed mental illness."*[413]

The treating teams of neither Mr. nor Mrs. X could have been expected to have foreseen the deaths of the couple. However based on what was known about the couple at the time, particularly as Mr. X's mental state began to deteriorate in August 2009, an incident of some kind was foreseeable, even if the magnitude of it was not. Whilst the deaths of Mr. and Mrs. X may not have been predictable they were, in the view of the Independent Investigation Team, preventable. The Independent Investigation Team concluded that the treating teams involved had the knowledge, the opportunity, and the means to intervene in August 2009. Had steps been taken to prevent Mr. X's state of crisis it is highly probable that the events of September 2009 that led to the deaths of Mr. and Mrs. X would not have occurred.

- ***Causal Factor One. The failure to assess, monitor, manage and support Mr. X in the community in the summer of 2009 led to his reaching a point of crisis which ultimately led to the deaths of both him and his wife. The treating teams had the knowledge, the opportunity and the means to intervene but did not do so.***

12.1.13. Clinical Governance and Performance (to include clinical supervision, professional leadership and organisational change)

12.1.13.1. Context

"*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish*".[414]

413. Trust Coroner Correspondence
414 Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

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

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

The CQC conducted a Compliance Review at the 5 Boroughs Foundation NHS Trust in November and December 2011. These reviews focused upon the quality of inpatient care and treatment. These reviews found:

- levels of patient engagement were poor;
- person-centred planning was not being fully implemented into the work of the unit;
- there was a reactive style of working with patients with little evidence of learning from incidents in order to reducing the likelihood of them occurring again;
- the quality of recording was also not always robust enough to measure and use in future planning.

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the deaths of Mr. and Mrs. X. The issues that have been set out below are those which have relevance to the care and treatment that Mr. and Mrs. X received. The Issues highlighted in the CQC report as set out above concur with the findings of this report.

12.1.13.2. Findings

5 Boroughs Partnership NHS Foundation Trust Clinical Governance Systems

(The following has been taken from the Trust 2011 Annual General Meeting Report).

Clinical Risk and Clinical Governance Committee

Linking closely with the Audit Committee, the Clinical Risk and Clinical Governance Committee assures the Board that appropriate structures, systems and processes are embedded in the organisation to manage patient safety and clinical risk and ensure that services are continuously improving. This includes ensuring appropriate actions are taken to address any deviation from accepted standards and informing the Board of any significant lapses. It also ensures that learning occurs as a result of risk analysis and feedback to services. The Committee provides assurance that:

- The Trust has effective systems to monitor the level of compliance with relevant safety legislation, policy and national implementation guidance. It will ensure that processes are in place for managing and responding to the recommendations arising from external agency visits, inspections and accreditations.
- Regular, ongoing internal analysis of Serious and Untoward Incidents (SUIs), complaints, compliments and claims occurs and that the Trust can demonstrate lessons learnt from these through service improvement.
- There is provision of a forum for service users' and carers' representatives, Chair of the staff-side committee and Executive and Non-Executive Directors to seek evidence of clear lines of accountability and management of the risks associated with meeting the requirements of the Annual Health Check and key safety recommendations in respect of service users, carers, staff and clinical governance and clinical risk.
- There is oversight of the Trust's annual clinical audit programme and ensure that outcomes result in service improvement.
- Trust policies are formally ratified with the exception of accounting policies which are ratified by the Audit Committee.
- It receives reports by exception as well as relevant action plans and annual reports as agreed in the annual work plan, from the groups that have a statutory requirement to report directly to the Committee.[415]

Risk Management

The Trust Risk Management Strategy sets out the overall aims and objectives for Risk Management. These are delivered through an annual work plan set against each of the objectives. The Risk Management Strategy is supported by the Risk Management Policy which describes a clear structured and systematic approach to the management of risk across

415. Trust 2011 AGM Report P. 19

organisational, financial and clinical activities. The Risk Management Policy sets out both the collective responsibilities of the Trust Board and its Committees and the individual responsibilities of the Chief Executive, Directors and all levels of staff across the Trust. The Trust Audit Committee seeks assurance that the risk management process is comprehensive, effective, complies with regulatory requirements and is fit for purpose by taking independent objective advice through the appointment of internal auditors. It also approves the Annual Governance Statement.

Risk Management Strategy

The overall aim of the Risk Management Strategy is to ensure that high-quality healthcare services are delivered with the safety, health and well-being of services users, carers and staff at the forefront of everything that the Trust does and to provide assurance through clear reporting structures that the Risk Management system across the Trust is embedded and effective. The Trust is committed to ensuring the safety of service users, staff and the public through an integrated approach to managing risk, whether financial, organisational or clinical, within systems that are open and transparent and demonstrate sound governance. The Risk Management Strategy is approved by the Trust Management Team annually and is supported by the Risk Management Policy and Incident Management Policy, which set out the framework and methodology for effective risk and incident management across the Trust. The Risk Management Strategy is linked and supports other Trust strategies – specifically the Falls Prevention, Lessons Learned, Safeguarding Children and the Learning and Development Strategies.

Risk Management Process

The Trust's Risk Management Policy has adopted the overarching process for managing all risk within a single framework. The Risk Management Policy details the framework for identification, evaluation, analysis, treatment, control, monitoring and review of risks within a single Trust-wide Risk Register.

The Risk Management Policy clearly describes the process for authority to manage risk within the Trust with low-level risk being managed locally and high-level risk escalated to the Trust Management Team and reported to the Trust Board.[416]

416. Trust 2011 AGM Report P. 22

The Trust Board receives bimonthly reports on the current status and management of all risks within the Trust. Directors attending the Trust Operational Performance Team meetings review high-level risks monthly and in further detail at the Clinical Governance and Clinical Risk Committee, which is a sub-committee of the Trust Board. Risk movement and control is monitored monthly at the Trust Operational Performance Management meetings, where accountabilities for risk control, and risk movement are discussed. The operational groups for managing risk are the Trust Management Team (Quality) and the Corporate Quality, Performance and Risk Forum, which receives a monthly Safety and Quality Metrics Report. 'System of Internal Control and Risks to the Trust's Strategic Objectives' are managed by a System of Internal Control. The System of Internal Control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives.

The System of Internal Control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives (via the Assurance Framework).
- Evaluate the likelihood of those risks being realised and the impact should they be realised and manage them efficiently, effectively and economically. Maintaining and reviewing Systems of Internal Control throughout the Trust is monitored through the Trust Board, its sub-committees and through an effective governance structure.

The Assurance Framework

The Trust regards the Assurance Framework as an essential element of the management of risk within the Trust. The Assurance Framework is integrated into the overarching risk management framework. The Assurance Framework provides key evidence to support the Annual Governance Statement. The Trust Board approves the Assurance Framework and receives bi-monthly reports detailing progress against risk control and assurance for the delivery of objectives. The Trust's Leadership Forum is the accountable and responsible group for monitoring and critical review of the Assurance Framework.

Progress against key targets is discussed at each meeting. The Internal Audit Plan is developed based on the risks identified in the Assurance Framework, providing the Trust Board and Audit Committee with assurance on internal controls that are in place.[417]

Wigan Local Authority Governance Systems

At the time of writing this report Wigan Local Authority was unable to provide any information to the Independent Investigation Team regarding governance systems. The Wigan Local Authority website contains no easily accessible information and this Investigation was not able to gather sufficient data to make any comment here. The Independent Investigation Team made numerous requests, both face-to-face and in writing, for this information to be sent so that it could be included in this report. The Independent Investigation Team is disappointed to note that this vital area of public interest cannot be examined.

Clinical Supervision

National Context

There has been a growing interest in and awareness of the importance of clinical supervision in all health and social care professions over the past two decades, particularly in mental health professions. There are guidance documents from registration and professional organisations [418] which stress the importance of supervision for clinical governance, quality improvement, staff development and maintaining standards.

The NHS Management Executive defined clinical supervision in 1993 as:

'...a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations.'[419]

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

417. Trust 2011 AGM Report P. 23
418. Nursing and Midwifery Council. (2008) Clinical supervision for registered nurses
419. Nursing and Midwifery Council, Advice Sheet C. (2006)

5 Boroughs Partnership NHS Trust Clinical Supervision Policy (2008)

The Trust policy that was in place at the time Mr. and Mrs. X were receiving their care and treatment from the Trust incorporated supervision arrangements for all health and social care disciplines including, doctors, which is good practice. The policy also defined the differences between clinical supervision, caseload supervision and management supervision.

All Trust health and social care workers were required to have protected time allocated to them so that both clinical and management supervision could take place. Team managers were responsible for auditing the process and reporting the findings to the associate Director of Nursing.

The policy set out a variety of supervision models that could be used by Trust staff and stated that it would support an individual practitioner's preferred choice whenever possible. The requirements for the regularity of clinical supervision for professionals was as follows:

- **Doctors.** Senior House Officers and Specialist Registrars were identified as requiring one hour of 'indirect' supervision each week by the Consultant when audit and case management would be discussed. 'Direct' supervision would take place in ward round, Outpatient Clinics, Case Conferences and multidisciplinary team meetings. Supervision was statutory for doctors of this grade. Staff Grade and Speciality and Associate Specialist Doctors did not have to receive statutory supervision, but is recommended as being 'desirable'. Appraisal was required once a year. Consultant Psychiatrists were required to have an annual appraisal.
- **Nurses and their Support Workers.** No recommended intervals of regularity were advised. It was noted that nurses could decide upon the model that they preferred and that clinical supervision was not a statutory requirement.
- **Social Workers and their Support Workers (not working in childrens' services).** The policy stated that operational and professional supervision would have to be managed separately and did not specify the requirement for regularity in the policy.

Management supervision was identified as being a requirement for *all* Trust employees. The purpose was described as ensuring:

- *"That work is being carried out according to job descriptions, competencies, person specifications and Trust policies and procedures.*

- *Individuals receive feedback on their performance and positive support. This will include caseload management for some groups of staff.*
- *Ensure that development and training opportunities are being accessed from the objectives agreed in the supervisee's personal development plan and KSF post outline.*
- *To consider and review individual's work programme and delegate work as appropriate.*
- *Promotion of a healthy life/work balance will also be encouraged in line with the Improving Working Lives standard."*[420]

It was recorded that:

"Sessions should:

- *Be planned and arranged 12 months in advance, the performance appraisal session and half yearly review should be agreed at the same time.*
- *Held on a monthly basis or more frequently if deemed appropriate by the Supervisor in specific circumstances.*
- *Last 1 to 1.5 hours as appropriate.*
- *Be structured and recorded using the standard templates.*
- *Adequate time should be allocated for preparation for both Supervisor/Supervisee to review previous supervision notes and obtain necessary information, for example OTTER.*
- *The manager who provides the supervision will be responsible for maintaining supervision records.*
- *All supervision records should be signed by both parties.*
- *A copy will be retained on supervisee's personal file and a copy also given to the supervisee."*[421]

Clinical Supervision Practice for the Golborne and Hindley and Ince CMHTs 2008-2009

The Trust/Local Authority Internal Investigation Review Team found that clinical and managerial supervision processes failed to operate well during the time that Mr. and Mrs. X were receiving their care and treatment. The evidence suggested that supervision arrangements were *ad hoc*. This was considered to have impacted negatively on the amount

420. Trust Clinical Supervision Policy (2008) P.48
421. Trust Clinical Supervision Policy (2008) P. 49

of caseload supervision that occurred and the degree of scrutiny that managers could provide regarding policy and procedure adherence. The reason for poor levels of supervision during this period was given as being due to staff shortages. The Older Persons' CMHT staff in particular were having to cover duties for missing workers for on average one and a half days each. Pressures would be increased even further when having to cover for staff sickness and annual leave.

The Independent Investigation Team concurred with these findings. The evidence was that some kind of 'supervision' occurred, but in an informal manner. Witnesses to this Investigation stated that team communication was frequent about both Mr. X and Mrs. X within the respective teams caring for them. Much of this discussion was on an anecdotal level as both teams were located in the same building and team members had frequent informal contact. This may have led to a false sense of security about the understanding and level of intervention appropriate to the case. However the conversations and clinical discussions, whilst regular and supportive for the staff involved, could not be described as formal supervision. Staff appear to have confused clinical discussions and team update meetings with actual supervision sessions. It was evident to the Independent Investigation that supervision was not conducted within the teams providing care and treatment to Mr. and Mrs. X in accordance with Trust policy.

Leadership Roles

Professional leadership relationships, roles and functions were not clear when examining the case of Mr. and Mrs. X. Whilst teams appeared to discuss the caseload, escalation of difficult or problematic cases did not seem to occur. A loose arrangement appeared to be in place in 2008 and 2009 which relied upon each individual practitioner's perception of when challenges needed to be escalated and advice sought. It was apparent when witnesses met with the Independent Investigation Team at interview that there was a poor understanding of what constituted a clinical or service leader. Whilst people understood the role of a manager, it was less easy for individuals to articulate the roles and responsibilities of Care Coordinators and Responsible Clinicians. There was a high degree of blurring between the roles of unqualified and qualified staff which meant that workers were often deployed to conduct tasks they were not appropriately best placed to do.

12.1.13.3. Conclusions

It must be remembered that no matter how sophisticated a clinical governance system may be, it needs to be sensitive enough to assure the most simple aspects of the delivery of care and treatment. These basic building blocks of care form the foundation upon which services are provided. The 5 Boroughs Partnership NHS Foundation Trust has a fit for purpose clinical governance framework. However when examining the case of Mr. and Mrs. X it did not appear to have been sensitive enough to either detect or address significant departures from best practice guidance.

It was known that Wigan-based services had considerable workforce pressures during 2008 and 2009. These pressures appear to have led to a virtual cessation in supervision and a departure from local and national best practice policy guidance, which went unnoticed.

- ***Contributory Factor Twelve. Trust and Local Authority governance systems were not sensitive enough to pick up the degree of policy non adherence that occurred in the cases of both Mr. and Mrs. X. This made a significant contribution to the poor overall quality of the care and treatment that was delivered to the couple.***

12.2. The Care and Treatment of Mrs. X

N.B In order to avoid repetition the reader is asked to refer to the relevant context subsections set out above pertaining to the care and treatment for Mr. X as they contain the same information pertaining to the care and treatment of Mrs. X.

12.2.1. Diagnosis, Clinical Assessment, Medication and Treatment

12.2.1. 1. Context

Lewy Body Dementia

There is a wide body of information available about Lewy Body dementia. *"There is considerable overlap between Lewy body dementia and two other disorders: Alzheimer's disease and Parkinson's disease. In Lewy body dementia, patients experience a loss of dopamine-producing nerve cells similar to that seen in Parkinson's disease. They also lose acetylcholine-producing nerve cells, similar to what occurs in Alzheimer's disease. Patients*

with Lewy body dementia often experience cognitive problems associated with Alzheimer's disease, such as memory loss, spatial impairment and language difficulties. They may also develop Parkinsonian symptoms, such as muscle rigidity, a blank facial expression, soft voice, tremor, poor balance and gait disturbances… People with Lewy body dementia also tend to show marked fluctuations in their cognitive functioning, often several times a day. In addition, they tend to fall asleep easily during the day and have restless, disturbed sleep with behavioural acting out."[422]

Key clinical features of Lewy Body dementia are visual hallucinations and visuospatial difficulties. Sufferers may have difficulty in initiating movement, have a stiffening of the limbs, and may be unsteady on their feet, being prone to falls. Other key features include difficulties with concentration and memory. Sufferers may also become easily confused and distracted, this can fluctuate wildly and they may also experience night waking. Being a carer for a person with Lewy Body dementia becomes a fulltime task that can be both challenging and distressing.

12.2.1.2. Findings

Summary of Events

Mrs. X had been treated by her GP for *"nervous tension," "panic attacks"* and depression since 1975.[423] On the 23 February 2006 Mrs. X was referred by her GP to the Memory Clinic as she had been experiencing memory loss.[424] On the 26 April 2006 Mrs. X was seen in the Memory Clinic by Consultant Psychiatrist 1 who referred Mrs. X for a neuro-psychological assessment. It was noted that Mrs. X had been very stressed by her husband and Consultant Psychiatrist 1 wanted to understand whether the memory problems and cognitive impairment were due to Alzheimer's Disease or anxiety and depression. Mrs. X was encouraged to continue taking the Sertraline 100mg (an antidepressant) that her GP had been prescribing.[425] On the 12 May 2006 Consultant Psychiatrist 1 wrote to Mrs. X's GP. He had reviewed Mrs. X in the Outpatient Clinic with her friend in attendance. The diagnosis was *"?early dementia ?anxiety and depression".* The Consultant asked the GP to conduct a physical examination and wrote that he would be referring Mrs. X for a CT scan. The plan was to follow her up in four-months time in the Outpatient Clinic. Mrs. X explained that her memory was poor and

422. johnshopkinshealthalerts
423.Mrs. X GP Record PP. 5, 9 and 35-36
424. Mrs. X GP Record P. 178
425. Mrs. X Vol. 5 P. 257

that her husband irritated her.[426] Mrs. X did not wish her husband know any details about the consultation or her diagnosis.

On the 23 August 2006 Mrs. X was reviewed in the Outpatient Clinic and Consultant Psychiatrist 1 wrote to the GP to say that the diagnosis was *"? anxiety and depression ?early dementia".* The management plan was to increase the Sertraline from 100mg to 150mg once daily. The Psychiatrist planned to follow Mrs. X up in the Outpatient Clinic again in three-months time. Mrs. X appeared to have improved a little since May. She continued to be distressed caring for her husband who was noted as having a Bipolar Affective Disorder. During the consultation she became *"weepy and was very tearful"* She denied any thoughts of suicide or self harm.[427] It is important to note that Mr. X's diagnosis had been erroneously assigned to him at this stage and this information had been passed on incorrectly from the GP to Consultant Psychiatrist 1.

On the 5 June 2007 Consultant Psychiatrist 1 wrote to the GP to say that Mrs. X had not been attending her Outpatient appointments.[428] On the 29 August 2007 Consultant Psychiatrist 1 wrote to the GP to say that Mr. X had telephoned to say that his wife did not need any further appointments as she was fine. The GP was asked to refer Mrs. X back to if it became necessary.[429] It is important to note that at this stage Mr. X apparently did not know what was wrong with his wife.

In January 2008 the GP wrote that Mrs. X had marital problems. Mrs. X had reported that her husband was depressed and verbally abusive, not physically violent, but he shouted at her and broke her things.[430] In February 2008 the GP had a chat with Mrs. X about her husband's controlling attitude. She was encouraged to stay in contact with her female friends and get out more.[431]

By the summer of 2008 Mrs. X's situation had not improved. The GP wrote on the 7 August that Mrs. X presented with a blunted affect and had difficult home circumstances due to her husband's Bipolar Disorder. It was recorded that she was less able to cope and was

426. Mrs. X Vol. 5. PP. 258-261
427. Mrs. X GP Records PP.147-148
428. Mrs. X GP Records P. 146
429. Mrs. X GP Record P. 163
430.Mrs. X GP Record P. 178
431.Mrs. X GP Record P.178

forgetful.[432] On the 18 August the GP wrote that Mrs. X was upset because her husband *"still had a bad temper not physically violent, but breaking things & shouts and swears".*[433]

On the 3 September 2008 Mrs. X visited the GP once again. On this occasion Mrs. X was described as being shaky and wanting something to calm her down. She was referred for guided self help.

The next interaction that Mrs. X had with services was on the 2 October 2008. At this stage the Wigan Central Duty Team reviewed Mrs. X's case. It is unclear from the extant record how Mrs. X came to be referred. The Central Duty Team Contact Form stated that an incident had occurred on the 1 October at 15.03 hours. Mrs. X told services that Mr. X had been hitting her *"from time to time"* over the past eight years when he lost his temper. It was known that by this time she had left the marital home and was living with her son.[434]

There would appear to have been no further action taken by services. On the 8 October 2008 Mrs. X's son telephoned the Central Duty Office on the advice of Claire House who had told him someone would come and *"see his mum within two days".* The son had not been able to go to work for three weeks since his mother had come to live with him because she could not be left on her own. He was worried about losing his home if he could not work.[435]

On the 9 October 2008 a worker from the Golborne Older Persons' CMHT received an immediate referral from the Central Duty Team. Mrs. X's son had telephoned to say that he could no longer cope with his mother. A call was made to Lakelands Residential Care Home to see if a bed was available. An 'Initial Core Assessment' was conducted. It was recorded that Mrs. X had been assessed as being an immediate referral due to an incident of abuse and the fact that her son could not continue to cope as her carer. Mrs. X was too frightened to return home as her husband was there. The son refused a care package to be brought into his home to care for his mother as he did not want to be her carer. The son was however prepared to keep his mother at home until a suitable place could be found for her.[436] Mrs. X was assessed on a Risk Screen at this point as being vulnerable.

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432. Mrs. X GP Record P. 177
433.Mrs. X GP Record P. 177
434. Mrs. X Vol. 2 PP. 92-94
435. Mrs. X Vol. 2 PP. 98-100
436. Mrs. X Vol. 2 P. 82 and Mrs. X Vol. 3. PP. 146-153

On the 15 October 2008 it was decided that Mrs. X should be found a bed at Lakelands Residential Care Home for respite for a two-week period. The Doctor conducted a Mini Mental State Examination. The score was 14/30. Mrs. X was disorientated and her memory was poor. The opinion was that Mrs. X probably had *"a dementia syndrome, suggestive of underlying Alzheimer's Disease".* A CT brain scan was indicated and "*medication for dementia"* was prescribed (Duloxetine 60 mg once daily and Donepezil 5 mg once daily). A bilateral tremor was noted in her arms and a referral for a neurology appointment was made. The plan was to commence Mrs. X on a cholinesterase inhibitor.[437] Care plans were developed to address Mrs. X's memory problems, tremors, anxiety and social isolation. A crisis plan was also developed. [438]

It is not recorded exactly when Mrs. X was admitted to Lakelands Residential Home. However Care Coordinator 2 visited Mrs. X there on the 7 November 2008. Plans for the future were discussed and a request for an Occupational Therapy assessment was made.[439]

In November 2008 the POVA took place (see subsection 12.2.4 below).

No further entries relating to assessment, care and treatment were made until the 20 January 2009. On this date a CPA review took place it was deemed that no changes needed to made to her care plans.[440] Mrs. X saw Consultant Psychiatrist 1 who wrote that the MRI scan showed *"deep white matter changes, probably related to small vessel disease".* Mrs. X's cognitive deficits remained unaltered. She had been started on Galantamine (difficult to specify when exactly from reading the clinical record), and had initially experienced side effects. However it was decided to increase the Galantamine as she had been stable on it for some time with no further side effects detected. The referral to the Neurologist was yet to take place to investigate her tremor. The plan was to review her at the Outpatient Clinic in six-months time.[441]

437. Mrs. X Vol. 3 PP. 111-117
438. Mrs. X Vol. 3. PP. 136-145
439. Mrs. X Vol. 2 PP. 76 and 95-96
440. Mrs. X Vol. 1 P. 6
441. GP Records P. 154

On the 2 February Care Coordinator 2 assessed Mrs. X was assessed as being anxious and wanting to return home. Mrs. X recognised that she did not want to live on her own and that she would need help and support.[442]

On the 17 February 2009 Mrs. X was assessed by an Occupational Therapist. Mrs. X wanted to return home, but not on her own. On the 19 February it was determined that Mrs. X had the capacity to make the decision to return home (see subsection 12.2.3. below). A discharge planning meeting was arranged for the 25 February 2009 to take place between the treating teams of both Mr. and Mrs. X. The outcomes of this meeting were not recorded and no care plans appear to have been developed.[443]

On the 27 February 2009 a letter was sent to Mrs. X stating that an Outpatient appointment had been arranged at the Thomas Linacre Centre for the 28 April 2009 with the Consultant in Neurology.[444]

On the 2 March 2009 it was noted that Mrs. X had been struggling to look after herself prior to her admission to Lakelands. It was stated that Mrs. X would require *"intense"* support once she returned home.[445]

Mrs. X returned to live at her home on the 17 March. Her husband was on leave from Holdenbrook Ward and joined her there. Anchor (a social care provider) was due to deliver a care package into the home and this was due to commence the following day. The Occupational Therapist was to carry out an assessment of Mrs. X.[446] This assessment was conducted on the 24 March when it was identified that the couple may struggle to look after themselves.[447]

It was discovered on the 9 April 2009 that the incorrect amount of Donepezil had been prescribed to Mrs. X (20mg instead of 5mg daily). The GP was notified of this and blister

442. Mrs. X Vol. 3. PP. 127-128
443. Mrs. X Vol. 2 PP. 89-91
444. Mrs. X Vol. 1 P. 8
445. Mrs. X Vol. 3 PP. 120-123
446. Mrs. X Vol. 1 P. 47
447. Mrs. X Vol. 3 PP. 118-119

pack medication was prescribed from this time forward.[448] It was however noted that on the 17 April 2009 that Mrs. X had not been taking her medication.[449]

On the 28 April 2009 the Neurologist saw Mrs. X who was accompanied by a Support Worker. Unfortunately she did not bring her medication with her and it was not possible for the Neurologist to know whether she had commenced cholinesterase inhibitors. He agreed that she had *"dementia syndrome".* Due to her reported visual hallucinations the Doctor thought she may have Lewy Body Dementia and Parkinson's Disease was also queried.[450]
On the 7 May 2009 it was noted once again that Mrs. X had not been taking some of her medication.[451] However three days later it was recorded that Mrs. X was taking all of her medication once again.

Between May and 13 July 2009 Mrs. X was visited by her Support Worker, Care Coordinator 2 and the Occupational Therapist on a regular basis (the reader is referred to the chronology in section 10 of this report). On the 13 July Mr. X made an urgent request for Care Coordinator 2 to contact him as his wife was unwell. Care Coordinator 2 was out of the office so the CMHT Review officer visited Mrs. X and then called for an ambulance. Mrs. X was admitted to Orrell Ward where she was treated for a urinary tract infection and dehydration. She was seriously ill with systemic sepsis.[452]

Mrs. X was discharged from hospital on the 21 July. From this time on she continued in good physical health. However she was frequently described as being dishevelled, *"edgy"* and *""feeling terrified and nervous when he's [Mr. X] angry".*[453] No further formal assessment took place between her discharge and the time of death in September 2009.

12.2.1.3. Conclusions

Diagnosis

The Independent Investigation Team concluded that the diagnoses Mrs. X was assigned were based on sound formulations. However whilst Alzheimer's Disease and Lewy Body Dementia are similar in presentation there are significant differences.

448. Mrs. X Vol. 1 P. 41
449. Mrs. X Vol. 1 P. 42
450. Mrs. X GP Records P. 164 and Mrs. X Vol. 1 P. 37
451. Mrs. X Vol. 1 P. 36
452. Mrs. X Vol. 1 P. 27
453. Mrs. X Vol. 1 P. 14 and Mrs. X Vol. 1 P. 22

It was evident that whilst Mr. X was given a leaflet to help him understand his wife's Alzheimer's Disease prior to their discharge home, he was not given fresh advice once the Neurologist had reviewed Mrs. X's diagnosis in April 2009. People with Lewy Body Dementia can suffer from extraordinarily vivid and detailed visual hallucinations. This can make the management of a person in their own home extremely challenging. Whilst it was recorded by the Neurologist that this was a significant feature of Mrs. X's presentation there was no mention of it elsewhere in the clinical record, and no consideration made as to how this feature would impact upon Mr. X's ability to care for his wife at home. It was known that Mrs. X was often confused, given to shouting outbursts, and accusing her husband of breaking and hiding her things. If she was also experiencing visual hallucinations then she would have been severely disorientated at times and even more challenging to manage in the home.

People with Lewy Body Dementia are also prone to falling. The initial assault that was alleged to have taken place in the autumn of 2008 was described by Mr. X as being a misunderstanding when they couple had had a tussle and Mrs. X fell. Another feature of Lewy Body Dementia is shaking and difficulties with initiating movement, both of which are mentioned in the clinical record as being things Mrs. X was troubled with. For example, on the 6 July 2009 Mrs. X was described as being *"edgy"* and unable to move.[454] Once again this feature of the diagnosis which was also part of Mrs. X's presentation did not appear to have been understood by the treating team in the context of her diagnosis and the additional support both Mrs. And Mrs. X would require in the home.

To summarise: the clinical features of Lewy Body Dementia and the challenges they would present when caring for Mrs. X in her home did not appear to be understood by her treating team. This may have impacted negatively on the ability of both Mr. X and CMHT workers to care for her effectively.

Assessment

Mrs. X had psychiatric, neurological, occupational therapy and nursing assessments conducted. This was good practice. However it is difficult to ascertain how the neurology assessment of April 2009 was actually used to inform the development of Mrs. X's care and

454. Mrs. X Vol. 1 P. 18

treatment package. The Occupational Therapy assessments were frequent and thorough, however once again it is difficult to understand how the significant deficits, which were identified with the couple's functioning, were actually mitigated against as the care plans in the extant clinical record were not explicit in setting out how this was to be achieved.

Nursing assessments were part of the CPA process. The main weakness identified is that these assessments do not appear to have taken place in a dynamic manner as response to clinical need, do not appear to have informed care plans, and do not appear to have always been recorded appropriately. These assessments are examined in the CPA subsection 12.2.2. below.

Medication and Treatment

The medication that Mrs. X was prescribed was in keeping with best practice guidelines. However more attention should have been taken with regard to medicines management. It was evident to both treating teams that Mr. X was often not adherent to his medication regimen. It was also known that Mrs. X did not always take her medication as prescribed, which led her to missing doses on frequent occasions. A care plan was indicated to ensure that this aspect of her care and treatment was managed more effectively. This was of particular importance as the person who acted as Mrs. X's main carer could not be relied upon, for whatever reason, to ensure she took her medication.

Summary

On the whole Mrs. X received an appropriate level of care and treatment with regards to diagnosis and medication. However a more coherent response was required in the formulation of a care and treatment package to address the needs identified/indicated as a result of both the neurology and occupational therapy assessments.

12.2.2. Care Programme Approach (Care Planning and Care Coordination)

12.2.2.1. Findings

On the 9 October 2008 Mrs. X was designated as being on Enhanced CPA.[455] On the 14 October 2008 Mrs. X was allocated a Care Coordinator from the Golborne Older Persons'

455. Mrs. X Vol. 4. PP. 154-156

CMHT.[456] The Trust 2008 CPA policy stated that a Care Coordinator should be allocated within 72 hours of a service user being accepted onto Enhanced CPA.[457]

Care Coordinator 2 commenced the CPA assessment on the 15 October 2008. This initial assessment provided a comprehensive overview of Mrs. X's situation. The Care Coordinator was able to involve both Mrs. X and her son in the process. This was good practice.[458] The resulting care plans that were developed at this stage sought to address Mrs. X's problems regarding:

- memory loss;
- anxiety;
- marital separation;
- accommodation;
- social isolation.

A crisis plan was also developed. The assessment was conducted, and the care plans developed, well within the time requirement as set out in the Trust policy guidance in operation at the time. Whilst it was evident that Mrs. X was not able to contribute fully it was evident that she had been involved as much as possible with the process. This was also good practice.[459]

Between the middle of October 2008 and 20 January 2009 few entries were recorded by Care Coordinator 2. It would appear that the Care Coordinator visited Mrs. X either at her home or at Lakelands on six occasions during this time. It is unclear how the care plans that had been developed for Mrs. X were being implemented or monitored as this was not recorded in the clinical record. On the 20 January 2009 a CPA review took place. There is only a single page extant in the clinical record, it was documented that the care plan did not require any changes to be made. Mrs. X's level of need was identified as being *"critical".*[460]

On the 2 February 2009 it was recorded that Mrs. X had decided that she wanted to return home.[461] On the 17 February Mrs. X was assessed in her home by an Occupational Therapist

456. Mrs. X Vol. 1 P. 3
457.Trust Effective Care Coordination Policy and Procedures 2008. PP.23-25
458. Mrs. X Vol. 3 PP. 111-117
459. Mrs. X Vol. 3. PP. 136-145
460. Mrs. X Vol. 1 P. 6
461. Mrs. X Vol. 3. PP. 127-128

and Care Coordinator 2.[462] On the 25 February a meeting was held between the treating teams of both Mr. and Mrs. X. The Independent Investigation Team was told that the apparent purpose of this meeting was to plan for the couple's discharge. Unfortunately no record was made of this meeting and the decisions that were made. Witnesses' recollections were poor and so it is not possible to know what approach was decided upon. It is a fact that no joint care or management plan was developed to ensure the couple were discharged in a coherent manner. It was also apparent that no carer assessment was offered to Mr. X.

Mrs. X was discharged from Lakelands Residential Home on the 17 March 2009. There is no extant record to suggest that a discharge CPA review was conducted in order to assess Mrs. X's needs and to ensure that new care plans were developed to manage them. This should have been arranged prior to Mrs. X being sent back home. Trust policy required service users to have a seven-day follow up after being discharged. It may have been interpreted by the Care Coordinator that this was only required following an inpatient admission, however it would have been good practice for Mrs. X to have been formally followed up in this manner given her history, vulnerability and levels of need. There is no documentation to suggest that this occurred.

Between the 17 March and the 2 April 2009 the couple were visited by workers from the Golborne Older Persons' CMHT on three occasions. One of these visits was conducted by an Occupational Therapist who assessed that the couple may struggle to look after themselves.[463] On the 2 April Care Coordinator 2 received a telephone call to say that Mr. X had cancelled the social care package provided by Anchor (this provided support to his wife with bathing etc.) as he thought he could manage on his own.[464]

Care Coordinator 2 visited Mrs. X on the 6 April and recorded that she appeared to be well, even though her husband was not. Mr. X denied this saying that he only had bowel problems and needed to have his driving license back. On the 9 April a significant drug error had been reported regarding Mrs. X's medication. At this juncture it would appear that a CPA review was indicated for the following reasons:

- it had been identified by the Occupational Therapist that the couple were going to struggle to look after themselves;

462. Mrs. X Vol. 2 P. 59
463. Mrs. X Vol. 3 PP. 118-119
464. Mrs. X Vol. 2 PP. 84- 88

- Mr. X had cancelled the social care package;
- Mr. X had been described as not being very well by his wife;
- Mrs. X had been on the receiving end of a significant drug error.

No review took place and it does not appear that any workers from the Golborne Older Persons' CMHT visited Mrs. X again until the 17 April.

On the 28 April Mrs. X was seen by the Neurologist who diagnosed Lewy Body Dementia. At this stage it would have been good practice to have reviewed the care plan and to have offered Mr. X a carer assessment and care plan in the light of any specific challenges that were now identified in the context of Mrs. X's new diagnosis. This was not done.

Throughout May 2009 it was apparent that Mrs. X was becoming increasingly worried about her husband's health and behaviour. Mrs. X expressed her concerns about her husband on the 7, 8, 14, 18 May and on the 3 June. At this stage it would have been reasonable to have expected the Care Coordinator to have reviewed the situation and to have contacted the Hindley and Ince Adult CMHT. This was not done.[465]

On the 24 June Care Coordinator 2 visited Mrs. X and noted that she looked unkempt. Mr. X seemed to be preoccupied about his driving license. The plan was that Care Coordinator 2 would discuss Mrs. X with Consultant Psychiatrist 1. There is no record of this discussion having taken place.[466]

In July 2009 Mrs. X became seriously ill and had to be admitted into hospital with systemic sepsis. This had been caused by dehydration and a severe urinary tract infection. Mrs. X was in hospital for a week. When she was discharged on the 21 July the Anchor social care package had been reinstated. By the 29 July there appeared to be problems with the social care package. Mrs. X was described as being dishevelled, and Mr. X was described as struggling to cope with his wife's illness.[467] On the 4 August Mr. X cancelled the social care package because his wife did not like being bathed by strangers.[468] It was decided that CMHT workers would bathe Mrs. X until something else could be sorted out. By this stage it was

465. Mrs. X Vol. 1 PP. 24-36
466. Mrs. X Vol. 1 P. 29
467. Mrs. X Vol. 1 P. 22
468. Mrs. X Vol. 1 P. 21

evident that a full CPA review was required for both Mr. and Mrs. X as they were not able to cope. This was not arranged.

On the 11 August 2009 Mr. and Mrs X attended a CPA review with Consultant Psychiatrist 1 and Care Coordinator 2 present. It was noted that Mr. X's mental health could fluctuate and that CMHT support would continue to be needed for Mrs. X.[469] The care plans were rudimentary in the extreme and did not address in any depth the problems that the couple had been facing since March 2009. It was noted that Mrs. X was stable and that Mr. X was coping with inputs from the Older Persons' CMHT. It was noted that Mrs. X had been reminded to drink plenty of fluids following her hospital admission of the previous July.[470]

From this point forward Mr. X's mental health deteriorated rapidly. Mr. X made two attempts to contact his CMHT in order to get help. This was not forthcoming in the manner that he needed. Throughout the rest of August concerns were raised by his wife's treating team about Mr. X's mental health and the effect that this could have on Mrs. X. Care Coordinator 2 requested that the Hindley and Ince Adult CMHT assessed Mr. X. This was conducted by unqualified workers who thought he was fine. Care Coordinator 2 had to go on annual leave. The risk and CPA review documentation which was commenced on the 11 August was completed on the 28 August before she left.

Mrs. X was seen on the 2 September by an unqualified Support Worker who reported that Mr. X may have caused an injury to his wife. The plan was to discuss this with the Care Coordinator when she returned from annual leave (16 September) and to visit Mrs. X again on the 23 September 2009. Mr. and Mrs. X were found dead on the 10 September 2009.

12.2.2.2. Conclusions

Role of the Care Coordinator

The Care Programme Approach (CPA) should ensure that service users in the community do not fall through the safety net of care. CPA should provide ongoing assessment, care planning and case management. A Care Coordinator should communicate and liaise with agencies as required and to ensure that service user and carer needs are both identified and addressed.

469. Mr. X Vol. 8 PP. 459-461
470. Mrs. X Vol. 4. PP. 166-168

Activity alone should not be mistaken for meaningful engagement. It was evident that workers from the Golborne Older Persons' CMHT made regular visits to Mrs. X, however visits alone should not be mistaken for CPA provision. It is a common mistake for practitioners to confuse the role of Care Coordinator with that of a Community Psychiatric Nurse or Social Worker. It is common for practitioners to 'play to their professional strengths' and focus upon specific professional inputs. The role of the Care Coordinator has to go beyond this. In the case of Mrs. X it did not.

It was evident during several stages between March and September 2009 that Mrs. X required a full CPA review as it was obvious that neither Mr. nor Mrs. X were thriving in the community. Concerns about Mr. X's mental health should have been formally raised with the Hindley and Ince Adult CMHT and joint CPA review conducted so that care could be jointly planned and managed.

It is difficult to understand how workers from the Golborne Older Persons' CMHT could record, following almost every visit to the home, that Mr. X was struggling and that his wife was worried, anxious and at times terrified, and do nothing. It appears that workers were too focused upon helping Mrs. X go to the hairdressers and bathe to look more deeply into the dynamic that was developing between the couple. From an examination of the clinical record a steady escalation is evident. The Care Coordinator role should have been focusing on this dynamic and escalation in order to manage the situation.

CPA in General

When Mrs. X was first allocated to the Golborne Older Persons' CMHT and to Care Coordinator 2 a good initial assessment was conducted and care plans developed which could be identified as good practice. However it is difficult to understand how those care plans were actually implemented, monitored and reviewed.

CPA reviews were conducted however these became fairly superficial affairs over time and no changes were made to the care plans even though Mrs. X's situation continued to change. The fundamental error seems to have occurred with the thinking behind the CPA review process. Each review identified that Mrs. X had a set of needs which did not appear to change, however this was missing the point. Whilst her basic needs remained fairly consistent (her memory loss, social isolation, activity of daily living needs) her care giving context did

not. It was naïve in the extreme not to have amended Mrs. X's care plans in the light of the changes that occurred to her place of residence and the issues regarding her carer. This made her fairly straightforward needs complex. The care plans should have reflected this. The care plans that were developed in October 2008 were no longer fit for purpose in March 2009, and could be regarded as totally inadequate by August 2009. In particular, reliance on Mr X as the main carer for his wife was unrealistic and took no account of the mental health difficulties he was experiencing. In keeping with the Trust CPA policy extant during 2008 and 2009 an assessment review and care planning revision should have taken place whenever clinically indicated. This activity should have been considered:

- when Mrs. X was initially placed at Lakelands Residential Home;
- during the discharge planning process in February 2009;
- prior to Mrs. X leaving Lakelands in March 2009;
- following the initial break down in the social care package in April 2009;
- following her admission into hospital in July 2009;
- as a response to the rapid deterioration in her husband's mental health in August 2009.

Communication with Other Agencies

It is a key function of CPA to ensure all necessary agencies are liaised with on a regular basis. The social care package delivered by Anchor broke down on two occasions to the detriment of the support that was provided to the couple. It was evident that neither Mr. nor Mrs. X were happy with the service that they were receiving. The Care Coordinator did not seek to examine this with Anchor, but instead accepted that the couple had declined services. A more assertive approach should have been taken to try and work though the issues. The cancellation of services should have raised concerns and prompted a review of the care plan, and should have revived concerns about Safeguarding issues.

Witnesses when interviewed by the Independent Investigation Team were adamant that their key responsibilities were to Mrs. X and not to Mr. X. it was evident that they did not think it was part of their function to monitor his health and provide support to him. This is clearly erroneous thinking. A key function of CPA is to provide support to carers and to monitor their ongoing health and wellbeing needs. The Care Coordinator should have liaised with the Hindley and Ince Adult CMHT to have arranged a joint CPA review in the interests of the

health and wellbeing of both service users. The needs of neither patient could be considered in isolation, and the care for one should not have been planned without consideration of the impact of this on the other.

The crisis and contingency planning for Mrs. X were weak. These plans were not revised in accordance with her changing situation and the plans that may have been adequate in October 2008 could not be so considered in March 2009. It is not evident how the GP was communicated with as to any role that primary care should have in the maintenance of the couple in their home.

Summary

The CPA that Mrs. X received did not provide the safety net under her care to the level that should have been expected. Care Coordination was confused with care giving. It is a key function of CPA to provide assessment and care planning to both service users and carers and for all necessary agencies to be liaised with on a regular basis. Had CPA been managed in accordance with Trust policy expectation then both Mr. and Mrs. X would have been assessed, monitored and reviewed in a more coordinated manner and the interventions that had become increasingly necessary would most probably have been identified and provided.

It would appear that the Golborne Older Persons' CMHT did not understand how to work with CPA or what was expected of either Care Coordinators or the wider team in this regard. It was evident that Trust policy was not adhered to except in the most rudimentary manner. The Independent Investigation Team could find no evidence to suggest that CMHT workers had read the CPA policy or understood their obligations to it. The failure to adhere to this policy made a significant contribution to the failure to monitor and support Mrs. X in the manner that both her diagnosis and circumstances required.

12.2.3. Mental Capacity

12.2.3.1. Context (please refer to subsection 12.1.7.1. above for a full context section)

Adult safeguarding is not set in primary legislation in the same way as in children's safeguarding. The statutory guidance provides a framework for organisations to use in order to work with individuals who are vulnerable to, or experiencing, abuse. At the heart of this process is the consent of the individual to work with the agencies to find ways to protect

themselves. One of the most important considerations, therefore, is the mental capacity of the vulnerable person to give this consent.

In the case of an individual without mental capacity, the decision making is clearly defined in line with the Mental Capacity Act (2005).[471] This Act came into force in October 2007, in order to give time for organisations to train their personnel to understand and use it effectively.

Under the Mental Capacity Act a person is presumed to make their own decisions *"unless all practical steps to help him (or her) to make a decision have been taken without success".* Incapacity is not based on the ability to make a wise or sensible decision.

In the case of an individual who lacks capacity to keep themselves safe, a best interest's decision can be made which may enable staff, in an extreme situation, to facilitate removal of the individual from harm.

It is much more problematic when the vulnerable individual has capacity to make decisions but refuses to take action to keep themselves safe.

There is no formal action that public sector staff can take in these circumstances other than to maintain structured contact in order to leave open the option for the individual to change their mind. If a crime has been committed, the Police can pursue an investigation of the alleged perpetrator but often, this does not progress into the criminal justice system due to the unwillingness of the victim to participate.

The additional law that must always be considered in these circumstances is the Human Rights Act.[472] Article 8, in essence, states;

1. Everyone has the right to his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the

471. Mental Capacity Act (2005) Chapter 9, Part One: *Persons Who Lack Capacity*, HMSO, 4/2005 305602 19585
472. Human Rights Act (2000) Article 8, The right to respect for private and family life

prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

This Article means that public authorities cannot intervene in the lives of individuals where they have capacity and are making unwise choices, unless there is a crime being committed or the issue is impacting on the lives of others.
The Mental Capacity Act 2005 has the following five key principles:

- A presumption of capacity: every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- The right for individuals to be supported to make their own decisions: people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
- That individuals must retain the right to make what might be seen as eccentric or unwise decisions.
- Best interests: anything done for or on behalf of people without capacity must be in their best interests.
- Least restrictive intervention: anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

12.2.3.2. Findings

It is not the role of the Independent Investigation Team to assess whether or not Mrs. X had capacity. The role is instead to understand what processes were deployed by the Trust/Local Authority staff in determining her capacity and to assess their appropriateness.

It would appear that between October 2008 and September 2009 Mrs. X was judged to have full mental capacity. This was however at odds with key decisions made on her behalf and without her consultation in the autumn of 2009. The first being to not continue with the Police investigation into her husband's alleged assault (this decision was made by her son), and the second to place her in Lakelands Residential Home (this decision was made by the CMHT).

On the 20 February 2009 an entry was made in Mrs. X's clinical record to say that *"[Mrs. X] has the capacity to make her own decisions."*[473] No other documentation was completed. This assessment had been made in order to determine her capacity regarding her decision to return to her home. The Independent Investigation Team was told by witnesses when interviewed that staff were both skilled and experienced in assessing capacity. However when the staff who conducted the assessment were interviewed it was evident that they had not:

- read the Mental Capacity Act (2005);
- read the Trust/Local Authority Policy;
- attended the Trust/Local Authority training;
- known which paper work to complete.

It was evident that when interviewing witnesses they held in their minds a 'notion' of what mental capacity was, but did not in actual fact know what it meant. This fundamental lack of knowledge on the part of assessors is sufficient to cast serious doubt on the validity of any assessment that was made regarding Mrs. X's capacity to make her decision to return home.

It was recorded that Mrs. X was:

- confused;
- disorientated;
- suffering from short term memory loss;
- suffering from dementia;
- alleged to have suffered a history of domestic violence;
- unable to manage her activities of daily living needs independently;
- socially isolated and would be dependent on her return home on her alleged abuser.

Based on what was known about Mrs. X it was evident that she was highly vulnerable and would remain so as her condition was such that a general deterioration would inevitably ensue. If Mrs. X did indeed have capacity then she would nevertheless require a robust and detailed care plan in order to ensure her continued health, safety and wellbeing. Care plans were not developed in a sufficiently robust manner to ensure this.

473. Mrs. X Vol. 2 PP. 89-91

12.2.3.2. Conclusions

The Independent Investigation Team concluded that the mental capacity assessment was not conducted in an appropriate manner in keeping with the requirements of the Act. If Mrs. X did indeed have capacity then her vulnerability was such as to require robust and ongoing monitoring and review arrangements. These were not put into place to the extent required.

The assessment of capacity should not be seen as being a 'once only' task. Service users with a degenerative disease of the brain, which affects cognition and judgement, should be assessed on a regular basis. It would have been reasonable for Mrs. X to have been assessed on a regular basis either when her ability to cope in the home was deteriorating, or her presentation indicated a worsening of her mental state. It must be remembered that Lewy Body Dementia does not always present in the same manner as Alzheimer's Disease. Patients with Lewy Body Dementia can have a widely fluctuating presentation. Individuals can have periods of lucidity *or* confusion. It is essential to assess individuals with this kind of disorder over a period of time in order to ensure that a correct impression regarding mental capacity is reached. It would appear that the worker who undertook the capacity assessment of Mrs. X in February 2009 did not know her that well.

It is the conclusion of the Independent Investigation Team that this aspect of Mrs. X's care and treatment was managed poorly and was not in keeping with either local or national policy best practice expectation.

12.2.4. Safeguarding Vulnerable Adults

Please see subsection 12.2.7.1. above for context information regarding safeguarding.

12.2.4.1. Findings

The following chronology outlines key events relating to safeguarding issues, Mrs. X's vulnerability and capacity between 20 April 2006 and September 2009. The list is long, but it serves to illustrate well that a great deal of ongoing concern had been recorded about this couple, and that safeguarding concerns were not of a transient nature.

- **1998:** Mrs. X visited her GP and stated that her husband's mental health was poor and that as a result she was tense and not able to sleep.[474]

474.Mrs. X GP Record P. 28

- **6 November 1998:** Mr. X was seen at an emergency outpatient clinic. It was noted that according to Mrs. X she sometimes became afraid of him because he "*becomes verbally aggressive and has pushed her around frequently"*.[475]
- **20 April 2006:** Mrs. X was seen at the Memory Clinic by Consultant Psychiatrist 1 who referred Mrs. X for a neuro-psychological assessment. It was noted that Mrs. X had been very stressed by her husband and Consultant Psychiatrist 1 wanted to understand whether the memory problems and cognitive impairment were due to Alzheimer's Disease or anxiety and depression exacerbated by her husband's condition.[476]
- **29 August 2007:** Mrs. X did not attend her Outpatient appointment with Consultant Psychiatrist 1. He wrote to the GP to say that her husband had rung to say his wife did not need any further appointments as she was fine. The GP was asked to re-refer in the future if it became necessary.[477]
- **17 January 2008:** The GP wrote that there were marital problems. Mrs. X reported that her husband was depressed and verbally abusive, not physically violent, but he shouted at her and broke her things.[478]
- **11 February 2008:** The GP had a chat with Mrs. X about her husband's controlling attitude. She was encouraged to stay in contact with her female friends and get out more.[479]
- **18 August 2008:** Mrs. X visited her GP who wrote that Mrs. X was upset because her husband *"still had a bad temper not physically violent, but breaking things & shouts and swears".*[480]
- **17 September 2008:** Mr. X allegedly assaulted his wife. It remains unclear what occurred. Mrs. X claimed that her husband pushed her to the ground and punched her in the chest. Mr. X claimed that there was a tussle and she fell to the ground. He denied punching her. Mr. X was arrested by the Police on the 2 October 2008. The charges were dropped by Mrs. X at a later date, however no further clarification of what actually happened was established.
- **29-30 September 2008:** Mr. X was referred to secondary care services by his GP. During the initial assessment he said that his wife had always been very supportive of

475. Mr. X CMHT Record PP.27 and 49-50
476. Mrs. X Vol. 5 P. 257
477. Mrs. X GP Record P. 163
478. Mrs. X GP Record P. 178
479. Mrs. X GP Record P.178
480. Mrs. X GP Record P. 177

him but that in recent years Mrs. X had become less tolerant of his mental health problems. She would get angry and shout at him. She would accuse him of stealing her things, blaming him when she could not get things to work (such as the television remote control and new electric fire) and deriding him in front of her friends. Mr. X was finding the situation *"intolerable."* Mr. X was depressed about his wife leaving him and felt abandoned and socially isolated as his family would have nothing to do with him.[481]

- **2 October 2008:** the Central Team screened a referral for Mrs. X. The Central Duty Team Contact Form stated that an incident had occurred on the 1 October at 15.03 hours. There had been a report of domestic harassment by Mr. X over the telephone towards his son. Mrs. X had said that Mr. X had been hitting her *"from time to time"* over the past eight years when he lost his temper.[482]
- **3 October 2008: a** Risk Screen was conducted. It was recorded that Mr. X was vulnerable and had been subject to domestic abuse in the form of his wife accusing him of sundry things he had not done and as *"having shouting outbursts at him."* Mr. X was also identified as being at risk of self neglect.[483]
- **8 October 2008:** a 'Contact Assessment' form was completed for Mrs. X. Mrs. X's son had contacted the Central Duty Office on the advice of Claire House who had told him someone would come and *"see his mum within two days."* The son had not been able to go to work for three weeks since his mother had come to live with him because she could not be left on her own.[484]
- **8 October - 12 November 2008:** it was routinely recorded in the clinical notes that Mr. X was unkempt, had a strong body odour and was drinking heavily.
- **9 October 2008:** the Golborne Older Persons' CMHT received an immediate referral from the Central Duty Team. Mrs. X's son had telephoned to say that he could no longer cope with his mother. A call was made to Lakelands Residential Care Home to see if a bed was available. There was discussion with Mrs. X and no mental capacity assessment undertaken regarding where she wishes to live.[485]
- **14 October 2008:** a Protection of Vulnerable Adults (POVA) investigation was commenced for Mrs. X in relation to the alleged assault on her by her husband.[486]

481. Mr. X Vol. 2 PP. 23-26
482. Mrs. X Vol. 2 PP. 92-94
483. Mr. X Vol. 2 PP. 29-31
484. Mrs. X Vol. 2 PP. 98-100
485. Mrs. X Vol. 2 P. 82
486. Mrs. X Vol. 2 P. 77

- **15 October 2008:** Mrs. X was visited at her son's home. Mrs. X agreed to go to Lakelands Residential Home. It is not clear how this decision was reached or whether a mental capacity assessment had taken place. This was indicated as the right to choose where one lives is a key Human Rights Act Article 8 decision.[487]
- **22 October 2008:** Consultant Psychiatrist 1 wrote to the GP stating that Mrs. X was fearful of her husband and had significant cognitive impairment to the point where she did not know who her son was on occasions.[488]
- **Late October:** Mrs. X was admitted to Lakelands Residential Home.
- **12-13 November 2008:** Mr. X was admitted onto Holdenbrook Ward. The Risk screen that was conducted assessed him as being a risk to others (his wife, and health and social care professionals if he drank alcohol), at risk as a vulnerable adult (from his wife's verbal abuse), and at risk of self neglect.[489]
- **17 November 2008:** Mrs. X was visited by the Social Worker leading the POVA. The record notes that Mrs. X was not planning to pursue the case against her husband and that the Police had closed the case. This decision appears to have been made largely at the instigation of the son who felt that his mother could not cope with taking her husband to Court.[490] Once again it does not appear that Mrs. X's capacity was formally assessed at this stage or her views elicited.
- **10 December 2008:** it was decided that the POVA would be closed and that no case conference was required as a Protection Plan had been developed. The central premise of the plan was that Mr. and Mrs. X would never be living together again.[491]
- **27 December 2008:** the Risk Screen that was conducted assessed Mr. X as being a risk to others (his wife, and health and social care professionals if he drank alcohol), at risk as a vulnerable adult (from his wife's verbal abuse), and at risk of self neglect.[492]
- **19 January 2009:** the Risk Screen that was conducted assessed Mr. X as being a risk to others (his wife, and health and social care professionals if he drank alcohol), at risk as a vulnerable adult (from his wife's verbal abuse), and at risk of self neglect.[493]

487. Mrs. X Vol. 2 P. 80
488. Mrs. X Vol. 5. PP. 242-243
489. Mr. X Vol. 3 PP. 90-94
490. Mrs. X Vol. 2 P. 75
491. Mrs. X Vol. 2 P. 73 see also P. 254
492. Mr. X Vol. 3 PP. 78-81
493. Mr. X Vol. 3 PP. 74-76

- **3 February 2009:** a Risk Screen was conducted and Mr. X was assessed as presenting no risks to either others or to himself. Mr. X was not assessed as being at risk from vulnerability or from neglect.[494]
- **19 February 2009:** it was recorded that Mrs. X was expressing a desire to return back to her own home. It was also recorded that she had the capacity to make her own decisions.[495]
- **25 February 2009:** the treating teams of both Mr. and Mrs. X understood that the couple wanted to return home together.[496]
- **2 March 2009:** it was recorded in Mrs. X's clinical record that she remained vulnerable and that she would require an *"intense"* level of support on her return home.[497]
- **17 March 2009:** Mrs. X was discharged without a coherent, documented discharge plan.
- **24 March 2009:** an Occupational Therapy (OT) assessment was conducted in the home. It was noted that the couple may struggle to look after themselves.[498]
- **25 March 2009:** Mr. X was discharged without a coherent, documented discharge plan.
- **2 April 2009:** Mr. X cancelled the social care package because he thought he could manage alone.[499]
- **8 April 2009:** a Risk Screen was conducted for Mr. X he was assessed as being a risk to others, at risk of vulnerability and also at risk of neglect.[500]
- **22 April 2009:** Care Coordinator 1 visited Mr. X and it was recorded that he was non compliant with his medication and that he was drinking alcohol again. On the same day Care Coordinator 2 witnessed an altercation between Mr. and Mrs. X. However Mr. X gave the assurance that he would never hurt his wife, and Mrs. X said that she wished to stay in her own home with her husband.[501] [502]

494. Mr. X Vol. 11 PP. 609-611
495. Mrs. X Vol. 2 PP. 89-91
496. Mrs. X Vol. 2 P. 58
497. Mrs. X Vol. 3 PP. 120-123
498. Mrs. X Vol. 3 PP. 118-119
499. Mrs. X Vol. 2 PP. 84- 88
500. Mr. X Vol. 8 PP. 466-470
501. Mr. X Vol. 11 P. 601
502. Mrs. X Vol. 1 P. 40

- **28 April 2009:** Mrs. X was seen by a Consultant Neurologist who agreed that she had *"dementia syndrome".* Due to her reported visual hallucinations the Doctor thought she may have Lewy Body Dementia and queried Parkinson's Disease.[503]
- **7 May 2009:** it was recorded that the couple were not getting on and that Mrs. X had called her husband a bully. It is apparent that Mrs. X dementia and confusion may have been leading to a strain in the relationship.[504]
- **8 May 2009:** it was recorded that Mrs. X described her husband as being like a *"mad man."*[505]
- **18 May 2009:** Mrs. X was described a struggling to cope with her husband.[506]
- **2 June 2009:** Mr. X was seen at the Outpatient Clinic, he appeared to be well and was described as being *"very happy."*[507]
- **24 June 2009:** Care Coordinator 2 recorded Mrs. X as looking unkempt, although she also recorded that the couple appeared to be doing well.[508]
- **6 July 2009:** it was recorded by the Support Worker that Mrs. X seemed to be *"edgy"* and that Mr. X did not appear to well as he trouble with his *"water works."*[509]
- **11 July 2009:** Mrs. X was described as being a *"little on edge."*[510]
- **13 July 2009:** Mr. X contacted Care Coordinator 2 urgently as Mrs. X was ill. An ambulance was called. Mrs. X was admitted to Orrell Ward where she was treated for a Urinary Tract Infection and dehydration.[511] There were no queries regarding neglect raised at this stage.
- **21-23July 2009:** Mrs. X was discharged from hospital back to her home. A new social care package was to be provided to Mrs. X from Anchor Care, commencing on this day.[512] Mr. and Mrs. X were recorded as now accepting the need for support in the home. Mrs. X had been seriously ill with a systemic sepsis as a result of a urine infection.[513]

503. Mrs. X GP Records P. 164
504. Mrs. X Vol. 1 P. 36
505. Mrs. X Vol. 1 P. 35
506. Mrs. X Vol. 1 P. 23
507. Mr. X Vol. 11 P. 601 and GP Record P. 220
508. Mrs. X Vol. 1 P. 29
509. Mrs. X Vol. 1 P. 18
510. Mrs. X Vol. 1 P. 19
511. Mrs. X Vol. 1 P. 27
512. Mrs. X Vol. 1 P. 25
513. Mrs. X Vol. 1 P. 24

- **29 July 2009:** it was recorded that Mrs. X looked dishevelled and that Mr. X was struggling to come to terms with his wife's illness.[514]
- **4 August 2009:** Mr. X cancelled his wife's package of social care. He felt that he could give his wife her medication and that the CMHT Support Worker could bathe his wife. He was informed that this could be a temporary measure. Apparently Mrs. X had not liked strangers providing personal care to her.[515]
- **11 August 2009:** Mr. and Mrs. X were seen at the Outpatient clinic by Consultant Psychiatrist 1. It was agreed that the Golborne Older Persons' CMHT would continue to be involved as ongoing support was needed as Mr. X's mental health could fluctuate.[516]
- **17-20 August 2009:** on the 17 August Mr. X telephoned the Hindley and Ince Adult CMHT he was reported to have been *"really upset and crying"* saying that everyone was against him and that the DVLA were going to take his license from him. Mr. X could hardly talk for crying and said he could not cope. The plan was to discuss his case with the CMHT Manager. The Worker was asked to observe the condition of Mr. X's home to ascertain whether or not he was taking his medication. During the home visit it was evident that Mr. X was paranoid about his driving license. Otherwise Mr. X was deemed to have *"looked OK"* and to be taking his medication.[517] During the 19 and 20 August Mr. X continued to be agitated and Care Coordinator 2 was concerned about the effect this would have upon Mrs. X's wellbeing.[518] Mrs. X was described as being *"feeling terrified and nervous when he's angry."*[519]
- **25 August 2009:** Mrs. X appeared stable in mood although she had recently had a urine infection. Mr. X said that he did not want his wife to go back to Lakelands and would prefer her care to continue with the Older Peoples' CMHT. Mrs. X said she was happy at home. The Care Coordinator explained that she would be going on annual leave and what the support arrangements would be while she was away.[520]
- **28 August 2009:** a CPA review was conducted.

514. Mrs. X Vol. 1 P. 22
515. Mrs. X Vol. 1 P. 21
516. Mrs. X Vol. 1 P. 12
517. Mr. X Vol. 8 PP. 459-461
518. Mr. X Vol. 8 PP. 463-464
519. Mrs. X Vol. 1 P. 14
520. Mrs. X Vol. 1 P. 11

- **2 September 2009:** the Support Worker made a home visit to Mrs. X accompanied by another CMHT colleague. On this occasion it was noted that Mrs. X had what was described as a cold sore on her lip. Mrs. X said that her husband had *"done it."* On returning to the office the CMHT Manager was informed. It was decided that the Care Coordinator would be informed on her return from annual leave on the 16 September and the plan was for the Support Worker to visit again on the 23 September.[521]
- **10 September 2009:** workers from the Golborne Older Persons' CMHT had become anxious about Mrs. X as her prescription had not been picked up and the team had not been able to access to the house. Mr. and Mrs. X were found dead in their home later that day.

The first time that safeguarding issues should have been examined was in April 2006 when it was identified that Mrs. X may be suffering from dementia and that her husband's behaviour was causing her stress. As the months went by it was evident that both the Consultant and the GP knew that Mrs. X was experiencing episodes of domestic difficulty exacerbated by her failing cognition and her husband's well-established mental illness.

The second time that safeguarding issues should have been examined was between August 2007 and February 2008. By this stage Mrs. X had been diagnosed as having a dementia of some kind. Her husband had telephoned the Outpatient clinical in August 2007 and cancelled any further appointments. This was allowed to go unchallenged and no attempt appears to have been made to write to Mrs. X directly to enquire whether or not this was a decision that she was in agreement with. In the following months the GP had recorded that Mrs. X had described persistent acts of domestic abuse. It was evident that this was impacting negatively upon her mental health. It was also evident that Mrs. X had a cognitive impairment and was becoming increasingly vulnerable and unable to mange the situation on her own.

The third time that safeguarding issues should have been examined was at the point of Mrs. X's referral to the Central Duty Team on the 2 October 2008. It was recorded that Mrs. X had a deteriorating cognitive function and was a possible victim of domestic violence. A second referral was made on 8 October 2008.

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The case was formally allocated to POVA (safeguarding) on 14 October 2008 and an initial visit made on the 15 October 20. It was not until the 17 November 2008 that Mrs. X received a visit from those who were responsible for investigating the safeguarding issues. Good practice would have been to visit Mrs. X in a timelier manner in order to assess her needs in relation to her safety when the initial referral was received. The situation was clearly described as unstable and Mrs. X presented as someone who was very vulnerable. It was unclear from the extant record why there was a delay in allocating the case to safeguarding. It is possible that the team believed Mrs. X was in a 'safe place' and therefore was not a priority for them. However, timescales are present in safeguarding guidelines to ensure a prompt response to vulnerable adults at risk because, without meeting them, assumptions cannot be made about their safety.

In addition, the knowledge available to the workers from the referral, made clear that Mrs. X had significant issues in relation to her cognitive function. Statements had been made about her inability to recognise her son on occasion and her son had also stated that he could not go to work because she could not be left alone.

The workers should therefore have considered carefully whether Mrs. X required mental capacity assessments around the specific decisions she would be required to make as this would have formed a baseline for future working with this individual. It is not at all clear what Mrs. X's view was of moving to Lakelands, and given it affected her Human Rights Act Article 8 rights, it was beholden upon staff to record in full the process taken around this decision.

Following the visit to Mrs. X on 17 November 2008, it seems that a decision was reached that Mrs X was now 'safe' as she had been placed at Lakelands Residential Home and expressed the view that she would not wish to live with Mr. X again. Staff appear to have drawn the conclusion that she was therefore protected from any future harm. The case was closed without any investigation or multi-agency discussion and contingency planning for Mrs. X in the event that circumstances changed.

The decision in itself was not unreasonable given the need to prioritise workload and only follow a process when it was required. However, it was only reasonable in the context of this

episode of safeguarding forming part of an ongoing chronology for this individual. Through the interviews with Local Authority staff it became clear that each episode of safeguarding for an individual was treated independently of any other, this decision was therefore very problematic in the context of later events.

The fourth time that safeguarding issues should have been examined was on 2 February 2009. Mrs. X's son telephoned to say his mother wanted to return home. She subsequently made it clear to the Occupational Therapist on the 17 February 2009 that she did not wish to return home alone. At this stage Mr. X was also expressing the desire to go home and, as a voluntary patient, he had the right to do so whenever he chose. On 25 February 2009 Mr. and Mrs. X met and decided they wanted to return home together.

This decision should have triggered a safeguarding referral in the context of the previous safeguarding investigation and current protection plan, which now needed to be reviewed. Good practice would dictate that a chronology should have been drawn together to make clear the events leading to this point and a multi-agency strategy planning meeting held to consider the issues and devise a new protection plan for Mrs. X. These actions would have served to pull together all of those staff who were working with Mr. and Mrs. X in order to agree what the risk factors were and how support could be provided to mitigate against these. This was particularly important given the social isolation of the couple and the fact that their immediate family were estranged.

Instead the Team Manager, who had previously closed the safeguarding case, agreed the plan for Mrs. X to go home to live with her husband without any reference to safeguarding being made. This was a significant oversight. It is evident from the extant record that, at this point, staff believed Mrs. X to have had the mental capacity to make this decision. However, there is no record of how this was assessed.

The practitioners working with Mr. and Mrs. X did not seem to recognise and fully understand the risks and issues in bringing these two vulnerable people together. Not least of these was the fact that Mr. X was now becoming the main carer for his wife, upon whom he had always depended for practical support for his own mental illness.

Had a safeguarding process been re-instated at this point, it is possible that the monitoring of the protection plan, through regular case conferences, may have picked up indications that

things were going wrong for the couple. This could have meant a more focused response and intervention by all concerned.

The fifth time that safeguarding issues should have been examined was in July 2009. Mrs. X was admitted to hospital with a urinary tract infection and dehydration, this had resulted in systemic sepsis and she was seriously ill. It would have been reasonable at this point to question whether the couple were coping at home as this episode could have signified the effects of neglect. However this was not questioned and Mrs. X was discharged home with a new social care package.

Mrs. X's Care Coordinator did meet with the couple and agreed with them that a care package was necessary in order to support them. However, when Mr. X cancelled the package the following week, no further action was taken.

Good practice would certainly have supported the triggering of a safeguarding referral when Mrs. X was admitted to hospital and, failing this, when the care package was cancelled. Staff had recognised the need for additional support for this couple and had talked to them about it so the cancellation of the care package by her husband, should have engendered serious concerns amongst the staff.

The sixth time that safeguarding issues should have been examined was in August 2009. By this stage it was apparent that Mr. X's mental health was breaking down. Mrs. X was alternately described as *"edgy" "terrified"* and *"unkempt."* On the 2 September Mrs. X accused her husband of injuring her. It is a fact that staff thought this was a potential safeguarding incident, but nothing was done. The Trust/Local Authority Internal Investigation Review Team identified severe workforce capacity issues within the Golborne Older Persons' CMHT as being a key reason why this case was not managed in accordance with local policy at this stage.

12.2.4.2. Conclusions

The Safeguarding Vulnerable Adults in Wigan Policy (November 2008) was a robust and evidence-based document in keeping with national policy best practice expectation. That being said, it appears that there was a poor understanding over time on the part of all the

practitioners working with Mr. and Mrs. X regarding the interplay between abuse, vulnerability and capacity and their roles and responsibilities in managing adult safeguarding.

Based upon what was known, and what should have been about Mr. and Mrs. X, it is evident that safeguarding considerations should have featured in the approach to Mrs. X's care and treatment as early as April 2006. The long chronology of events listed above demonstrates that concerns were not of either a transient or short-term nature, but were persistent and of long-standing. At least 45% of the clinical record for Mrs. X featured safeguarding and vulnerability issues. It is difficult to understand why no concerted plan of care was developed. Individual practitioners obviously thought the concerns were noteworthy, but obviously not noteworthy enough to manage proactively. It is difficult to understand why events that were considered significant enough to record were not recognised as requiring action.

Both Mr. and Mrs. X were vulnerable and their needs complex. It is the conclusion of the Independent Investigation Team that the safeguarding practices deployed in this case were of a poor general standard and made a significant contribution to the overall poor management of both Mr. and Mrs. X to ultimate detriment of their continued health, safety and wellbeing.

12.2.5. Risk Assessment

12.2.5.1. Findings

A Risk Screen was conducted for Mrs. X on the 9 October 2008. It recorded that:

- *"risk to self - no;*
- *risk to others - no;*
- *risk of vulnerability - yes;*
- *risk of neglect - no."*[522]

On the 2 March 2009 another Risk Screen was conducted. The following was recorded:

- *"risk to self - no;*
- *risk to others - no;*
- *risk of vulnerability - yes;*
- *risk of neglect - no."*[523]

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There is no evidence in the extant clinical record that a full risk assessment was ever conducted in accordance with the CPA guidance for service users on Enhanced CPA. Neither was there any evidence that care planning was developed in the light of any risks that had been identified following assessment.

12.2.5.2. Conclusions

The standard of risk assessment for Mrs. X fell far below that to be expected for any patient receiving care and treatment from secondary care mental health services. It was evident that important decisions were made about Mrs. X in the absence of any risk assessment having been conducted. The fact that Mrs. X was vulnerable and was suspected of being the victim of domestic abuse makes this omission an extremely significant one. Because the decisions made about long-term care were not based upon everything was known about this individual, and because she was not understood or assessed fully in the context of her risk profile, then it cannot be said that these decisions were reasonable. The failure to manage risk has to be seen as the collective failure of each practitioner, (regardless of discipline, and also the individuals who managed them) who provided care and treatment to Mrs. X.

The failure to assess Mrs. X's risk made a significant contribution to the overall poor management of her case to ultimate detriment of her continued health, safety and wellbeing.

12.2.6. Service User Involvement

12.2.6.1. Findings

On occasion Mrs. X was involved actively in the decisions regarding both her short and long-term future and at other times she was not. For example, whilst it was decided that Mrs. X had the capacity to make decisions, this did not prevent the treating team from intervening in the autumn of 2008 when deciding her place of residence without first consulting her. It can be said that Mrs. X was always treated with kindness. However it cannot be said that she was treated in the manner due to an adult with full capacity. On many occasions Mrs. X said that she was worried about her husband, or that she was afraid of him. These concerns appear to have been 'brushed aside' and not listened to with the degree of seriousness that they merited. This was at best not respectful and at worst a failure in the duty of care towards her.

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It was evident that Mrs. X did not like the social care package that had been put into place for her in the home. She did not like strangers bathing her and attending to her personal hygiene needs. This led to Mr. and Mrs. X's total rejection the package in April, and then again in August 2009. Time should have been taken to understand what the issues were and how best to manage them. This was not done and led to the couple choosing to receive no social care rather than care they found unacceptable to them.

12.2.6.2. Conclusions

Whilst Mrs. X was always treated with kindness by her treating team the degree to which she was actively listened to was superficial. Her concerns regarding her social care package were not explored in depth and no new plan was constructed around her particular wishes. Neither were her concerns about her husband actively listened to, explored and addressed.

12.2.7. Documentation and Professional Communication

12.2.7.1. Findings

The basic standard of record keeping was poor. This issue was also raised at the Coroner's Inquest. Gaps appear in the clinical record for two reasons, the first being that certain actions pertaining to the Trust CPA and risk policies were not completed in an appropriate manner and these actions were therefore not recorded as they did not take place. The second being that certain actions and decisions were taken and were not recorded leaving the impression that there were more gaps in service delivery than in fact occurred.

The ongoing professional communications between the treating teams of both Mr. and Mrs. X was inadequate and illustrative of a lack of robust Care Programme Approach systems. Trust policies and procedures extant at the time Mr. and Mrs. X were receiving their care and treatment described the Trust's aspiration of providing a seamless service. This was not achieved in the case of Mr. and Mrs. X as teams appeared to work in separate silos.

12.2.7.2. Conclusions

Good quality record keeping and professional communication is essential in managing safe and effective patient care. Without it service users are in danger of being managed outside of the full context of their psychiatric history, assessed need and risk. This is a very basic tenant of good practice and one that all health and social care practitioners should be familiar with.

As such it is a serious failure to identify when assessing the practice of registered professionals.

The poor standard of clinical record keeping, when combined with the poor levels of recollection offered by witnesses to this Investigation, left a lasting impression that the care and service delivery offered to Mrs. X fell far short of that to be expected. The actual evidence presented to this Investigation is the only evidence that can be used to understand how Mrs. X's case was managed. The failure to record clinical interventions is poor practice and this Investigation cannot offer mitigation that is based on speculation and memory alone. The poor levels of record keeping have left practitioners, the Trust and the Local Authority in a position where they are open to criticisms that cannot easily be defended.

12.2.8. Adherence to Local and National Policy

12.2.8.1. Findings

The standard of Trust and Local Authority policies was found to be excellent. However it was evident that in the case of Mrs. X the following policies were not adhered to:

- CPA;
- Clinical Risk assessment;
- Supervision;
- Safeguarding;
- Mental Capacity Act (2005) assessment;
- Clinical Record Keeping.

The witnesses who were interviewed as part of this Investigation could not articulate even the most basic requirements of Trust and Local Authority policy and neither could they articulate their roles and responsibilities in regard to them. There would appear to be a widespread culture of policy non adherence within the Golborne Older Persons' CMHT. It was not easy to understand why. Many witnesses suggested that this was because they had not received training, but this does not appear to be supported by examining Trust training records. Neither was it easy to understand why managers and senior clinical leaders did not ensure that policy adherence occurred. Reasons were put forward in relation to severe workforce pressures that required service 'shortcuts' to be made.

It was apparent that workforce capacity led to both clinical and managerial supervision processes being compromised. Clinical supervision is an essential safety net of care. If this safety net is not present then it can become very difficult to detect practice when it diverges from policy guidance.

12.2.8.2. Conclusions

The Independent Investigation Team can offer no further insights into why the lack of policy adherence was so widespread and all encompassing as no further evidence was forthcoming. To try to do so would lead to unhelpful speculation. Sufficient to say that the Golborne Older Persons' CMHT did not follow Trust and Local Authority policy guidance. The responsibility for this has to be shared equally between the Trust and Local Authority Corporate Teams, CMHT Team Managers and Senior Practitioners, and each individual member of staff who was involved in the care and treatment of Mrs. X.

It is the conclusion of the Independent Investigation Team that failure to adhere to Trust and Local Authority policy guidance compromised the effectiveness of the care and treatment package that was provided to Mrs. X to the detriment of her continued health, safety and wellbeing.

12.2.9. Overall Management of the Care and Treatment of Mrs. X

12.2.9.1. Findings

The findings regarding the care and treatment of Mrs. X are largely similar to those of Mr. X. It was evident on examination that no holistic approach was taken to her case overtime.

First (diagnosis). The particular challenges of her diagnosis were not understood in relation to her needs in the home and the additional pressures that these would place on her carer. The long-term degenerative effects of Mrs. X's illness did not appear to have been considered and the plans for her management were in the short-term only. The difficulties that the couple had in coping were possibly due in part to the natural progression of Mrs. X's dementia. It was not good practice to have such a short-term plan in place, especially one that could never be regarded as a stable long-term management option, without some kind of progression planning having been considered.

Second (safeguarding and mental capacity). The processes used to determine Mrs. X's capacity were flawed. Mrs. X may have been correctly assessed as having capacity on the 20 February 2009. However it was not recognised at this time, that by virtue of her diagnosis, Mrs. X's lucidity would probably have been of a widely fluctuating and transient nature and that her capacity would require continuous reassessment. The dynamic between capacity, vulnerability and safeguarding was not understood by members of the treating team. Had the Safeguarding Vulnerable Adults in Wigan policy been adhered to then the treating team may have been able to understand better how Mrs. X's historic risk profile should have been assessed. Despite the detail available to the treating team no one appeared to have been able to determine that an unsafe threshold had been reached as each incident was seen in isolation. When it became apparent that safeguarding issues were present in September 2009 the Golborne Older Persons' CMHT did not have the capacity to progress an investigation.

Third (CPA). CPA and Care Coordination failed to operate in a manner that was compliant with Trust policy expectation. Assessment and care planning were of a rudimentary nature and did not ensure decisions were based on all of the information available to the treating team. Assessment and care planning were not dynamic in nature and did not respond to the changes in either Mrs. X's circumstances or presentation. The most significant failure was in relation to the support given to Mr. X in his role as carer to his wife. There was ample opportunity to ensure that liaison was ongoing with his treating team. This was not achieved.

Fourth (risk assessment). Risk assessment did not take place in accordance with Trust policy documentation. This meant that all decisions made about Mrs. X were arrived at without her historical information being considered and her current circumstances being understood.

Fifth (systems and culture). It was evident that the Golborne Older Persons' CMHT experienced severe workforce pressures during the period that Mrs. X received her care and treatment. This pressure can help to understand how certain standard policies and procedures may have been 'temporality suspended' due to capacity issues. What is not so easy to understand is the underlying culture. Throughout this Investigation it became apparent that most practitioners had virtually no understanding of either Trust or Local Authority policies and procedures, and neither did they understand their roles in relation to them. In short the overall impression was one of a lack of professionalism and this appeared to be pervasive.

It was evident that there was a strong divide in culture between the Trust and the Wigan Local Authority. This divide appeared to have been amicable, but caused a degree of additional confusion about who had to do what and when. It was evident that teams were integrated in name only. It was difficult for the Independent Investigation to understand what the dynamic actually was as the witnesses who were interviewed could not explain how things worked and what the barriers to seamless care were.

12.2.9.2. Conclusions

There was an overriding belief on the part of witnesses that the Independent Investigation Team interviewed that everything that could have been done had been done to ensure a good package of care and treatment was delivered to Mrs. X. Unfortunately it would seem that witnesses were mistaking activity for meaningful and structured intervention.

The Trust and Local Authority Internal Investigation Review Team cited as good practice the fact that workers from the Golborne Older Persons' CMHT went beyond their roles by bathing Mrs. X when the social care package broke down. The Independent Investigation Team disagrees strongly. It has been given as mitigation the fact that the CMHT was under severe caseload pressure, so much so that safeguarding investigations could not be initiated when required. It is therefore inconceivable that Care Coordinator 2 and the Support Worker spent time carrying out functions that should have been carried out by a different service. Their time would have been more usefully spent in managing the problem with Anchor Care (the social care provider) rather than taking on its workload.

There appeared to be confusion about roles, responsibilities and boundaries. When teams are under pressure it is essential that they respond in a professional and decisive manner. Without doubt priorities need to be identified, but these should be identified in agreement with senior managers and clinical leaders to ensure that patient care is not compromised.

The picture portrayed during 2008 and 2009 is of a service under pressure. This was made more problematic by a health and social care model that had begun to pull away one from the other. Between 2008 and 2009 it can be seen when viewed through the lens of Mrs. X's case that system, policy and procedure was understood poorly and had ceased to be meaningful on

a day-to-day basis. As with the case of Mr. X a Swiss Cheese model can be seen to have operated.

The treating teams of neither Mr. nor Mrs. X could have been expected to have foreseen the deaths of the couple. However based on what was known about the couple at the time, particularly as Mr. X's mental state began to deteriorate in August 2009, an incident of some kind was foreseeable, even if the magnitude of it was not. Whilst the deaths of Mr. and Mrs. X may not have been predictable they were, in the view of the Independent Investigation Team, preventable. The Independent Investigation Team concluded that the treating teams involved had the knowledge, the opportunity, and the means to intervene in August 2009. Had they done so it is highly probable that the events of September 2009 that led to the deaths of Mr. and Mrs. X would not have occurred.

- ***Causal Factor Two.. Mrs. X was a vulnerable adult whose needs were not assessed or addressed appropriately. She was dependent upon her husband and also at risk from him. The failure to assess, monitor, manage and support Mr. X in the community in the summer of 2009 led to his reaching a point of crisis which ultimately led to the deaths of both him and his wife. The treating teams had the knowledge, the opportunity and the means to intervene but did not do so.***

12.3. Summary of the Way in Which the Couple were Treated Jointly

12.3.1. Findings and the Care Pathway

Mr. and Mrs. X were mutually co-dependent. What affected the health of one affected the health of the other. It is difficult to understand how their care and treatment was to become so fragmented. They were both registered with the same practice and their respective CMHTs were housed in the same building.

The decision to allocate the couple to different CMHTs was made in the autumn of 2008. It remains unclear what actually led to Mr. X being allocated to the Hindley and Ince Adult CMHT, but it is evident that medical staffing problems within the Golborne Older Persons' CMHT appeared to have played a part in this decision being made. Mr. X was referred to

secondary care services on the 29 September 2009 and Mrs. X was referred to services on the 2 October 2009. Both Mr. and Mrs. X were processed through the Central Duty Team and the Golborne Older Persons' CMHT. It would have been good practice at the allocation stage to have considered the needs of the couple together. This was not done.

An assumption was made at an early stage that the couple had irrevocably separated and that Mrs. X was the victim of an assault perpetrated by her husband. Regardless of which CMHT each individual was allocated to it would have been good practice for both treating teams to have discussed the needs of the couple together at the initial assessment stage. This was not done.

The care and treatment of both Mr. and Mrs. X continued independently of each other until February 2009 when it was decided that they wished to return home together. Apart from a single meeting between the two treating teams on the 25 February 2009, the outcomes of which were not recorded, no other joint meeting or case review was to take place. It would have been good practice to have developed a joint discharge plan for the couple at this stage. This was not done.

Once Mr. and Mrs. X had been discharged back to the marital home in March 2009 the two CMHTs continued to work with Mr. and Mrs. X separately. It was evident that neither team conducted a carer assessment for Mr. X and that neither team communicated one with the other regarding the health and wellbeing of either service user. In all three sets of teams were visiting the home: the Golborne Older Persons' CMHT, the Hindley and Ince Adult CMHT, and Anchor Care. This was something that Mr. X disliked and must have proved disruptive to the couple. It is a fact that Mr. X asked for the Support Worker from his CMHT to stop visiting as he could not understand what her visits were trying to achieve in addition to what was already going on. It would have been good practice at this stage to have reconsidered whether or not the couple should be allocated to the same team. Services were under pressure and by the end of May 2009 Mr. X was without care coordination as Care Coordinator 1 had left earlier in the month and his case was not reallocated. This was not done.

The findings of this report show that the couple failed to thrive in the marital home and that they struggled to cope. It was increasingly evident throughout the summer of 2009 that the situation was getting worse as the weeks went by. The situation was untenable. It is difficult

to understand why a joint CPA review was not held in August 2009. At this stage it was not too late to have provided a range of interventions that could have supported the couple. These interventions could have prevented Mr. X from reaching the crisis that led to the deaths of both him and his wife.

12.3.2. Conclusions

The Independent Investigation Team concluded that the treating teams involved had the knowledge, the opportunity, and the means to intervene in August 2009. Had they done so it is highly probable that the events of September 2009 that led to the deaths of Mr. and Mrs. X would not have occurred.

The Knowledge. The treating teams knew that Mr. X's mental health was in decline. It was recorded in the clinical record that if this situation was allowed to continue it would have a negative effect on the health and wellbeing of his wife.

The Opportunity. Mrs. X's CMHT was visiting the home on a regular basis and as such had the opportunity to monitor the couple's progress and to intervene as required.

The Means. Both treating teams had the means by which to intervene. Mr. X was asking for help. This was not a situation when a service user was refusing to engage, this was a situation when a service user was telephoning the CMHT office in tears asking for help.

The Independent Investigation Team understands that it has had the opportunity to look in depth at the cases of both Mr. and Mrs. X. However everything that is now known to us was also known, or should have been known, to both the Golborne Older Persons' CMHT and the Hindley and Ince Adult CMHT at the time they were working with the couple. It was the conclusion of the Independent Investigation Team that, without the benefit of hindsight, it should have been apparent to both treating teams that the couple presented an ongoing, complex set of challenges and risks which needed to be managed in a robust and coherent manner. The failure to achieve this left both Mr. and Mrs. X in a situation where their needs as a couple were not being met and their risks as couple were not mitigated against.

13. Findings and Conclusions Regarding the Care and Treatment Mr. and Mrs X Received

13.1. Findings

The findings have been identified following a full review of the care and treatment that Mr. and Mrs. X received from the 5 Boroughs Partnership NHS Foundation Trust. These have been set out below together with their accompanying relevant causal, contributory and service issues.

The issues pertaining to Mr. X are the principle ones pertaining to this Investigation and are numbered 1-12.

1. **Diagnosis.** Mr. X did not receive a clear diagnosis. This was for two principle reasons. First: at some point in time, prior to the GP referral being made in September 2008, Mr. X's clinical record was co-mingled with those of two other service users. This meant that three diagnoses were extant in his record, namely: Bipolar Disorder, Paranoid Psychosis, and Depression and Anxiety. Whilst it might be possible that all three diagnoses had been correctly attributed to Mr. X at some stage, examination of the clinical record suggests that this was unlikely. Therefore Mr. X re-entered secondary care mental health services in September 2008 with an incorrect set of information in his clinical record. This was to serve as a persistent point of confusion. Second: this point of confusion was exacerbated by Mr. X's case never being subjected to an appropriate level of diagnostic formulation. His diagnosis remained unclear until the time of his death.

- ***Contributory Factor One. The failure to provide a robust diagnostic formulation for Mr. X ensured that his care and treatment programme was not developed to its full potential. This contributed to the poor overall management of Mr. X's health and social care management.***

2. **Medication and Treatment.** Medication and treatment choices did not follow those recommended by the National Institute of Health and Clinical Excellence (NICE) guidance; neither did the medication regimen follow the basic best practice British National Formulary guidance. Mr. X was prescribed a medication regimen that was at times detrimental to his health and had not been selected in a coherent manner following a robust diagnostic formulation. Mr. X had distinct medication adherence issues and these were not taken into account as part of an ongoing medicines management approach. Psychological therapy treatments were indicated but were not provided.

- ***Contributory Factor Two. The failure to provide a comprehensive care and treatment programme contributed to the poor overall management of Mr. X's health and social care management.***

3. **Use of the Mental Health Act (1983 and 2007).** The Mental Health Act (2007) does not play a significant part in the care and treatment that Mr. X received from the 5 Boroughs Partnership NHS Foundation Trust. However there would appear to have been a lack of understanding on the part of Trust workers as to when the Mental Health Act could have been considered. On the 8 October 2008 Mr. X had reached the stage where he was no longer looking after himself and his mental health was deteriorating rapidly. The Independent Investigation Team concluded that when Mr. X refused to be admitted onto Holdenbrook Ward a Mental Health assessment should have been arranged on this occasion as he was at significant risk of self neglect.

   By the 13 October 2008 Consultant Psychiatrist 2, Care Coordinator 1 and the GP were prepared to arrange a Mental Health Act (2007) assessment. It is evident that Mr. X's mental health continued to deteriorate but that no further action was taken. It is probable that the treating team thought that Mr. X did not require such an intervention, however it is unusual for the rationale not to have been recorded. The extant clinical record and the information provided by clinical witnesses to this Investigation give the impression that Mr. X's mental health was allowed to deteriorate without intervention until he reached a point of crisis.

- ***Contributory Factor Three. The opportunities to use the Mental Health Act (2007) were not considered in a timely manner. This contributed to the poor overall management of Mr. X's health and social care management.***

4. **Care Programme Approach (CPA).** The Care programme Approach (CPA) failed to operate in a coherent manner in the case of Mr. X. It was evident from examining the clinical record that a rudimentary approach to CPA was taken. Assessment and care planning were minimal and Care Coordination was largely absent. From May 2009 Mr. X, even though he had been designated as requiring 'Enhanced' CPA, had no designated Care Coordinator. This situation continued until the time of his death in September 2009. The minimum level of care that could and should have been expected from Mr. X's CMHT was not delivered to him. The treating team had the knowledge (of both his condition and his situation), the opportunity, and the means to intervene. Mr. X was asking for help and was not seeking to avoid engagement. Had the treating team assessed Mr. X's condition on an ongoing basis in accordance with CPA guidance, and had the treating team ensured that his care plans were both developed and implemented, it is entirely possible that he would not have reached the state of crisis that led to the deaths of both himself and his wife.

- ***Contributory Factor Four. The failure to provide a robust CPA for Mr. X ensured that his needs were not assessed appropriately and that his care and treatment programme was not delivered. This made a significant contribution to the poor overall management of Mr. X's health and social care management.***

5. **Risk Assessment.** It would appear that Mr. X did not receive a formal risk assessment. On several occasions a Trust Risk Screen was conducted, but a full assessment did not take place in accordance with Trust policy requirements. This meant that Mr. X was never understood in the context of his full risk profile and that no risk management plans were either developed or implemented in order to mitigate against it. Her Majesty's Coroner said the following about Mr. X. *"At the time of his death he was under the care of a Community Mental Health Team. He was not appropriately monitored and his risk of harm to himself and others was not*

appropriately assessed. He took his own life whilst the balance of his mind was disturbed by a diagnosed mental illness.''[524]

- ***Contributory Factor Five. The failure to provide multidisciplinary risk assessment for Mr. X ensured that his risk profile was not properly understood and that consequently no fit for purpose risk management plans were put into place. This made a significant contribution to the poor overall management of Mr. X's health and social care to the detriment of his continued safety and wellbeing, and also to that of his wife.***

6. **Referral, Admission and Discharge Planning.** Referral, admission and discharge planning processes lacked coordination in the autumn of 2008. Prolonged referral and admission processes left Mr. X subject to delays in receiving appropriate levels of assessment and also in being given the care and treatment interventions that he required. Poorly managed discharge processes in March 2009 left Mr. X and his wife in a vulnerable position which meant that their continued health and wellbeing could not be maintained once the couple were living back in the community.

- ***Contributory Factor Six. Referral and transfer processes did not operate in a seamless and timely manner. This contributed to Mr. X's mental health being allowed to deteriorate on at least two occasions. Discharge processes did not conform to Trust policy expectations and did not provide for the assessment and management of Mr. X's needs once he had returned to the community in March 2009. This went on to make a significant contribution to the subsequent breakdown of his mental health.***

7. **Safeguarding Vulnerable Adults and Mental Capacity.** Mr. X's needs regarding safeguarding were never identified either in relation to himself or his wife. Mr. X was an individual with significant mental health problems and poor activities of daily living skills. Mr. X was socially isolated and had physical health problems and impaired mobility. He drank, was non compliant with his prescribed medication, and was the main carer to his wife who had dementia. There was an assumption made by

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services that the input they gave to Mrs. X was sufficient to maintain her in the community and to ensure her health, social care and safety needs were met. However it was evident from entries in the clinical records that she was frequently unkempt and that she had difficulties shopping, cooking and looking after the house. It was also evident that Mr. X struggled to make up the short fall in the care package provided and that he himself had been identified as being vulnerable and prone to self neglect. The couple were maintained in the community in a situation that was far from ideal and which required a more coherent care plan that was shared and jointly implemented between the treating teams of both Mr. and Mrs. X.

- ***Contributory Factor Seven. Safeguarding processes were neither understood nor implemented in keeping with either extant local policy or national best practice guidelines in relation to Mr. X and his wife. The failure to do so placed the couple at significant risk and made a significant contribution to the circumstances that led to their deaths.***

8. **Service User Involvement in Care Planning and Treatment.** Mr. X did not receive person-centred care and treatment. It was evident that he was neither known well nor understood by his treating team. He was seen as being a stubborn person who could at times reject the care that offered to him. However Mr. X never disengaged from services and frequently sought intervention when in crisis. Had a therapeutic relationship been built up with Mr. X over time then it may have been possible for services to have constructed a care plan that was both effective and acceptable to him. It is a sad fact that most of the health and social care practitioners that provided care and treatment to Mr. X directly, and were interviewed as part of this investigation, could not remember him at all. This illustrates well how superficial levels of engagement with this gentleman were.

- ***Contributory Number Eight. Mr. X remained an unknown quantity. Engagement with him was often on a superficial level and this made a contribution to the poor formulation of his care and treatment needs.***

9. **Carer Assessment and Involvement.** Mr. X was the main 24-hour carer for his wife who had dementia. It was evident that he struggled to support his wife and to maintain their activities of daily living. Mr. X had physical and mental health problems of a long-standing nature. It was recorded by his Care Coordinator at the point of his discharge in March 2009 that he would require a care plan to support him in his carer role. This was never provided for him. In the summer of 2009 it was recorded that Mr. X was experiencing difficulties in coping with his wife's condition. In August 2009 it became apparent to members of his wife's treating team that Mr. X's mental health was deteriorating. It was recorded that the team had concerns that this could impact negatively upon the continued health and wellbeing of his wife. However despite documenting the difficulties that he was experiencing no interventions were made and Mr. X continued to care for his wife. At this stage both of the CMHTs engaged in the care and treatment of Mr. and Mrs. X should have ensured that the couple were reassessed with immediate effect. This did not occur and Mr. X eventually reached a state of crisis.

- ***Contributory Factor Nine. Mr. X's needs as a carer were neither assessed not addressed. This placed a great deal of stress upon him and made a significant contribution to the circumstances that led to both his death and that of his wife.***

10. **Documentation and Professional Communication.** Two major issues were identified regarding documentation and professional communication. First: Mr. X's historic clinical record had been subject to a significant degree of co-mingling with other service users of the same name. This led to ongoing confusion exacerbated by poor clinical diagnostic formulation. That this co-mingling occurred signifies that the Trust and Local Authority record management systems were not robust enough to ensure patient identification protocols were fit for purpose. Second: Trust and Local Authority staff of all grades and disciplines worked to poor levels of clinical practice regarding maintenance of the clinical record. Risk assessment, safeguarding, and CPA documentation was maintained in the most rudimentary manner, and was not in keeping with extant policy and procedure guidelines. Clinical meetings, ward rounds and general clinical discussions were not recorded making it impossible to understand what was talked about and what clinical decisions were made. Witnesses who gave evidence to this Investigation had poor levels of recollection leaving the Independent

Investigation Team no option but to conclude that in the absence of any documentation detailing the required clinical interventions, these interventions did not in fact take place.

- ***Contributory Factor Ten. Trust and Local Authority record keeping arrangements failed to provide a fit for purpose system that ensured patient information was maintained correctly. Trust and Local Authority staff failed to adhere to best practice professional record keeping guidance. These two failures in combination contributed to the poor overall management of Mr. X's case.***

11. **Adherence to Local and National Policy and Procedure, Clinical Guidelines.** Trust and Local Authority Policies were of an excellent standard. However there was a prevailing culture amongst Trust and Local Authority staff of all grades and disciplines which led to the view being taken that it was somehow not their responsibility to know what these policies contained. Consequently policies were not adhered to and this had a detrimental effect on the care and treatment that Mr. X received. Trust audit processes did not appear sophisticated enough at the time to either detect or address policy non-adherence issues.

- ***Contributory Factor Eleven. Failure on the part of the Trust, the Local Authority and each individual practitioner involved to adhere to policy guidance made a significant contribution to the failure to manage Mr. X's case in an evidence-based and professional manner to the detriment of his health, safety and wellbeing.***

12. **Management of the Care and Treatment of Mr. X.** The Independent Investigation Team concluded that there were serious failures regarding the way in which care and treatment was provided to Mr. X. These failures were both significant and comprehensive in nature to the extent that the management of the case was severely compromised to the ultimate detriment of Mr. X's health, safety and wellbeing. Clinical decisions were not made based upon the best information available to the treating team at any one time. Mr. X was never understood as an individual and he had poor levels of assessment, care planning and treatment throughout the last 12 months of his life. It is the conclusion of the Independent Investigation Team that

significant omissions in the management of his care and treatment allowed his mental health to deteriorate to the stage where he reached crisis point.

The Independent Investigation Team concluded that the treating teams involved had the knowledge, the opportunity, and the means to intervene in August 2009. Had they done so it is highly probable that the events of September 2009 that led to the deaths of Mr. and Mrs. X would not have occurred.

- ***Causal Factor One. The failure to assess, monitor, manage and support Mr. X in the community in the summer of 2009 led to his reaching a point of crisis which ultimately led to the deaths of both him and his wife. The treating teams had the knowledge, the opportunity and the means to intervene but did not do so.***

13. **Clinical Governance and Performance**. The Trust has robust clinical governance structures and systems in place in 2012. The Trust has recently been developing its work as a learning organisation to ensure that Serious Untoward Incident processes have additional safeguards built into them. A significant amount of work has occurred to ensure that Trust audit processes are sensitive enough to detect non compliance in areas such as the Care Programme Approach. Audit standards are now very specific and are monitored on a regular basis. Care Pathways have been developed to ensure that a robust structure is provided when providing services to service users. The Local Authority was not able to supply any information to this investigation.

- ***Contributory Factor Twelve. Trust and Local Authority governance systems were not sensitive enough to pick up the degree of policy non adherence that occurred in the cases of both Mr. and Mrs. X. This made a significant contribution to the poor overall quality of the care and treatment that was delivered to the couple.***

14. **The Care and Treatment of Mrs. X.** The Independent Investigation Team concluded that there were serious failures regarding the way in which care and treatment was provided to Mrs. X. These failures were both significant and comprehensive in nature to the extent that the management of the case was severely compromised to the ultimate detriment of Mrs. X's health, safety and wellbeing.

Clinical decisions were not made based upon the best information available to the treating team at any one time. It is the conclusion of the Independent Investigation Team that significant omissions in the management of her care and treatment placed this vulnerable adult in a situation where she was at risk of both abuse and neglect.

- ***Causal Factor Two. Mrs. X was a vulnerable adult whose needs were not assessed or addressed appropriately. She was dependent upon her husband and also at risk from him. The failure to assess, monitor, manage and support Mr. X in the community in the summer of 2009 led to his reaching a point of crisis which ultimately led to the deaths of both him and his wife. The treating teams had the knowledge, the opportunity and the means to intervene but did not do so.***

15. **Summary of the Way in Which the Couple were Treated Jointly.** The care and treatment that the couple received was not managed in a coherent manner which took into their joint needs as a couple. The involvement of two separate teams served to fragment care and prevented a full assessment of both need and risk from taking place. This was to the ultimate detriment of the health, safety and wellbeing of the couple.

13.2. Conclusions

The Independent Investigation Team came to the conclusion that Mr. and Mrs. X received a poor level of care and treatment from both the 5 Borough Partnership Foundation NHS Trust and Wigan Local Authority. Both organisations must share the responsibility for this jointly.

When examining the quality of the care and treatment a person receives from mental health services the following four categories can be utilised when causality is being considered.

Category 1. The Trust implemented high standards of service delivery that were appropriate, effective and in keeping with best practice and the Independent Investigation Team was unable to identify any causal or contributory factors relating to the homicide in question.

Category 2. The Trust implemented high standards of service delivery that were appropriate, effective and in keeping with best practice. However a single act or omission, or the unexplained practice of a single team, led directly to the circumstance in which a serious untoward incident occurred. Causality was found between the untreated mental state of the service user/the quality of the care and treatment provided, and the subsequent actions of the service user.

Category 3. The Trust delivered less than effective services where systems were chaotic and best practice standards were not implemented. However no direct causal relationship between what the services actually did or did not do was connected to the incident.

Category 4. The Trust delivered less than effective services where systems were chaotic and best practice standards were not implemented. Causality was found between the untreated mental state of the service user/the quality of the care and treatment provided, and the subsequent actions of the service user.

It was the conclusion of the Independent Investigation Team that the 5 Boroughs Foundation NHS Trust and Wigan Local Authority joint practice fell into Category 4 during the period that Mr. and Mrs. X were receiving their care and treatment. The overall standard of care treatment fell below that to be expected from secondary care mental health and social care services. Corporate and team systems and processes failed to protect the health, safety and wellbeing of Mr. and Mrs. X, and individuals collectively failed in their duty of care to the couple.

It was evident that the essential safety nets of care failed to operate and that Mr. and Mr. X were not supported in the manner that their circumstances required. The responsibility for this has be shared between the corporate body, the clinical and management team leaders and all of the individual professionals concerned.

The Independent Investigation Team would like to state that the quality of the Trust Internal Review was of a high standard and many useful findings and conclusions were made and recommendations set. This is to be commended when taking into consideration the difficulties that the ongoing Police Investigation presented to the work of internal investigation process.

The Independent Investigation, whilst concluding that the Trust and Local Authority failed to ensure the health, safety and wellbeing of Mr. and Mrs. X would like to state here that the Trust has worked diligently since the time of the incident to learn lessons and to ensure that processes and systems are in place and that services are being delivered in accordance with all due policy and procedure at the present time. Whilst it cannot ever be stated with confidence that such an occurrence will never happen again, the Independent Investigation Team, during the course of the inquiry process, were able to identify significant service improvements pertinent to this case and could determine that the Trust is a learning organisation.

14. 5. Borough Partnership Trust Response to the Incident and Internal Review

14.1. The Trust Serious Untoward Incident Process

Initial Reporting of the Incident

When the incident occurred on 10 September 2009, the manager on call at that time was informed and instructed staff to report the incident *via* the Trust's serious incident fast-track form. The fast-track form was sent to the Trust Executive Team, Governance Team, Operational Services, Safeguarding and Communications Departments later the same day at 19:30pm. The incident was reported to the Strategic Health Authority on 11 September 2009.

The 72 Hour Report

The 72 hour review process was not in place at the Trust in 2009, therefore a review of this nature was not carried out.

14.2. The Trust Internal Review

The Internal Investigation Review Team comprised the following personnel:

- a Trust Dual Diagnosis Practitioner;
- the Halton and St. Helens Head of Older Persons' Service;
- a Service User and Carer Reviewer;
- a Local Authority representative.

The Terms of Reference

There were no Terms of Reference as such. However the aims of the Investigation were as follows:

- *"To examine the care received from the 5 Boroughs Partnership NHS [Foundation] Trust and Wigan Local Authority Department of Adult Services*
- *To consider if the care provided reflected national guidelines, 5 Boroughs Trust and Wigan Department of Adult Services procedures at the time*

- *To learn lessons from the incident and make improvements*
- *To consider the findings and recommendations of 'A Review of Cases Requiring Independent Investigation in the North West' September 2009 in relation to this incident*

The relatives of Mr. and Mrs. X wished to have the following questions addressed by the Review Team:

1. What structure was put in place to oversee the rehabilitation of Mr. and Mrs. X once back in their home (March 2009 onwards)?
2. What review process was in place to assess the ability of Mr. and Mrs. X to cope with their own care?
3. Why was Mr. X unsupported between May and August 2009?
4. How were the concerns raised about Mr. X's mental state at the end of August 2009 managed and decisions about the ongoing health and wellbeing of the couple made?

Methodology

Limitations

The Internal Review Team had to proceed without the original case files as these had been taken by the Police. Photocopies of the records were made available but it became evident that these were incomplete. Assessment documentation detailing the support package that was put into place when Mr. and Mrs. X returned home was missing.

Care Coordinator 1 left the employ of the Local Authority following the incident and refused to cooperate with the Internal Investigation. This meant that the Reviewers could not interview her and the gaps in the clinical record could not be filled in. Other key witnesses had also left the trust and were difficult to locate in time for the Investigation to be concluded.

The Reviewers wanted to make contact with the family of Mr. and Mrs. X but were advised that they had to this via the Police. At the time of completing the report the Reviewers had not been able to make contact with the family. The Police however did forward onto the Review Team a list of questions that the family wished to have addressed.

Mr. and Mrs. X Investigation Report

Process Followed

The Reviewers examined the clinical records and developed a timeline of events. Clinical witnesses from both the Trust and the Local authority were interviewed. A report was requested from the GP to include the prescriptions that were issued to Mr. X following his discharge from Holdenbrook ward on the 25 March 2009. An analysis of the findings were made, recommendations developed and the Investigation report was written.

Care Management and Service Delivery Problems

1. *"Neither Mr. and Mrs. X had a risk management plan in place. This may have contributed to the decision as to whether Mr. X would have been allocated to another Care Coordinator when his Care Coordinator left the employment of the Local Authority.*
2. *Mr. X was reluctant to engage with the services offered***.**
3. *Mr. X was known to use alcohol as a coping strategy.*
4. *Mrs. X was reluctant to accept some services at times.*
5. *Medication compliance had been noted as being an issue with both parties.*
6. *Attempts were made to include [a family member] in plans but records show intermittent engagement.*
7. *The reviewers note that some staff did not have a clear understanding of the effective Care Coordination policy in relation to Care Programme Approach/Non Care programme Approach (CPA/NonCPA).*
8. *There are inconsistencies across teams when recording information on the Trust electronic recording system (OTTER). (This makes ease of access and tracking information very difficult with the potential for missing important factors).*
9. *The Local Authority Team Manager of OPCMHT is not using the Trust global email system, preferring to use the Local Authority system. Even though Trust senior manager cascade information to team managers, this could still impact upon communications from the Trust to the team.*
10. *Staff reported a lack of capacity to carry out Protection of Vulnerable Adults (POVA) investigations. The team manager reported this inhibited his ability to address the needs of Mrs. X following a second suspected assault by Mr. X just prior to their deaths.*

11. *The team manager of OPCMHT had a further 6 investigations requiring POVA investigations and had no capacity to allocate this (7th) case when the alert was noted.''*[525]

Internal Review Team Analysis and Conclusions

Analysis and Findings

- Risk management was deemed to be poor and that if a comprehensive assessment had been conducted it may have ensured a Care Coordinator was reallocated to Mr. X in the spring of 2009 when Care Coordinator 1 left the Local Authority. The fact that Consultant Psychiatrist 2 left the Trust at the same time meant that there were issues regarding continuity of care.
- Some staff were uncertain as to which forms to fill in on the OTTER system and this led to inconsistencies and gaps in information that may have assisted staff in decision making. Records of reviews were sometimes not recorded.
- Staff showed little understanding of policies, specifically the Effective Care Coordination policy, Clinical Supervision and Management Supervision policies.
- Recorded interventions did not always show evidence that risk was either understood or managed. Risk was often identified but not followed up. There was no evidence to suggest that a POVA was expedited prior to the discharge of Mr. and Mrs. X back to their marital home, despite earlier concerns about a previous alleged assault.
- The Older Persons' Service was under considerable pressure having to cover the Duty System together with all other day to day responsibilities. Staffing numbers had been reduced resulting in fewer clinical cases being allocated. This put additional pressure on staff when covering Duty as unallocated cases became the responsibility of Duty Workers.
- The Local Authority had not filled vacancies and POVAs were more difficult to prioritise due to the high number of cases requiring attention across the borough.
- Change management and transformation of services may have affected continuity of care. This may have been responsible for the heavy reliance on unqualified staff, who may have had limited skills, when following up Mr. X's distress calls in the summer of 2009.

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- The quality of record keeping was poor and the content of clinical records was misleading. The Team Manager of the Golborne Older Persons' CMHT did not access the Trust Global email system which would have restricted information being cascaded to the team. Many witnesses interviewed by the Reviewers did not understand the need for quality record keeping. It was evident they were confused by the requirements of the ECC policy even though training was made available to them.
- The Reviewers noted that mandatory training was accessed by practitioners in both teams, the training offered by the Trust was available, but not mandatory for, Local Authority staff who did not always access it.
- Staff felt stressed by the workload and did not always access regular managerial supervision. There was a lack of protected supervision time. Managerial supervision should have been conducted on a monthly basis with meetings planned 12 months in advance. The nursing staff stated that managerial supervision was supplied on an *ad hoc* basis with another nurse in the team. This may have restricted the opportunity for workload and governance issues to be addressed. Supervision was not documented and there was evidence to identify how issues were being identified and addressed.
- During March and September 2009 Older Persons' CMHT Workers were covering duties for missing staff on average one and a half days a week in addition to their individual practitioner workloads.
- When staff were interviewed they were asked how Mrs. X's capacity was assessed. Reviewers were told that her capacity was assessed based on her ability to make decisions and understand the decisions made. The reviewers could find no documentation that could have supported the conclusions regarding capacity that were reached.

Conclusions

"The Reviewers recognise that planning for the collective needs of two service users can be fraught with difficulties, particularly when risks are present. Also the difficulties presented in maintaining individual rights, expressed desires and supporting individual needs presents additional tensions in care decision making.

The review found significant written evidence to suggest that both parties were offered adequate care and support by the appropriate agencies, given some difficult challenges faced

by the care givers in terms of complicated relationships and a reluctance at times from the service users to engage with services offered.

However. During this review, some fundamental issues have been identified as lacking, which require urgent attention through management intervention, to address supervision and training deficits.
In addition, some record keeping issues have been identified that also need to be addressed. There was no risk management plan completed for either service user which, if implemented, would have given significant information in terms of chronology and relapse indicators to assist effective communication and inform risk management.

The quality and content of clinical records did not give a clear picture of the presentation of the service users, especially their pre-morbid personality.

Unfortunately, two significant members of staff left the Trust within weeks of each other. The loss of the Consultant Psychiatrist and the Care Coordinator, left a gap in the care delivery to Mr. X. Gaps in record keeping at the time may have impacted upon decisions being made regarding reallocation and a plan of management for Mr. X.

Attempts were made to involve relatives but the family were showing signs of distress, finding it difficult to engage at times.

Regular managerial supervision of staff was not taking place in accordance with Trust policy thereby preventing formal and planned opportunities for sharing concerns.

The Reviewers were made aware that routine allocation meetings were not taking place regularly, probably due to lack of capacity within existing resource to take on new cases. Therefore the unallocated cases became part of the Duty Officer's responsibility.

When individuals are requesting assistance, the reviewers fail to see why continuity of care is interrupted, simply because they are not open to that particular service. This results in disrupted care being provided. On occasion, phone calls made to teams are not dealt with, leaving clients distressed.

Ultimately there are several issues that can be addressed through improved supervision, specific training and learning from the audit process."[526]

Internal Review Team Positive Factors Identified

1. *"Care delivery to Mrs. X showed evidence of frequent face to face contacts. Collaboration with Mrs. X was evident when identifying needs and care planning. Attempts were made to include the family.*
2. *Assessments which were undertaken, took into consideration the individual and collective needs of Mr. and Mrs. X, especially when for the couple to return home to live together.*
3. *Staff very often provided activity which could be regarded as outside of their remit (e.g. bathing in home environment, grocery shopping).*
4. *Consideration was given to individual preferences and decisions once made were supported.*
5. *Support services were identified and commissioned to meet needs.*
6. *Care delivery to Mr. X also showed evidence of some good practice up to the time that his Care Coordinator left her employment, at which point a decision was made not to reallocate, as Mr. X was reported to be fine.*
7. *Assessment of need was appropriate; again consideration was given to individual and collective needs taking into account the short term memory loss experienced by his wife.*
8. *Other services were offered even though they were not always accepted by Mr. X.*
9. *Attempts were made to include relatives when planning care for both parties and support was offered."*[527]

Independent Investigation Team Feedback on the Internal Investigation Report Findings

The Independent Investigation Team concluded that the Trust and Local Authority Internal Review was conducted in a robust manner and made many useful and insightful findings. The Internal Review may not have identified the same findings as the Independent Investigation or reached the same conclusions; this is however not unusual and should not imply that the

526. Trust Internal Investigation Report. PP. 26-27
527. Trust Internal Investigation Report P. 20

internal process was lacking in any way. The Independent Investigation Team acknowledges the difficulties that the Internal Review had in accessing a full set of clinical data due to the impending Criminal Justice proceedings which impacted upon all aspects of the internal investigation process.

14.3. Being Open

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

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

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

On the 23 September 2009 a letter was sent from a senior Officer at the 5 Boroughs Partnership NHS Foundation Trust to the family of Mr. and Mrs. X offering support and inviting them to contact the Trust.

On the 13 November 2009 two senior officers of the Trust met with members of the family in presence of a Police Liaison Officer at the premises of the family GP. It was confirmed on this occasion that any further contact with the family had to be arranged via the Police.

On the 18 November 2009 another letter was sent to Mr. and Mrs. X's two sons. This letter provided information as to how they could access psychological support.

Subsequently the lead Reviewer requested that the offer of a meeting be made so that the Review Team could meet with the family. This request was made via the Family Liaison Officer.

14.4. Staff Support

Support was offered to the staff involved with the case. None of the staff sought support via a formal route, preferring to support each other. No trauma was reported at the time of the Internal Investigation report being written.

Significant support was also offered to staff from both the Trust and the Local Authority during the course of the Independent Investigation.

14.5. Trust Internal Review Recommendations

"The original aim of the report was to examine the care received from the 5 Boroughs Partnership NHS Foundation Trust and the Local Authority [and to] consider if the care reflected national guidelines and Trust policy and procedure. To learn lessons and make improvements the review team recommend the following:

1. *Senior Managers to carry out a debriefing session with all involved in this case, using the review findings as a vehicle to clarify roles and responsibilities.*

2. *For all staff from Hindley and Ince CMHT, Golborne Older Persons' CMHT and Wigan and Leigh in-patient services to be trained in identifying and managing risk.*
3. *All staff from Hindley and Ince CMHT, Golborne Older Persons' CMHT and in-patient services to be trained in the use of the Trust electronic recording system, Effective Care Coordination and the use of the Care Programme Approach. Particular attention to be paid to completion of carers assessments and recording of carer's concerns (i.e. Form 7 review).*
4. *Ensure all staff including medical staff access the safeguarding adults training and audit completion rates across teams.*
5. *Team managers to identify Health staff that require clinical supervision training and nominate for same. Team managers also to demonstrate evidence that staff access clinical supervision via the Trust supervision audit system.*
6. *To develop a working protocol with essential criteria to assist managers when making decisions around reallocation of cases following staff leaving post.*
7. *To ensure that paper clinical records are included in the Trust record keeping audits. This is to include unallocated cases in accordance with Trust policy. (The audit tool has been under review from July 2009 and reintroduced in October 2009).*
8. *For the Trust and the Local Authority to review how procedures and processes with regard to the Protection of Vulnerable Adults are implemented across the Health services in the Wigan Borough.*
9. *Senior representatives of the Trust and the local Authority to be identified and offer to meet with the family to address their concerns.*
10. *The issues relating to Safeguarding Vulnerable Adults highlighted by the report will be referred to the Wigan Adult Safeguarding Board.*

The above recommendations should reduce confusion and improve working practices both in in-patient and community services. Also valuable lessons should be learned which will improve the delivery of services in the future and reduce the possibility of risks not being identified or left unmanaged."[528]

528.Trust Internal Investigation Report PP. 27-28

14.6. Progress against the Trust Internal Review Action Plan

Actions Already Implemented

Management Supervision

"Early in the review process an email was sent to Community Team Managers reminding them of the Trust policy that management supervision is mandatory and that it should be planned in advance at monthly interval. In addition, all disciplines should access professional supervision within their own professional group, i.e. Occupational Therapist, Nurses and Social Worker, and that managers need to be able to demonstrate that practitioners have access to both managerial and professional supervision. There is a system of audit of supervision across the Trust, with results being provided to managers via the Trust audit department." [529]

Access to Mental Health Services

"Access to mental Health Services has been under review and a centralised system now operates under 'Single Point of Access' where all referrals are seen and screened in one place prior to passing on to the relevant team/service. This ensures consistency of decision making and better compliance with admission/referral criteria."[530]

Improving Electronic Record System

"a 'request for change' request on the OTTER system has been submitted, which will enable 'blank' forms/gaps in forms to be more easily identified in the management reporting system. This will reduce the potential for incomplete record keeping."[531]

Improved Information Giving

"Clinical staff have been informed of the importance of giving carers the facts and the opportunity to discuss the impact on family and carers of caring for a relative with a diagnosis of dementia."[532]

529. Trust Internal Investigation Report P. 26
530. Trust Internal Investigation Report P. 26
531. Trust Internal Investigation Report P. 26
532. Trust Internal Investigation Report P. 26

The Trust has also provided the following Information to the Independent Investigation as Part of an Updating Process.

Actions already implemented

Management Supervision

- There has been a review of the Management Supervision processes within the Trust and robust monitoring systems are now in place. Clinical notes are now selected at random to ensure all essential elements of care planning are evident. The management supervision template covers specific prompts including safeguarding.

Improving Electronic Record System

- Since the incident there has been a review of the Records Management Lifecycle Policy. An e-learning package has been developed and launched and there has been significant emphasis placed on the appropriate use of the NHS number and numerical filing throughout the organisation.

- The Trust is piloting the use of NHS number wristband identification in its older peoples setting.

- The Trust has completed an audit of all care records for service users that have the same name open to the same team.

Improved Information Giving

- The Trust has been working closely with service users and carer groups to develop a comprehensive discharge pack which provides information to signpost individuals to additional sources of support and help post discharge.

- Since the incident it is now routine that both medical and nursing staff undertake a joint assessment to ensure all risks are clearly visible within the care plan.

- The Trust has set an internal target that all patients will be seen within 72 hours after discharge, this is monitored at board level.

Safeguarding

- Since the incident there has been significant investment in the Safeguarding Adults provision.

- Safeguarding Adults training is mandatory and is monitored at the Board. Bespoke training packages have been developed and e-learning is supplemented by targeted face to face sessions.

- An Electronic Communication Form has been introduced which records all clinical issues of concern, confirms action to be taken and monitors all outcomes.

- The Local Authority's safeguarding referral pathways have been aligned with the Trust's, this is jointly monitored fortnightly.

Actions that are Ongoing

Trust Narrative

- The Trust launched its 'Values' initiative in March 2011 following extensive staff consultation. A programme has been designed to promote a culture of personal responsibility, engagement and empowerment.

- Since the incident the Trust has invested significantly in a coaching training programme. By promoting a coaching culture and by encouraging more involvement in decision-making, improved innovation and creativity it is expected this will lead to staff taking greater ownership for clinical and non clinical decision making.

- The Trust has introduced an unannounced; outcome focused clinical review process that places emphasis on policy to practice. Results are fed back directly to teams and thematic analysis is undertaken to inform Trust-wide actions.

15. Wigan Local Authority Response to the Incident and Internal Review

Wigan Local Authority worked with the 5 Boroughs Partnership NHS Foundation Trust in the development and compilation of the internal investigation report. The Local Authority developed the subsequent action plan with the Trust.

16. Notable Practice

During the course of the Independent Investigation four main points of notable practice were identified.

Policy and Procedure

- The Trust and Local Authority policies were of an excellent standard. The Wigan Local Authority Safeguarding Policy was of particular note.
- The Independent Investigation Team noted new audit processes that have been introduced to ensure both policy adherence and quality care and treatment provision.

Medicines Management

The Independent Investigation Team found that the Trust has made significant improvements to its medicines management processes since the time of the incident and this constitutes notable practice which other Trusts may find to be of interest.

- The Trust has a robust medicines reconciliation process which allows a member of the Medicines Management team to liaise directly with primary care to discuss and ensure medication prescriptions are correct on admission.

- Since the incident there has been significant investment on the Medicines Management Service. Pharmacists now work closely with community teams to support service users with side effects or adherence issues.

- The Trust undertakes regular benchmarking audits as part of the Prescribing Observatory for Mental Health's (POMH) national quality programme and has received positive assurance that the Trust is working towards to implementing NICE guidance.

- A new prescribing formula has been introduced within the Trust to ensure consistency of approach.

- The Trust has developed a number of standardised audit tools against NICE guidance and regularly audits prescribing practices against NICE guidance.

- A newly-launched 'patient empowerment letter' is now routinely enclosed with all out patients' appointments - prompting service users to identify side-effects for discussion during out patient consultation.

- The Trust has a pharmacy advisor who provides help and support to GP's. Prescription cards are reviewed regularly as is antipsychotic prescribing in both in patient and community settings. Previously this was a review of dispensing only. The advisors are also visible in the community and attend clinical reviews and are available for clinical advice. Pharmacists also attend service and carer forums and carry out workshops on the wards.

General Service Improvements since the Time of the Incident

- The Trust has introduced a Safer Mental Health Audit tool. The tool has been piloted in older people's services and will be rolled out across the rest of the Trust. The aim of the audit is to proactively identify areas of potential risk and put in place targeted interventions to enhance patient safety.

- The Acute Care Pathway will launch on the 11 June 2012, this provides three consistent, clear referral pathways across Adult Services. Later Life and Memory Services in Wigan have an operational Acute Care Pathway in place. 'Storm Training' is now a mandatory aspect of our acute care pathway.

- Wigan Memory Service is one of only a handful of services that have achieved accreditation to the Royal College of Psychiatry MSNAP.

- The Trust now has an internal panel that gives assurance to the Medical Director that medical staff have the appropriate competencies to apply the Mental Health Act (1983 and 2007). A new Mental Health Act e-learning package has been introduced to support this.

- E-learning packages, training sessions and workshops are now available to support staff to understand issues around mental capacity.

- Individual Patient Passports have been piloted and are due to be rolled out across the Trust, these are designed to chart the service users' journey and highlight important data such as carer responsibility and risk factors.

- The Trust has invested in the Productive Ward and Productive Community series looking at how clinicians can optimise their time to spend more quality time with service users. This is complimented with a local investment into a team of ward-based activity workers and the addition of psychology onto wards.

- The Trust has reviewed and re launched the 'Did Not Attend' (DNA) pathways for services across the Trust.

- The Trust has a policy in place to support staff through the inquest process; this involves pre investigation support and support during the inquest. The new policy was revised and ratified in 2011. The Trust has recently commenced an audit of all staff that have attended an inquest in the past 12 months to establish if the Trust can improve on the support they receive.

The Trust has developed an Involvement Scheme designed to provide a safe and efficient process appropriate to enable volunteers to become involved in all stages of designing, delivering and monitoring Trust services.

- Service users and carers from all six business streams are invited to a range of Forums that meet regularly providing opportunities to meet with members of the Trust Leadership Group via 'Take it to the Top' which operate as open question and answer sessions.

- Over 320 service users, carers and volunteers are signed up to Trust Involvement Scheme, co-ordinating participation in over 50 business activities including staff training, recruitment of senior managers, audit, serious untoward incident investigation and working groups, promotional events and corporate committees.

- Participation of service users and carers with staff in Essence of Care Audits (a framework tool that focuses on benchmarking the basics of care) and PEAT (Patient

Environment Action Team) Audits (an environmental audit tool, results are benchmarked nationally).

- An innovative opportunity for service users and carers to comment on services and express views using a Big Brother style audio/video box. Footage is shown to the Trust Board, senior managers meetings and staff training.

- Over 180 service users, carers and representatives from third sector organisations attended the Trust's fourth Annual Involvement Event.

17. Lessons Learned

The lessons identified in this section are of a generalisable nature and can be usefully applied to other providers of secondary care mental health services. Over the past twenty years HSG (94) 27 Investigations of this kind have routinely found the following lessons learned:

- failure to implement the Care Programme Approach;
- failure to provide risk assessment and risk management plans;
- failure to ensure multi-agency communications take place in a timely manner;
- failure to manage transitions of care (e.g. referral, transfer and discharge processes).

This Investigation has identified all of the above lessons that are universally offered in reports of this kind. The reader is asked to take these lessons 'as read' and to consider some of the other potential lessons that underlay the failures to deliver care and treatment in an optimal manner.

Lesson One: Policy and Procedure Adherence

The principle lessons identified following the examination of the care and treatment that Mr. and Mrs. X received are those of systems, process and accountability. Policy, procedure and national best practice guidelines are put into place to ensure that care and treatment is provided to service users in an evidence-based manner which has been subject to rigorous research and objective testing. These policies, procedures and national best practice guidelines constitute essential safety nets of care. If practitioners work without these essential safety nets in place they risk putting both the health and wellbeing of the service user and their own professional credibility in jeopardy.

Health and social care practitioners have an individual accountability to ensure that they adhere to policy, procedure and guidelines. Registered professionals have a duty of care placed upon them by both their registration bodies and by their personal contracts of employment to adhere at all times to practices that promote the health, safety and wellbeing of the services users in their care. It was evident that the failure to adhere to policy, process and national best practice guidelines placed Mr. and Mrs. X in a situation of heightened risk which ultimately led to their deaths. There is a distinct lesson here for all individual practitioners in that decisions made by them to depart from evidence-based policy and

procedure can cause serious untoward incidents to occur. Policies and procedures are in place for a reason and no practitioner should take it upon themselves to work outside these parameters unless there are compelling reasons to do so.

Whilst individual practitioners have a duty of care to work within strict guidelines and procedures corporate bodies have a statutory duty of care to ensure that suitable policies and procedures are in place and the service adheres to them.

Lesson Two: Knowing the Patient and Maintaining Robust Clinical Documentation

Knowing the patient and developing a substantial psychiatric history constitutes a basic building block of care. This kind of activity is considered to be of such a fundamental kind that the failure on the part of treating teams to undertake such an activity often remains undetected by Trust and Local Authority governance processes. This can best be described as a sub-audit 'blind spot'. Sub audit blind spots are best detected *via* processes such as case, clinical and managerial supervision. Mr. X was understood poorly by his care and treatment team. This ensured that 'factoids' (unsubstantiated beliefs) were accepted as being concrete facts and this was to the overall detriment of the care and treatment provided to both Mr. X and his wife.

Lesson Three: Supervision and Clinical Leadership

Case, clinical and managerial supervision form an essential safety net of care beneath the practice of all health and social care workers, both registered and unregistered. It is sometimes tempting for individuals to perceive supervision as something they do not have to attend, or something that can be provided informally in an *ad hoc* manner. This perception is often strengthened when services are experiencing workforce pressures. Supervision is a mechanism which can ensure sub audit blind spots are detected, can identify poor levels of practice and can support the ongoing development of practitioner, especially when they are working with service users who present challenge. Statutory organisations and health and social care workers alike should ensure that supervision takes place on regular basis with a formal agenda which is subject to external audit.

Lesson Four: Activity Versus Meaningful Engagement

Both practitioners and health and social care practitioners often mistake activity for meaningful engagement. It is often the case that service users are visited on a regular basis. Regular visits and inputs may not however take place within a structured care, treatment and risk management plan. The fact that the activity is taking place often lulls service providers into a false sense of security when in actual fact the service user's condition may be deteriorating before the eyes of the workers involved.

Health and social care workers should be visiting service users and providing interventions in a structured manner. In the case of Mr. and Mrs. X it was possible to detect that activity was often of a kind not usual for a mental health team to provide, e.g. bathing Mrs. X. The time taken to bath Mrs. X, for example, would have been better spent in ensuring that risk assessment activity was up-to-date and that care and treatment plans were in place and being implemented. The lesson here is that all activity should be purposeful and constitute part of an ongoing structured care and treatment plan.

Lesson Five: Professional Accountability

The topic of professional accountability is a consistent thread that runs through lessons 1-4 set out above. It must be stated that all registered health and social care professionals are personally accountable for the quality care and treatment that they provide. During this Investigation it was apparent that registered health and social care professionals consistently did not understand the duty of care that they held personally in relation to Mr. X and his wife. Professionals often had not read policies, attended training or supervision. However despite understanding that they did not always 'know what they were doing' carried on regardless.

NHS Trusts and Local Authorities have a duty of care to ensure that governance processes are in place to ensure best practice and that all employees work to quality standards of care provision. However a key lesson here is that registered health and social care professionals enter their professional awarding bodies' registers on a voluntary basis and retain a personal accountability when ensuring the safe and effective care and treatment of the services users on their caseloads.

18. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the 5 Boroughs Partnership NHS Foundation Trust to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice have been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process.

18.1. 5 Boroughs Partnership NHS Foundation Trust and Wigan Local Authority Progress against the Internal Investigation and Recommendations from the Independent Investigation

The Executive Directors of the 5 Boroughs Partnership NHS Foundation Trust and Senior Officers at the Wigan Local Authority had the opportunity to review the recommendations required for this case at both the preliminary feedback stage and during the factual accuracy checking stage. The Trust should be given recognition for the work that it has put into this process and the progress that it has already made.

19.1. Diagnosis

- ***Contributory Factor One. The failure to provide a robust diagnostic formulation for Mr. X ensured that his care and treatment programme was not developed to its full potential. This contributed to the poor overall management of Mr. X's health and social care management.***

Trust Progress and Commentary

A new and robust model of care has been introduced across the Trust Adults Services and the Later Life and Memory Services in Wigan. The new models of care have enabled the

modernisation of services and have focused on improving access to assessment, diagnosis and evidenced based treatment whilst streamlining the patient journey through services, offering more effective early intervention and home/community based support and treatment.

The Acute Care Pathway was launched on June 11 2012 across adult services and concentrates timely access to services whilst focusing on clinical quality. The model provides an enhanced assessment service that will provide three teams that will directly support GP practices and the 3 local acute Trusts within the footprint of the Trust up to 24 hours per day.

The increased capacity and skill-set of the service will ensure that adults requiring assessment will be subject to only one comprehensive assessment, wherever or whenever that assessment is required. The new enhanced assessment service offers a model of consultation, liaison and diagnosis at the interface between primary and specialist mental health care. The model provides a dedicated and focussed home treatment service that will work closely with existing adult inpatient services to increase the effective capacity of the treatment team. This will provide greater integration between inpatients and community services.

The model encompasses a dedicated community Mental health service to deliver person-centred interventions and care on the basis of need not age, in accordance with the Department of Health's four priority areas These are an integral part of improving the care and experience of service users and carers.

The Later Life and Memory Service new model of care introduced in Wigan provides a single point of access / gateway function that provides cognitive and functional screening with direct access to advanced assessment and consultation. The model also outlines a Crisis Intervention function for Older Adults requiring specialist Old Age mental health services, and will provide greater integration between inpatients and community services allowing for extending hours to services.

Recommendation 1

It is recommended that the Trust and Local Authority develop a range of key performance indicators to monitor access to care and treatment within the new models of care. These key performance indicators are to be developed:

- **in conjunction with the commissioners of mental health services;**

- **in accordance with national best practice guidance (to include NICE, DoH and RCP guidelines);**
- **available for a full audit to take place within six month of the publication of this report.**

Recommendation 2

All patients must receive a diagnosis and diagnostic formulation following assessment. This activity will be monitored through:

- **clinical audit processes;**
- **medical appraisal.**

19.2. Medication and Treatment

- ***Contributory Factor Two. The failure to provide a comprehensive care and treatment programme contributed to the poor overall management of Mr. X's health and social care management.***

Trust Progress and Commentary

The Trust now has a pharmacy advisor who provides help and support to GP's. Prescription cards are reviewed regularly as is antipsychotic prescribing in both inpatient and community settings. Previously this was a review of dispensing only. Pharmaceutical advisors are now also visible in the community and attend clinical reviews and are available for clinical advice. Pharmacists also attend service and carer forums and carry out workshops on the wards. (Please see notable practice section).

The implementation of the new Acute Care Pathways will address this as described against Contributory Factor 1.

Recommendation 3

The effectiveness of the new medicines management process should be audited to ensure that the system is effective. This should include:

- **an evidence-based audit should be conducted across all five boroughs to provide feedback to prescribing clinicians (Trust and general practice alike) with regard to their prescribing practice;**

- **service users with a history of medication non adherence must have a medicines management care plan which is reviewed on a regular basis.**

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

- ***Contributory Factor Three. The opportunities to use the Mental Health Act (2007) were not considered in a timely manner. This contributed to the poor overall management of Mr. X's health and social care management.***

Trust Progress and Commentary

(Please see commentary under 19.1.)

Recommendation 4

All Trust and Local Authority registered health and social care professionals working in the Wigan area should receive a training update on the Mental Health Act (1983 and 2007). This training should highlight:

- **assessment thresholds;**
- **duty of care issues for service users in inpatient settings; these to include the differentiation between informal and voluntary admissions;**
- **Section 117 aftercare planning and discharge arrangements (NB. This was not a particular issue in relation to Mr. X, but was identified as having been conducted poorly when examining the records, ambient inadvertently, of a service user of the same name during the course of this investigation).**

19.4. Care Programme Approach (CPA)

- ***Contributory Factor Four. The failure to provide a robust CPA for Mr. X ensured that his needs were not assessed appropriately and that his care and treatment programme was not delivered. This made a significant contribution to the poor overall management of Mr. X's health and social care management.***

Trust Progress and Commentary

The new care pathways will ensure effective risk assessment and safe management of risk with Trust Policy and National Guidance on CPA within multidisciplinary teams that will provide an advanced assessment along with appropriate evidence-based interventions and

specialist consultation. Essentially, the service user will have their needs assessed and care/intervention provided within one 'umbrella' team, thus reducing the need for multiple assessments, whilst streamlining the pathway to treatment.

The Trust has reviewed and implemented a new Management Supervision process that ensures compliance with our internal CPA Policy and National Guidance. Management supervision now includes case note review that involves checking the quality of the care plan and risk assessment for cases open to the practitioner.

The assessment functions have been consolidated into one coordinated assessment service that has a 24hour seven day per week accessibility. This new service interfaces with all localities within the community and acute hospital.

Recommendation 5

The Trust can demonstrate improvement to processes around the delivery of effective care planning and risk assessment. This work is at an early implementation stage and work needs to continue to ensure its continued effectiveness. Audit processes should include:

- **Assurance that all those referred to secondary mental health services have a comprehensive assessment of their needs;**
- **there is a clear formulation of the individual's difficulties and needs;**
- **care plans are informed by appropriate assessment and formulation;**
- **all care plans have clear goals or outcomes;**
- **service users and, with their consent, their families and carers, are involved in the assessment of need, the planning of care, and any changes to either the care plan or the care co-ordinator;**
- **the agreement of families and carers is obtained before care plans are finalised which involve actions on their part;**
- **families and carers, with the agreement of service users, are provided with current care plans, including crisis management plans;**
- **where there is multidisciplinary or multi-agency involvement all those involved in delivering care and support are appropriately involved in the assessment and planning process with the knowledge and consent of the service user.**

19.5. Risk Assessment

- ***Contributory Factor Five. The failure to provide multidisciplinary risk assessment for Mr. X ensured that his risk profile was not properly understood and that consequently no fit for purpose risk management plans were put into place. This made a significant contribution to the poor overall management of Mr. X's health and social care to the detriment of his continued safety and wellbeing, and also to that of his wife.***

Trust Progress and Commentary

(Please see commentary under 19.4.)

Recommendation 6

The Trust can demonstrate improvement to processes around the delivery of effective care planning and risk assessment. This work is at an early implementation stage and work needs to continue to ensure its continued effectiveness. The following actions need to take place:

- **all registered health and social care practitioners in the Borough of Wigan should be subject to a comprehensive risk training programme;**
- **all registered health and social care practitioners mentioned in this report should receive clinical risk management training and their caseload should be subject to specialist supervision for a period of six following the publication of this report;**

risk assessment processes should be audited to ensure:

- **that the formulation of the individual's problems and needs informs the understanding of his/her risk and can been demonstated to be multidisciplinary in nature;**
- **that robust and meaningful risk management plans are put in place and are subject to timely review;**
- **that the service user and other relevant individuals are involved in the assessment and planning process;**
- **that the risk management plan is appropriately disseminated.**

19.6. Referral, Admission and Discharge Planning

- ***Contributory Factor Six. Referral and transfer processes did not operate in a seamless and timely manner. This contributed to Mr. X's mental health being allowed to deteriorate on at least two occasions. Discharge processes did not conform to Trust policy expectations and did not provide for the assessment and management of Mr. X's needs once he had returned to the community in March 2009. This went on to make a significant contribution to the subsequent breakdown of his mental health.***

Trust Progress and Commentary

The introduction of the new care pathways in adults and Later Life and Memory Services will ensure that all services users are sign posted within one assessment team. This will provide the service user with a single pathway of care from referral to discharge.

Recommendation 7

The Trust and Local Authority should develop in conjunction with its commissioners a robust performance management tool to ensure that the new care pathways are effective and are implemented as currently planned. (Please see Recommendation 1).

19.7. Safeguarding Vulnerable Adults and Mental Capacity

- ***Contributory Factor Seven. Safeguarding processes were neither understood nor implemented in keeping with either extant local policy or national best practice guidelines in relation to Mr. X and his wife. The failure to do so placed the couple at significant risk and made a significant contribution to the circumstances that led to their deaths.***

Trust Progress and Commentary

Since the incident there has been significant investment in the Safeguarding Adults provision.

The Trust has recently introduced a programme of internal inspections across all in patient wards to look at compliance with policy to practice with specific emphasis on safeguarding. The Trust's Head of Nursing who is a professional advisor to the CQC has led the inspection programme supported by the Corporate Matron. The inspection teams have been made up of

a cross section of operational managers, clinical staff, including the matrons, and corporate support staff.

The inspections have covered compliance with the CQC Essential Standards informed by analysis of each ward's patient safety data, CQC and Mental Health Act reports, Trust Quality Risk Profile.

Safeguarding Adults training is mandatory and is monitored at the Board. Bespoke training packages have been developed and e-learning is supplemented by targeted face to face sessions.

An Electronic Communication Form has been introduced which records all clinical issues of concern, confirms action to be taken and monitors all outcomes.

The Local Authority's safeguarding referral pathways have been aligned with the Trust's, this is jointly monitored fortnightly.

Recommendation 8

The Trust and Local Authority should develop a framework of assurance that will measure policy to practice. This framework must:

- **be developed with local commissioners;**
- **be based upon national best practice guidance.**

Recommendation 9

All registered health and social care practitioners mentioned in this report should receive an update for safeguarding and Mental Capacity Act training and their caseload should be subject to specialist supervision for a period of six months following the publication of this report;

19.8. Service User Involvement in Care Planning and Treatment

- ***Contributory Number Eight. Mr. X remained an unknown quantity. Engagement with him was often on a superficial level and this made a contribution to the poor formulation of his care and treatment needs.***

Trust Progress and Commentary

The Trust has developed an Involvement Scheme designed to provide a safe and efficient process appropriate to enable volunteers to become involved in all stages of designing, delivering and monitoring Trust services.

- Service users and carers from all six business streams are invited to a range of Forums that meet regularly providing opportunities to meet with members of the Trust Leadership Group via 'Take it to the Top' which operate as open question and answer sessions.
- Over 320 service users, carers and volunteers are signed up to Trust Involvement Scheme, co-ordinating participation in over 50 business activities including staff training, recruitment of senior managers, audit, serious untoward incident investigation and working groups, promotional events and corporate committees.
- Participation of service users and carers with staff in Essence of Care Audits (a framework tool that focuses on benchmarking the basics of care) and PEAT (Patient Environment Action Team) Audits (an environmental audit tool, results are benchmarked nationally).
- An innovative opportunity for service users and carers to comment on services and express views using a Big Brother style audio/video box. Footage is shown to the Trust Board, senior managers meetings and staff training.

Recommendation 10

The Trust will ensure through the audit process that:

- **all care plans are developed, where possible with service users;**
- **all care and service delivery is provided in manner sensitive to the needs and wishes of the service users;**
- **all care plans are signed, where possible, by service users;**
- **all service users are given a copy of their care plans.**

19.9. Carer Assessment and Involvement

- ***Contributory Factor Nine. Mr. X's needs as a carer were neither assessed not addressed. This placed a great deal of stress upon him and made a significant contribution to the circumstances that led to both his death and that of his wife.***

Trust Progress and Commentary

The new care pathways were developed through listening to service users and carers regarding their transfer between the range of existing community services. The new pathways have addressed existing issues with the timeliness of referrals, capacity of teams and assessment functions and the whole family assessment in planning the care and treatment of service users where appropriate.

Trust strategic objectives emphasise that recovery focused mental health services require statutory and voluntary agencies to work together and closely with service users, carers and families to ensure that services are needs-led, local, accessible and well resourced.

The new pathways have focused on building current partnership working with statutory and voluntary sector organisations that will enable the provision of additional support on a range of areas including accommodation, welfare benefits, advocacy, and carer assessment.

As part of the care pathway in Later Life and memory Service carers will have access to a variety of psychosocial interventions including:

- education on dementia (individual or group based);
- access to peer support groups;
- support via the telephone or the internet;
- supportive counselling;
- psychotherapy;
- rapid support in crisis;
- faith based spiritual assistance.

As part of the involvement scheme the Trust launched a Service User/Care SUI Reviewer initiative that was designed to utilise the experience and expertise of Service Users and Carers as full reviewers within the Trust's reviews of Serious Untoward Incidents. This initiative draws heavily upon the National Patient Safety Agency principles of *Being Open* (NPSA, 2008). The scheme is now in its third year and growing from strength to strength**.**

The aims of involving Service Users and Carers in Serious Untoward Incident reviews were:

- to increase objectivity into the review process;
- to avoid an overly professional approach to conducting reviews;
- to add the User & Carer dimension to our reviews - putting user and carer views forward;
- to help reviewers consider a different point of view, as Service User/ Carer reviewers often ask the 'but why' questions, providing a different type of scrutiny to reviews;
- to involve the volunteers and increase understanding of the lived experience of mental illness;
- to utilise 'Being Open' philosophy in a transparent manner.

The volunteers are to complete the 2 day Root Cause Analysis Training and are part of the review team in addition to the two reviewers allocated to each review. The volunteer reviewers are involved in:

- planning meetings;
- reviewing clinical records;
- attending team reviews;
- interviewing staff alongside another reviewer;
- discussion on the outcomes of meetings, interviews, case note review;
- analysis of findings and making recommendations for the final report.

The volunteer can do as much or as little as they wish to within the review.

In 2011 the Trust carried out a review with the service users and carers involved to measure the impact of the initiative. Feedback received was that they felt a sense of increased confidence and feeling of worthiness and engaged in the Trusts business and improvements through learning. The Trust is continuing to expand the role with a new recruitment of service users and carers being carried out in 2012. One of the service user reviews is also a member of the Patient Safety Panel that scrutinises all completed Serious Untoward Incidents.

Recommendation 11

The Trust will ensure through the audit process that:

- **all care plans are developed, where appropriate with carers;**

- **collateral information is sought from carers;**
- **information pertaining to risk is shared with carers and that, when appropriate, contingency and crisis plan information is shared in full with them;**
- **all carers, where appropriate, to be offered a carer assessment and a funded care package and support package as required;**
- **carers who refuse carer assessments should be followed up on a regular basis and health and social care professionals should continue to offer support and remake the offer of an assessment at regular time intervals.**

19.10. Documentation and Professional Communication

- ***Contributory Factor Ten. Trust and Local Authority record keeping arrangements failed to provide a fit for purpose system that ensured patient information was maintained correctly. Trust and Local Authority staff failed to adhere to best practice professional record keeping guidance. These two failures in combination contributed to the poor overall management of Mr. X's case.***

Trust Progress and Commentary

The Trust is on a constant journey to continually improve its record keeping standards which started in 2006/2007 when the Trust was unable to report compliance with the standards required for Records Management and Information Governance for the Annual Health Check for 2006/2007. Since then there has been sustained action towards ensuring compliance against national record keeping standards and legislation. By 2009 and to the current date the Trust has declared compliance at Level 3 against national standards.

During 2011 the approach to monitoring compliance has changed; the objective is to ensure that audit and compliance is not regarded as a tick box exercise but as essential to service user safety. The Records Management Team when visiting teams engage with managers and staff to explain the importance of good record keeping practices, to provide help when needed and explain that good record keeping is essential not only to service user safety but their own and their colleagues safety and by having good record keeping practices we will contribute to the Trust.

Recommendation 12

In the long term the Trust must conduct an audit of all service users with the same name, held within the same team, during all record keeping audits. In the short term the Trust must:

- **conduct a record review of the clinical records of the three services users of the same name mentioned in this report to ensure that all records are repatriated appropriately across primary and secondary care;**
- **identify systems and processes in conjunction with primary care and the Local Authority to ensure that similar record comingling cannot occur again in the future;**
- **conduct an audit into the quality of clinical record keeping within the teams identified within this report to ensure that appropriate professional standards are being upheld.**

19.11. Adherence to Local and National Best Practice Policy Guidelines

- ***Contributory Factor Eleven. Failure on the part of the Trust, the Local Authority and each individual practitioner involved to adhere to policy guidance made a significant contribution to the failure to manage Mr. X's case in an evidence-based and professional manner to the detriment of his health, safety and wellbeing.***

Trust Progress and Commentary

Clinical Audit is one of the main components of clinical governance, as it is an effective quality improvement tool which leads to the implementation of initiatives to improve services.

Clinical Audit within the Trust is supported by a Policy and Procedure that meets NHSLA standard requirements. All Clinical Audits require approval by the Research and Audit Governance Group, a multidisciplinary team which meets monthly.

The Trust has an annual Clinical Audit calendar (programme), which is reviewed by the Research and Audit Governance Group and the Clinical Effectiveness Panel, for consideration and approval.

The prioritisation of the clinical audit calendar is based upon many factors, including; organisational need, specific reporting requirements, for example CQUIN target deadlines and national audit submission dates, and the availability of resources. The standards by which the clinical audits are undertaken against include NICE guidance, Trust policies, NHSLA risk management standards, CQC standards of quality and safety, mental health legislation, National Patient Safety Agency, Royal College of Psychiatrists, national service frameworks, Department of Health

The majority of clinical audits assess against more than one of the above standards, guidelines, best practice or policies. As an example the Trust currently has 35 audits that are either approved or on-going or currently on the Calendar for future undertaking that are relevant to Trust Policies, these audits assess policy to practice, and include service evaluations.

The Clinical Effectiveness Panel monitors Clinical Audit, NICE and high level reporting and implementation across the Trust to ensure appropriate governance arrangements are in place and that lessons are learnt that lead to service improvement. The Clinical Effectiveness Panel meet bi-monthly, both Clinical Audit and NICE are standard agenda items. The Clinical Effectiveness Panel reports Clinical Governance and Clinical Risk Committee.

The process for disseminating audit findings is established at the approval stage, to ensure that findings can be appropriately addressed. The main arena for presenting clinical audit findings is the Trust's Research and Audit Forum that meets every two months. The schedule of presentations is approved by the Associate Medical Director who chairs the Forum.

Recommendation 13

The Trust and Local Authority should develop a cycle of audit that tests policy to practice for all policies and procedures linked to the delivery of care planning and treatment. These audits must:

- **be developed in conjunction with commissioners;**
- **include NICE treatment guidelines;**
- **form links with case, clinical and managerial supervision processes to ensure that sub-audit blind spots are identified;**

- **inform the Trust and Local Authority continuing professional development programme;**
- **provide regular feedback to the Board, care and treating teams and individuals.**

19.12. Clinical Governance and Performance

- ***Contributory Factor Twelve. Trust and Local Authority governance systems were not sensitive enough to pick up the degree of policy non adherence that occurred in the cases of both Mr. and Mrs. X. This made a significant contribution to the poor overall quality of the care and treatment that was delivered to the couple.***

Trust Progress and Commentary

Clinical Leadership

The Trust has placed increased emphasis in recent years on Clinical Leadership within the Trust High Level Objectives. A review of the involvement of the clinical leaders across the Trust and their contribution clinical decision making in terms of quality and patient safety has and remains high on the Trust Board agenda. The role of the Clinical Leadership Group has been reviewed by the Director of Nursing and Medical Director to ensure that business decisions and service developments remain clinically focused.

In 2011 the Trust carried out a review of the governance arrangements in place from initial notification of a potential Serious Untoward Incident requiring investigation through to the dissemination and implementation of actions and measuring effectiveness of actions taken. The review focused on increasing involvement of the Clinical Leads from each Business Stream to provide clinical involvement and quality assurance for every commissioned SUI.

Serious incidents are notified by the Trust fast-track system that is cascaded to by immediate automatic notification to the senior management team in the Trust including the Chief Executive, Medical Director, Directors, Operational Assistant Directors, Risk Management and Safeguarding. A 72-hour review is now undertaken for every fast-tracked incident to set the Terms of Reference and to identify the clinical expertise required for the commissioned SUI review.

Clinical Audit

Clinical Audit is part of the Trust's Nursing and Governance Directorate; it is one of the main components of clinical governance, as it is an effective quality improvement tool which leads to the implementation of initiatives to improve services.

Clinical Audit within the Trust is supported by a Policy and Procedure that meets NHSLA standard requirements. All Clinical Audits require approval by the Research and Audit Governance Group, a multidisciplinary team which meets monthly. Clinical Audits are scheduled into the Trust's Clinical Audit Calendar and progress against all audits is reported to the Trusts' Clinical Effectiveness Panel on a bi-monthly basis and to each of the Trusts Business Streams on a monthly basis.

The process for disseminating audit findings is established at the approval stage, to ensure that findings can be appropriately addressed. The main arena for presenting clinical audit findings is the Trust's Research and Audit Forum that meets every two months. The schedule of presentations is approved by the Assistant Medical Director who chairs the Forum.

Quality and service improvements brought about or monitored by clinical audits are included in both the Quality Accounts and the Clinical Audit Annual Report, which also details the progress against objectives set for Clinical Audit.

Recently the Trust has developed Clinical Audit Days; an initiative to improve the way clinical audit supports the Trust to establish the level of compliance to best practice from NICE Clinical Guidelines. The success of these clinical audit days has lead to the initiative being short listed for the Trust's Annual Awards in the category of innovation.

Risk Management

The Trust Risk Management Policy sets out the overall aims and objectives for Risk Management that are delivered through an annual work plan set against each of the objectives. The Risk Management Policy describes a clear structured and systematic approach to the management of risk across organisational, financial and clinical activities.

Operational staff are integral to effective risk management across all Trust activities, in existing services we provide and in the development of new systems, processes and front line

services. Staff members identify and assess risk on a daily basis and report through the Trust on-line risk management system DATIX. Staff are involved in the on going management of risk throughout the Trust and receive timely and effective communication of existing risks and emerging risks through monthly Business Steam Risk Report and the Safety and Quality Metrics Reports. Meetings are held throughout the year where specific risks are raised, discussed and progress monitored. These include but are not limited to: Safeguarding Strategic Committee, Infection Control Committee, Safe Place to Work Group, Health and Safety Committee, Medical Devices Committee and Medicines Management Committee. In addition working groups are established to focus on areas of clinical risk to implement and monitor incident and look at specific clinical interventions.

The Trust Board receives an Assurance and Risk Report at each meeting to review the identification, evaluation and control of financial, clinical and non clinical risk and the risks against the achievement of the Trust High Level Objectives.

Clinical Quality

Quality Measures

The Trust has just produced the third Annual Quality Accounts which establishes a set of quality measures that continue to drive the safety and quality of the service.

When selecting the Quality Measures, the Trust wanted to ensure that they are measuring quality across our different client groups. These measures cover inpatient and community mental health and learning disabilities and community services across all business streams and fit to the same domains of patient safety, patient experience and clinical effectiveness.

Quality Priorities and Quality Measures are evaluated annually by the Trust Board and through extensive engagement with stakeholders. The Trust will continue to monitor the Quality Measures as part of the Quality and Safety Strategy.

Quality Priorities

The Trust has three quality priorities that will demonstrate improvement in patient safety, patient experience and effectiveness of services, these priorities are revised each year but remain aligned to safety, patient experience and effectiveness and the Trust objectives.

Safety - Reduction in avoidable harm.

Clinical Effectiveness - Increasing engagement and embedding person centred care planning.

Experience - Listen to what service users and carers think about the services provided to build on positive experiences and change where improvements should be made.

Policy to Practice

In December 2011 the Trust was assessed against the 2011/2012 National Health Service Litigation Authority Risk Management Standards for NHS Trusts Providing Mental Health and Learning Disabilities Services. The 2011/2012 standards encompassed the transfer of Integrated Community Services into the Trust. The Trust achieved 100% compliance with the required standards. As part of the Clinical Audit cycle there are 35 audits that have been carried out or are within the audit calendar to test the level of compliance with the policies in practice.

Recommendation 14

The Trust has accomplished a significant amount of work in relation to clinical governance processes. The Trust should audit progress against the new systems within six months of the publication of this report. This audit should be framed in conjunction with commissioners and should provide assurance in the public interest that implementation stages have been successfully embedded within the Trust.

19.13. Management of the Care and Treatment of Mr. X

- ***Causal Factor One. The failure to assess, monitor, manage and support Mr. X in the community in the summer of 2009 led to his reaching a point of crisis which ultimately led to the deaths of both him and his wife. The treating teams had the knowledge, the opportunity and the means to intervene but did not do so.***

Recommendations 1 – 14 have been developed to address the issues raised by this causal factor.

19.14. Joint Management of Mr. and Mrs. X

- ***Causal Factor Two. Mrs. X was a vulnerable adult whose needs were not assessed or addressed appropriately. She was dependent upon her husband and also at risk from him. The failure to assess, monitor, manage and support Mr. X in the community in the summer of 2009 led to his reaching a point of crisis which ultimately led to the deaths of both him and his wife. The treating teams had the knowledge, the opportunity and the means to intervene but did not do so.***

Recommendations 1 – 14 have been developed to address the issues raised by this causal factor.

19. Glossary

Alzheimer's Disease	*"Alzheimer's disease is the most common form of dementia, a group of disorders that impairs mental functioning. (Dementia literally means loss of mentation, or thinking.) At the moment, Alzheimer's is progressive and irreversible. Abnormal changes in the brain worsen over time, eventually interfering with many aspects of brain function. Memory loss is one of the earliest symptoms, along with a gradual decline of other intellectual and thinking abilities, called cognitive functions, and changes in personality or behaviour.* *Alzheimer's advances in stages, progressing from mild forgetfulness and cognitive impairment to widespread loss of mental abilities. In advanced Alzheimer's, people become dependent on others for every aspect of their care. The time course of the disease varies by individual, ranging from five to 20 years. The most common cause of death is infection."*[533]
Aripiprazole	Aripiprazole has been approved by the FDA for the treatment of acute manic and mixed episodes.
Bi-Polar Disorder	Bipolar disorder is a condition in which people go back and forth between periods of a very good or irritable mood and depression. The 'mood swings' between mania and depression can be very quick.
British National Formulary	The British National Formulary (BNF) is a medical and pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about all medicines available on the National Health Service (NHS), including indication(s), contraindications, side effects, doses, legal classification.
Brufen	Brufen relieves pain and reduces inflammation.
Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.
Care Coordinator	This person is usually a health or social care professional who coordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.

533. http://www.alzinfo.org/07/about-alzheimers/what-is-alzheimers-disease

Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.
Care Coordination	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Computerised Tomography Scan (CT)	A CT scan is a Computerised Tomography scan. It is a special type of X-ray using a scanner and computer equipment to take pictures of the brain or spine. It differs from a standard X-ray as it produces pictures of cross-sections of the brain or spine.
Delusion	A delusion is a fixed false belief that is resistant to reason or confrontation with actual fact.
Diazepam	Diazepam is a type of medicine called a benzodiazepine. Benzodiazepines are used for their sedative, anxiety-relieving and muscle-relaxing effects.
Donepezil	*"Donepezil is used to treat dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and may cause changes in mood and personality) associated with Alzheimer's disease (AD; a brain disease that slowly destroys the memory and the ability to think, learn, communicate and handle daily activities). Donepezil is in a class of medications called cholinesterase inhibitors. It improves mental function (such as memory, attention, social interaction, reasoning and language abilities, and ability to perform activities of daily living) by increasing the amount of a certain naturally occurring substance in the brain. Donepezil may improve the ability to think and remember or slow the loss of these abilities in people who have AD. However, Donepezil will not cure AD or prevent*

	the loss of mental abilities at some time in the future."[534]
Duloxetine	The main uses of Duloxetine are in major depressive disorder and general anxiety disorder.
Electro-Convulsive Therapy (ECT)	*"ECT is a treatment for a small number of severe mental illnesses…ECT consists of passing an electrical current through the brain to produce an epileptic fit – hence the name, electro-convulsive. On the face of it, this sounds bizarre. Why should anyone ever have thought that this was a sensible way to treat a mental disorder? The idea developed from the observation that, in the days before there was any kind of effective medication, some people with depression or schizophrenia, and who also had epilepsy, seemed to feel better after having a fit. Research suggests that the effect is due to the fit rather than the electrical current."*[535]
Esomeprazole	Esomeprazole is commonly used to treat conditions such as gastroesophageal reflux disease.
Ezetimibe	Ezetrol tablets contain the active ingredient Ezetimibe, which is type of medicine known as a cholesterol absorption inhibitor.
Finasteride	Physicians use Finasteride for the treatment of benign prostatic hyperplasia (BPH), informally known as an enlarged prostate. The approved dose is 5 mg once a day, and six months or more of treatment with Finasteride may be required to determine the therapeutic results of treatment.
Galantamine	Galantamine cannot cure dementia or Alzheimer's disease but it can slow down the progression of dementia and can help to ease the symptoms of memory loss, confusion and changes in behaviour. It works by increasing the amount of a natural chemical in the brain called acetylcholine which is known to be lower in people with Alzheimer's dementia.
Haloperidol	Haloperidol is an antipsychotic used for Schizophrenia and other mental health problems affecting thoughts, feelings and behaviours.
Lewy Body Dementia	*"Lewy Body Dementia is a common type of progressive dementia and some of its common symptoms include staring into space, constant tiredness and disorganised speech. Hallucinations are also another symptom as is the*

534. http://www.nlm.nih.gov/medlineplus/druginfo/meds/a697032.html
535. http://www.rcpsych.ac.uk/mentalhealthinfoforall/treatments/ect.aspx

	loss of spontaneous movement. *The condition gets its name from the fact that the symptoms are caused by a build up of Lewy Bodies. These Lewy Bodies are basically bits of alpha-synuclein proteins which have built up inside the part of the brain which is responsible for the memory. It is sometimes extremely difficult to make a proper diagnosis of this type of dementia as it is so similar to both Parkinson's disease and Alzheimer's disease. Usually the condition affects people spontaneously and there is never usually a family link. However, there are some uncommon cases where more than one person within a family has had the condition, but usually it is uncommon."*[536]
Lithium Carbonate	Lithium is used to treat and prevent episodes of mania (frenzied, abnormally excited mood) in people with bipolar disorder.
Lofepramine	Used in the treatment of symptoms of depressive illness. Recommended dosage: 70mg twice daily (140mg) or three times daily (210mg) depending upon patient response. Special warnings Suicide/suicidal thoughts or clinical worsening. … Close supervision of patients and in particular those at high risk should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregivers of patients) should be alerted about the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present.
Mental Health Act (1983 and 2007)	The Mental Health Act 1983/2007 covers the assessment, treatment and rights of people with a mental health condition.
Mini Mental State Examination	*"The mini–mental state examination (MMSE) or Folstein test is a brief 30-point questionnaire test that is used to screen for cognitive impairment. It is commonly used in medicine to screen for dementia. It is also used to estimate the severity of cognitive impairment at a specific time and to follow the course of cognitive changes in an individual over time, thus making it an effective way to document an individual's response to treatment."*[537]
Magnetic Resonance Imaging Scan (MRI)	An MRI scan is a Magnetic Resonance Imaging scan. It uses strong magnetic fields and radio waves to take pictures of the brain or spine. It differs from a standard X-

536. http://www.blurtit.com/q537006.html
537. http://en.wikipedia.org/wiki/Mini%E2%80%93mental_state_examination

	ray as it produces very detailed pictures of the brain or spine.
Named Nurse	The 'Named Nurse' is a nurse designated as being responsible for a patient's nursing care during a hospital stay and who is identified by name as such to the patient. The concept of the named nurse stresses the importance of continuity of care.
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Olanzepine	Olanzapine is used to treat Schizophrenia, moderate to severe episodes of mania in Bi-polar Disorder (manic depression) and prevention of recurrence.
Paroxetine	See Seroxat below.
Pericyazine	Pericyazine is an antipsychotic used to treat Schizophrenia and other nervous, mental, emotional and behaviour problems.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts.
PRN	The term "PRN" is a shortened form of the Latin phrase *pro re nata*, which translates roughly as "as the thing is needed". PRN, therefore, means a medication that should be taken only as needed.
Procylidine	Procylidine is used in patients with parkinsonism and akathisia and to reduce the side effects of antipsychotic treatment given for schizophrenia. Signs of Procylidine overdose are those of an anticholinergic and include confusion, agitation and sleeplessness that can last up to or more than 24 hours.
Propranolol	This is used to treat a wide variety of cardiac problems and is also used in the treatment of anxiety. Side effects can include insomnia, disorientation and visual disturbance.
Psychosis	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place. *"There are four main symptoms that are associated with a*

	psychotic episode: • *Hallucinations;* • *Delusions;* • *confused and disturbed thoughts;* • *a lack of insight and self-awareness.* ”[538]
Risk assessment	An assessment that systematically details a person's risk to both themselves and to others.
Risperidone	Risperidone is a second generation or atypical antipsychotic. It is used to treat Schizophrenia (including adolescent Schizophrenia), Schizoaffective Disorder, the mixed and manic states associated with Bi-Polar Disorder, and irritability in people with autism.
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.
Senna	Senna or Senokot is a laxative used to treat constipation.
Seroxat	Seroxat (also known as Paroxetine) is used to treat major depression, obsessive-compulsive disorder, panic disorder, social anxiety, Post traumatic stress disorder and generalized anxiety disorder in adult outpatients.
Sertraline	*"Sertraline is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). It is also used to relieve the symptoms of premenstrual dysphoric disorder, including mood swings, irritability, bloating, and breast tenderness. Sertraline is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amounts of serotonin, a natural substance in the brain that helps maintain mental balance.* ”[539]
Service User	The term of choice of individuals who receive mental health services when describing themselves.
SHO (Senior House Officer)	A grade of junior doctor between House Officer and Specialist Registrar in the United Kingdom.

538. http://www.nhs.uk/Conditions/Psychosis/Pages/Symptoms.aspx
539. http://www.nlm.nih.gov/medlineplus/druginfo/meds/a697048.html

Specialist Registrar	A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant.
Staff Grade Doctor	In the United Kingdom, a staff grade doctor is one who is appointed to a permanent position as a middle grade doctor.
Tamsulosin	Tamsulosin is primarily used for benign prostatic hyperplasia, but is sometimes used for the passage of kidney stones by the same mechanism of smooth muscle relaxation via alpha antagonism.
Venlafaxine	Venlafaxine (Effexor) a drug prescribed for the treatment of depression with associated symptoms of anxiety.
Waterlow Pressure Score	The 'Waterlow score (or scale) gives an estimated risk of a patient developing a pressure sore.
Zopiclone	Zopiclone (brand name Imovane in Canada, Australia and Zimovane in the UK) is a non-benzodiazepine hypnotic agent used in the treatment of insomnia.

Appendix One

Timeline for Mr. and Mrs. X

Care pathway for Mr. and Mrs. X

Details for Mr. X given in black text
Details for Mrs. X given in blue text

Date	Event	Variation from Policy and Procedure
July 1990	Mrs. X went to her GP on several occasions with panic attacks.	
1995 & 1996	Mrs. X was treated with Prozac.	
1998	First evidence of Mr. X receiving services from mental health services. Mrs. X attended her GP Practice and told her GP her husband was mentally ill being paranoid and depressed. She was feeling tense and was not sleeping.	
6 November 1998	Mr. X was seen as part of an urgent referral. It was noted that Mr. X had been seen in the Outpatient Clinic *"for many years until he was discharged"*. The diagnosis was *"paranoid psychosis? Depressive illness"*. According to Mr. X's wife he had been doing well for a few years and then started to become aggressive and paranoid. It was noted that Mr. X suffered from insomnia and also drank up to two and a half bottles of whiskey a week. It was noted that sometimes his wife became afraid of him because he "*becomes verbally aggressive and has pushed her around frequently"*.	
25 October 2001	A CMHT referral form was filled in. The date of the first referral was 25 October 2001. Medication was Olanzapine 40 mg once daily and Paroxetine 5 mg once daily.	
10 September	Mr. X was assessed. His designated details were as follows: **Presenting Problems:** anxiety, lowness of mood and self esteem. He found it	

2002	difficult to go out without his wife and felt that, when outside, people were against him. **Medication:** Olanzapine 5mg once a day, and Paroxetine 40mg at night. **Substance misuse:** it was noted that Mr. X drank whiskey for relaxation in the evening. **Physical Health Problems:** it was noted that Mr. X had high blood pressure, dizzy spells arthritis in the hips and that he had recently had a knee replacement. It was also noted that Mr. X had experienced a mining accident in 1967 and that his psychological problems stemmed from this time. At this time Mr. and Mrs. X felt that they were coping and did not need any additional support. The plan was to review Mr. X 'at CPA' every three months. Mrs. X was asked if she needed a carer assessment and she didn't feel that she needed any assistance at this time. Both his wife and his sons were described as being supportive at this time. **He was noted as requiring Enhanced CPA.**	***First Factor for Consideration*** ***This is the only background information and psychiatric history available for this individual.***
4 April 2003	Mr. X was reviewed by a Staff Grade Doctor in the presence of his Care Coordinator. Mr. X was reported as feeling well. His mood was Euthymic, he was well dressed and had good eye contact. *"He still thought people were against him."* It was decided to increase the Olanzapine from 5mg to 10mg. The plan was to review him in three-months time.	
29 April-2 May 2003	The care plan focused on Mr. X's depression and anxiety. He was being prescribed Olanzapine 10mg at night. A review date was given as being October 2003. The address was Hall Lane.	
10 May 2004	A risk assessment was conducted. Mr. X's address was noted as being Whiteside Avenue.	
31 January 2005	Mrs. X telephoned the Ashton CMHT to say that Mr. X was too physically unwell to attend his Outpatient appointment. The GP was written to and told that Mr. X would be followed up in one month's time.	
14 March	Mr. X failed to turn for his Outpatient appointment with the Ashton CMHT. It	***Second Factor for Consideration.***

2005	was noted in the letter sent to his GP that at the last appointment Mr. X had been stable. The plan was to offer him another appointment with a view to discharging him.	***Most of this information was not in the CMHT record. The source was the GP record. It is unclear why these records were not held in Mr. X's Trust folders. This caused the first breach in continuity of care.***
25 July 2005	Mr. X failed to attend his Outpatient appointment. The plan was to discuss him with the CMHT with a view to discharge.	
23 February 2006	Mrs. X was referred to the memory clinic by her GP as she had been experiencing memory loss.	
20 April 2006	Mrs. X was seen in the Memory Clinic by Consultant Psychiatrist 1 who referred Mrs. X for a neuro-psychological assessment. It was noted that Mrs. X had been very stressed by her husband and Consultant Psychiatrist 1 wanted to understand whether the memory problems and cognitive impairment were due to Alzheimer's Disease or anxiety and depression.	
12 May 2006	The Consultant Psychiatrist wrote to Mrs. X's GP. He had reviewed Mrs. X in the Outpatient Clinic with her friend in attendance. The diagnosis was *"? early dementia ?anxiety and depression"*. The Consultant encouraged her to take her Sertraline (100mg) on a regular basis. The Consultant asked the GP to conduct a physical examination and wrote that he would be referring Mrs. X for a CT scan. The plan was to follow her up in four months time in the Outpatient Clinic. Mrs. X explained that her memory was poor and that her husband irritated her. Mrs. X reported that she had a bad memory, but that she always was *"scatter-brained"*. Mrs. X said that her husband's condition stressed her and that he had a bi-polar disorder and had not been well for some time. The opinion was that Mrs. X had a mild cognitive impairment and that she should be monitored to see how things developed.	***Third Factor for Consideration.*** ***This is the first time Mr. X is described as having a bi-polar disorder. It would appear that Mrs. X had been told this by the GP but it was not correct as this diagnosis probably belonged to a different patient of the same name.***
23 August 2006	The SHO wrote to the GP to say that Mrs. X had been reviewed in the Outpatient Clinic. She was accompanied by her friend. The diagnosis was *"? anxiety and depression ?early dementia"*. The management plan was to increase her	***Fourth Factor for Consideration.*** ***Should she have been referred for a Social Services carer assessment? Should this have***

	Sertraline from 100mg to 150mg once daily. The GP was asked to forward on the blood results that had been requested the previous May. The Psychiatrist planned to follow Mrs. X up in the Outpatient Clinic in three-months time. Mrs. X appeared to have improved a little since May. She continued to be distressed caring for her husband who was noted as having a bi-polar affective disorder. During the consultation she became *"weepy and was very tearful"* She denied any thoughts of suicide or self harm.	***explored more fully? Should Mrs. X have been categorised as a vulnerable adult at this stage?***
21 November 2006	Mr. X was reviewed. The outcome was that Mr. X no longer required a secondary care service. A copy of the contingency plan was sent to the GP. Mr. X was discharged on Olanzapine 10mg. The contingency plan basically was for Mr. X to telephone the Rapid Response Service or the GP on call service. He was also offered voluntary sector helpline telephone numbers. Mr. X was discharged from his Section 117 by the Consultant. **It was noted that this Mr. X had not had any mental health problems for two years that had required secondary care services.**	***Fifth Factor for Consideration.*** ***This was not the same patient. However this information was accessible to the treating team in October 2008 when Mr. X was referred to the CMHT. This should have been picked up upon. If this had been Mr. X's record it should raised the antennae of the CMHT.*** ***SixthFactor for Consideration.*** ***What was/is the Trust practice when discharging someone from a Section 117?***
5 June 2007	Mrs. X did not attend the Psychiatric Outpatient Clinic and that another appointment was sent.	
11 August 2007	An 'Essential Data Form' was completed. Mrs. X was designated as requiring CPA, although her needs were assessed as being low.	
29 August 2007	Mrs. X did not attend her Outpatient appointment with the Consultant Psychiatrist. He wrote to the GP to say that her husband had rung to say his wife did not need any further appointments as she was fine. The GP was asked to re-refer in the future if it became necessary.	***Seventh Factor for Consideration.*** ***Would this be usual practice, especially knowing the history between husband and wife and her growing mental health problems? Should a more assertive approach have been taken? e.g. a home visit?***
17 January	The GP wrote that there were marital problems. Mrs. X reported that her husband	***Eighth Factor for Consideration.***

2008	was depressed and verbally abusive, not physically violent, but he shouted at her and broke her things.	***Was this an early safeguarding warning? What should the GP have done?***
11 February 2008	The GP had a chat with Mrs. X about her husband's controlling attitude. She was encouraged to stay in contact with her female friends and get out more.	
7 August 2008	The GP described Mrs. X as having a blunted affect with difficult home circumstances due to her husband's Bi-Polar disorder. She was less able to cope and was forgetful.	
18 August 2008	GP wrote that Mrs. X was upset because her husband *"still had a bad temper not physically violent, but breaking things & shouts and swears".*	
3 September 2008	Mrs. X was reviewed by the GP. Mrs. X was shaky and wanted something to calm her down. She was referred for guided self help.	***Ninth Factor for Consideration.*** ***Was this counselling approach appropriate for someone with dementia? Should there have been a referral?***
29 September 2008	The Crisis Team sent a FAX referral for Mr. X to the Central Duty Team following receipt from the GP. Checks were made on SWIFT. Checks were also made on the Trust electronic system. It was noted that Mr. X's case had been closed previously in November 2006. The FAX narrative (from the GP) stated that Mrs. X had left her husband one week previously to go and live with her son. Mr. X had stated that he intended to commit suicide as he could not cope. Mr. X had answered the door in his underwear. It was noted that Mr. X presented a risk to himself and had thoughts of suicide. **The GP was annoyed** that no swift referral process occurred. He did not feel, however, that a Mental Health Act assessment was required at this stage. 'Gateway' was supposed to review at the case, but it would not commit to taking Mr. X on. The Duty Team advised the GP to liaise with Gateway directly. The GP did this and telephoned the Duty Team again. He had been told that he would	***Tenth Factor for Consideration.*** ***Unsatisfactory referral process.*** ***At interview we learnt that the GP should have approached Gateway for a general referral and the Central Duty Team for a Mental Health Act assessment. It was evident that the GP was not aware of the process he should have followed and services did not signpost him well. Communication from gateway to the GP was poor as he had ultimately to continue checking that the case***

	be contacted once they had processed the referral. However no one had got back to him and the Gateway service closed at 17.00 hours. Apparently the Gateway Service had referred Mr. X to the Older Peoples' CMHT. The electronic record showed that the case was open although not yet allocated. The GP stated that he had had to make several telephone calls in order to progress the case. The GP had spoken to Mr. X's son who had said that his father had taken the break up with Mrs. X badly. Mrs. X was staying with her son. A note was made *"CONCLUSION: URGENT TO OPCMHT AT Claire House".*	***had been taken on by a team (in this case the OPCMHT).*** • ***Referral process*** • ***Issues with communication*** • ***Signposting***
29 - 30 September 2008	An 'Initial Core Assessment' was compiled by a Triage Nurse at the Golborne Older Peoples' CMHT (OPCMHT), who visited Mr. X with a Social Worker. It was recorded that Mr. X was on Enhanced CPA. It was recorded that Mr. X had: • been referred to the CMHT as urgent by his GP; • Mr. X's wife had left him and he was distraught, expressing paranoid ideas, neglecting himself and not eating; • Mr. X had not expressed any suicidal ideas; • Mr. X had a long history of mental health problems; • Mr. X had been seen by services a few years ago. Mr. X said that his wife had previously had a brain scan, but that she had not allowed him to accompany her. She told him the scan had been *"clear".* Mr. X described a poor relationship with one of his sons and that no one in the family was talking to him at the present time. Mr. X felt isolated. Under the 'Carer Section' of the form it was noted that the son was telephoned. He had apparently said that services should *"put his father away that they could not cope with him anymore and that his mother was very distressed about the situation."* Mr. X was assessed as having "*severe paranoid ideas".* He was also described as being tearful and dishevelled and was neglecting himself. He did not want to be	

	admitted to hospital. Mr. X agreed to be followed up the following week and to comply with his medication. He said he had thoughts of suicide but no plans. The plan was to: • discuss with Team Manager; • to get case allocated *"asap";* • *"to speak to Consultant and get meds PX";* • *"to visit this week to give support and medication".*	
1 October 2008 15.03 hours	An urgent referral was sent to the older peoples' CMHT consultant. The FAX said there were seven pages. The Investigation Team have been given the front cover only. The FAX front cover stated *"urgent referral for Doctor…"* The GP was faxed and asked to *"commence Risperidone 2 mg at nocte [at night]."* A domiciliary visit to Mr. X was made at the request of the GP. The CMHT workers who visited were worried about Mr. X as he was paranoid and finding coping with his wife's angry outbursts difficult. It was noted that Mr. X needed to be seen by a Consultant Psychiatrist *"as a matter of extreme urgency".* A significant risk of Mr. X committing suicide was recorded.	
2 October 2008	The Central Duty Team received the information that Mr. X had been reported to have assaulted his wife. Mrs. X told Police that since she retired eight years ago Mr. X hit her from time to time. On the 17 September 2008 Mrs. X claimed Mr. X had *"shoved"* her to the floor and punched more than once to the chest. On this occasion she had left the house and gone to stay with her son. Mr. X was arrested for assault and bailed with the condition that he did not attempt to contact his wife. This information was forwarded to the Older Peoples' CMHT. A worker at the Central Duty Team screened a referral for Mrs. X. The Central Duty Team Contact Form stated that an incident had occurred on the 1 October at	

	15.03 hours. There had been a report of domestic harassment by Mr. X over the telephone towards his son. Mrs. X had said that Mr. X had been hitting her *"from time to time"* over the past eight years when he lost his temper. Since Mrs. X left the marital home on the 17 September Mr. X had been telephoning his son.	
3 October 2008	A 'Summary of Intervention' form was completed. The CMHT was recorded as being the Hindley and Ince CMHT. It was recorded that Mr. X was on Enhanced CPA. The Care Coordinator was listed as being the Consultant Psychiatrist. It was recorded that Mr. X had been diagnosed many years ago as having a Paranoid Psychosis. A joint visit took place and it was noted that Mr. X was paranoid and drinking alcohol, both whiskey and lager. Mr. X continued to drink throughout the interview. It was recorded that Mr. X's fixed paranoid ideas were affecting his ability to look after himself as he was not leaving the house. It was thought Mr. X's mental health was deteriorating but that the risks he presented were low and that he presented no risk to others and he denied intent of harming himself. It was decided that Mr. X would require monitoring from the Crisis Team over the weekend. The Older Persons CMHT Manager recorded the difficulty experienced by staff in locating a Consultant Psychiatrist that could make a home visit. It was decided that Mr. X's case needed to be referred to the Adult CMHT due to the functional nature of his presentation. The Crisis Team were to be on standby over the weekend with medical support if required. It was recorded by members of the Crisis Team who visited Mr. X that he did not want people coming to the house as he did not want any fuss. Mr. X agreed to Home Treatment Team intervention at the weekend and for his case to be reviewed by his Care Coordinator on Monday.	
4 October 2008	A telephone call was made by the Crisis Team to Mr. X to arrange a home visit. Mr. X declined the offer. Mr. X said he would contact his Care Coordinator on Monday.	

5 October 2008	A member of the Crisis Team telephoned Mr. X to arrange a visit. He declined this and also the offer for a telephone call later that same day. This information was to be passed to the Care Coordinator.	
Estimated to be around this time	A Risk Screening form was completed The following was recorded: • *"risk to self - no;* • *risk to others - no;* • *risk of vulnerability - yes;* • *risk of neglect - yes."* No date was recorded on the form but the electronic printout shows it was printed on the 3 October 2008.	
6 October 2008	The Consultant Psychiatrist and a Social Worker from the Adult Team visited Mr. X at his home. He seemed calm, although tearful, and refused to come into hospital. The Doctor did not think Mr. X was Sectionable at the time. Mr. X agreed to engage with regular support. It was noted during the visit that the allocation of a Care Coordinator was required in order to provide further assessment.	
7 October 2008	It was agreed another home visit would be made to Mr. X. The visit took place and Crisis Team input was offered. Mr. X did not want to accept this kind of support. Mr. X telephoned the CMHT to say that someone from the Crisis Team had contacted him and that he did not want their support. It was agreed that Mr. X needed continuity of care and that it was important for a Care Coordinator to be allocated. Discussions took place between the CMHT and the Crisis Team to ensure a safe handover. Mr. X decided that he would receive daily visits from the Home Treatment Team for the next five days until a Care Coordinator was allocated. The allocation meeting was due on Friday in five days time. He refused a visit from them on this day as he had already previously received a home visit from the CMHT.	

8 October 2008	Mr. X telephoned the Golborne CMHT and asked for a hospital admission as he was not coping. The clinical records stated: *"[Mr. X] to transfer today".* A scheduled joint visit was made by the Golborne Older Peoples' CMHT and the Adult CMHT. Mr. X was dishevelled and smelt. Mr. X was ambivalent about going to hospital. They arranged for his dog to be taken to his wife. A Social Worker from the Adult CMHT accompanied Mr. X to the hospital. Everything was described as going reasonably well until he arrived on the ward. At this point Mr. X said he wanted to go home. Mr. X felt that everyone was against him. There was a considerable delay in the ward doctor arriving to commence the admission. Mr. X became upset and would not accept anything to eat. After a wait of over an hour Mr. X became distressed and refused to stay on the ward. He was told that the bed would be kept for him that night. Mr. X returned home without being seen by any medical staff. He was advised of how to contact the CMHT and what to do if he needed help out of hours. The plan was to discuss Mr. X with the Adult CMHT Consultant Psychiatrist the following day. The Crisis Team was scheduled to continue daily contact until the end of the week A 'Contact Assessment' form was completed for Mrs. X Mrs. X's son had contacted the Central Duty Office on the advice of Claire House who had told him someone would come and *"see his mum within two days".* The son had not been able to go to work for three weeks since his mother had come to live with him because she could not be left on her own. He was worried about losing his home if he could not work.	
9 October 2008	The Crisis Team attempted a home visit but Mr. X refused them entry. The Adult CMHT was informed. When Mr. X was finally visited he was found to be under the influence of alcohol. Whiskey and strong lager were found in his lounge despite the Doctor's	

	advice about not drinking. It was noted that Mr. X looked unkempt. (It is unclear who made this assessment). Consultant Psychiatrist 2 was asked to visit Mr. X at his home. She recorded in a letter to the GP that Mr. X was miserable and crying and believing that people were talking about him. He was drinking alcohol to help him sleep. It was noted that he had been married for 50 years and had two grown up sons and that his wife had left him two weeks previously. It was also noted that Mr. X had a long mental health history of depression going back some 30 years. The GP was asked to prescribe Risperidone 2 mg twice daily and to increase Mr. X's current Seroxat to 40 mg a day. The OPCMHT received an immediate referral from the Central Duty Team. Mrs. X's son had telephoned to say that he could no longer cope with his mother. A call was made to Lakelands Residential Care Home to see if a bed was available. An 'Initial Core Assessment' was conducted. It was recorded that Mrs. X had been an immediate referral due to an incident of abuse and the fact that her son could not continue to cope as her carer. Mrs. X was too frightened to return home as her husband was there. The son refused a care package to be brought into his home to care for his mother as he did not want to be her carer. The son was however prepared to keep his mother at home until a suitable place could be found for her. A risk screen was conducted. The following was recorded: • *"risk to self - no;* • *risk to others - no;* • *risk of vulnerability - yes;* • *risk of neglect - no."* Mrs. X was designated Enhanced Level CPA.	***Eleventh Factor for Consideration.*** ***There are issues here regarding both Carer assessment and Capacity. Mrs. X's son was eligible for a carer assessment and/or a swift resolution to the situation he was facing. Mrs. X should not have been considered for a bed in a Residential Care Home until her capacity/best interests/circumstances had been assessed.*** ***There was no MDT assessment or decision making. Should there have been a joint health and social care assessment conducted at this stage?*** ***?***
10 October	The Social Worker from the Adult CMHT telephoned Mr. X who said that he did	***Twelfth Factor for Consideration.***

2008	not want a visit to his home and that he had not changed his mind about going to hospital. He said he had eaten and taken his medication. The Social Worker and Consultant Psychiatrist agreed that they would visit him the following Monday. If his condition remained unchanged a Mental Health Act assessment would be arranged. The GP surgery was informed. The Crisis Team agreed to remain in contact over the forthcoming weekend. **On this date the Social Worker became the Care Coordinator**	***There were many delays and a great deal of confusion in relation to how Mr. X's referral was processed. For a period of 13 days he had no Care Coordinator and at times was being treated by three different clinical teams. It is important to understand that during this time he had no proper assessment or care planning and his mental state was deteriorating This was in breach of CMHT Operational policy and CPA policy.***
11 October 2008	The Crisis Team telephoned Mr. X he declined their input.	
13 October 2008	Care Coordinator 1 spoke to the GP. He was informed of the current situation and was agreeable to take part in a Mental Health Act assessment if it was deemed to be necessary.	
14 October 2008	Mrs. X's case was allocated to Care Coordinator 2 who recorded that a first contact with the client was to be made the following day. Mrs. X was designated as a new client. A POVA was commenced.	***Thirteenth Factor for Consideration.*** ***It took three weeks for Mrs. X to be allocated even though she had been designated at requiring Enhanced CPA. This was in breach of the CPA policy.***
15 October 2008	A visit to Mrs. X took place on this day. It was recorded that Mrs. X was too anxious to discuss the care plan. Care Coordinator 2 and Consultant Psychiatrist 1visited Mrs. X. She said was afraid and agreed to go into Lakelands for respite for a period of two weeks. Her son was struggling to cope with her and he did not want her to live with him. The Doctor conducted a Mini Mental State Examination. The score was 14/30. Mrs. X was disorientated and her memory was poor. A CT brain scan was indicated and "*medication for dementia"* was prescribed. A FAX was sent to Lakelands. A CPA assessment was commenced. The assessment stated that Mrs. X had been living with her son for the past three weeks and that he could no longer cope as	

	he needed to get back to work. It was noted that Mrs. X had cognitive problems and short-term memory impairment. Mrs. X was frightened of her husband and did not want to return home. The plan was for Mrs. X to go to Lakelands Residential Care Home for a period of respite. A bilateral tremor was noted in her arms and a referral for a neurology appointment was made. The medication was Duloxetine 60 mg once daily and Donepezil 5 mg once daily. Mrs. X was recorded as having two sons neither of whom maintained regular contact with her due to their father's behaviour. Care plans were developed to address Mrs. X's memory problems, tremors, anxiety and social isolation. A crisis plan was also developed.	
22 October 2008	The Consultant Psychiatrist wrote to Mrs. X's GP. He had been asked to see Mrs. X by the OPCMHT. Mrs. X had been developing gradually cognitive problems which included short-term memory impairment. Mrs. X's activities of daily living abilities had also declined. Mrs. X had grown increasingly frightened of her husband and was living with her son who was finding it difficult to look after her because she got confused and did not always know who he was. The opinion was that Mrs. X probably had *"a dementia syndrome, suggestive of underlying Alzheimer's Disease".* The plan was to refer Mrs. X for a neurological assessment and to commence her on a cholinesterase inhibitor. The Consultant was to follow her up in three months time and the CMHT was to maintain contact with her.	***Fourteenth Factor for Consideration.*** ***Was there a protocol for the memory Service? The follow up arrangements were unspecified. NICE guidance criteria may not have been adhered to. How are patients followed up? How is medication monitored?***
30 October 2008	A Multi Disciplinary Team meeting recorded the diagnosis as being *"Psychotic Depression Paranoid".* At this time he denied experiencing hallucinations or of having thoughts of killing himself. It was noted that Mr. X drank heavily and he	***Fifteenth Factor for Consideration.*** ***The Care Coordinator did not liaise with the Court or the Police Station. The criminal***

	was advised to cut down. The GP was written to. It was noted in this letter that Mr. X was drinking about one and a half bottles of whiskey a week and that he was attending the Police Station as part of his bail conditions.	***justice system process did not appear to influence risk assessment for wither Mr. or Mrs. X, or inform the CPA process.***
12 November 2008	An Inpatient Psychiatric Interview and Clinical Examination took place. Mr. X had been referred by a Hindley and Ince CMHT Duty Worker due to *"agitation/anxiety".* It was recorded that: • Mr. X had a long history of mental health problems; • his wife had left him in October since which time he had become depressed with feelings of anxiety and not being able to cope, she was no longer talking to him; • his wife had contacted the Police and claimed that Mr. X had assaulted her; • a referral had been made to Consultant Psychiatrist 2 for a hospital admission and had Mental Health Act assessment *"a few weeks ago";* • Mr. X had thoughts about harming himself but *"doesn't want to die and won't do anything on the ward";* • the psychiatric history noted *"anxiety, depression, ...no admissions? has been under Section 117, ?paranoid psychotic";* • (current listed medication illegible in the clinical record); • Mr. X lived in his own house; • no forensic history was noted; • Mr. X had paranoid thoughts about people talking about him; • Mr. X denied hearing voices or having visual hallucinations; The diagnosis given at this stage was Agitated Depression.	***Sixteenth Factor for Consideration.*** ***It would appear that no Mental Health Act Assessment occurred. It was certain no CPA was developed. Mr. X's mental state deteriorated and he self-referred for help in a state of crisis.***
12-13 November	Mr. X was listed as being on Enhanced CPA.	

2008	The assessment recorded that Mr. X had been admitted onto the Holdenbrook Unit for a period of assessment as an informal patient. Actions required were identified as: • admit to ward; • allocate to Named Nurse; • nurse on appropriate observations; • monitor mood and document changes; • liaise with Multi Disciplinary Team and administer prescribed medication; • facilitate ventilation/exploration of feeling. It was also noted that Mr. X was known well known by the CMHT and that he had telephoned Claire House *"10+"* times asking for help. Medication on admission: Risperidone 3 mg twice daily, Paroxetine 20mg once daily, Esomeprazole 40mg once daily, Finasteride 5mg once daily, Tamsolusin 400mcg once daily, Ezetimide 10mg once daily, Perphenazine 2mg twice daily, Diazepam 2mg as required (maximum three times a day), Zopiclone 7.5mg as required at night. Senne two tablets as required at night. It was recorded that Mr. X was compliant with his medication regimen. In addition Mr. X admitted drinking alcohol (whiskey and lager) to help him cope. A Risk Screen was completed by the Duty Officer. The following was recorded: • *"risk to self - no;* • *risk to others - yes;* • *risk of vulnerability - yes;* • *risk of neglect - yes."*	
17 November 2008	The Social Worker conducting the POVA visited Mrs. X Mrs. X's son was to visit and also to provide information about the attack and physical abuse. The Police had finished their investigation and Mrs. X was not going to pursue the case.	***Seventeenth Factor for Consideration.*** ***The decision was made to drop the Court case without assessing Mrs. X's capacity and without investigating the circumstances***

		around her safety. Mrs. X's capacity had not been assessed at this point.
10 December 2008	The POVA investigation was completed. The Social Worker was to have a planning meeting with the OPCMHT Manager. Mrs. X was not to return home and would be looking for alternative accommodation. Mrs. X dropped the charges against her husband. It was decided to close the POVA and not to have a conference as it would not achieve anything in addition as a protection plan was in place and Mrs. X was to remain in 24-hour residential support until an alternative could be found.	***Eighteenth Factor for Consideration.*** ***The protection plan hinged on the fact that Mrs. X would not be returning home to her husband. There was no case conference or multidisciplinary team discussion. There is no evidence to suggest Mrs. X had her capacity assessed or that her wishes were taken into account.***
14 January 2009	A 'Summary of Intervention' form was completed by a student nurse. Mr. X was unhappy and wanted to discharge himself. It was decided that he would have some escorted leave. Mr. X was to be prescribed Procylidine for the side effects of the Risperidone, and his Propranolol was to be increased to 20 mg three times a day.	
16 January 2009	Mr. X was designated as being *"NonCPA".* The Consultant Psychiatrist had suggested that Mr. X would benefit from psychological therapy. Mr. X was still having difficulties dealing with his estrangement from both of his sons and his wife. It was noted that Mrs. X had dementia and that Mr. X had not yet been informed. At this time Mrs. X was living in respite care and being followed up by the Golborne Older Peoples' CMHT. Risks were noted regarding his alcohol misuse and paranoid, persecutory thoughts. Mr. X was advised that once at home staff would visit him in pairs if he continued to drink.	***Nineteenth Factor for Consideration.*** ***In the event Mr. X did not receive psychological therapy and neither did he receive treatment for his alcohol problems.***
19 January 2009	A Risk Screening form was completed. The following was recorded: • *"risk to self - no;* • *risk to others - yes;*	

	• *risk of vulnerability - yes;* • *risk of neglect - yes."* It was noted that Mr. X was in a confused state and was reacting to his paranoid thoughts. Mr. X was placed on "*Level 2-15 for further assessment"*. Mr. X's mental state was described as fragile and he was also unsteady when mobilising. Mr. X was prescribed Level 2: 15 minute observations because he was paranoid, was low in mood and psychotic.	
21 January 2009	Mr. X thought everyone on the ward wanted to hurt him, or even kill him. At this time Mr. X was being treated for Psychotic Depression. There had been a change in his mental state since his medication had been reviewed. Mr. X continued to refuse ECT. Mr. X's behaviour was bizarre and he was hallucinating. The plan for Haloperidol PRN (*pro re nata*/as required).	
27 January 2008	A ward round was held, it was not recorded who attended Mr. X denied experiencing persecutory delusions. However Mr. X expressed paranoid ideas about the Police and described auditory hallucinations in which people were talking about him. Mr. X was experiencing dizzy spells. It was decided to discontinue the Ariprazole and the Propranolol.	***Twentieth Factor for Consideration.*** ***It was unclear whether Mr. X had a reaction to his medication (propranolol) or a psychotic episode. He was seen by several doctors over a period of four days each of whom made 'diagnoses' or changed his medication. This occurred in an unplanned manner and led to his being prescribed haloperidol and risperidone at the same time. Mr. X's regimen was complex and did not appear to be subject to any medicines management.***
17 February 2009	A ward round was held on this day. Both the Consultant Psychiatrist and the Care Coordinator were present. Mr. X wanted something to be done about his anxiety and also wanted home leave. The ward nursing staff a medication increase (not specified), that Mr. X should have three-four hours of home leave three times a week, two overnight periods of leave. Inputs were also recommended from	

	psychology and the CMHT Support Worker. Mrs. X was assessed at her home by an Occupational Therapist and Care Coordinator 2. Mrs. X wanted to return home, but did not want to go on her own.	
19 February 2009	An *"OPCMHT Res/Nursing Care Application Panel"* form was completed. On the 20 January 2009 Mrs. X had been assessed by Consultant Psychiatrist 1On this occasion she had expressed the desire to remain at Lakelands. However she was now saying that she wished to return home. It was stated that Mrs. X had *"the capacity to make her own decisions."* A joint meeting was to be held between Consultant Psychiatrist 2 and Consultant Psychiatrist 1 on 25 February to discuss the way forward.	***Twenty-first Factor for Consideration.*** ***It would appear that individuals conducting capacity assessments at this time had not been trained, read the policy or knew about the Capacity Act. This calls the quality of the assessment into doubt.***
25 February 2009	A Multidisciplinary Team meeting was held and a 'Summary of Intervention' form was completed. Mr. X was recorded as being *"Non CPA"*. At this meeting it was agreed that Mr. X was eating well and interacting with others. He refused to consider ECT. Mr. X's Haloperidol and Diazepam were stopped and Pericyazine 2.5mg twice daily commenced. It was thought by the Team that Mr. X's main issue was anxiety. Mrs. X was escorted to Holdenbrook Ward to visit her husband. Mr. and Mrs. X said they wanted to be together and acknowledged the need for support. Mr. X was briefed about Mrs. X's illness. Planned home leave was discussed and arranged.	***Twenty-second Factor for Consideration.*** ***At this stage there was no consideration that the protection plan needed to be revisited. It appeared that the safeguarding issues had been 'closed down' and could not be reconsidered unless another incident took place first.***
2 March 2009	The 'Hospital Anxiety and Depression Scale' form was completed. Mr. X was scored as being 'borderline for depression and one point over 'borderline' for anxiety. It was not recorded who completed the assessment as there appears to be no place on the form for a signature. A Risk Screen was completed for Mrs. X. The issues of abuse were recorded. It was also noted that Mrs. X had been struggling to look after herself prior to her admission to Lakelands. It was stated that Mrs. X would require *"intense"* support once she returned home. The following was recorded: • *"risk to self - no;*	

	• *risk to others - no;* • *risk of vulnerability - yes;* • *risk of neglect - no."* Mrs. X was recorded as being on Enhanced level CPA.	
5 March 2009	Mr. X went home for the day with a CMHT Support Worker. The visit went well. Mrs. X was escorted between her home and Lakelands for a home visit.	
11 March 2009	A message on Mr. and Mrs. X's son's answer machine to say that his parents would be at home on overnight leave and that he may wish to visit them. No message was returned.	***Twenty-third Factor for Consideration.*** ***Family liaison and communication appears to have been limited. It was recognised that the couple needed 'intense support' yet the family were not involved.***
12 March 2009	Mr. X was placed on a one day leave from the ward. He was collected by a CMHT worker. The leave went well and he requested overnight leave. Mr. X appeared to be well with no suicidal thoughts. The Multidisciplinary Team plan was to agree to the overnight leave and if this went well to give Mr. X a one week period of leave. Mr. X's family were informed.	
13 March 2009	Mrs. X was escorted home for an overnight leave. The overnight leave went well. There was no evidence to suggest that Mr. X was being aggressive.	
17 March 2009	Mrs. X was escorted home from Lakelands Residential Care Home. Mrs. X had not been aware she was due to return home but was *"ecstatic"* to do so.	***Twenty-fifth Factor for Consideration.*** ***Neither patient had a risk assessment or comprehensive care plan in place at this stage. At this stage they were home alone.***
24 March 2009	An Occupational Therapy (OT) assessment was conducted in the home. It was noted that the couple may struggle to look after themselves.	***Twenty-sixth Factor for Consideration.*** ***The assessment that the couple may struggle came after the discharge when it should have been conducted prior to discharge.***

25 March 2009	A prescription review took place. Esomeprazole 40mg once daily, Finasteride 5mg once daily, Tamsolusin 400 mcg once daily, Ezetimide 10 mg once daily, Diazepam 2.5 mg twice daily, Zopiclone 7.5 mg at night, Lofepramine 70 mg three times daily, Ibuprofen 400 mg three times a day, Pericyazine 2.5 mg twice daily, Procylidine 5 mg once daily. The admission drugs that were discontinued were Risperidone and Paroxetine. The given diagnosis on the prescription sheet was Depressive Disorder with Psychosis. A ward round was held on this day. It was noted that Mr. X was *"doing fine in community"*. The plan was to discharge him in his absence with Care Coordinator 1 supporting him. His medication was to be supplied in blister packs and his Procylidine was to be reduced to 5 mg once daily. Mr. X was to be followed up in the community in four weeks time. Mr. X was duly discharged on Enhanced CPA.	***Twenty-seventh Factor for Consideration.*** ***Mr. X was discharged on Valium PRN. He was known to be non-compliant and had no medicines management plan. The Diazepam had been prescribed for at least six months and it would have been problematic for him to have abruptly ceased to take this drug.***
26 March 2009	A FAX was sent to the GP informing the practice that Mr. X had been discharged and that he would require blister pack medication. A discharge prescription was also provided.	
2 April 2009	A 'Central Duty Team Contact' form was sent to Care Coordinator 2 from Anchor Care to say that Mr. X had cancelled the care package because he thought he could manage alone.	***Twenty-eighth Factor for Consideration.*** ***It was known that Mr. and Mrs. X would need 'intense' support. The package was however cancelled and no action seemingly took place to intervene.*** ***Questions***
6 April 2009	Care Coordinator 2 visited Mrs. X at her home who seemed to be well. Mrs. X said that her husband was not so well. He however denied this saying that he only had bowel problems. Mr. X had his driving license back.	
8 April 2009	A 'Risk Screening' form was completed. The following was recorded: • *"risk to self - no;* • *risk to others - yes;* • *risk of vulnerability - yes;* • *risk of neglect - yes."*	

	It was noted that Mr. X could frequently disengage and that he was on Enhanced CPA. **Care Plan One noted that he was still waiting for a diagnosis.** The plan was for the Consultant to assess him and for the CMHT to continue to provide him with support. Care Plan Two addressed prostate issues. Care Plan Three addressed accommodation and social support issues. It was noted that his wife had dementia and he would require ongoing support. Care Plan Four addressed his social isolation. Contingency and Crisis Plan. There were no links made between this plan and the Golborne team caring for Mrs. X.	***Twenty-ninth Factor for Consideration.*** ***There was no plan to liaise with the Golborne service that cared for Mrs. X neither was a carer assessment considered.***
17 April 2009	Mrs. X was visited at her home who was noted to be less shaky. Mr. X was still in bed (it was 10.35). It was noted that Mrs. X was not taking her night medication. Mrs. X said that Mr. X had to go into hospital for an operation.	
21 April 2009	Mrs. X was visited at her home. Mr. and Mrs. X were finding it difficult to cope without their car. Their son was coming to take them out on occasion.	
22 April 2009	A home visit was undertaken by Care Coordinator 1 and a Team Doctor. Mr. X was noted to be non-compliant with his medication and was drinking alcohol. His medication was reviewed. (No details given). Care Coordinator 2 visited Mrs. X at home. Mr. X was angry and agitated about his driving license and blamed mental health services for the DVLA involvement. Mr. and Mrs. X had an altercation. However, after Care Coordinator 2 intervened, Mr. X said he would never hurt his wife. Mrs. X was certain that she wished to remain in her own home. Care Coordinator 2 discussed Mr. X's presentation with Care Coordinator 1 who planned to discuss Mr. X with the Team Doctor.	

28 April 2009	Mrs. X was visited at her home. Mr. X was saying that his bowels were causing him problems. Mrs. X was taken to see the Neurologist who queried Parkinson's Disease. It was decided that a review with Consultant Psychiatrist 1 was required. Mrs. X saw the neurologist on this day accompanied by a Support Worker. Unfortunately she did not bring her medication with her and it was not possible for the neurologist to know whether she had commenced her cholinesterase inhibitors. He agreed that she had *"dementia syndrome".* Due to her reported visual hallucinations the Doctor thought she may have Lewy Body Dementia.	***Thirtieth Factor for Consideration.*** ***There was no revision to the care plan made in the light of Mrs. X's diagnoses of Parkinson's Disease and Lewy Body Dementia. This was of significance, particularly with regards as to how she would cope in the home.***
1 May 2009	A home visit was made by Care Coordinator 1 prior to her leaving the employ of the LA. Mr. X appeared to be well. Mrs. X said that she was not taking some of her medication (this was reported to the Golborne Team). Mr. X said that he did not want the Support Worker from the Adult CMHT to visit him again. The Support Worker was advised of this.	
7 May 2009	A home visit was made to Mrs. X. Mrs. X had not been taking some her medication and was advised to do so. The couple did not appear to be getting along. Mr. X said that Mrs. X hid her handbag and then could not remember where she had put it. Mrs. X said her husband was a bully. Mrs. X agreed to visit the Day Centre.	
8 May 2009	A home visit was made to Mrs. X. Mrs. X did not want to go and have a look around the Day Centre as planned. She described her husband as being like a *"mad man".*	***Thirty-first Factor for Consideration.*** ***Things appeared to be going wrong. At this stage it would have been helpful for the two teams to have stood back and assessed jointly what was happening.***
2 June 2009	Mr. X was reviewed at outpatients by a duty worker and a Team Doctor. In a letter to the GP it was noted that Mr. X was eating and sleeping well. He was not feeling depressed and had no symptoms of anxiety. His medication was listed as being Lofepramine 70 mg three times a day and Pericyazine 2.5 mg twice a day. He was described as being settled in presentation and *"very happy".* The plan was to review him again in six-months time.	***Thirty-second Factor for Consideration.*** ***Mr. X was on Enhanced CPA and a carer to a wife with dementia. He had no care Coordinator during this period and no Care Coordination.***
3 June 2009	Mrs. X was visited at home to assess her washing and dressing. Mrs. X was worried about her husband as he had not been eating and did not feel very well.	***Thirty-third Factor for Consideration.*** ***Mr. X was his wife's main carer and he was***

	Mrs. X was advised to keep herself active as this would prevent further memory loss. She said she did not feel like doing anything when her husband was not well.	***not coping.***
12 June 2009	Consultant Psychiatrist 2 retired on this date. Care Coordinator 1 had also left by this stage and Mr. X did have his case reallocated.	
24 June 2009	Mrs. X was visited at her home. Her husband was present. Mrs. X looked unkempt. It appeared that Mr. and Mrs. X were doing well although Mr. X was worried about his driving license. The plan was to discuss Mrs. X with Consultant Psychiatrist 1.	
6 July 2009	A home visit was made. Mrs. X seemed *"edgy"* and could not move. Mr. X also said he was not well as he had trouble with his *"waterworks*" and was going to contact the Adult CMHT about it. The DVLA wrote to the GP to say that Mrs. X's driving license had been revoked due to cognitive impairment.	
11 July 2009	A home visit was made. Mrs. X seemed a *"little on edge".*	
13 July 2009	Mr. X made an urgent request for Care Coordinator 2 to contact him as his wife was unwell. A worker visited Mrs. X and then called for an ambulance. Mrs. X was admitted to Orrell Ward where she was treated for a Urinary tract Infection and dehydration.	
20 July 2009	A telephone call was taken by the OPCMHT from Orrell ward to say that Mrs. X was ready for discharge. Care Coordinator 2 informed the ward staff that she would arrange a package of care for Mrs. X. The package was to commence on the 22 July and Mrs. X was to be discharged on the 21.	***Thirty-fourth Factor for Consideration.*** ***Mrs. X had become very dehydrated and seriously ill. A joint case review could be seen as being appropriate at this stage if all of the other factors were taken into account.***
21 July 2009	A care package was to be provided to Mrs. X from Anchor Care, commencing the following day. Mrs. X was due to be discharged from hospital on this day.	
23 July 2009	A home visit was made following Mrs. X's discharge from hospital. The report from the hospital showed that Mrs. X had systemic sepsis as a result of a urine	

	infection. Both Mr. and Mrs. X said that they accepted they needed support.	
27 July 2009	A home visit was made. Mrs. X was just waking up. The Support Worker asked if the agency staff were attending to Mrs. X's needs appropriately and said that she would discuss the case with the Care Coordinator when she returned back to the office. Nothing untoward was recorded.	
29 July 2009	A home visit was made. Mrs. X looked a little dishevelled. There had been issues regarding the care package. Mr. X said he was struggling to come to terms with his wife's illness.	
31 July 2009	A home visit was made to Mr. X. Nothing of significance was noted.	
4 August 2009	Care Coordinator 2 telephoned Mr. X to say that she had received an email from the commissioning team to say that he had cancelled Mrs. X's care package. Mr. X said he was able to give his wife her medication and that a Support Worker would bath his wife. He was told that this could only be a temporary measure.	
11 August 2009	Mr. and Mrs. X were seen at the Outpatient clinic by Consultant Psychiatrist 1. A Support Worker was present. It was agreed that the Older Peoples' CMHT would continue to be involved as ongoing support was needed as Mr. X's mental health could fluctuate. This meeting served as a CPA review.	
17 August 2009	Mr. X telephoned the Hindley and Ince CMHT and spoke to a Support Time and Recovery Worker. Mr. X was *"really upset and crying* "saying that everyone was against him and that the DVLA were going to take his license from him. Mr. X could hardly talk for crying and said he could not cope. A worker said she would visit him at home later that day after talking to her Manager. After a talk with the manager the worker was asked to observe the condition of Mr. X's home to ascertain whether or not he was taking his medication. During the home visit it was evident that Mr. X was paranoid about his driving license. Otherwise Mr. X *"looked OK"* and was taking his medication.	***Thirty-fifth Factor for Consideration.*** ***Mr. X's mental state was not being monitored at his stage. His risk was no longer being assessed and his role as a carer was becoming difficult for him. He was asking for help.***
19 August 2009	A message was left in the CMHT office from Mr. X to contact him. When Mr. X was contacted by he said that the service was conspiring against him. Mr. X would not listen to the Support Worker when tried to offer help.	
20 August	Care Coordinator 2 telephoned the Adult CMHT Manager. An Older Peoples'	

2009	CMHT Support Worker had gone to her home to take Mrs. X out and noted that Mr. X was anxious and agitated stating that people were against him. The Care Coordinator was concerned that Mr. X's deteriorating mental state would impact upon his wife. The Adult CMHT Manager said that the Adult CMHT would follow Mr. X up. The Manager spoke to the Reviewing Officer at the Golborne Older Peoples' CMHT. The Reviewing Officer had met Mr. X at his home following a visit to his wife. The Reviewing Officer did not have any concerns about Mr. X's mental health. A home visit was made by a Support Worker. It was apparent that Mr. X was paranoid. Mrs. X was *"feeling terrified and nervous when he's angry*	
25 August 2009	Care Coordinator 2 visited Mrs. X at her home. She appeared stable in mood although she had recently had a urine infection. Mr. X said that he did not want his wife to go back to Lakelands and would prefer her care to continue with the Older Peoples' CMHT. Mrs. X said she was happy at home and agreed with her husband. It was explained that the Care Coordinator was going on leave and that two other workers would support them whilst she was away	
2 September 2009	Two workers made a home visit to Mrs. X. On this occasion it was noted that Mrs. X had what was described as a cold sore on her lip. Mrs. X said that her husband had *"done it"*. On returning to the office the OPCMHT Manager was informed. It was decided that the Care Coordinator would be informed on her return from annual leave on the 16 September and the plan was for workers to visit again on the 23 September.	***Thirty-sixth Factor for Consideration.*** ***At this stage it was evident Mrs. X may have been injured by her husband.***
10 September 2009	Mr. and Mrs. X were found dead	***Thirty-seventh Factor for Consideration.*** ***After raising concerns there was no further activity.***

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