NHS
North East

REPORT TO THE NORTH EAST STRATEGIC HEALTH AUTHORITY OF THE INDEPENDENT INVESTIGATION INTO THE HEALTH CARE AND TREATMENT OF 'PATIENT A'

Executive summary and recommendations

May 2012

Executive summary

This investigation was established under the terms of Health Service Guidance (94)27, on the Discharge of Mentally Disordered People and their Continuing Care in the Community, following Patient A's conviction for manslaughter on 22 November 2007.

Patient A was born on 11 August 1970. At the age of one he was diagnosed with a mild right congenital dystonic hemiparesis – a pre-existing (from birth) neurological movement disorder of involuntary spams causing muscle weakness to one side of the body.

In February 1996 (aged 25) Patient A presented to his GP with problems of anger and aggression related to anabolic steroid use. He was referred to the community mental health team (CMHT), but failed to attend any appointments offered. In September 1996 he was admitted to Newcastle General Hospital after being injured in an attack on his companion (an alleged drug dealer).

From February 1997, Patient A began to complain to his GP of symptoms of depression, sleeplessness, anxiety, nightmares and persecutory thoughts apparently arising from fears of reprisal from the families of the attackers, who subsequent to the incident had been convicted and sentenced to lengthy prison sentences. He was maintained by his GP on a regime of medication to address depression, anxiety and low mood, including, for periods, benzodiazepines.

Patient A's son was born in 1999. He was not living with the mother and did not maintain contact with his son beyond a few months. He explained to clinicians that he believed that he might expose his son to harm if he remained in touch with him.

He was again referred to the CMHT in January 2001 and was first seen in February 2001. In July 2001 a locum consultant psychiatrist made a diagnosis of a post traumatic

stress disorder (PTSD). From that point Patient A continued to attend outpatient appointments.

In May 2002 a referral was made to cognitive behavioral therapy services (CBT) (waiting time 12 months). In October 2003 Patient A was arrested in his car. His behaviour leading up to and at the time of this incident, and the discovery at his home of a large quantity of knives and replica weapons led to his being detained under Section 2 of the Mental Health Act (1983) for assessment and treatment. He was discharged from hospital in November 2003.

During this admission it became apparent that he had failed to respond to requests on the part of the CBT services to contact them during September to October 2003 and had therefore been removed from their list. He continued to attend outpatient appointments.

In February 2004 he was readmitted to hospital as a voluntary patient after he claimed that he had taken an overdose of pain killing medication. He was discharged after a few days following his subsequent claim that he had made the story up.

In April 2004 Patient A was referred for neuropsychological assessment. This resulted in an opinion that he had no generalised learning disability, but an abnormality of frontal functioning which was most likely developmental. He continued to attend outpatient appointments.

On 6 March 2006, he was arrested for breach of the peace and affray at St Nicholas Hospital. He was charged with lesser offences and bailed to attend court. On 27 March 2006 he was arrested and charged with criminal damage and bailed to attend court. On 4 April 2006 he was arrested for taking and crashing a car. He was bailed by the police who arranged for his mental health to be assessed, leading to his admission under Section 2 of the Mental Health Act (1983) on 5 April 2006. He was discharged from the section on 18 April 2006, but remained in hospital.

On 19 April 2006 he was referred to psychology services for CBT (stated waiting list six to nine months). It was planned to discharge him from hospital on 26 April 2006, however in the early hours of that day he discharged himself against medical advice.

Patient A failed to cooperate with planned follow up visits by his care coordinator, a community psychiatric nurse (CPN), on 28 April and 5 May 2006.

On 7 May 2006 he signed an acceptable behavior agreement with the local authority and police. On 10 May 2006 he was arrested on suspicion of the murder of Victim A. He was charged (together with one other person) with the murder of Victim A and first appeared before the court on 12 May 2006 when he was remanded in custody. On 22 November 2007 having pleaded guilty to manslaughter on the basis of diminished responsibility he was sentenced to six years imprisonment.

At the time of the offence, Patient A was under the care of Northumberland, Tyne and Wear NHS Trust (now Northumberland, Tyne and Wear NHS Foundation Trust).

North East Strategic Health Authority commissioned this independent investigation to examine the circumstances surrounding the health care and treatment of Patient A, in particular:

- the quality and scope of his health care and treatment, in particular the assessment and management of risk

- the appropriateness of his treatment, care and supervision in relation to the implementation of the multi disciplinary care programme approach (CPA) and the assessment of risk in terms of harm to himself or others

- the standard of record keeping and communication between all interested parties

- the extent to which his care corresponded with statutory obligations and relevant guidance from the Department of Health

- to prepare a report of the findings of that examination and make recommendations to the North East Strategic Health Authority.

Recommendations

Responsibility – the panel's suggestions as to which bodies may be responsible for considering and implementing recommendations are indicated after each recommendation using the initials:

GPs	General Practitioners
FT	Foundation Trust
C	Commissioners

The panel invites the North East Strategic Health Authority to seek assurance from the relevant primary care organisations (the commissioners) that the recommendations will be acted upon.

Communication of appointments

- At both the primary and secondary health level, a presenting patient's literacy level should be established at the outset. Methods of offering or confirming appointments must take account of known lack of literacy. In such cases, patients' records should be clearly marked so that, where appropriate, patients' appointments are made and confirmed by telephone. Where referrals are made to other services for assessment or treatment, information about the need to communicate with such patients by telephone should be passed on. These steps will enable the trust to comply with its own care coordination policy which says that patients can expect to have "*access to information in a way they can understand."*
  (GPs, FT, C)

- Whether notice is given by letter, telephone, text or any other method it is essential that adequate notice is given.
  (FT)

GP issues

- GPs making referrals to secondary mental health services should review, with their patients, whether the referral has been acted upon by those services, and taken up by the patient. This is particularly important where avoidance may be part of the patient's condition. When GPs are notified by secondary mental health services that their patient – particularly a patient whose condition may lead to avoidance of treatment – has failed to take up, or engage with offers of treatment, they should arrange to review their patient with the object of increasing take up of what have been assessed to be beneficial and supportive services.
  (GPs, C)

- Where GPs are managing patients with mental health problems without involvement of secondary services, it is essential that long running prescriptions of medication – especially benzodiazepines – are regularly reviewed in face to face appointments. Where new medication has been introduced, or doses significantly altered, reviews should be arranged to monitor the effects of changes on patients.
  (GPs)

- Where GPs continue to see and prescribe for patients who are under the care of hospital psychiatrists, GPs should take responsibility for ensuring either that they prescribe in accordance with the decisions made by the psychiatrists, or that where prescriptions are different, this is immediately notified to the psychiatrists.
  (GPs)

- GPs and the relevant secondary mental health services should agree procedures which enable each party to notify the other promptly about prescription changes, so that the possibility of confusion, and under or over prescribing is minimised. It is not safe for clinicians to be several weeks out of date, nor for reliance to be

placed on the accounts given by patients who may be unable to recall prescribing decisions accurately, or who may, in some cases, be motivated to give inaccurate information.
(GPs, FT, C)

- Where a GP becomes aware that a patient has been discharged from psychiatric hospital (whether as a detained or a voluntary patient) it is good practice to review with the patient the discharge information and the discharge plan, not least so that the GP can consider what resources the primary care system is able, or is being requested, to make available to support the patient.
(GPs)

Difficult to engage patients

- The trust should amend its policy on difficult to engage service users (including non compliance with treatment) to reflect the reality that a principal reason for non engagement may be the nature of the patient's mental health problem. This might apply for example in cases of depression as well as in cases of PTSD. The policy should contain an expectation that patients in whom there is a real risk that avoidance will lead to non engagement with services, should be actively followed up to try to maximise the take up of services.
(FT)

Services for the diagnosis, assessment and treatment of patients with post traumatic stress disorder (PTSD)

- The trust should have clear pathways from diagnosis of post traumatic stress disorder (PTSD) to treatment. The panel understands that during this period (January 2001 to April 2006) no specialist resource for dealing with PTSD existed in the region. There is now a tertiary level regional service however it has limited resources and there is an expectation that secondary mental health services will be deployed before referral to the tertiary level is made. If there are individual

clinicians working within secondary mental health services that specialise in treatment of PTSD, their identity and the mechanisms for patients to be referred to them, should be cascaded to relevant clinical personnel. The criteria and referral process for the provision of secondary care through psychology services, as well as to the tertiary level specialist service for PTSD, should be clear.
(FT, C)

- The trust should review the organisational place of psychological services in relation to CMHTs, specifically to consider whether, and if so how, psychological services might in appropriate cases be introduced into the formulation or diagnostic process. This is important where the provisional diagnosis is one for which psychological services may offer the primary treatment, or where a patient may have co morbid conditions (for example learning disability, or acquired brain injury) which have the potential to obscure diagnosis and/or complicate delivery of treatment.
  (FT, C)

- In appropriate cases, arrangements for the provision of psychological assessment and/or treatment should include the provision of a fast track route to psychological services (whether at secondary or tertiary level). Such arrangements reflect the reality that in cases of PTSD there is a window for the provision of psychological therapy: if the window is missed there is increased likelihood of development of chronic and complex mental health problems.
  (FT, C)

- Additionally the trust should consider whether arrangements can be put in place to enable neuropsychology services to offer tailored advice to mental health services about treatment issues in appropriate cases, for example in particularly complex cases where acquired or developmental brain injury may affect choice or delivery of treatments. The panel recognises that the provision of services as suggested in the previous three paragraphs will have financial implications for the

trust, but considers that this case provides a good illustration of how investment in services which provide for the early introduction of appropriate, psychologically informed formulation and intervention, may in the long run produce greater savings.
(FT, C)

Clinical review

- The trust should review how, in all clinical contexts – for example CMHTs and outpatient clinics – patients who do not present with crises, but in whom untreated or undertreated conditions may become chronic and ingrained, may have the benefit of longitudinal reviews which consider the whole of the patients' underlying conditions and are not simply snapshot reviews of the patients' symptoms.
  (FT, C)

- Specifically, the trust should review its systems for the organisation of outpatient clinics. Where a patient attends outpatient clinics over a long period, arrangements should ensure that the patient is not seeing a succession of inexperienced junior doctors without mandatory periodic (at the least annual) review by a consultant psychiatrist. This may well happen in the context of a care programme approach (CPA) review where the consultant psychiatrist is the care coordinator.
  (FT)

Referrals

- Referrals to other disciplines of clinician for assessment or advice should be made in the name of the responsible consultant and if possible countersigned by them, or another senior clinician. This should ensure that the opinions of other disciplines are properly requested, that they come back to the consultant responsible for the patient's care and that they are incorporated into discussions

of what treatments are to be offered to the patient, and how they are to be delivered.
(FT)

- When a patient is referred to another discipline or to supportive resources within or external to the trust, it is good practice to supply a basic clinical context to the referral, and to specify its purpose.
(FT)

- Where referrals are made they should be followed up in a timely fashion. Save in exceptional circumstances, reports or responses from the person or service referred to should be made available to the patient (in a way which the patient is able to understand) and if appropriate their family member or carer, and their GP. Where the report is that a patient has failed to attend, or to engage, the referring clinician should try to ensure that the patient is engaged in discussion about this, and that the GP has been kept informed. Clinicians should record that these actions have been taken.
(FT)

Risk assessment

- In circumstances where a patient proposes to discharge himself or herself (or has done so) against medical advice, a risk assessment covering the potential risks to the patient and any other person should always be carried out and documented. **(FT)**

Care management

- Patients to whom CPA applies must have a named care coordinator whose appointment must be clear on the face of the records. Where CPA applies there must be documented reviews in accordance with the trust's current care coordination policy. The panel recommends that the policy and process for

identifying and allocating a community based care coordinator is reviewed, and that the allocation of interim care coordinators is avoided.
(FT)

- Training and reinforcement of care coordination is an ongoing process. The trust should review its training with a view to ensuring that its care coordination policy is fully adhered to, specifically with reference to the holding of reviews and, save where it is not appropriate, inclusion of carers at those reviews.
  (FT)