

INDEPENDENT INVESTIGATION

INTO THE CARE AND TREATMENT
PROVIDED TO MR SR

BY 5 BOROUGH PARTNERSHIP NHS
FOUNDATION TRUST

CONSEQUENCE UK LTD

MARCH 2013


North of England

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

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

The Independent Team members were:

- ❑ Ms Maria Dineen – Director, Consequence UK Ltd
- ❑ Dr Nigel Pearce – Consultant Psychiatrist, South London and Maudsley Mental Health Trust
- ❑ Kevin Jacobs – Independent Mental Health Nurse Advisor and associate, Consequence UK Ltd
- ❑ Chantal Cutland – Associate investigator, Consequence UK Ltd

Acknowledgements

The Independent Team wishes to thank:

- ❑ The family of the deceased;
- ❑ Staff employed by the Trust;
- ❑ Staff at Ashworth Hospital,

all of whom assisted in the investigation conducted.

Note

For the purposes of clarity and to avoid possible confusion, throughout this report the Independent Investigation Team will be referred to as the "Independent Team".

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ACRONYMS USED IN THIS REPORT

Acronym	Name in Full
A&E	Accident and Emergency
AOT	Assertive Outreach Team
CMHT	Community Mental Health Team
CPA	Care Programme Approach. Also referred to as Effective Care Co-ordination
EIT	Early Intervention Team
ECC	Effective Care Co-ordination. Also referred to as Care Programme Approach (CPA)
LASSL	Local Authority Social Service Letter
NHS	National Health Service
SHA	Strategic Health Authority

EXECUTIVE SUMMARY

Incident overview

On 19 February 2008, a Service User of the then 5 Boroughs Partnership NHS Trust, subsequently referred to in this report as Mr SR, attacked and unlawfully killed his sister, and left his mother grievously wounded. She subsequently died as a consequence of her injuries.

Purpose of the investigation

The purpose of the investigation was to provide answers to the following questions:

- Was the care and treatment of Mr SR reasonable and compliant with relevant local and national policy guidelines?
- Was the incident predictable and/or preventable, based on information 5 Boroughs Partnership Trust knew, or reasonably should have known, at the time?

The full terms of reference are tabled in section 2 of this report.

Conclusion of the Independent Team

The deaths of Mr SR's mother and sister were deeply shocking, and none more so than to the children of Mr SR's sister, who were in the home when the attack on their mother occurred.

Mr SR himself has been determined as suffering from a severe mental illness of paranoid Schizophrenia. As a consequence of this and the incident in which he was involved, he is now cared for in a high-security hospital.

With regards to the predictability of what happened on 19 February 2008, the Independent Team does not believe that the act of violence carried out by Mr SR was predictable. His immediate antecedent behaviours in the months prior to the incident were mostly associated with fire-setting risks and anti-social behaviour. With respect to his fire-setting risk, he did represent a risk of harm to others, but this was more than likely to have been accidental rather than purposeful. The Independent Team is mindful that Mr SR had a history of unacceptable behaviour towards his mother, a history the assertive outreach team were not as mindful of as they could and should have been. However, his behaviours were not of the magnitude where one would reasonably have considered Mr SR to have been a homicide risk.

With regards to the preventability of the incident, because Mr SR had been admitted under section 2 of the Mental Health Act on 20 December 2007 and observed by nursing staff between that date and 9 January 2008, when he was discharged, to display no signs of psychosis or treatable mental illness, observations which were endorsed by Mr SR's consultant psychiatrist, it is difficult to suggest that, after his discharge, Mr SR's management plan should have been any different to that which was *in situ*. This included a 7-day follow-up visit on 15 January, an outpatient appointment on 17 January (which Mr SR did not attend) and a second outpatient appointment on 31 January, which he again did not attend.

Mr SR was not on any medication during or after his discharge from hospital. Although treatment with a depot antipsychotic was considered at the time of

admission (Section 2), during the period of inpatient assessment there was insufficient clinical evidence to enforce treatment with a depot antipsychotic. Mr SR was prescribed oral antipsychotic medication but he consistently refused to take this and the prescription was formally discontinued as there was no objective evidence of a psychotic illness during the course of the assessment period.

Mr SR had been referred for a forensic psychiatric opinion on 31 January, but this appointment had not been offered at the time of the incident. With Mr SR's history, even had this appointment been offered earlier, it is unlikely that Mr SR would have received an appointment for assessment prior to the incident. Furthermore, if an appointment had been offered, noting Mr SR's history, it is completely uncertain as to whether he would have attended.

Based on the above, and on the balance of probabilities, it is unlikely that the attack Mr SR made on his mother and sister was preventable on the day on which it occurred.

The above being stated, the Independent Team considers that the care and treatment of Mr SR could have been improved in the following respects:

- ❑ Easier and more regular access to a medical opinion may, in the opinion of the Independent Team, have resulted in more structured assessments of Mr SR (where possible) and in a more robustly formulated management plan.
- ❑ The hand-over between the community mental health team and the assertive outreach team in January 2006 did not meet any of the CPA standards in place at the time.
- ❑ The assertive outreach team was not as aware as it could and should have been about Mr SR's considerable history with mental health services. Had it been more aware, the Independent Team considers that the team's risk formulations would have been more robust.
- ❑ The assertive outreach team should have communicated more proactively with the community pharmacist with regards to how Mr SR's medicines were dispensed to determine if this could be achieved in a manner that would have made the monitoring of Mr SR's compliance more achievable.
- ❑ Mr SR's family (his mother and sister) could and should have been utilised more effectively as informants for the assertive outreach team.
- ❑ When it was determined, in July 2007, that a more intensive service was required for Mr SR, how this was to be achieved should have been shown in his care plan. Furthermore, obstacles to achieving this should have been noted and communicated to Mr SR's consultant psychiatrist. The Independent Team did not see any evidence of an increase in the intensity of service offered to Mr SR.
- ❑ The assertive outreach team could and should have held a planning meeting with the housing provider for Mr SR in view of his fire-setting behaviour, because of the risks this posed to other tenants. At the very least, the housing provider should have been involved in the discharge planning for Mr SR. The situation where housing was not advised of his discharge on 9 January should not have occurred.

- ❑ More complete documentation regarding the assertive outreach team's assessment of Mr SR's mental state would have better enhanced the effort his care co-ordinators put into trying to deliver an effective service to him.
- ❑ When Mr SR was an in-patient, there was no evidence in the clinical records of a detailed mental state examination performed at any time after 20 December. This lack of documentation outlining the process by which Mr SR's diagnosis was changed was not acceptable.

The Independent Team knows that it is being exacting in stating the above and it recognises that Mr SR was a particularly challenging service user. It is therefore satisfied that:

- ❑ Mr SR's care co-ordinators undertook a frequency of visits that they believed Mr SR had agreed to and would tolerate.
- ❑ His care co-ordinators utilised their observational skills appropriately to determine whether or not Mr SR was frequenting his flat, even when he would not open the door to them.
- ❑ His care co-ordinators engaged appropriately with the mentally disordered offenders service when they were determining the extent to which Mr SR should be held responsible for his fire-setting behaviour.
- ❑ Mr SR's care co-ordinators were responsive to Mr SR's neighbours when they (the neighbours) approached them directly. The clinical records also confirm that appropriate advice was always provided.

In addition to the above, the Independent Team particularly wishes to note the actions of Mr SR's care co-ordinator [2] in December 2007. When she, her community psychiatric nurse colleague, and Mr SR's consultant psychiatrist were unable to achieve a face-to-face assessment of Mr SR, between 14 and 18 December, she undertook to obtain a warrant under s.135 of the Mental Health Act to enable an assessment of Mr SR to occur. Her decisive action, the Independent Team believes, should be appropriately acknowledged. Her actions at this time and during the conduct of the assessment undertaken were central to securing a period of in-patient care and treatment for Mr SR in December 2007.

Recommendations

Because of the development work already undertaken in the current 5 Boroughs Partnership NHS Foundation Trust (the Trust) and in particular the appointment of a full-time psychiatrist to the Wigan assertive outreach team, the Independent Team has only two recommendations for the Trust.

Recommendation 1: The assertive outreach teams at the Trust should review their current approach to the traffic light system used to zone clients on the caseload. The model used when Mr SR was a patient did not set out a robust and clear management framework for each zone. For example, for service users in the Red zone, it did not set out the maximum gap between medical assessments or the frequency of care co-ordinator assessments. Neither did the tool set out the rules by which a service user could be moved from the RED zone to the Amber zone, and so on.

Because, in Mr SR's assertive outreach team, the traffic light system was used as a clinical management rather than workload management tool, it is essential that the tool is designed in such a way that its efficacy and reliability of use can be subjected to periodic audit.

It is therefore recommended that the assertive outreach service managers, team leaders and clinical leads explore:

- ❑ the range of approaches currently in use across all Trust assertive outreach teams;
- ❑ approaches in other mental health trusts and other teams such as early intervention services;
- ❑ the range of criteria that might constitute a robust framework for dictating the necessity for clinical discussion of a service user at the weekly clinical team meeting, and/or the service user's escalation up the zoning system;
- ❑ the process by which service users, once escalated up the zoning system, can be 'de-escalated'.

In conjunction with the above, it is recommended that:

- ❑ clear guidelines are developed for the zoning system agreed;
- ❑ documentation standards around clinical decision-making are agreed;
- ❑ the way the zoning system is to be audited, including audit criteria and the frequency of audit, is agreed and planned for.

In formulating an appropriate audit process, the Independent Team recommends that at least the following factors are incorporated:

- ❑ The appropriateness of the traffic light level/zone;
- ❑ The quality of documentation when a decision is made to manage a service user outside of the protocol guidelines;
- ❑ The quality of documentation when a decision is made to move a service user to a lower risk tier of the traffic light system;
- ❑ Whether the documented frequency of medical review shows protocol compliance, and, where the frequency does not meet this, do the notes provide a reasonable explanation as to why? (E.g. a decision has been made for less frequent reviews and is a documented component of the management plan, or the service user has not attended for appointments);
- ❑ Appropriateness and frequency of medication review;
- ❑ Appropriateness of actions planned, following consecutive periods of non-attendance for planned contacts, that the traffic light system says requires action.

Target audience: The Director of Nursing and Governance, the service managers and the clinical leads and team managers for all assertive outreach teams.

Timescale: It is anticipated that the Trust should be able to have developed a project management and commenced the delivery of this within six months of the publication of this report.

Recommendation 2: This investigation identified a lack of knowledge about Mr SR's past history in the professionals directly engaged in his care and treatment. There was at the time an over-reliance on the information stored on the electronic record-keeping system. Had a comprehensive and thorough chronology of his past contacts with mental health services been complied with, it is less likely that these knowledge gaps would have occurred.

The Independent Team acknowledges that now most records are made electronically; however, it is not tenable to rely only on the CPA documents to provide complete information. It is therefore the recommendation of the Independent Team that for all new assertive outreach clients in the Trust an integral component of the activities undertaken when a service user is accepted on to the caseload is a comprehensive case history that clearly sets out:

- ❑ A clear chronology of the service user's contact with mental health services, the circumstances of this and diagnostic history;
- ❑ Historical risk behaviours and the context of these;
- ❑ Contemporary risk behaviours and known context;
- ❑ Physical health history;
- ❑ Current medication;
- ❑ Known vulnerabilities.

Where feasible, it will be advantageous if information from the family/known carer(s) is a key component of this process.

Target audience: The Director of Nursing and Governance, the service managers and the clinical leads and team managers for all assertive outreach teams.

Timescale: The Independent Team is aware that this recommendation will require an investment of time, and therefore the Trust will want to consider the principles of this recommendation within its governance forums before committing to an action implementation plan. Consequently, the Independent Team suggests that the Trust should be able to provide NHS North West with its response to this recommendation within three months of the publication of this report, aiming for an action implementation plan within six months.

1.0 INTRODUCTION

This investigation was commissioned by North West Strategic Health Authority to determine:

- whether the quality of care and treatment afforded Mr SR was reasonable and in keeping with local and national standards; and
- whether or not the incident on 19 February 2008 could have been prevented by different management and/or actions by the specialist mental health services in the then 5 Boroughs Partnership NHS Trust.

On 19 February 2008, Mr SR went to his sister's home and attacked his mother and his sister with a knife. He then left the house. His sister and mother were taken by emergency services to the nearest emergency department, where his sister subsequently died (RIP). His mother initially survived however she too died later that year (RIP).

On 28 August 2009, Mr SR was found by jury at Liverpool Crown Court to have killed his mother and sister. He was ordered to be held indefinitely under the Criminal Procedure (Insanity) Act 1964; until such time as he became 'fit to plead', he was to be detained in a special high-security hospital.

1.1 Overview of Mr SR's contacts with specialist mental health services in 5 Boroughs Partnership NHS Trust

Mr SR has a long history with specialist mental health services, dating from his late teens, *circa* 1985, to the date of the incident. In 1980, as a consequence of his fire-setting behaviour, he completed his education at a residential boys' school, returning to the family home in 1985.

In June 1989, Mr SR was referred to mental health services, then delivered by Wigan Community Trust, and subsequently admitted on an informal basis for an assessment of his mental state in September 1989. At this time he was diagnosed as having schizophrenia.

During the course of his contact with specialist mental health services, Mr SR had many formal and informal admissions and periods in supported living accommodation. Notably in 1995, he was cared for in a nursing home, where there were further incidences of fire-setting.

It had also been noted that a feature of Mr SR's presentation was non-compliance with medication. This feature persisted throughout.

Prior to 2006, when Mr SR was accepted on to the assertive outreach caseload, he displayed a variety of symptoms, including verbal aggression, hearing voices, swearing and making derogatory comments, anger and verbal aggression – particularly towards his mother – talking to himself, pressure of speech, and some flight of ideas. His paranoia, auditory hallucinations and pressure of speech were features through to 2005.

In 2004, Mr SR experienced independent living for the first time; he had his own flat assigned to him on 16 February 2004.

As stated previously, Mr SR's diagnosis was originally schizophrenia; however, there was uncertainty about this from time to time. At the time of the transfer of care co-ordination responsibility to the assertive outreach team, he had a diagnosis of schizo-affective disorder.

With regards to his physical health, Mr SR did suffer from heart problems and had a heart attack in March 2004.

1.2 Concise overview of Mr SR's contacts with specialist mental health services in 5 Boroughs Partnership NHS Trust between January 2006 and February 2008

31 January 2006: Mr SR's case was closed to his community mental health team and opened to the assertive outreach team.

16 February 2006: Mr SR's appointed care co-ordinator, a community psychiatric nurse, made telephone contact with Mr SR regarding a pending medical review on 23 February.

23 February 2006: Mr SR's care co-ordinator took him to his outpatient appointment with his consultant psychiatrist, during which he refused to engage and was verbally abusive to the consultant. On the return trip home, Mr SR made it clear to his care co-ordinator that he would contact him if he needed to; otherwise it was just "*wasting his time*".

April 2006: Mr SR's care co-ordinator made one home visit on 12 April, but Mr SR was not in. Telephone communication with his housing provider revealed that complaints had been made about Mr SR by his neighbours because of excessive noise. Later the same month (24 April), Mr SR's care co-ordinator was informed by the housing provider that Mr SR had acquired an air pistol. When questioned about this, Mr SR claimed to have had it for one year. However, his housing support worker did not believe this to be true. Mr SR's care co-ordinator sought advice from the local firearms department and was advised that possession of an air pistol was not in itself illegal. However, the air pistol was subsequently removed from him by the police.

11-17 May 2006: Mr SR's care co-ordinator made a number of attempts to contact him, successfully achieving this by telephone on 17 May. Mr SR informed his care co-ordinator that he was planning to go to India on holiday with his brother. A home visit was agreed for later the same day. He was noted to be stable.

7 June 2006: Mr SR informed his care co-ordinator that the plans for India had been cancelled. The records also noted that Mr SR had "*sacked*" his housing key worker because he wanted to be independent. Mr SR again reiterated that he did not want assertive outreach visits. Mr SR was noted to have said that he didn't "*see psychiatric services as featuring in his future and will not attend outpatients' appointments in future unless he arranges it*".

5-13 July 2006: Mr SR was not at home on either 5 or 7 July. Neither did he respond to telephone calls. However, when his care co-ordinator contacted his mother, Mr SR answered the phone. He reported to his care co-ordinator vandalism that had occurred to his property. The care co-ordinator agreed to contact the police about this on Mr SR's behalf.

On 13 July, Mr SR was at home and expressed an interest in voluntary work. His care co-ordinator offered to support him in achieving this. Medication compliance was noted; also that Mr SR was looking for alternative medication. He was at this time encouraged to persist with his current regime as he (Mr SR) had reported feeling well at the time. Again, Mr SR was noted as saying he *"only wants people's assistance when required"*. Some paranoia was noted at this home visit, in that Mr SR told his care co-ordinator that his *"flat was being monitored"*. It was also noted that Mr SR was aware that his thoughts may be as a result of paranoia he had developed whilst an in-patient. The next home visit was agreed for four to five weeks' time.

30 August 2006: Mr SR's care co-ordinator was informed about a *"string of public disorder offences"* which needed to be addressed. It was also noted that housing had decided to issue a formal warning to Mr SR, and a recommendation had been made to the mentally disordered offenders team to let Mr SR's case go to the Crown Prosecution Service with a view to him being charged. If Mr SR was convicted of using racially abusive language, his housing tenancy would be terminated.

8 September 2006: Mr SR would not allow his care co-ordinator into his flat. The clinical record noted that Mr SR was *"offended that the CPN [community psychiatric nurse] had called when they had an agreement of monthly visits"*.

22 September 2006: Mr SR presented himself at Boston House in crisis, feeling frustrated, angry and anxious, not having the necessary social skills to function in the real world. His care co-ordinator attended at Boston House and restated to Mr SR that he could and would see him more frequently, but that he (Mr SR) would only agree to monthly contact. At this time, Mr SR did agree to more frequent contact with his care co-ordinator. Also, at this contact, some pressure of speech was noted, but not more than usual, and Mr SR denied any change in his circumstances.

23 September 2006: An assertive outreach occupational therapist (OT) visited Mr SR at home and he again identified feelings of *"frustration, anxiousness and anger"* because he felt he lacked the necessary skills to *"function in the real world"*. Together, Mr SR and the OT identified a range of activities that might help him engage more positively. The OT noted mild agitation, pressure of speech, but no overtly psychotic symptoms.

25-28 September 2006: Mr SR's care co-ordinator attempted to visit Mr SR. However, on the first occasion he was approached by a neighbour of Mr SR's who wanted to raise concerns about him, and on the two subsequent visits Mr SR was not at home.

10 October 2006: When the care co-ordinator attended for a home visit, Mr SR was not initially at home. A note was left for Mr SR reminding him of his outpatient

appointment with his consultant psychiatrist on 12 October at 10am. Mr SR returned to his flat as his care co-ordinator was leaving. Mr SR informed his care co-ordinator that he did not wish to be visited and accused him (the care co-ordinator) of getting the police to “*pick him up*” a few weeks previously.

12 October 2006: Mr SR did not attend his medical review. His care co-ordinator informed the consultant psychiatrist of recent events and they agreed to try and keep making contact with Mr SR.

19 October-28 November 2006: Mr SR’s care co-ordinator was not able to achieve a face-to-face meeting with him. On 28 November, the local police left a message for the care co-ordinator advising that Mr SR had been arrested, as he had “*failed to answer bail*”. Mr SR’s care co-ordinator established that his sister was going to attend court with Mr SR and act as appropriate adult for him.

29 November 2006: The care co-ordinator attended at Mr SR’s flat. On attendance, it was noted that the door was boarded up. Mr SR, it transpired, had not answered the door to the police, so they had entered the flat under warrant. The care co-ordinator telephoned Mr SR’s mother and Mr SR answered the phone. He told his care co-ordinator he was staying at his mother’s house owing to the lack of access to his flat. A face-to-face meeting was offered and refused. It was recorded that, “*Throughout the conversation [Mr SR] was calm, appropriate and friendly in manner*”.

12 December 2006: Mr SR’s care co-ordinator attempted to meet with him. However, there was no answer from Mr SR’s flat. A calling card was left for him advising that his care co-ordinator would call again on 18 December. Again, when the care co-ordinator called on 18 December, there was no answer. Signs of movement were, however, noted. Net curtains had been put up and paint tins moved from Mr SR’s window sill.

3 January 2007: A new care co-ordinator was appointed to Mr SR. She and the previous care co-ordinator visited Mr SR on 3 January. Mr SR again stated he did not want the assertive outreach team to visit him, and that he felt they are all against him. Care co-ordinator [2] explained their legal obligation to visit under s.117. However, Mr SR was fixed in his belief. The outgoing care co-ordinator [1] noted that there were medication boxes by Mr SR’s door and shook a couple to make sure that medication was in them.

15 February 2007: Mr SR did not attend for his medical review. Care co-ordinator [2] suggested making an afternoon appointment next time and this was agreed. The consultant psychiatrist was informed that “*no mental disturbances*” had been “*noted*”. Another appointment was to be offered for three months’ time.

26 February 2007: The assertive outreach team had been unsuccessful in making contact with Mr SR. However, on this day the practice nurse at Mr SR’s GP practice informed the assertive outreach team that Mr SR had not been attending for his physical check-up appointments. A subsequent home visit on 27 February was not successful.

1 March 2007: There was no answer when the assertive outreach team called to Mr SR's flat. Following information received from a neighbour that he had not been around for four weeks, the community psychiatric nurse called Mr SR's mother. She informed the assertive outreach professionals that her son had been in India with his brother for the last four weeks, having gone to visit his father, who died three days into his visit. The nurse told Mr SR's mother that he would visit her son when he had returned, on 8 March at 14.00 hours.

11 April 2007: Mr SR's sister reported concerns to the Out of Hours service that her brother was harassing their mother and for the past two weeks had been threatening to kill people. The Out of Hours GP attended at Mr SR's home, but he was refused entry. The visiting GP then asked the police to undertake a welfare check and advised the family to ring back if Mr SR was no better.

26 April and 3 May 2007: Home visits were attempted by the assertive outreach team, but Mr SR was not at home.

5 June 2007: Mr SR telephoned the assertive outreach team, leaving a message for his care co-ordinator, who called him back. A home visit was agreed for 6 June. At this visit Mr SR was noted to be in a positive and chatty state, clear and reasonable in his demeanour; however, his appearance was unkempt. The purpose of Mr SR making contact with the assertive outreach team was to:

- seek their support with renewal of his bus pass;
- establish if he had the right to buy his property and, if so, how?; and
- gain information about Hyndelle Lodge, Hyndley Creative Support and also a similar facility at Pemberton.

Mr SR told the assertive outreach staff that he did not want to see them and that he had purposefully been avoiding them, as this was the only way that he could "*make it clear that he did not want their service to visit him*".

21 June 2007: Unsurprisingly, Mr SR was not in for this home visit.

1 July 2007: An attending police officer found Mr SR at home with cans of petrol, threatening to kill himself and his neighbours. The police officer requested a Mental Health Assessment (MHA). It was confirmed that Mr SR was not subject to a s.136. When in custody, Mr SR threatened to cut his own throat and harm himself. He was seen by the duty doctor, who advised that Mr SR was fit to be detained. Consequently, it was determined that a Mental Health Act assessment was no longer required. The records note that Mr SR was "*quite manic in presentation and kept jumping from one conversation to another*".

3 July 2007: On a home visit, Mr SR's care co-ordinator noted his deteriorating living environment and Mr SR told her his "*head [was] going mad, couldn't stand it*". An urgent appointment was made for Mr SR to see his consultant psychiatrist on 5 July, to which care co-ordinator [2] took him, accompanied by his community psychiatric nurse.

5 July 2007: At his medical appointment Mr SR was noted to appear calm and rational and "*displayed a good degree of insight into [his] health problems*". Mr SR

admitted that he had stopped taking his medication for his physical problems, but stated he had continued with his psychiatric drugs. His medications were reviewed and it was noted that he was *“erroneously taking two anti-depressants, Escitalopram and Sertraline”*. His consultant psychiatrist advised him to discontinue the Escitalopram immediately and continue the Sertraline 50mg once a day and Quetiapine (an anti-psychotic medication) 600mg at night. Mr SR was also advised to contact his GP to sort out his physical health status and reinstate his regular prescription. Mr SR was noted to have asked if he could go back to Brookfield’s Hostel, since he felt the state of his flat was contributing to his decline. No places were available at Brookfield’s, so it was agreed that he would be supported at home with *“intensive input from the AOT¹”*. When Mr SR was taken home, he refused to let care co-ordinator [2] take away his old medications.

18 July 2007: Mr SR was at home. The records reported that his flat had been cleaned up and that Mr SR said he was taking his medication. It was recorded that *“his presentation would suggest he was compliant”*. The assertive outreach professionals supported Mr SR with completing his passport application; arrangements were also made for his solicitor to attend with him on his visit to the police station on 30 July. During the visit, it was noted that Mr SR again asked to be moved to more supported accommodation; but when he was told that either his community psychiatric nurse or care co-ordinator [2] would look into that for him, he was noted to appear reluctant and said instead that he *“wanted it as an option”*. Mr SR’s consultant psychiatrist contacted care co-ordinator [2] while she was at Mr SR’s home. Consequently, an update was provided to him. The consultant was noted to be *“pleased with progress”*. The records also noted that Mr SR had agreed to go to the library, supported by the assertive outreach team when they next visited, with the aim of learning the internet. Mr SR was reported to be happy with the plans made and it was agreed to visit him the following Wednesday, 22 July.

25 July 2007: The next visit actually occurred on this day and Mr SR was not expecting the visit, thinking it was on 26 July. The community psychiatric nurse gave back Mr SR’s passport form, advising him that he needed to complete the first part before he (the nurse) would complete the section verifying who Mr SR was. Mr SR was noted not to be happy about this and appeared irritated. He did not acknowledge in any way that the mental health professionals were trying to assist him. As planned, they left for the library, but when the community psychiatric nurse asked Mr SR if he would wait a minute (before going to the library) so that he could put his diary in the car, Mr SR would not. Mr SR therefore left on his own. The nurse and care co-ordinator [2] followed him, but his pace, they noted, appeared to get faster and they eventually lost sight of him.

8 August 2007: Mr SR’s care co-ordinator attended at the home of Mr SR. He was in the garden and reported not expecting the mental health professionals that day, but said, *“Oh well, you might as well come in, I don’t want to be rude today”*. It was noted that Mr SR did not want to talk about his family, because if *“he leaves them alone, they leave him alone”*. The record also noted that Mr SR’s sister was *“going to contact us soon as she is able to be a Carer and wants to know about direct payments”*. Mr SR’s care co-ordinator asked him if he wanted them to contact his

¹ AOT = Assertive Outreach Team.

sister, to which he responded, *“No, it's all right; she is busy and she will phone you when she can”*. Mr SR also spoke of his arrest and told the professionals that *“he was going to tell them the truth”* about it. It was noted that Mr SR tried to get one of the professionals to say he was right to threaten to set fire to himself. When neither would do so, he was noted to become abusive and abruptly refused to discuss anything else, or agree to another appointment. As they left, Mr SR was reported to have said: *“you are good at bus passes, but the things that really matter you are no good, you're a waste of space; do what you want, I don't care, call yourselves mental health workers, you don't know what goes on in my mind, you don't care”*. Mr SR had reported being medication-compliant at this visit and it was noted that there was *“no evidence to suggest otherwise. His mental health appeared stable.”*

16 August 2007: The assertive outreach team attempted a home visit. Movement was noted at the windows, suggesting that Mr SR was at home. However, he did not let the professionals into his home.

22 August 2007: More complaints about Mr SR were received and Mr SR was arrested for a racially aggravated public order offence. Mr SR was intoxicated at the time of arrest. Furthermore, Mr SR told the police that he had not been taking his medications. The assertive outreach team was contacted on 23 August by Mr SR's sister about his arrest.

24 August 2007: An eviction notice was served on Mr SR.

5 and 6 September 2007: Attempted home visits were made, but with no success.

7 September 2007: The assertive outreach team was informed by the local police that a neighbour had complained that Mr SR had been ransacking his flat. Consequently, a community constable had visited him and he was let in. This community constable informed the assertive outreach team that Mr SR's flat was very empty and, although Mr SR was pleasant in manner, he kept pounding meat on the floor with a jar. Mr SR was also reported as telling the community officer that he was not taking his medications as a prescription needed changing.

8-29 September 2007: The assertive outreach team attempted a home visit. This was not successful. A further visit was made on 18 September, but when Mr SR opened the door, he immediately shut it on seeing the assertive outreach team professionals. A further attempt was made on 29 September. Again, this was not successful. However, the assertive outreach staff did see Mr SR on the street, but he was noted to put his head down and walk on. He would not interact with them.

22 October 2007: The housing provider advised assertive outreach that Mr SR had given four weeks' notice on his flat.

3-28 November 2007: Two home visits were attempted, but Mr SR was not at home or not answering the door. A telephone call was made to the housing provider on 28 November. The provider told care co-ordinator [2] that his neighbours had reported that they still saw him around. The housing provider was noted to have stated she would call the police to carry out a visit *“and inform Mr SR she intends to take him to*

court to have him evicted". The housing provider was also noted to have offered to find out "the state of play" regarding Mr SR's court appearance for the arson offence.

10 and 11 December 2007: Mr SR's GP contacted the assertive outreach team expressing his concern regarding Mr SR's behaviour, saying he was changing and getting disturbed. The GP reported that Mr SR had visited the surgery and asked what the GP's religion was and then wouldn't see him because of his religion. He also reported receiving communication from the mother of Mr SR, who was also noted to be increasingly concerned. Mr SR's GP suggested that if a home visit on 12 December was not successful, then a Mental Health Act assessment should be considered. The community psychiatric nurse, with whom the GP spoke, told him that this disengagement was Mr SR's usual pattern. However, the GP was noted to remain firm in his view that Mr SR was unwell.

12 December 2007: The assertive outreach team attended to conduct a home visit. However, Mr SR was not at home. A calling card was left for him. On the same day, a community constable attended at Mr SR's home with the housing provider to serve the eviction notice. He reported to the assertive outreach team that Mr SR was living in squalid conditions and did not appear well. Consequently, it was agreed that a Mental Health Act assessment was required.

14 December 2007 (Friday): Mr SR's consultant psychiatrist and a GP attempted a home visit with Mr SR. However, this was not successful and they did not gain access to his home. Over the same period arrangements were being made for a Mental Health Act assessment.

18 December 2007: Mr SR's care co-ordinator [2] attempted a home visit with the community psychiatric nurse. Although Mr SR opened the door to them, he shut it again as soon as he saw who it was. A neighbour informed the professionals that Mr SR had thrown milk at her the day before and he had again been arrested. The door to Mr SR's home also looked to be covered with rice pudding.

Following this unsuccessful home visit, Mr SR's care co-ordinator [2] spoke with his consultant psychiatrist and his GP and then obtained a s.135 warrant to enable them to enter Mr SR's home. The Mental Health Act assessment was arranged for 20 December 2007.

20 December 2007: The Mental Health Act assessment. On entry to Mr SR's flat, it was noted to be in a bad condition: the décor destroyed, minimal furnishing, a charcoaled oven and there were signs of fire-setting, including the smell of burning and a bag containing cinders next to a petrol can in the bedroom. Mr SR "*appeared to lack any insight into his behaviours*" and admitted not taking his medications because he wanted to drink. Mr SR refused to discuss his family, as he reported wanting "*nothing to do with them*". He also refused admission to hospital and was therefore admitted to the psychiatric in-patient ward under s.2 of the Mental Health Act for assessment.

20 December 2007- 9 January 2008: Mr SR remained an in-patient. During this time he consistently refused medications. It was determined that there were no grounds to detain him under s.3 of the Mental Health Act. Consequently, when staff

consistently reported no signs of psychosis in Mr SR, he was eventually taken off all medication. In terms of his behaviours during the in-patient period, Mr SR was abusive to staff, using racially aggravating language from time to time. He was advised that if he persisted in his behaviour then he would be prosecuted for this. Mr SR also engaged in behaviour that was generally irritating to others, such as banging doors. However, at no time were there any reports of *“observed mental health issues/concerns”*.

9 January 2008: On this day there was a discharge ward round at which a decision was made to change Mr SR’s diagnosis from Schizo-affective Disorder to Personality Disorder (anti-social type), because he had displayed no symptoms of psychosis on the ward and had been medication-free. The notes stated: *“no evidence of treatable mental illness”*. Because of the challenges presented by Mr SR, a decision was made to refer him for a Forensic Assessment. Mr SR walked out of the medical ward round before his consultant psychiatrist could inform him of his change in diagnosis. Mr SR could not be persuaded to return, so his care co-ordinator [2] informed him that he had been discharged.

15 January 2008: Mr SR received his 7-day follow-up visit.

17 January 2008: Mr SR did not attend his outpatients’ appointment. A letter was written advising him of a new appointment for 31 January.

29 January 2008: A home visit was attempted by Mr SR’s care co-ordinator [2] and community psychiatric nurse. Mr SR was noted to have come to the window with a sheet over him and asked what the date was. He kept the door locked the whole time and would not allow the professionals entry; so they left.

31 January 2008: Mr SR missed his outpatients appointment again and it was recorded on the ‘did not attend’ form as: *“Further OPA only if requested by care co-ordinator”*. Mr SR’s consultant psychiatrist and his care co-ordinator [2] were noted to have agreed that Mr SR was a fire risk and was unpredictable. It was also noted that both considered that *“he was responsible for his actions”* and *“fit for interview should the police require this”*. The notes also restated that the consultant psychiatrist would request a forensic assessment and write to Mr SR’s GP to advise of the change in diagnosis.

1-19 February 2008: There was no contact between Mr SR and the assertive outreach team during this time.

19 February 2008 at 19.00: Mr SR was arrested on suspicion of killing his sister and grievous bodily harm and the attempted murder of his mother.

Section Four of this report sets out, where relevant, greater detail regarding Mr SR’s contacts with 5 Boroughs Partnership Trust.

2.0 TERMS OF REFERENCE

The terms of reference provided to Consequence UK for this investigation were:

To examine:

- ❑ the care and treatment of the service user at the time of the incident, including from non-NHS providers if appropriate;
- ❑ the suitability of that care and treatment in view of the service user's 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 assessment 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; and
- ❑ the quality of the internal investigation and review conducted by the Trust.

To identify:

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

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

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

3.0 CONTACT WITH THE FAMILY OF MR SR, AND MR SR HIMSELF

In this case, contact with the family of Mr SR was initially challenging. Consequence UK was initially alerted to potential safety issues by Mr SR's current care team. Consequently, no contact was attempted with Mr SR's family until it was confirmed that it was safe to do so. Mersey Care NHS Trust, the police and Mr SR's aunt were instrumental in making it possible for communications to occur.

Written correspondence was sent to Mr SR's brothers and to his aunt, who also holds parental responsibility for his sister's (RIP) children.

As a consequence of this correspondence, one of Mr SR's brothers contacted Consequence UK, advising that he did wish to be informed of the findings of the investigation report prior to its publication. This individual was contacted via the email address he had provided once the report was completed and no response was received by the Independent Investigation Team.

Mr SR's aunt also confirmed that she and Mr SR's niece wished to meet once the report was completed and prior to publication. In January 2012 the Independent Investigation Team and a representative of NHS North West Strategic Health Authority met with Mr SR's aunt and his niece to share with them the findings, conclusions and recommendations of the independent investigation.

With regards to communications with Mr SR himself, the Independent Team conducted this via his consultant psychiatrist and social worker. In the interests of his mental health, direct communications with him were not appropriate. However Mr SR did provide consent for the Independent Investigation Team to access his relevant health records to enable the conduct of the investigation required.

4.0 FINDINGS OF THE INVESTIGATION

This section of the report sets out the Independent Team's findings following its investigation. As is often the case when undertaking a retrospective analysis of a service user's care and management by specialist mental health services, there are aspects of Mr SR's care and management that were good and aspects that could and should have been improved.

It is important to make clear that, in setting out its findings and subsequent conclusions, it is the responsibility of the Independent Team to avoid hindsight bias² and to report the findings of its investigation, and the analysis of the appropriateness of decisions made and/or not made on the basis of the information and circumstances that were present and/or available to the specialist mental health service at the time; in this case, information emerging between May 1999 and February 2008.

It is also the responsibility of the Independent Team to consider what a reasonable group of similarly qualified clinicians would have done in similar circumstances. This is what the National Patient Safety Agency (NPSA) refers to as the 'substitution test' in its incident decision tree.³

In this case, the Independent Team did not consider that seeking input from a broader range of professionals outside of its core members was necessary.

In the interests of delivering a report that met the terms of reference provided and presenting a report with a logical flow, the Independent Team has addressed its findings in relation to seven key questions:

- Was the transfer of Mr SR from the community mental health team to the assertive outreach team appropriate and was the transfer process conducted effectively?
- Mr SR remained under the care of his community mental health team's consultant psychiatrist because there was no dedicated consultant psychiatrist to the assertive outreach service in Wigan. As a consequence, the Independent Team set out to determine whether:
 - The medical reviews Mr SR received were sufficient.
 - Medical advice was sought and provided in a timely manner about his care and treatment by the assertive outreach team.
 - Mr SR's care and treatment would have been materially different if there had been a dedicated consultant psychiatrist for the Wigan assertive outreach team.
- Was Mr SR's management plan and the conduct of the assertive outreach team appropriate? That is, did they do all that they reasonably could and

² Hindsight bias is the inclination to see events that have occurred as more predictable than they in fact were before they took place. Hindsight bias has been demonstrated experimentally in a variety of settings, including politics, games and medicine. In psychological experiments of hindsight bias, subjects also tend to remember their predictions of future events as having been stronger than they actually were, in those cases where those predictions turn out correct. This inaccurate assessment of reality after it has occurred is also referred to as "creeping determinism".

³ [http://www.msnpsa.nhs.uk/idt2/\(jg0xno55baejor55uh1fvi25\)/index.aspx](http://www.msnpsa.nhs.uk/idt2/(jg0xno55baejor55uh1fvi25)/index.aspx)

should have to try and maintain contact with Mr SR and conduct appropriate assessments of him?

- Did the assertive outreach team conduct:
 - An effective assessment of Mr SR's risks (past and current) and devise a reasonable risk management and crisis intervention plan for him?
 - Appropriate reviews of Mr SR's risk assessments in response to emerging information and reported changes in his behaviours?
 - Appropriate escalation of him through their traffic light/zoning system?
- In December 2007, Mr SR's diagnosis was changed to Personality Disorder.
 - Was this change in diagnosis based on an appropriate assessment and understanding of him?
 - Was a reasonable plan devised regarding his ongoing management within the assertive outreach team?
- On the basis of what is recorded in Mr SR's clinical records, and the memory recall of staff engaged in his care and treatment, is the Independent Team satisfied that there was appropriate support provided to, and communication with, Mr SR's mother and sister?
- Was the incident in which Mr SR was involved predictable and/or preventable on the basis of information the assertive outreach team could or should have been aware of?

4.1 Was the transfer of Mr SR from the community mental health team to the assertive outreach team appropriate and was the transfer process conducted effectively?

Summary opinion

The Independent Team considers that it is indisputable that Mr SR met the criteria for care and treatment by the assertive outreach team. However, although it is clearly evident that the then appointed care co-ordinator for Mr SR made efforts to inform himself about Mr SR's previous history, there is no evidence of the formalised process that one would expect to see in a team-to-team transfer for a service user such as Mr SR. There was no transfer CPA conducted.

The Independent Team further considers that there was also inconsistency as to the aspirations of the assertive outreach team. There is no evidence of a longitudinal case review of Mr SR being conducted. Normally, one would expect this task to be allocated to a trainee psychiatrist for subsequent presentation to the team. However, in this assertive outreach team there were no dedicated medical sessions and consequently no realistic opportunity for this to be led medically. It is the feeling of the Independent Team that the compilation of a comprehensive case review was within the competency of Mr SR's care co-ordinator, but that it was not customary within the team to compile a comprehensive historical summary of a service user's contact with mental health services and salient features of a service user's presentation over the same period. There was, the Independent Team considers, an over-reliance on the information contained on the then electronic record-keeping system (OTTER).

Mr SR was transferred to the assertive outreach team's caseload on 31 January 2006, from the community mental health team who, until then, had been responsible for his care and treatment. The operational policy for all assertive outreach teams operating within 5 Boroughs Partnership NHS Trust in 2006 set out the profile of service users for whom an assertive outreach service was appropriate. It also set out the service's eligibility criteria.

Both are set out in full below. Where Mr SR met the stated criteria is denoted with (✓).

3.2.0 "Service User Profile

- 3.2.1 Service users who suffer from severe and enduring mental illness, who have complex needs and have demonstrated that they are unable or unwilling to engage with other community mental health services (✓)
- 3.2.2 Service users who have experienced frequent relapses or repeated use of in-patient services
- 3.2.3 Service users that are vulnerable and at risk due to the nature of their mental illness and have difficulties in engaging with other community mental health services (✓)
- 3.2.4 Service users that require more frequent contact according to their assessed needs

- 3.2.5 Service users that present a significant risk of self-harm or harm to others or severe self-neglect (✓ history of self-neglect, particularly after moving in to independent living in 2004)
- 3.2.6 Service users that have a history of repeat offending behaviour and a diagnosed serious mental illness (✓ low-level offending and public disorder, and diagnosis of SMI)
- 3.2.7 Service users managed on Enhanced CPA who meet the above profile (✓)

3.3.0 Service Eligibility Criteria

- 3.3.1 The primary eligibility criteria is that of a severe and persistent mental disorder such as Schizophrenia, Schizo-affective Disorder, Bipolar Affective Disorder, Recurrent Severe Depressive Illness associated with a high degree of disability (✓)
- 3.3.2 Service users must be aged 18 and 65 (✓)
- 3.3.3 A history of high use of in-patient or intensive home-based care (for example, more than two admissions or more than 6 months in-patient care in the last two years)
- 3.3.4 Service users who are at risk of significant deterioration of their mental health, including risk to their safety, or safety of others, or at risk of poor quality of life (✓)
- 3.3.5 Multiple complex needs, including a number of the following:
 - A history of violence or persistent offending behaviour
 - Significant risk of persistent self-harm or neglect
 - Poor response to previous treatment (✓)
 - Dual Diagnosis of substance misuse and serious mental illness
 - Detained under the Mental Health Act on at least one occasion in the previous two years
 - Unstable accommodation or homelessness
 - A severe inability to establish or maintain a personal social support system (✓ Mr SR could not make friends. He was generally OK when in intensive supported living/nursing home; otherwise he was variable in his ability to manage and maintain relationships)
- 3.3.6 A history of poor, intermittent or chaotic engagement with services, including difficulty in engaging in treatment or poor compliance with treatment and follow-up (✓)
- 3.3.7 People with Personality Disorder who also have a diagnosis of severe mental illness. Care will be taken not to exclude people with complex needs from AOT on the basis of their co-existent Personality Diagnosis (✓)
- 3.3.8 AOT services will be provided on the basis of their ability to meet the needs of the individual service users, rather than criteria such as age. Therefore, whilst older people with mental health problems may have other sources of intensive support at home, they are not excluded from provision of AOT simply on the basis of age. If an older person is receiving a service from AOT, joint working with Older People's Services may be appropriate

3.3.9 Referrals will be accepted by electronic referral via the OTTER system.”

The clinical records provided to the Independent Team did not contain any record of a CPA handover between community health team and the assertive outreach team. The last record the Independent Team found from the community mental health team was an Episode of Intervention activity report dated 19 December 2005. This was a record of telephone contact from Mr SR’s housing support officer, and said: *“TC from ... support worker from [housing provider] to say that [Mr SR] has been painting the floor and put paint on him[self]. He also refused to let [the support worker] into his flat. [Mr SR was] allowed ‘home’ this week. [The support worker] was concerned about [Mr SR’s mental health]. I suggested to [the support worker] that he should contact the ‘Action Team Manager’.”* The support worker agreed to contact.

The next entry was on 16 February 2006 by the assertive outreach team.

The team manager for the assertive outreach team told the Independent Team that the usual process was *“to go out and do a screening and complete a form which would be based on eligibility criteria. If the client was suitable we then go into [a] handover period and work jointly with the old team and then what should happen is there is a review meeting to formalise who comes to AOT.”* This process was validated by the business manager for the assertive outreach team. The process, then, reflects the contemporary process and is generally a reliable one.

The Independent Team liaised with the Trust’s CPA co-ordinator, who helpfully provided a complete list of when electronic documents were created and/or viewed in relation to Mr SR between 2005 and 2008. This list showed:

Form Accessed	Activity	Date	Professional	Team
form 1b	Updated	15/2/2006	CPN	Assertive Outreach
form 1b	Created	15/2/2006	CPN	Assertive Outreach
form 1a	Created	15/2/2006	CPN	Assertive Outreach
form 8	Viewed	15/2/2006	CPN	Assertive Outreach
form 3a	Viewed	15/2/2006	CPN	Assertive Outreach
form 3a	Created	10/2/2006	Clinical governance co-ordinator	
form 8	Viewed	26/9/2005	Community mental health team	
form 8	Viewed	23/9/2005	Community mental health team	
form 8	Updated	23/9/2005	Community mental health team	
form 8	Updated	23/9/2005	Community mental health team	
form 8	Created	23/9/2005	Community mental health team	

Form 1a was the ‘Key Information’ document

Form 1b was the ‘Key contacts sheet’

Form 3a was the risk screening form

Form 8 was a Summary of Intervention.

The list of documents does not show a discharge/transfer of CPA occurring for Mr SR. The Independent Team, at this length of time after the fact, has not been able to determine why this did not occur. However, the then and current team manager told the Independent Team that now (2011) this area of practice is monitored using a supervision tool that has been implemented in the Trust.

Mr SR's appointed care co-ordinator, within the assertive outreach team, was a new member of the team, having previously worked in an in-patient unit. This individual recalled being asked to be care co-ordinator as he had met the service user previously as an in-patient. He also recalled attending to meet with Mr SR at his home with the housing support worker, so that he could introduce himself. He did not, however, recall being involved in any of the assessment or hand-over processes as described above. Nevertheless, the mental health nurse did believe that it was appropriate for Mr SR to be transferred to the assertive outreach team.

The mental health nurse did recall that in the period leading to transfer Mr SR had not been engaging with his community mental health team care co-ordinator and was refusing to meet with him. This was confirmed by an Episode of Intervention (EOI) Activity Record Report dated 1 November 2005, which said: *"[Mr SR] was seen at home. Discussed recent request to change care co-ordinator and need by [Mr SR] to have minimal contact with the mental health service. Plan: 1) To review need for change in care co-ordinator; 2) To be reviewed by the consultant psychiatrist on 10 November 2005."*

The mental health nurse told the Independent Team that one of the aims of Mr SR coming on to the assertive outreach caseload was to enable more structured boundaries to be implemented with regards to acceptable and non-acceptable behaviours with him. However, Mr SR generally engaged only when he wanted something; for example, his rubbish being cleared.

Mr SR's consultant psychiatrist validated the information provided by the mental health nurse by telling the Independent Team that:

"[Mr SR] had a long history of contact with mental health services and was known to pose management problems from time to time, mainly due to his abusive and hostile behaviours towards staff involved in his care. There was a long-standing problem with non-compliance with medication and disengagement with psychiatric services, which led to his case being transferred from the community mental health team to the AOT."

The consultant psychiatrist also confirmed that, in his opinion, the transfer to the assertive outreach team was necessary, as the level of in-patient Mr SR required was more than a community mental health team service could provide.

Comment by Independent Team

The information contained in Mr SR's records and provided to the Independent Team at interview shows conclusively that he was an appropriate candidate for the assertive outreach team. However, the Independent Team has not been able to achieve clarity about the process by which care co-ordination responsibility was

transferred from the community mental health team to the assertive outreach team. It understands from the current managers for the assertive outreach team that there is a clearly-defined process and that this reflects the process that in place in 2006. It usually worked well.

4.2 Mr SR remained under the care of his community mental health team consultant psychiatrist because at the time there was no dedicated consultant psychiatrist for his assertive outreach team. Consequently:

- ❑ Were the medical reviews Mr SR received sufficient?
- ❑ Was medical advice sought and provided in a timely manner about his care and treatment by the assertive outreach team?
- ❑ Would Mr SR's care and treatment have been materially different if there had been funded medical sessions for the Wigan assertive outreach team?

Summary

The situation of no dedicated medical sessions to an assertive outreach team was not common-place for this type of service in 2006. However, a decision had been made in 5 Boroughs NHS Trust, in 2004, that each of its assertive outreach teams would liaise with a service user's consultant psychiatrist in the relevant community mental health team, and that these consultants would have a half-session a week dedicated to outpatient appointments specifically for their assertive outreach team. There were six community mental health teams feeding referrals into Mr SR's assertive outreach team.

It is clear to the Independent Team that, for Mr SR, there were plans for medical review, but that Mr SR often did not attend for these. It is also clear to the Independent Team that if mental health professionals' care co-ordinating for a service user needed medical input, then this could be achieved either via booking a non-urgent or urgent outpatient appointment. All professionals told the Independent Team that this was possible, and that Mr SR's consultant psychiatrist was approachable. Medical advice was also available on an *ad hoc* basis. However, it is the opinion of the Independent Team that the medical provision to Mr SR's assertive outreach team was far from ideal, and that it:

- ❑ Reduced the opportunity for a proactive approach to Mr SR's management;
- ❑ Reduced the opportunity for planned home visits, including the consultant psychiatrist;
- ❑ Promoted a reactive model of clinical management;
- ❑ Did not provide for any opportunity for medical input and senior clinical leadership into the assertive outreach team weekly clinical team meetings.

Mr SR's consultant psychiatrist was wholly reliant on what the assertive outreach team professionals thought relevant to tell him.

The above being said, it is the perspective of the Independent Team that Mr SR was offered sufficient medical reviews for compliance with CPA good practice guidance of reviews on a six-monthly basis for those on enhanced CPA. However, in view of the increase in chaos surrounding Mr SR from July 2007 to December 2007, the Independent Team considers that there was insufficient medical input to Mr SR's management and that this was a direct consequence of the absence of funded medical sessions to the team.

4.2.1 Were the medical reviews Mr SR received sufficient in the lead-up to and following his transfer to the assertive outreach team?

The Department of Health Policy Implementation Guidance for Mental Health, 30 March 2001, set out the framework for assertive outreach teams. It stated that an assertive outreach service should have brief daily review meetings at which:

- all service users are reviewed
- a member of the medical staff is involved
- risk is reviewed.

It also said that there should be weekly review meetings with a consultant psychiatrist where action was agreed and changes in treatment were discussed by the whole team. This never occurred for Mr SR for the whole time he was a patient of the assertive outreach team. The Independent Team set out to understand the thinking behind the way his assertive outreach team was formulated and which led to this occurrence.

The commissioners for mental health services in Wigan told the Independent Team that:

“The PCT have a history of significant investment in the 5 Boroughs and have increased investment by more than a third since 2002. ...

... the current Assertive Outreach Team was resourced by a combination of some new investment, service redesign and funding released by a ward closure.

The 5 Boroughs were aware ... that a team had to be developed which provided fidelity to the AO PIG guidance, and they ultimately proposed a model that was agreed to meet fidelity requirements that was signed off by the SHA, which included their plans as to how consultant cover would be provided, and indeed they had to declare that fidelity annually to the SHA.

... in about 2002, prior to additional investment, an audit of the existing AO service was conducted by the team manager which identified that there was no specific consultant cover at that time and in fact [the PCT] forwarded that audit to the Department of Health ... at that time to see whether they felt that that current service met fidelity. They came back with a number of comments to suggest that it didn't meet fidelity requirements, but did not comment on the consultant arrangements. As a consequence of their feedback, the 5 Boroughs were made aware that they would have to deliver a fidelity model, and additional funding was provided, as well as funding made available through the closure of a ward to make that happen.

In the time [the current mental health commissioner has] been commissioning services, [he does] not recall having been requested, nor having refused, to fund an additional consultant for AO, nor has it ever been raised since the 2002 audit that the model was not a fidelity model. 5 Boroughs would acknowledge that the model was resourced fully through the combination of resources I have referred to, and it is a matter for the 5 Boroughs how they operationally deliver that service, as long as it has been deemed PIG compliant, or an agreed variance with the SHA.”

A range of senior managers at the Trust told the Independent Team that, prior to the development of an assertive outreach team in Wigan, there had been an intensive support team. It was this team that evolved to become the assertive outreach team.

At the time the assertive outreach team was set up, a decision was made to develop a multi-professional team, including psychology, with medical input being provided half a day a week. (Wigan, Ashton and Leigh all had a half-day medical session a week.) At the time these decisions were made there was not the amount of medical input into the service design as there would be now. Neither were decisions made on a shared basis between managers and clinicians. Consequently, it seems fair to say that the risks of the model agreed were not considered from a clinical management perspective as they would be today.

It was determined by managers at the time that the medical sessions identified would be dedicated outpatient sessions for assertive outreach patients. In reality, although some consultant psychiatrists maintained this, others did not, largely because of the logistics of trying to deliver an effective medical resource across three different teams (community mental health, early intervention and assertive outreach).

Although at interview a number of staff reported to the Independent Team that there were concerns about the lack of medical input, there appears not to have been awareness of this amongst managers. The main reason for managers' lack of awareness was that there were no triggers to highlight that there was a problem. The extensive performance indicators used at the time did not highlight any under-performance issues. Neither did Mr SR's team have a volume of complaints, or incidents that would have brought the team to the attention of the service manager or locality director.

4.2.1.1 The medical input received

A retrospective analysis of Mr SR's mental health records showed that there were plans to assess Mr SR medically on the following dates between January 2006 and the date Mr SR was admitted to hospital under the Mental Health Act on 20 December 2007:

- ❑ 23 February 2006 (the electronic record noted that Mr SR walked out after being abusive to the consultant. However, this was not reported in the consultant's letter to the GP)
- ❑ 12 October 2006 (Mr SR did not attend)
- ❑ 15 February 2007 (Mr SR did not attend)
- ❑ 5 July 2007 (2nd face-to-face medical assessment booked urgently by care co-ordinator [2])
- ❑ 14 December 2007 (Mr SR would not let the consultant nor his GP into his flat).

Although the offered appointments met good practice expectations of six-monthly medical reviews for service users on enhanced CPA, successful face-to-face contact was only achieved on two occasions: one on 24 March 2006 and the other on 5 July 2007. However, on 24 March the assessment was not completed, as Mr SR left the

appointment before its conclusion, having been abusive to the consultant psychiatrist.

The Independent Team is not convinced that the assertive outreach professionals could have achieved a greater success rate than this without Mr SR becoming more agreeable to attending these appointments.

Analysis of the medical contact achieved on 5 July

The letter to the GP from the consultant psychiatrist set out that:

- An emergency appointment had been organised by Mr SR's care co-ordinator;
- The consultant psychiatrist had been advised that Mr SR had been neglecting himself;
- At the appointment Mr SR appeared to be calm and rational and *"displayed a good degree of insight into his health problems"*.
- Mr SR admitted not taking his medications for his physical problems, but that he did continue with his psychiatric drugs.
- Mr SR was erroneously taking two anti-depressants: Escitalopram and Sertraline. The GP was advised to discontinue prescribing the Escitalopram immediately, but to continue with the Sertraline and Quetiapine.
- Mr SR had asked for a placement at Brookfield's Hospital as he felt that his flat was contributing to his decline. However, there were no beds available, so *"intensive input from AOT"* was agreed as an alternative.

As the only substantive record of the medical appointment, and in consideration that this was the first face-to-face medical assessment in more than 12 months, the Independent Team did expect to read a more detailed account of the consultant psychiatrist's assessment of Mr SR's mental state. In particular, the Independent Team would have expected to have seen documented the consultant psychiatrist's opinion of Mr SR's state of mind when he made the threat of fire-setting and how this altered his level of risk. If the above was not possible, either due to the length of time Mr SR was present or because Mr SR did not allow this clinical investigation by refusing to answer questions, then this should have been documented in the consultant's letter and in the clinical record.

Other opportunities for medical review

In addition to the above, opportunity for medical assessment presented on:

- 1 July 2007 (Mr SR was assessed in custody following a threat to set himself alight with petrol)
- 20 December 2007 (Mental Health Act assessment with section 135 warrant)
- In-patient care, 20 December 2007 to 9 January 2008.

On 1 July the assessing doctor determined that Mr SR was fit for interview and that no Mental Health Act assessment was required.

On 20 December the assessment conducted resulted in Mr SR's detention under s.2 of the Mental Health Act. He remained an in-patient until 9 January 2008.

The Independent Team's assessment of Mr SR's in-patient record revealed Mr SR was assessed by a staff-grade doctor on admission to the in-patient ward, where assessment proved to be difficult because he was not at all co-operative. The management plan was for further medical assessment the following day, of which there is no evidence. Subsequent to this, Mr SR was reviewed on a consultant-led ward round on 2 January 2008 and again on 9 January 2008. On neither occasion is there evidence of a detailed mental state examination, nor any documentation to say that it was attempted but not possible owing to Mr SR's lack of co-operation.

Following discharge from hospital on 9 January 2008, Mr SR was offered an outpatient appointment with his consultant psychiatrist for 17 January, but he did not attend for this. A further appointment was offered for 31 January 2008. He did not attend for this either.

The perspective of Mr SR's consultant psychiatrist

With regards to the consultant psychiatrist's experience of Mr SR, he told the Independent Team that he did not recall a doctor-to-doctor hand-over of Mr SR's case in 2005. Essentially, he inherited a number of patients, approximately 75, on a block transfer basis from Mr SR's previous consultant, and Mr SR was one of these. At the time of the transfer, although he could not recall precisely, the consultant psychiatrist believed that there was probably not a review and assessment of Mr SR. However, this consultant also told the Independent Team that he would have had the opportunity to conduct a full assessment of Mr SR's history and risks via the outpatient system. However, whereas it would normally be undertaken with the contribution of the service user, in the case of Mr SR this proved to be challenging as he had a high percentage non-attendance rate. Consequently, the consultant did not get to see Mr SR "very many times". The behavioural trait of non-engagement was one of precipitating factors, prompting his referral to the assertive outreach team.

Accepting the above, the Independent Team highlighted to Mr SR's consultant psychiatrist that, when he took over medical responsibility for Mr SR's care and treatment, he already had a number of volumes of clinical records, five in total. The Independent Team was interested to know what the usual practice was in relation to records review to enable a consultant to have a sufficient detailed knowledge and understanding of a service user. Mr SR's consultant told the team that:

"It is common practice to book patients who are new to the clinician a full hour slot for the first appointment, where notes are reviewed and the case is discussed in detail with the care co-ordinator before the patient is brought in for the review. Any significant past psychiatric or forensic history, including risks to self and others, are noted at this initial review." At the time Mr SR was transferred to this consultant's caseload, he was well known to the local mental health services.

With regards to the ongoing medical assessment of Mr SR, his consultant psychiatrist told the Independent Team that:

"the specialist teams, Early Intervention Team (EIT) and Assertive Outreach Team (AO), did not have a dedicated Consultant Psychiatrist, so EIT and AO had appointments at the outpatient clinic for the patients to be reviewed. If the patients

didn't attend, care co-ordinators had a wasted trip. Appointments were given by admin as requested by the team. There were no dedicated AO slots; it was a standard outpatient clinic. I had more than one clinic at Boston House, so I fitted them in, [and] there was a degree of flexibility. Requests for urgent appointments were always accommodated."

Mr SR's consultant psychiatrist told the Independent Team that he was aware that other colleagues did have dedicated outpatient appointment slots for AO patients. The reason he did not was largely a matter of logistics and workload. At the time he had:

"5 outpatient clinics in total per week, of which one was a dedicated clinic for new patients (Gateway and Advice Clinic). There were 3 routine outpatient appointment clinics in which patients from CMHT/AOT/EIT were seen. There was a further clinic for emergencies where patients from any of the above teams were reviewed on an 'as required' basis."

He considered that he had organised a system whereby he was as accessible as he could be for routine (i.e. planned) medical reviews at outpatients and also ensured that there were always 'emergency' slots available on a weekly basis.

With regards to Mr SR, the consultant psychiatrist recalled that the reality of the situation was that his role was one of *"gathering info from CCO"* and responding appropriately to any requests for assessment. For example, in December 2007 staff were concerned about his *"non-attendance and [had] general concerns about how he was, so I was asked to go out and see him in the community"*.

Mr SR's consultant concurred with the Independent Team's consultant psychiatrist, who suggested that the medical input, by virtue of the size of the caseloads and not having any dedicated time for assertive outreach, was reactive rather than proactive and that he (Mr SR's consultant) was reliant on *"practitioners, [and] the threshold for seeking help was variable to some degree dependent on the practitioner"*.

With regards to the practicalities of conducting an assessment with Mr SR, his consultant revealed that it was very challenging. He told the Independent Team that *"it was not easy to get info from [Mr SR] – I can distinctly remember his confrontational behaviour; he would answer a question with a question with an aggressive flavour."*

The Independent Team's consultant psychiatrist reflected, *"if you asked him too much he would walk off"*. Mr SR's consultant agreed with this, saying, *"yes, that's right, you were walking on eggshells, careful not to offend him, which was very easy to do. He [walked] into the room in a bad mood and you [were] trying to get things going, very careful how you phrased questions to him. It was difficult to engage in a therapeutic relationship. [He] put his views across quite forcefully, very opinionated."*

With regards to the frequency of planned medical reviews, the Independent Team highlighted that there appeared to be a gap of five to six months in the period leading up to his eventual admission to hospital. The consultant's recollection of this was of

“being updated informally about the case, mainly difficulties with engagement. I think it was only nearer the admission that my intervention was requested in terms of seeing [Mr SR] in the community.”

He did not recall a formalised review of how his recommended management plan of more intensive community contact was evolving. But he did recall being *“briefed on the management of [Mr SR] in the community by his care co-ordinators, ... informally”*. One of the reasons he was requested to assess Mr SR at home was because of the *“failed engagement with outpatient appointments”*.

In retrospect, the consultant agreed that there was rather a long gap between planned medical reviews, but this was balanced by the continued attempts of the assertive outreach staff in trying to engage him. He considered both of the care co-ordinators for Mr SR to have been very experienced and competent in their work. One was an approved social worker and the other a very experienced mental health nurse. Both he considered *“were trying everything possible within their power and [he] was aware [Mr SR] was very difficult”*.

4.2.2 Was medical advice sought and provided in a timely manner about his care and treatment by the assertive outreach team?

Summary

The focal period of time where the Independent Team considers that medical advice should have been sought by the assertive outreach team was between July 2007 and December 2007. This was the period where Mr SR's behaviours deteriorated and his risk factors were increased. As already noted, the assertive outreach team did seek the input of the consultant psychiatrist after Mr SR had threatened to set himself and his flat alight in July 2007, and also in December 2007, when there were increasing concerns being raised about Mr SR by his housing provider, his mother, his GP and the general community in which he lived. The Independent Team considers that medical advice should also have been sought between 22 August and 28 August and also mid-November and 28 November, when Mr SR was facing eviction from his flat. During both of these periods there were enhanced concerns expressed about Mr SR.

The medical input sought

The first occasion: Mr SR's care co-ordinator [2] made arrangements for medical review following a home visit on 3 July 2007. This was following his arrest and subsequent discharge home after he had threatened to set himself, and others, alight with cans of petrol.

The second occasion: Mr SR's community psychiatric nurse contacted his consultant psychiatrist after a concern had been raised by his GP on 11 December 2007. The records infer that the GP was keen that careful consideration was given to the need for a Mental Health Act assessment in view of the continual concerns being raised about Mr SR. He believed that Mr SR was very unwell. As a consequence of this communication and concerns raised by the then duty Approved Social Worker (ASW) (not Mr SR's care co-ordinator at the time) about conducting a Mental Health Act assessment, the consultant psychiatrist attended at Mr SR's home on 14 December with one of the GPs. Mr SR would not answer the door or allow them in. Consequently, a decision was made to progress to a Mental Health Act assessment on 20 December. As events transpired, this was conducted under section 135 of the Mental Health Act, initiated by Mr SR's then care co-ordinator. (That is where a warrant is obtained from the magistrate to enable forcible entry into a service user's home.)

The above information illustrates appropriate involvement of Mr SR's consultant psychiatrist, by the assertive outreach team.

As highlighted in the summary, however, the Independent Team does consider that some formalised communications should have occurred in August and November. The Independent Team accepts that informal and therefore undocumented communications may have occurred. However, in the circumstances, there should have been a record of this. Furthermore, the Independent Team suggests a greater level of documented detail regarding discussions about Mr SR at the assertive outreach team clinical team meetings would have represented optimal practice.

The Independent Team notes that, in the July, intensive input had been requested from Mr SR's consultant psychiatrist for him as an alternative to a residential placement. There is no evidence that Mr SR's consultant psychiatrist sought updates about this; nor that any were provided to him.

Mr SR's consultant psychiatrist told the Independent Team that, generally speaking, he was updated on an informal basis about assertive outreach patients to whom he was a consultant. He recalled that it was not unusual for a care co-ordinator for 'patient A' to attend with that patient for an outpatient appointment and to take the opportunity at the end of an appointment to speak with him about another patient. The Independent Team was also informed by the assertive outreach team that if an appointment with a consultant psychiatrist was required, it always happened.

In stating the above, the Independent Team is mindful of the barrier to effective communications the non-provision of dedicated medical cover for the assertive outreach team would have caused. The purpose of the Policy Implementation Guidance was in part to ensure seamlessness between assertive outreach team members and across services. That a consultant psychiatrist was not a key member of the team was disadvantageous to the achievement of this. All staff believed that it would have been advantageous to the day-to-day management of assertive outreach service users to have had more regular medical input to the team. The Independent Team can only agree with this.

4.2.3 Would Mr SR's care and treatment have been materially different if there had been funded medical sessions for the Wigan assertive outreach team?

The Independent Team considers that, on the balance of probabilities, the management of Mr SR would have been materially different in the following respects if dedicated medical sessions had been provided to the assertive outreach team:

- ❑ At transfer – the Independent Team suggests that it would have been more thorough and comprehensive.
- ❑ There would have been a more comprehensive management plan.
- ❑ There would have been an earlier and more comprehensive overview of Mr SR's medicines management. In the event, this occurred by chance.
- ❑ A much more flexible and rapid response when things were not working would have been a reasonable expectation, including more assessment of Mr SR, in terms of team reflection, medical home visits, and the assessment of his mental state.
- ❑ Medication monitoring, the Independent Team suggests, would have been more robust.
- ❑ The approach to Mr SR should have been altogether more proactive rather than reactive, as it seemed to be; including the monitoring of the volume of 'did not attend' events.
- ❑ There would have been the opportunity for more concrete consideration of Mr SR's diagnosis over a longer period of time.
- ❑ Possibly earlier consideration of Mr SR's position as an appropriate assertive outreach patient.
- ❑ Evidence of more gravitas being given to the concerns being raised by the housing provider; by Mr SR's family; by the police. The clinical records suggest that the assertive outreach team was inured to this.

The Independent Team is not suggesting that the assertive outreach team did not consider the above points; but, on balance, it does believe that, had a consultant psychiatrist been present in the team, there would be greater evidence of the considerations within the team of how to address the challenges presented by Mr SR, the options available, and more evidence of risk management planning.

Furthermore, it is the strongly held belief of the Independent Team that the thinking time available for this patient would have been increased and greater consideration given to the range of Mr SR's behaviours linked to personality disorder and those more reflective of a serious mental illness.

Finally, the Independent Team considers that the need to regularly explore Mr SR's auditory and command hallucinations would not have been forgotten. The need to not lose sight of these would have been emphasised.

4.3 Was Mr SR's management plan and the conduct of the assertive outreach team appropriate? That is, did they do all that they reasonably could and should have to try and maintain contact with Mr SR and conduct appropriate assessments of him?

In this section, the Independent Team will address the matters of medication management, compliance with CPA expectations and the frequency and quality of contacts achieved with Mr SR. The matter of risk assessment is addressed in section 4.4.

4.3.1 Medication Management

Summary

It is clear to the Independent Team that Mr SR was difficult to engage with, and monitoring medication compliance was challenging for staff, especially in light of the frequency with which he did not make himself available to meet with them. The clinical records do indicate that medication compliance was on the minds of the professionals and there were 12 clinical entries that reference medication between February 2006 and December 2007. However, the documentation did not show an overly assertive approach to staff enquiries and surveillance of Mr SR's medication compliance. The Independent Team accepts that this was made challenging by Mr SR himself, but nevertheless, the Independent Team considers that the range of activities used to assess this could have been more expansive.

The evidence on which the Independent Team has based its opinion is as follows:

At the time Mr SR was transferred on to the caseload of the assertive outreach team, his prescribed medications were:

- ❑ Amisulpride 200mg (twice a day)
- ❑ Carbamazepine 100mg (twice a day)
- ❑ Carbamazepine 200mg (twice a day)
- ❑ Haloperidol 1.5mg (3mg three times a day)
- ❑ Orphenadrine 50mg (four times a day)
- ❑ Zopiclone 7.5mg at night
- ❑ Diazepam 5mg at night
- ❑ Orphenadrine 50mg (one tablet as required).

On 13 July 2006 Mr SR's care co-ordinator conducted a home visit. Mr SR reported being medication-compliant. However, it was also noted in the records that he enquired as to whether there was an alternative medication. The community psychiatric nurse noted that he advised Mr SR to remain on his current medication, particularly as Mr SR reported feeling well at the time.

On 23 September reference is again made about Mr SR's reported compliance with his medication, although it was noted that his sleep was disturbed. At this home visit, the visiting occupational therapist also discussed with Mr SR his non-engagement with his care co-ordinator and non-attendance at his medical reviews. Mr SR was noted to have agreed and that he would try and improve in this area.

On 29 November 2006 it was noted in the progress records that the community psychiatric nurse had offered to collect a prescription for Mr SR; however, Mr SR reported that he had medication.

On 3 January 2007 the community psychiatric nurse noted that there were medication boxes by Mr SR's door and that he shook a couple to make sure the medication was in them.

On 15 February 2007 the community psychiatric nurse said, in a letter to Mr SR's GP and also to his consultant psychiatrist, that he "*assumed that [Mr SR] was taking his medication*". There was nothing to suggest that he was not.

On 3 July 2007 Mr SR was reported to have told his community psychiatric nurse and care co-ordinator [2] that he was not taking his physical health or his psychiatric medications. The social worker was noted to have made an urgent appointment for Mr SR to see his consultant psychiatrist as a consequence of this information exchange. At the time, the medication Mr SR was taking was:

- ❑ Nicorandil 10mg bd (a type of medicine called a potassium-channel activator. It is used to help the heart work more easily)
- ❑ Atorvastatin 20mg nocte (a medicine used to reduce the risk of a heart attack)
- ❑ Clopidogrel 75mg morning (a medicine used to prevent heart attacks and strokes. It works by helping to prevent harmful blood clots that may cause heart attacks or strokes)
- ❑ Aspirin enteric coated 75mg morning (used to reduce the risk of the patient forming blood clots in the arteries)
- ❑ Atenolol 50 mg morning (this is used as an anti-hypertensive, as well as to slow the heart rate down and therefore prevent it from beating too fast. In this case it was probably used as an anti-hypertensive)
- ❑ Lisinopril 10mg morning (Lisinopril is an angiotensin-converting enzyme (ACE) inhibitor used for treating high blood pressure and heart failure)
- ❑ Quetiapine 600mg at night (an oral anti-psychotic medicine used for treating schizophrenia and bi-polar disorder)
- ❑ Sertraline 50mg daily (an anti-depressant)
- ❑ Escitalopram 10mg morning (an anti-depressant)
- ❑ Orphenadrine 50mg twice a day (this is used to prevent the extrapyramidal⁴ effects of anti-psychotic medication, the main one being muscle stiffness).

The Independent Team agrees that booking a medical review was an appropriate action. However, it would have expected greater details about the discussions the mental health professionals had with the MSHU regarding his medication.

⁴ **Extrapyramidal system** is a neural network located in the brain that is part of the motor system involved in the co-ordination of movement. The system is called "extrapyramidal" to distinguish it from the tracts of the motor cortex that reach their targets by travelling through the "pyramids" of the medulla.

On 5 July 2007 Mr SR attended at outpatients with the community psychiatric nurse and care co-ordinator [2] to meet with his consultant psychiatrist. At this appointment the consultant reviewed Mr SR's medications and removed the Sertraline 50mg, as he was on two different types of anti-depressant, which was not necessary. Mr SR's GP was advised of this and asked to stop any further prescriptions for Sertraline. The letter to the GP also stated that Mr SR, although admitting to not taking his physical health medications, reported continuing to take his psychiatric medications. This was contrary to what he had said to the community psychiatric nurse and care co-ordinator [2] two days previously.

The assertive outreach progress notes also stated that when Mr SR was taken home by the MHS and care co-ordinator [2] he would not allow them to remove his old medications.

8 August 2007: Care co-ordinator [2] visited Mr SR at his home. It was clearly noted in the record made that Mr SR told both staff that he was taking his medications. The staff noted that there was *"no evidence to suggest otherwise"*.

15 August 2007: In a letter to Mr SR's mother, the community psychiatric nurse and care co-ordinator [2] noted that there appeared to be an inconsistency in what her son was saying about his medication compliance. The letter informed Mr SR's mother that her son had confirmed some weeks earlier that he was taking his mental health medication but not his physical health medications. The letter also noted that if Mr SR was not taking his mental health medication then he had proven *"to be able to maintain a good standard within the community"*, going to India and showing *"strength of character and resolve"* when his father died.

16 August 2007: Care co-ordinator [2] and Mr SR's community psychiatric nurse attended at Mr SR's home. At the time the pharmacist was delivering Mr SR's repeat medications. The assertive outreach record noted that both they and the person delivering the medications knocked loudly. Mr SR did not respond; consequently, the medications were posted through his door. While the assertive outreach staff remained in the vicinity of Mr SR's flat, he was noticed *"at his window, bobbing up and down"*.

7 September 2007: A telephone message was left for the community psychiatric nurse working with Mr SR. The message reported that, amongst other things, the community constable had asked Mr SR about his medication and that Mr SR had told him that he had a prescription that needed changing. The individual taking the message was noted to have advised the community constable that she would inform the relevant staff and arrange for a home visit to Mr SR.

Following a period of prolonged lack of engagement of Mr SR with the assertive outreach team, in a draft letter written by care co-ordinator [2] it was noted that she believed Mr SR was *"abusing alcohol and that this [was] impacting on his rationale, along with non-compliance with medication. ... There is no clarity as to whether [Mr SR] is compliant with medication"*, but his behaviour suggested he was not compliant.

20 December 2007: The assertive outreach record noted that Mr SR reported stopping his medication because he wanted to drink alcohol. It was also noted that he appeared to lack any insight into his behaviours. Mr SR was admitted to hospital on this day under Section 2 of the Mental Health Act.

Between this day and 30 December, Mr SR remained non-compliant with medication. Conversion of his detention under section 2 of the Mental Health Act was considered, but there were insufficient grounds to enable this to occur.

Mr SR's refusal of medication continued on 1 January 2008. At this time there were no features of mental illness.

On 2 January 2008 Mr SR was advised to take his medication and told staff he did not need them. The plan, therefore, was to stop his Sertraline and Quetiapine.

On 9 January 2008 it was noted that, despite Mr SR taking no anti-psychotic medications, no psychotic symptoms had been noted. As a consequence, staff agreed that his pre-existing diagnosis of schizo-affective disorder should be changed to personality disorder.

What staff said

When the Independent Team asked those staff who had most contact with Mr SR about medication monitoring and compliance, all confirmed that it was difficult to gauge the level of Mr SR's medication compliance. He would say he was taking his medication and, except over the period immediately prior to his admission to hospital in December 2007, there was no indication that he was not. He was having all of his medications delivered by his local pharmacist, so 'non-collection' of medication was not usable as an indicator of non-compliance. The community psychiatric nurse and Mr SR's consultant psychiatrist separately told the Independent Team that, after he had been admitted to hospital, it became clear that Mr SR had not been taking his medications for around eight months, even though he had been reporting that he was medication-compliant. The community psychiatric nurse recalled that the extent of Mr SR's medication non-compliance only became clear when they were able to have a look around his flat. Mr SR's psychiatrist also recalled that, if Mr SR did not want a particular medication, then "*that was that*", there would be "*no way of convincing him otherwise*".

Mr SR's consultant psychiatrist was also clear in his impression that Mr SR "*showed no signs of mental state deterioration when reviewed in clinic and was willing to continue medications as prescribed*". His recollection validates the recollections of the community psychiatric nurse and care co-ordinator [2], who provided written information to the Independent Team, which said:
"*[Mr SR] and his sister reported this 8-month non-compliance with medication; a stockpile of medication was found which appeared to correspond to this. [Mr SR] used to have his medication prescription collected and then delivered to him by his*

chemist; this made monitoring of his concordance problematic and AOT were reliant on the reports of [Mr SR] and his family.”

At interview, the community psychiatric nurse was asked if the assertive outreach team had a process in place to check medication compliance. He told the Independent Team that usually they liked to see blister packs, but Mr SR felt that his word should be good enough. He could not recall whether Mr SR was issued with blister packs.

With regards to the system implemented for the delivery of Mr SR's medications, the community psychiatric nurse recalled that this had been organised when Mr SR was a patient of the community mental health team. He was asked if it was his usual practice to liaise with a community pharmacist when trying to determine the level of medication compliance. The response provided suggested to the Independent Team that it was not his usual practice. The social worker (care co-ordinator [2] in the assertive outreach team) was asked:

“1. To what extent were you able to view his [Mr SR's] medicine bottles to determine whether or not there were less pills in them since the last visit?

[Response]: I was not able to monitor medication because [Mr SR] would not allow us in consistently enough to judge consumption. We did note a stock-pile, suggestive of several months' medication, behind the door, which was in keeping with [Mr SR's] & family reports he was not taking medication.” (This refers to December 2007)

And

“2. Did you at any time think about negotiating with the pharmacist to alter the established system to one that may have enhanced the assertive outreach team's ability to more effectively monitor medication?

[Response]: On what basis would I have considered this? [Mr SR] had capacity to make choices and he chose not to take medication. As this situation deteriorated to the point that I felt [Mr SR] met the criteria for the Mental Health Act, I moved forward with an assessment under the Act. Whilst on the ward, this was the opportunity to review medication.”

The Independent Team understands the perspective of the social worker to a point. However, there was a considerable period of time where Mr SR was reporting medication compliance, where it seems this was not the case. The Independent Team considers that the assertive outreach professionals working with Mr SR could and should have considered exploring with the community pharmacy ways of continuing the delivery service, which may have made it easier for them to have monitored more reliably Mr SR's true level of compliance. It may have enabled the assertive outreach team to have demonstrated enhanced scrutiny in the monitoring of Mr SR's medication compliance after July 2007, one of the purposes of the intensive support as requested at the time by his consultant psychiatrist. The Independent Team does, however, consider reasonable the perspective of the consultant psychiatrist who felt and feels that at the time the social worker and community psychiatric nurse did try to determine Mr SR's level of compliance in so far as he would allow them to do this.

With regards to trying Mr SR on different medication, this was only feasible when he was in hospital. Consideration was given to this; notably anti-psychotic depot medication. Mr SR's consultant psychiatrist told the Independent Team that they had considered converting his detention in hospital under section 2 of the MHA to section 3, which would have enabled them to enforce treatment. However, there were insufficient grounds to do this, which rendered the use of depot in the community as not feasible without Mr SR's agreement and engagement. This was not at all forthcoming. He, in fact, refused all medication, which resulted in him being taken off all medications in January 2008. Given the documented lack of signs of psychosis and the team's consideration of a change in Mr SR's diagnosis, this was not an unreasonable action at the time.

Mr SR's physical health medications

From a physical health perspective, Mr SR was on a range of medications for his heart condition as well as his mental health condition. A component of effective care co-ordination is to ensure that a service user receives at least an annual health check. In the case of Mr SR, awareness of his physical health issues and the medications he was on was an important responsibility for his care co-ordinators. Consequently, the Independent Team did ask the community psychiatric nurse about this. He informed the Independent Team that now (2011) ensuring that physical health checks occurs is standard practice; however, in 2006 it was not. At that time the physical health checks were done via the GP. In the case of Mr SR, it was *“done via the GP via a home visit when the physical problems came to our attention”*. This was triggered by one of the GP practice nurses contacting the assertive outreach team with concerns about Mr SR's medication compliance and his lack of attentiveness to his health needs. The community psychiatric nurse did not recall having knowledge of Mr SR's physical health issues at the time he was transferred from the community mental health team. It is the perspective of the Independent Team that Mr SR's community psychiatric nurse should have been aware of his physical health issues when he took over care co-ordination responsibility in February 2006. It is also the contention of the Independent Team that the assertive outreach team, including Mr SR's consultant psychiatrist, should have had a clear view on the two pharmaceutical treatment streams for Mr SR. The complexity of this should have been reflected in Mr SR's care plan.

4.3.2 Frequency and quality of contacts between Mr SR and the assertive outreach team

Summary

In circumstances where a service user does not want to engage with mental health services and is not sufficiently unwell to warrant an assessment under the Mental Health Act, it is difficult for professionals to achieve a therapeutic relationship and contact levels tend to be sub-optimal. In this case, the frequency of successful face-to-face contacts with Mr SR was much less than an assertive outreach service would have hoped for. Although it is clear that his assertive outreach team did achieve some success in making contact with him, and the frequency of attempted contacts in 2006 was reasonable, the Independent Team considers that after July 2007 there was insufficient evidence of an escalation in tempo in response to the plan for more intensive visits to try and achieve more reliable contact with Mr SR. There is no information to suggest that any effort was made to increase attempted contact to more frequently than alternate weeks. In the opinion of the Independent Team, this did not meet the common interpretation of 'intensive outreach' or meet common assertive outreach standards.

With regards to the quality of contacts the assertive outreach team achieved, this was difficult to determine. The records show that the assertive outreach team tried to engage with Mr SR via opportunities presented to them, and that they offered a range of practical support to him. Passing references were also made from time to time about his mental state. It is this element of the record-keeping that the Independent Team considers could and should have been better. It accepts that Mr SR did not want to be assessed and was, for the most part, non-communicative about his mental state. Nevertheless, he was under the care and management of an assertive outreach team and the Independent Team would have expected his care co-ordinators to have at least set out their efforts to explore Mr SR's mental state or, at the very least, how they hoped to assess the mental state of Mr SR.

4.3.2.1 Frequency of contact

Frequency of contact with Mr SR was challenging for the assertive outreach team because, from an early juncture, he made it clear that he did not want to engage with them, except in circumstances where he saw the value of this; largely occasions where he identified that the assertive outreach team could assist in his achievement of practical objectives.

Nevertheless, in 2006 the assertive outreach staff made at least 21 attempts at face-to-face contact with Mr SR. Of these, only six constituted successful contacts; that is, where a meaningful interaction with Mr SR occurred. On a further four occasions the assertive outreach team did 'sight' Mr SR, but he would either not interact with them or the sighting was 'at a distance'. The care plan in 2006 stated that visits to Mr SR would be on a two-weekly basis. The number of attempted visits falls short of this ratio, but not significantly so. The Independent Team does not believe that, had all 26 prescribed attempts been made, the ratio of successful contacts with Mr SR would have been markedly different.

In 2007 the assertive outreach team attempted face-to-face contact with Mr SR on 30 separate occasions, including one CPA review. On nine of these occasions, their efforts to make contact with Mr SR were successful: i.e. resulted in meaningful interaction with Mr SR. He was sighted on a further two occasions.

In July 2007 Mr SR was arrested for threatening to set fire to himself with petrol. At a subsequent outpatient appointment, Mr SR asked for residential care; however, this was not available and it was agreed that Mr SR would be supported at home with “*intensive input from the AOT*”. The records do not contain information that demonstrates any enhancement in his care plan from that prior to the incident of fire threat. Visits, as shown above, remained approximately every two weeks, which is more akin to what would be expected of a community mental health team than an assertive outreach team. The Independent Team suggests that visits should have been attempted on at least a weekly basis, and that, in view of the potential risks to Mr SR and the public by his fire threat, the plan for more intensive and effective outreach to Mr SR should have at least considered the involvement of:

- ❑ Mr SR’s family (notably his mother and sister);
- ❑ the housing provider;
- ❑ a support and time recovery worker; and
- ❑ the crisis and home treatment team.

It is the contention of the Independent Team that, in trying to achieve a more assertive approach for Mr SR, a support and time recovery worker would have been an ideal strategy to have tried. Working with service users such as Mr SR was the whole *raison d’être* for the role (Mental Health Policy Implementation Guide: Support, Time and Recover (STR) workers,⁵ Department of Health, February 2003). In saying this, the Independent Team is mindful that in June 2006 his then care co-ordinator offered Mr SR a support worker from the assertive outreach team after Mr SR decided that he did not want to continue with the support worker provided by the housing provider. However, Mr SR refused the care co-ordinator’s offer. Nevertheless, it would have been prudent to have re-offered this.

In addition to evolving a more dynamic plan for Mr SR involving family and other teams, the Independent Team would have expected to have found information showing analysis regarding the frequency of Mr SR’s unavailability rate and what precisely the assertive outreach team were trying to achieve with him, along with serious consideration of what the merits of retaining him on the assertive outreach caseload were.

The gap in frequency of contacts that the Independent Team has most concern about was between 3 November 2007 and 12 December 2007. This was a period of five weeks. There is no rationale for this gap documented in Mr SR’s records and nothing to show that any attempt was made to contact him during this period.

⁵ An STR worker is someone who works as part of a team which provides mental health services and focuses directly on the needs of service users, working across boundaries of care, organisation and role. They will provide Support, give Time to the service user, and thus promote their Recovery. (<http://www.nhs.uk/jobs/vocational/Details.aspx?Id=518>)

A review of the assertive outreach team weekly clinical team meeting minutes revealed:

- 7 November: the unsuccessful visit of 3 November was noted;
- 21 November: “[Mr SR] – not seen and unsuccessful failed visits”; and
- 28 November: “Amber, he left the property, not known where he is (? at mother’s) and [care co-ordinator [2]] trying to get hold of [housing].”

In light of the medical plan of more intensive input to Mr SR, the efforts made by the assertive outreach staff should have been comprehensively documented in the daily progress notes. It is not good practice that the only information regarding activity was recorded in brief minutes of the clinical team meeting.

All the above being said, it would be unreasonable to suggest that the assertive outreach team did not endeavour to enhance the success rate of contacts with Mr SR. Mr SR’s community psychiatric nurse told the Independent Team that *“in order to try and engage [Mr SR], the AOT operated various approaches. They completed general appointments, visited [Mr SR’s] home on an ad hoc basis, waited around outside of his home just in case [he] turned up. The team tried to engage [Mr SR] in things he was interested in, such as hobbies, educational activities. [The community psychiatric nurse] reported [Mr SR] was not interested at all.”*

The community psychiatric nurse also reflected on Mr SR’s relationship with his key worker, telling the Independent Team that *“[Mr SR] had a good relationship with [the housing provider] and the support worker there at one point in time. [The community psychiatric nurse] stated he tried to re-instigate this relationship. The support worker from this organisation took [Mr SR] shopping and [he] seemed to be doing well with this approach, but then [Mr SR] ended this contact and gave no reason for doing so. When [the community psychiatric nurse] tried to re engage [Mr SR] with this organisation [he] failed to engage. [The community psychiatric nurse] felt that everything possible to engage [Mr SR] was done.”*

The Independent Team enquired from the housing provider what happened with regards to the support worker. The Independent Team was informed that Mr SR’s housing support worker *“visited [Mr SR] on 2/6/06 and found a letter from [Mr SR] on the front door saying he did not want to continue with support. His case was formally closed on 28/6.”* The support worker had been working with Mr SR for about one year, providing support with budgeting and ongoing adjustments to living in the community.

The consultant psychiatrist to Mr SR confirmed to the Independent Team that, in his opinion, both of the assertive outreach professionals who held care co-ordinator responsibility for Mr SR between January 2006 and February 2008 did their reasonable best to try and achieve successful engagement with Mr SR. This included providing Mr SR with a change in care co-ordinator in January/February 2007 to see if a new approach would make any difference to his willingness to engage. The Independent Team agrees that this was a good strategy.

The Independent Team also noted that, in addition to the recording of the occasions where successful contact was achieved with Mr SR, the records demonstrate that on a number of occasions following a series of unsuccessful efforts to make contact with Mr SR the assertive outreach team would contact his mother. She was able from time to time to provide useful information about her son's whereabouts, and on other occasions Mr SR himself answered the phone. However, even on these occasions Mr SR would refuse face-to-face contact with the assertive outreach team. The Independent Team suggests that the assertive outreach team could and should have explored with her ways of achieving successful contact with her son, even if this transpired to be not possible.

4.3.2.2 Quality of contacts with Mr SR

Summary

In commenting on the apparent quality of contacts achieved with Mr SR, the Independent Team is mindful that he was a patient who was difficult to interview and who was reported to have become angry unless staff followed his script. On occasion, he terminated meetings because staff were simply not talking about the things he wanted to discuss. The Independent Team's review of Mr SR's records left a sense that communicating effectively with Mr SR was somewhat of a battle. For example, on a home visit on 8 August 2007, when Mr SR was asked about his family, he stated he had no wish to discuss them, and then immediately started to talk about them. Mr SR was also noted to become irate when his care co-ordinator and the community psychiatric nurse did not agree with him that his fire-threat behaviour was understandable. Mr SR was someone who would talk about things when it suited him, but not in response to reasonable enquiry from the assertive outreach team. This attitude makes quality of contact hard to achieve.

The above being stated, the Independent Team would have expected to see:

- ❑ Clear documentation as to how the assertive outreach team assessed Mr SR's mental state and concluded that it was OK (no information about this is in the records);
- ❑ Clarity about what was discussed at clinical team meetings, strategies considered and decisions made (no information about this is in the records);
- ❑ Some linkage between the progress notes and the documented care plan for Mr SR (weak information in the records);
- ❑ Evidence of exploring with Mr SR previously reported auditory hallucinations in the 2nd and 3rd person (no information about this is in the records);
- ❑ Evidence of exploring with Mr SR any delusional framework (no information about this is in the records);
- ❑ Evidence of what the professionals considered was "*expressed high emotion*" following concerns raised by his sister with Mr SR about potential harassment of their mother by Mr SR on 11 April 2007 (no information about this is in the records);
- ❑ Evidence of how the assertive outreach team investigated the concerns raised by Mr SR's sister, including the reported threat to harm others (no information about this is in the records);
- ❑ Evidence of clinical communications between the assertive outreach team and Mr SR's consultant psychiatrist (information about this is in the records);
- ❑ Evidence of consideration of public safety risk in relation to Mr SR's more risky behaviours (e.g. fire threats) (information about this is in the records); and
- ❑ Evidence of activities aimed at promoting the engagement of Mr SR with the assertive outreach team (good evidence of this is in the records. Mr SR's first assertive outreach care co-ordinator supported Mr SR in his interest to re-attend college. However, when this professional booked an appointment for Mr SR to progress this, he did

not attend. The same professional also agreed to obtain information for Mr SR about 'Hyndelle Lodge Creative Support.'⁶).

The lack of recorded detail about how the assertive outreach team conducted their assessments of Mr SR means that, on the basis of records analysis alone, it is hard to say that the quality of contact with Mr SR met with standards expected of an assertive outreach service.

The Independent Team found that the records were largely descriptive about what was going on for Mr SR there and then. The Trust's own investigation team also commented on this. The records simply did not demonstrate analytical thinking. There was also, in the opinion of the Independent Team, an over-use of loaded language such as 'attention seeking'. It would have been better if the assertive outreach team had set out factually what was said to Mr SR, his response, and the professionals' analysis of the response(s). This would have enabled the Independent Team to better judge the quality of the contacts achieved with Mr SR.

Although the Independent Team considers that the depth and breadth of documentation could have been better, the records made do show how challenging Mr SR was to work with, and how rude he could be. They also show Mr SR's ability to try and manipulate the mental health professionals when it suited him, and that he displayed odd and sometimes provocative behaviours. The records also demonstrate that the professionals spent reasonable periods of time with Mr SR when this was possible and that efforts were made to try and engage him, and relevant issues were explored with him. Such occasions were:

- ❑ 13 July 2006;
- ❑ 22 September 2006;
- ❑ 23 September 2006;
- ❑ 3 January 2007;
- ❑ 6 June 2007;
- ❑ 3 July 2007;
- ❑ 18 July 2007;
- ❑ 25 July 2007;
- ❑ 8 August 2007;
- ❑ 19 December 2007 (resulted in the obtaining of a s.135 warrant)
- ❑ 20 December 2007 (Mental Health Act assessment and last meaningful face-to-face assessment of Mr SR by the assertive outreach team prior to the incident).

Comprehensive documentation in relation to third-party information/intelligence gathered about Mr SR was also documented on:

- ❑ 16 August 2007;
- ❑ 7 September 2007;
- ❑ 10 December 2007;

⁶ Hyndelle Lodge provides support to persons in the community with mental health and behavioural problems. It is a service provided by Bridgewater Community Healthcare NHS Trust.

- ❑ 12 December 2007;
- ❑ 19 December 2007.

Clarity in the records regarding the assertive outreach team's efforts to form an opinion on whether Mr SR was using his flat and maintaining a level of functionality was achieved on:

- ❑ 3 November 2007;
- ❑ 13 November 2007.

The clinical records also show that the assertive outreach team undertook practical supportive activities for Mr SR when he indicated that this would be useful to him.

For example:

- ❑ Notifying the police on Mr SR's behalf when an unknown individual had damaged his flat.
- ❑ Providing him with support in finding a dentist.
- ❑ Offering to research suitable voluntary work for him when he expressed an interest in undertaking this.

Mr SR, as stated above, only "*wanted people's assistance when required*".

This was, however, at odds with the purpose of assertive outreach and meant that the assertive outreach team needed to demonstrate how they were going to find the balance between respecting Mr SR's wishes and ensuring that they achieved adequate monitoring of him, including appropriate interventions when required.

At interview, care co-ordinator [2] told the Independent Team that:

"the situation appears to have become reactive, resulting in the above-mentioned 'falling out' with various team members. I was very clear with [Mr SR] what I could and would do and equally what I could not do. This gave him little lee-way when his requests were unrealistic. My approach was to enable him to problem solve, by helping and assisting him to resolve his own problems rather than to solve them for him."

The Independent Team considers the approach care co-ordinator [2] decided to take was entirely reasonable, and it is satisfied that her records sufficiently demonstrate that she defined and maintained boundaries with Mr SR.

4.3.3 Adherence to CPA requirements

Summary opinion

It is the contention of the Independent Team that there was insufficient compliance with the Effective Care Co-ordination Policy in place at the time. Mr SR was an enhanced CPA patient and therefore there was a requirement for CPA reviews, including the reviewing and updating of CPA care plans and risk assessment documents on at least a six-monthly basis. There is no evidence that these reviews occurred for Mr SR. With regards to medical reviews, as previously noted, the frequency of planning for these did meet with CPA expectation.

The Assertive Outreach Operational Policy in 2006 said:

That service users are managed within the Care Programme Approach (CPA) and an appropriate treatment/care plan and risk management plan agreed. The care plan will include the views of the service users and their carers. In particular, assertive outreach aims to:

- ❑ Improve the service user's engagement with services.
- ❑ Reduce hospital admissions.
- ❑ Reduce the length of stay when in-patient care is required.
- ❑ Increase stability and quality in the lives of service users and their carers/families.
- ❑ Improve social functioning.
- ❑ Promote the service user's participation in their own recovery and through educational support develop coping strategies and mastery of symptoms of mental illness.
- ❑ Ensure failure to engage will not lead to case closure.
- ❑ Conduct an integrated approach on health and social issues.
- ❑ Provide psychiatric treatment in the least restrictive and least stigmatised setting and emphasise choice.
- ❑ Prescribe appropriate antipsychotic medication in accordance with NICE guidelines.
- ❑ Convey a message of hope and optimism.
- ❑ Work collaboratively and refer appropriately to other Trust services such as Crisis Resolution Home Treatment Services, In-patient Services, Community Mental Health Teams, Drug and Alcohol Services, Early Intervention Services, Forensic Services, Criminal Justice Liaison Services, Older People's Services and any new services that are developed. (In 2006/2007 it was difficult to gather information to assess this area of practice. In 2011 this information can be gathered via established data quality processes.)
- ❑ Ensure service users have access to local advocacy services.
- ❑ Assess the needs of carers and ensure appropriate support is given within available resources.
- ❑ Actively involve service users and carers in planning and delivering mental health services.
- ❑ Promote social inclusion.

The Trust policy in September 2007 said it was the role of the care co-ordinator to deliver:

- ❑ A co-ordinated package of care in conjunction with the service user, their family, significant others and relevant professionals.
- ❑ Reviews of the care plan at regular intervals or when there is a change of circumstance or cause for concern. For service users on enhanced ECC (CPA), the review must be agreed either by a multi-disciplinary meeting or multi-disciplinary consultation.
- ❑ Copies of the completed written care plan, as agreed with the service user, to the service user, carer as appropriate and relevant professionals and agencies.
- ❑ Shared information with other agencies as appropriate, ensuring all participants in the care plan are aware of any changes in circumstances and any identified risks and their management.
- ❑ Where risk is indicated in the assessment, it and its management are transferred on to the care plan.

A review of Mr SR's clinical records revealed the following CPA documentation:

- ❑ 23 August 2004: Enhanced CPA care plan (pre-assertive outreach).
- ❑ 27 October 2004: Effective Care Co-ordination Risk Screening (pre-assertive outreach).
- ❑ 20 March 2006: Effective Care Co-ordination Enhanced Assessment (this document has a handwritten date of 20 March 2006, and a computer-generated date of 21 June 2006). Interrogation of the CPA archive revealed that a Form 5 (a CPA assessment document) was completed on 20 March.
- ❑ 23 March 2006: A Risk Screening and Risk Assessment (form 3a and 3b) was created. This was also recorded on the electronic system as updated in May 2006.
- ❑ 16 May 2006: A review of the electronic CPA archive revealed a care plan was created (form 6).
- ❑ 5 April 2006: Enhanced Assessment summary formulation.
- ❑ 12 October 2006: A review of the electronic CPA archive revealed a care plan was created (form 6).
- ❑ 15 November 2006: A CPA assessment was undertaken (form 5), revealed on interrogation of the CPA archive.
- ❑ 12 December 2006: A risk assessment was undertaken (form 3b).
- ❑ 15 February 2007: A 'form 7' review document was completed by care co-ordinator [2].
- ❑ 2 March 2007: A Risk Screening and Risk Assessment form was completed by Mr SR's community psychiatric nurse (forms 3a and 3b).
- ❑ 6 June 2007: A form 1a and 1b was completed by care co-ordinator [2]. This was a demographic information and contact information sheet.
- ❑ 17 July 2007: A care plan was created by an individual whose name does not appear to feature in the day-to-day progress notes for Mr SR.

The Independent Team established that this individual provided administration support and in this instance had entered the handwritten care plan document completed by Mr SR's care co-ordinator [2] on to the electronic record-keeping system.

- ❑ 20 December 2007: Enhanced Care Plan (completed by in-patient services).
- ❑ 20 December 2007: Risk Screen form completed by the in-patient mental health nurse when he was care co-ordinator. The form noted that the current care co-ordinator was an approved social worker.
- ❑ 8 January 2008: Enhanced Care Plan; but it appears to have been completed on a 'copy and paste' basis, as it refers to Mr SR having an air pistol, which was the situation in April 2006 and not January 2008.
- ❑ Undated Effective Care Co-ordination Enhanced Assessment document completed by Mr SR's first care co-ordinator.
- ❑ 14 and 17 January 2008: A form 8 and 3a were completed by in-patient staff five and eight days after Mr SR's discharge.

Reviewing the electronic log of CPA documents completed between 2005 and February 2008, provided to the Independent Team, it appears that Mr SR's care plans were initially created by the assertive outreach team in May and October 2006. The print-out shows a care plan created in July 2007 and then again when Mr SR was admitted to hospital under section 2 of the Mental Health Act. Because the printed care plan documents do not state clearly the date they were created, and do not make clear in the printed copies what aspects of the care plan were:

- ❑ new;
- ❑ no longer relevant; or
- ❑ completed,

determining the extent to which care planning met good practice standards was challenging to the Independent Team. The Trust's Head of Care Delivery Frameworks provided invaluable support to the Independent Team in trying to determine what additions to the care plans belonged to what time periods. It was concluded that, although electronic record-keeping makes accessibility much easier for professionals on a real-time basis, working with the documents to conduct a retrospective analysis of care and treatment, where the care plans have not been printed chronologically as created, can and does involve challenges.

Notwithstanding the challenges posed, although it was clear from the electronic register provided that the electronic documents were accessed on a regular basis by staff, the Independent Team is not altogether satisfied with the quality of care planning for Mr SR. The Independent Team discussed the lack of care planning with Mr SR's care co-ordinator [2]. Her memory recall is that all of the care plans for Mr SR were created by hand and that these were then transcribed in to the electronic format by administration staff. At the time of the incident, care co-ordinator [2] recalls that there were a number of documents that she had created manually awaiting 'typing' in the admin filing tray. She does not know what happened to these as, following the incident, all records were removed from the assertive outreach office.

An example of a care plan/assessment the Independent Team considered could have been better was the enhanced assessment completed three months after Mr SR became an assertive outreach client. This identified that:

- ❑ Mr SR had a diagnosis of Schizo-affective Disorder, and had been in contact with mental health services since 1989.
- ❑ Mr SR had previous admissions to hospital in 1991, 1995, 1996, 2000, 2001, 2002. The 2002 admission was a compulsory admission.
- ❑ Early warning signs of relapse reported by Mr SR were noted as: poor sleep, verbal abuse, rude and offensive behaviour, hyper-critical and complaining, expression becomes negative about anything, becomes unco-operative and anti-establishment.
- ❑ Clinical signs of relapse were noted as: pressure of speech, hallucinations, expresses paranoid thoughts, displays inappropriate behaviour such as destruction of property and damaging furniture. It was also noted that he shaved his head when unwell, and would become agitated and intolerant of others.
- ❑ Mr SR had a history of non-compliance with medication.
- ❑ Mr SR had a history of starting small fires, at school, in his mother's garden and/or threatened to do so. He also had a history of damage to property and furniture.
- ❑ Mr SR showed hostility to services and liked to dictate what input he received. He also had unrealistic ideas regarding treatment and that he would be cured. The assessment also noted that he didn't like to be questioned about his mental state.
- ❑ Mr SR had acquired an air pistol he said was for shooting cans.
- ❑ Mr SR could be verbally aggressive, especially towards his mother and psychiatric services.
- ❑ Mr SR lived in a rented flat with supportive Key Worker provided by the housing provider. Mr SR was noted at the time to be happy with independent living. The care co-ordinator also noted that Mr SR believed the key worker was to be withdrawn "*at some time soon*".
- ❑ With regards to Employment and Leisure, the assessment noted that Mr SR had tried a variety of college courses and day centres in the area. (It does not say how he got on with these.) It noted that he would like to do a course in computing.

- ❑ Mr SR had a history of Ischemic Heart Disease. He was also under investigation for diabetes, but he had missed his appointments for this. Medication of Clopidogril, Lisinopril, Nicorandii and Aspirin were all noted as prescribed, but that Mr SR was not taking them at present.
- ❑ Mr SR had been on Guardianship Orders in the past. He was noted to be on Disability Living Allowance, Incapacity Benefit and Housing Benefit. He was also noted as managing his finances at the time the care plan was written.
- ❑ Mr SR had some past misuse of illicit substances, but denied any current misuse.
- ❑ Mr SR was amenable most of the time.

Other notable figures were recorded as:

- ❑ Mr SR's mother, who provided "*informal support*";
- ❑ Mr SR's consultant psychiatrist;
- ❑ The housing provider;
- ❑ The practice nurse.

Contributors to the assessment were noted as:

- ❑ Mr SR;
- ❑ The clinical records;
- ❑ The care co-ordinator.

Independent Team comment

The assessment, as far as it goes, is comprehensive and provides a sufficient overview of Mr SR's past and current history, and his risk factors to develop a care plan for him. The Independent Team noted, however, that the care co-ordinator did not seek to obtain any informative history from other persons engaged with the service user, such as Mr SR's mother or his key worker. For someone with such an extensive period of contact with mental health services, to have done so would have been prudent. Furthermore, it would have been prudent for the care co-ordinator to have documented Mr SR's perspective regarding the invitation of the other involved persons present to future CPA reviews. Given Mr SR's complex co-morbidity, known problems in relation to his behaviours in the community, the long-term support provided by his mother, and his verbal aggressiveness and hostility towards her from time to time, the Independent Team suggests that all persons and agencies listed would have been valuable persons to invite to subsequent CPA reviews, or at least to have been approached for third-party information.

The other notable absence in this CPA-enhanced assessment document was any record of Mr SR's position with regards to information sharing. The Independent Team understands that the system in the Trust at the time was that a specific document was completed for this. No document was completed for Mr SR. The reasons for this have not been established.

Under 'action required', it was noted that he "*required monitoring*" and was encouraged to "*maintain his tenancy by respecting others and being aware of [how] his behaviours impact on his neighbours*".

The Care Plan documented as completed between 16 May 2006 and 21 June 2006

The care plan emerging from the above assessment identified five main needs. These were:

- Mr SR's diagnosis and verbal aggression;
- symptoms of pre-occupation with past experiences of services, verbal aggression and disturbing thoughts and voices;
- physical health issues;
- needing to live in a sociably acceptable way; and
- the possession of an air pistol and the need to determine the legality of this.

In relevant order, the documented actions required were:

- *"For [Mr SR] to be given time to verbalise his feelings. For [Mr SR] to be involved in discussions and decision-making that affect his treatment. To withdraw if [Mr SR] becomes abusive and discuss matters at a later date."* Involved individual – Care Co-ordinator.
- *"We will attempt to establish a therapeutic relationship. We will assess/review your mental health symptoms. We will explore your mental health symptoms and needs. We will encourage you to take your medication. We will monitor the effects of your medication. We will assist you to develop ways to cope with your mental illness. We will monitor your mental health every 2 weeks. We will encourage you to discuss issues that are causing distress. Your mental health will be reviewed every 6 months. We will provide carer/family with relevant information and support."* Involved individuals – Care Co-ordinator and Consultant Psychiatrist.
- *"We will encourage you to access appropriate services. Attend outpatient appointments."* Involved individuals – GP, Practice Nurse, [Mr SR].
- *"[Mr SR] to decide to turn his music low after 10pm and to try and consider others when tempted to shout."* Involved individual – [Mr SR].
- *"To monitor mental health.*
 - *To obtain the legalities of ownership.*
 - *To discuss [Mr SR's] plans for use of the same.*
 - *Look into membership of local club.*
 - *Discuss the responsibilities of ownership and safe transportation."*

Involved individual – Care Co-ordinator.

The crisis plan was not completed. This was not and remains unacceptable.

Although the Independent Team is of the view that the initial information gathered by Mr SR's care co-ordinator [1] was reasonable, it was aware of a much richer history, following its retrospective analysis of the records. For example, in 2003 it was noted that not only was Mr SR verbally aggressive towards family members, but could be physically aggressive too. There were some reports of him having held his mother by

her throat. The Independent Team had also identified from its review that Mr SR appeared to manage better when in a highly-structured setting such as residential care. These are issues that one would reasonably expect to see reflected in the contemporary assessments and care plans for Mr SR.

Consequently, the Independent Team asked the team leader of the assertive outreach team about the extent to which it was customary within the team to interrogate the clinical records to ensure that all salient information about which the assertive outreach team needed to be aware was reliably obtained. He told the Independent Team that there were a range of effective care co-ordination documents on which historical notes would be recorded, and the assertive outreach team would refer to these for information. He also advised that, on occasions where this has revealed insufficient information, the team would from time to time seek further information from the referring team.

The Independent Team asked the team leader if there was a guideline or agreed process for drawing together relevant history for new assertive outreach service users. The team leader told the Independent Team that he did not know; it was *“just a good practice thing. Information would be based on OTTER⁷ & CPA info rather than historical.”* However, the team leader did concede that, given the length of time Mr SR had been a patient of mental health services, *“the historical [information] would not have been on OTTER, [and I] don’t know how much history is part of assessment”*. This information validated the impression held by the then care co-ordinator, who was new in post at the time Mr SR was allocated to his caseload.

Independent Team comment

Overall, the Independent Team considered that the care planning for Mr SR while he was an assertive outreach client was adequate, but lacked the robustness expected in assertive outreach. It would have expected the plan to separate out Mr SR’s issues more discretely and to state more clearly the issues for Mr SR and the plan to address them. The Independent Team noted that part of the care plan looks to have been pre-written; although this method can enhance care plan quality, conversely, it can also prevent professionals from thinking through the needs of the individual service user. The exception to this in Mr SR’s care plan relates to the issues of Mr SR’s possession of an air pistol. The consideration and actions were clearly formulated specifically for Mr SR’s care plan, and did not originate from a ‘pick and mix’ list provided via the electronic documentation system. This discrete element of the care plan was good.

An example of what the Independent Team expected to see in Mr SR’s care plan was reference to the need for voice exploration. The Independent Team considers that the care plan should have explicitly identified the need to:

- ❑ Explore Mr SR’s voices in terms of what they said, how they said it and under what circumstances. For example, were they there all of the time or only under certain conditions?
- ❑ Map strategies for managing the voices.

⁷ OTTER is the electronic record keeping and care planning system used by the then 5 Boroughs Partnership NHS Trust

- ❑ Map Mr SR's reported actual responses to his voices and how he felt like responding.
- ❑ Consider using a simple rating scale to monitor the volume of the voices and how troubling they were to Mr SR; if he was willing to fully engage with this by rating the voices himself.
- ❑ Explore with Mr SR how he felt like responding to them and how he did respond to them.

This degree of specificity would have enabled clarity about what the assertive outreach team was trying to achieve with and for Mr SR. It should also have enabled more structured day-to-day documentation that emphasised the professionals' efforts to deliver the care plan. As has already been stated, the Independent Team found it difficult to draw a clear link between the plan documented and the day-to-day progress notes. Some of that difficulty, in the Independent Team's opinion, is because the care plans appear not to have been updated in any meaningful way between 2006 and 2008.

The Independent Team also noted that, although passing reference was made to the needs of family members, there is no specific reference to family needs, or the requirement for a Carer's Assessment. The assessment document noted that Mr SR's mother provided 'informal support', but did not state the detail of this. The assessment document and the care plan also identify that Mr SR could be verbally aggressive towards his mother. There should have been a specific plan of action as to how the care co-ordinator intended to:

- ❑ Validate the extent to which Mr SR was aggressive towards his mother, and under what circumstances; and
- ❑ Explore the mother's needs and to provide her with a Carer's Assessment.

With regards to the responsibility of mental health services in relation to Mr SR's physical health at minimum, the Independent Team would have expected the care plan to notate that the care co-ordinator would:

- ❑ Liaise with primary care services to:
 - Obtain clarity regarding Mr SR's diagnosis;
 - Obtain clarity regarding Mr SR's medication regime;
 - Find out what physical health tests Mr SR needed to attend;
 - Build a relationship with the practice nurse.

Similarly, with regards to the care plan relating to Mr SR's housing needs. He had a severe mental illness and had lived for substantial periods in fully-supported accommodation. It was known to the assertive outreach team that there had been problems in the past with Mr SR's tenancy. Maintaining the tenancy for him as a component of his stability was therefore highly desirable. However, the Independent Team recognises that mental health staff often have only limited influence with the housing provider. The Independent Team also recognises that in this case the mental health staff's ability to influence Mr SR's anti-social behaviour was limited. However, in addition to the statements made in the care plan about Mr SR's own

responsibilities, the Independent Team would have expected to see reference to a joint meeting with his housing key worker so that there could be a shared strategy for times when Mr SR's behaviour was unacceptable.

Finally, but by no means least, the Independent Team would have expected the issues of medication compliance to have been given more careful attention in the care plan. Mr SR was receiving all of his medication via repeat prescription and delivery by the local pharmacy. At the very least, the care plan should have set out:

- ❑ The medications Mr SR was on;
- ❑ The monitoring of side-effects, and listing specific ones;
- ❑ The obtaining of up-to-date information about Mr SR's medicines, so that the care co-ordinator was aware of any potential for conflict between the medicines prescribed for his heart condition and those prescribed for his mental health;
- ❑ Strategies for determining the level of compliance, including asking Mr SR.

The Independent Team noted that in October 2004 Mr SR had been provided with a blister pack for his medicines on a weekly rather than monthly basis, which had enhanced the ability of the community mental health team to monitor his medication compliance.

The next care plan in Mr SR's records was dated 20 December 2007, some 20 months after the creation of the first. It was created by the in-patient services following Mr SR's admission in to hospital. Prior to this date there had been a range of issues emerging for Mr SR commencing in July 2007. Mr SR's care plan should have been reviewed and updated at least from this time onwards. According to Trust policy, it should have been reviewed in September 2006 and March 2007.

During a face-to-face meeting with care co-ordinator [2], she informed the Independent Team that she recalled writing care plans for Mr SR, which were then placed for typing by the admin support team, who would ensure that the documents were logged on to the OTTER system. However, she also recalled a pressured workload comprising her day-to-day caseload: one day a week on duty as the Approved Social Worker, and working one weekend in four as the Approved Social Worker. On this week, her availability to clients on her day-to-day caseload was reduced to one day, as she worked a four-day week. Without being able to recall precisely, care co-ordinator [2] considered it within the realms of possibility that rigour in documentation standards may have slipped from time to time. Another contributory factor was her experience of a lack of effective case management supervision. Effectiveness in this area, in her opinion, can and does impact on good standards of record-keeping.

4.4 Risk assessment

Did the assertive outreach team conduct:

- ❑ An effective assessment of Mr SR's risks (past and current), and devise a reasonable risk management and crisis intervention plan for him?
- ❑ Appropriate reviews of Mr SR's risk assessments in response to emerging information and reported changes in his behaviours?
- ❑ Escalate him appropriately through their traffic light/zoning system?

Summary opinion

The Independent Team is not convinced that the assertive outreach team conducted an effective assessment of Mr SR's past and current risks between 2006 and February 2008. A contribution to this was undeniably the reticence of Mr SR to engage with the assertive outreach team, and his reported refusal to discuss mental health issues with them. The Independent Team understands that non-engagement makes effective risk management challenging. Nevertheless, neither is there evidence of the assertive outreach team utilising other intelligence that may have enabled them to be best informed about Mr SR; for example, meeting with his mother to obtain a detailed account from her about her son's past and current behaviours.

With regards to the question of appropriate reviews, the consideration of the team manager was that risk reviews should occur annually, unless there were indicators to update a risk assessment at an earlier juncture. There were such occasions for Mr SR in 2007. However, there are no revised formalised risk assessments over this period. On the other hand, there is evidence that the assertive outreach team did take the risk of fire-setting seriously in July 2007, organising an emergency medical assessment and also attending the Mentally Disordered Offenders Team meeting to determine next steps. The Independent Team is not reassured that other earlier risk escalation indicators were given the attention they should have been.

With regards to the usage of the assertive outreach team's traffic light/zoning system, the Independent Team noted that Mr SR was rated only as red following his assessment under the Mental Health Act in December 2007. Otherwise, he appeared to be mainly a 'green-rated client'. He was, nevertheless, discussed within team meetings on a regular basis, which was good. However, there is no information to demonstrate any risk-orientated discussions occurring.

4.4.1 Detailed analysis of the written evidence, i.e. the clinical records

A review of Mr SR's records, looking specifically for risk-orientated documentation, revealed:

- ❑ On 26 April 2006 it was noted that Mr SR had an air pistol.
- ❑ Between 5 and 7 July 2006 there was damage to Mr SR's property, alleged to have been caused by a third party.
- ❑ On 30 August it was recorded that Mr SR had a "*string of public disorder offences*". Also, that local residents were complaining about his use of racially abusive language. Broken windows were also identified.
- ❑ On 5 September 2006 Mr SR was noted to have been verbally aggressive and threatened to "*disappear*" when issued with a warning from his housing provider.
- ❑ On 23 September 2006 Mr SR was noted to have reported feelings of "*frustration, anxieties and anger*".
- ❑ On 10 October 2006 Mr SR was noted to have been verbally aggressive to his care co-ordinator (the mental health nurse).
- ❑ On 28 November 2006 he was arrested for public order offences.
- ❑ On 29 November 2006 there was damage noted to his flat and the window and door were boarded up – this was linked to the police arrest the day previously.
- ❑ On 15 February 2007 the records recorded "*no mental disturbances noted ... a few weeks earlier*".
- ❑ On 1 March 2007 Mr SR's mother reported that her son heard voices "*negating him*" and that he could not control these.
- ❑ On 2 March 2007 a "Risk Screening" was conducted by the mental health nurse.
- ❑ On 11 April 2007 Mr SR's sister contacted the assertive outreach team to advise that she was worried that her brother (Mr SR) was harassing her mother and that for the past two weeks he had been threatening to kill people. It was also noted that the Out of Hours GP had attended at Mr SR's flat, but that Mr SR had slammed the door in his face. The police were therefore contacted to conduct a welfare check.
- ❑ On 6 June 2007 it was noted in the records that Mr SR considered that his mother now understood him. He also volunteered to the assertive outreach professionals that he considered himself to be "*more mature*" and experiencing "*no delusions*".
- ❑ On 1 July 2007 Mr SR threatened to pour cans of petrol over himself and to set himself alight in his flat. He was arrested by police and taken to a place of safety under section 136 of the Mental Health Act. However, subsequent assessment of him in the cells determined that no Mental Health Act assessment was required.
- ❑ On 3 July 2007 Mr SR was assessed by care co-ordinator [2] and his community psychiatric nurse. The records report that he told the professionals that his "*head was going mad*" and that he "*couldn't stand it*". An urgent appointment was made for him to be assessed by his consultant psychiatrist.

- ❑ This occurred on 5 July.
- ❑ On 19 July 2007 the assertive outreach team received a letter from Mr SR's mother setting out her concerns about her son.
- ❑ On 24 July 2007 there was a Diversion Panel Meeting at which the assertive outreach team attended.
- ❑ On 7 August it was documented that the conclusion of the Diversion Panel was that Mr SR had threatened arson with intent and that it should be dealt with through the criminal justice system.
- ❑ On 8 August 2007 it was documented that Mr SR told the assertive outreach team that if his *"family left him alone, he left them alone"*. It was also noted that Mr SR became irate when the assertive outreach professionals did not agree with him that it was an acceptable thing to do *re. threatening to set himself alight*.
- ❑ On 10 August Mr SR was again noted to be verbally abusive.
- ❑ On 22 August 2007 it was reported that Mr SR had destroyed the communal garden and that there were broken whiskey bottles in it. On the same day it was also noted that Mr SR was arrested for using racially abusive language. This was reported to the assertive outreach team by Mr SR's sister, who also reported that she believed he knew what he was doing.
- ❑ On 7 September 2007 neighbours reported that Mr SR was ransacking his flat. When a community constable attended to conduct a check, Mr SR was reported to be polite to this individual.
- ❑ On 29 September the assertive outreach team located Mr SR in a public place and decided not to confront him in that situation.
- ❑ On 11 December 2007 Mr SR's GP contacted the assertive outreach team because of concerns being raised with him via Mr SR's mother. There was a general concern in the GP about the changes occurring in Mr SR's behaviours, such as staring through the windows of his neighbours and that they feel they need to keep their curtains drawn. It was also noted that Mr SR would not see the GP because he was Jewish. The GP was pushing the assertive outreach team to conduct a Mental Health Act assessment at that time.
- ❑ On 12 December it was reported that there were squalid conditions in Mr SR's flat.
- ❑ On 19 December it was noted that Mr SR had thrown milk at his neighbour and had thrown rice pudding all over his door.
- ❑ On 20 December Mr SR's care co-ordinator [2] obtained a warrant under section 135 of the Mental Health Act to enable forced entry to Mr SR's flat so that an assessment under the Act could be conducted.

In the continuum of the clinical records there is nothing to suggest that Mr SR posed a risk of deliberate intent to harm others. However, the above features do indicate an individual who is a risk of harm to others by virtue of:

- ❑ His known past behaviour of aggression;
- ❑ His unpredictability;

- His fire-setting risk.

There was a risk screening form completed by Mr SR's care co-ordinator [1] on 2 March 2007. This noted that he:

- Had some insight into his illness;
- Had a long history with services;
- Lived alone in a one-bedroom flat;
- Had instances of self-harm in 1995 and 1998;
- Could become vulnerable at times;
- Had *"hit out in the past"* (in response to a question about physical harm to others in the past);
- Was on bail for racial abuse;
- *"Becomes verbally aggressive towards family members when ill"*;
- Accepted his mental health issues, but blamed services for poor care and not meeting his needs;
- Had suffered a heart attack, and was currently under investigation for possible diabetes. Poor history of attending appointments;
- Was paranoid at times and held very philosophical conversations;
- Wrote his thoughts on walls, and had a history of causing damage to furniture /belongings;
- Had a history of non-compliance with medication;
- Posed a risk of mistrust and withdrawal from services;
- Risked relapse if there was no contact with services;
- Was subject to section 117 [s. 3 2002] aftercare;
- Was a tenant of supported housing;
- Was in contact with the criminal justice system because of anti-social behaviour;
- Had left the country to go to India in February 2007 without notifying services.

As a consequence of the mental health nurse's screening, Mr SR was assessed as being of:

- Medium risk to self;
- High risk to others;
- Medium risk of vulnerability;
- Medium risk of neglect.

The risk notes said:

"Can be verbally aggressive to mental health workers, [Mr SR] also [had] a history of lighting fires in mum's garden when unwell. No action appears to have been taken regarding this."

The form states in bold: ***"If Any Risks Identified Proceed to Risk Summary/Management Plan. Is Risk Summary /Management Plan Attached?"***

The Independent Team could not locate such a plan attached to the March 2007 assessment; it did, however, find such a document completed on 20 December 2007 after Mr SR had been admitted to the in-patient unit under s.2 of the MHA.

Independent Team's comment on the above risk summary

It is considered to be good practice that, when risks are identified (past or current), detailed account is provided so that the risk can be understood from a contextual perspective. This is important for the current and future management of risk. The assessment detailed above provides 'highlights' only. There was no depth of information. For example, when did Mr SR "hit out"? How was his verbal aggression expressed? Were there threats of harm, or was it usage of foul language? Mr SR was noted to be paranoid at times, but in what way? What was the content of his paranoia?

An understanding of the above is essential to good risk management practice. If the mental health nurse tried to explore these issues and Mr SR would not engage, then this should have been explicitly stated.

The Independent Team knows from its own review of Mr SR's records that at least one critical piece of information was missing from the risk summary. He had been known in the past to have put his hands around his mother's throat. This constitutes high-risk behaviour.

The risk summary of March 2006 is the only evidence of a structured risk assessment the Independent Team found in Mr SR's clinical records. However, the chronology detailed highlights a number of features after March 2007 which should have prompted a review and updating of the risk assessment and the formulation of a risk management plan, and consideration of his escalation to a higher traffic light/zoning level.

The most notable occasions were on:

- ❑ 11 April 2007 (concerns of harassment of Mr SR's mother and reports of threats to harm others);
- ❑ 1 July 2007 (the fire incident);
- ❑ 22 August 2007 (Mr SR destroying the communal garden and leaving broken whiskey bottles).

On at least these occasions there should be clear evidence in the clinical records of the risk management discussions that were conducted and the detail of these.

A review of the assertive outreach team minutes showed that:

- ❑ After Mr SR's sister's report on 11 April, the next time Mr SR was raised at the assertive outreach team meeting was 16 May, some five weeks later. The record simply says "*can't get hold of him*".

A review of the assertive outreach clinical records showed there was no report of any contact with Mr SR, or attempted contact, between 4 April and 26 April 2007. There is no evidence that the assertive outreach team explored the concerns of Mr SR's sister in a timely manner. Not until 13 June 2007 is there a mention of the issue in the team meeting minutes, when it was reported that Mr SR's GP had contacted the assertive outreach team, raising a concern about Mr SR abusing his mother. Again, there is no corresponding entry in the assertive outreach progress records to show how the team responded to this information.

With regards to the incident of 1 July 2007, Mr SR was assessed by his care co-ordinator [2] and the community mental health nurse on 3 July. His sister was also present. The combined record of the nurse and social worker sets out comprehensively the issue of Mr SR's complete non-compliance with medication and also the fact that he appeared manic, "*jumping from one conversation to another*". The detail of the first threat incident is also set out. The outcome of this assessment was an urgent consultant psychiatrist appointment and a home visit from his GP the following week. The assertive outreach team minutes also show that he was moved to the Amber Zone of the traffic light system on 4 July. The subsequent meeting notes show that he was maintained in the Amber Zone on 11 July and remained in this Zone until 20 December.

The zoning guidelines at the time stated:

Zone	Criteria/characteristics	Intervention
Red	Non-engagement/disengagement/isolation High risk to self or others In crisis requiring daily review Have extensive unmet needs In danger of relapse Increase in behaviours consistent with relapse Non-compliance with medication Recently discharged from hospital Patients on leave from hospital Clients who have recently been screened and accepted by the AOT	High level of support necessary to client's current situation Joint visits if necessary Monitoring medication High risk panel meetings MAPPA Liaising with other services (police, probation, MDO (mentally disordered offender team), Approved Social Worker, Consultants GPs) Discussing in team meeting on regular basis Effective care co-ordination reviews Social support Family support/education
Amber	Low-engagement/isolation Low risk to self or others Mentally unwell but with some positive functioning Patients requiring intensive support Medication compliance irregular	Support client's situation Monitoring mental health Monitoring medication Social support Effective care co-ordination reviews Family support/education
Green	Engage/over-engaging Low risk to self or others Minimal visits required Requiring only 'maintenance care', which could still mean high input Patients that are elsewhere – hospital/prison	Monitoring mental health Monitoring medication Effective care co-ordination reviews Social support
Blue	Clients being screened Clients stable for 6 months on one contact a month Clients stable for two years (no admissions and no serious indications of relapse) The clients do not present with the problems that they have been referred with Clients that have not engaged, or the assertive outreach team agree that there is nothing more that assertive outreach can do with the client because there has been no improvement over 1-2 years	Discussion at team meeting Transfer to CMHT over a period of up to 3 months Where a referral does not seem appropriate for assertive outreach, assertive outreach team to suggest other alternatives that may be appropriate

The behaviours Mr SR was displaying, when mapped against the traffic light zoning table above, clearly put Mr SR into the Red Zone. The response of his then care co-ordinator [2] was commensurate with this, in that an urgent medical review was arranged. It is not clear why Mr SR was not placed into the Red Zone at the time.

The Independent Team accepts that a zoning tool is for guidance only and it is reasonable for clinicians to decide to place a service user in a different zone to that which their presentation might seem to indicate. However, there should have been clear guidance on how this was achieved. It is the experience of the Independent Team that this is most safely achieved with any decision to place a service user in a lower risk zone to that indicated by their behaviour as a consequence of a multi-disciplinary team meeting, preferably medically led. This seems not to have been the case for Mr SR's assertive outreach team. It is the understanding of the Independent Team that dynamic debate and discussion regarding risk did not occur as it should. It is the Independent Team's contention that the absence of dedicated medical sessions at assertive outreach team meetings would not have facilitated the most effective use of the traffic light system, or a robust risk management approach by the team.

On the subject of documentation, for completeness it would have been best practice if the professionals present had noted:

- ❑ Any conversation they had with Mr SR's sister and the informant history obtained from her;
- ❑ Their attempts to determine whether or not Mr SR was hearing voices and the content of these. In August 2005 Mr SR was noted to have experienced command hallucinations and the Independent Team considers that establishing whether or not such hallucinations were present would have been expected practice.

Furthermore, as already addressed in the section relating to medical assessment (section 4.2, page 28), Mr SR was assessed by the consultant on 5 July as planned. The assertive outreach notes of this appointment are very brief. Some information relating to conclusions reached about Mr SR's mental state and the examination of this would have been helpful.

Finally, with regards to the reports made via the housing provider of Mr SR smashing the back garden of the flats where he lived, a succinct note of this was made in the assertive outreach progress notes. A consequence of the discussion between housing and assertive outreach was to hold a joint professionals meeting with housing and the police when Mr SR's care co-ordinator [2] returned from annual leave. There is no information to show that such a meeting occurred. However, there was evidence of telephone communication between housing and the assertive outreach team on:

- ❑ 28 August 2007, housing contacted the assertive outreach team to advise that Mr SR had been sent an eviction notice;
- ❑ 22 October 2007, housing contacted assertive outreach to advise that Mr SR had given them four weeks' notice of leaving his tenancy;
- ❑ 28 November 2007, the assertive outreach team contacted housing. Housing was noted to have informed assertive outreach that it was their

intention to take Mr SR to court to have him evicted as he continued to reside at the flat.

In addition to the above, on 7 September 2007 a community constable raised concerns with the assertive outreach team about the condition of Mr SR's flat, and Mr SR's behaviours; for example, pounding meat with a glass jar on the floor. It was also reported that Mr SR was pleasant in manner.

The Independent Team has not been able to establish from the clinical records any information that demonstrates that the assertive outreach team contemplated whether or not Mr SR was in relapse. The dominant impression was one of the professionals believing that Mr SR was responsible for his actions and knew what he was doing. However, the first care co-ordinator's (the community psychiatric nurse) assessment of March 2006 provided a comprehensive list of behaviours displayed by Mr SR when in relapse. Based on the content of the clinical record between July and December 2007, it seems to the Independent Team that he was displaying such behaviours between these dates.

In order to obtain a more complete understanding of the assertive outreach team's risk perspectives in relation to Mr SR, specific aspects of his risk profile were explored at interview.

What did the assertive outreach staff say?

With regards to risk assessment practice overall:

The team leader told the Independent Team that reviews should occur six-monthly, and that at this time the risk assessment would also be reviewed.

The Independent Team also asked to what extent the quality of care plans and risk assessments were reviewed during supervision sessions with staff. He told the Independent Team that

"notes would have been looked at, but not in as much detail as I would have liked to have done, [because of] time restrictions".

With regards to the 'fire incident' of July 2007:

The consultant psychiatrist for Mr SR told the Independent Team that he was informed about Mr SR's threat to set fire to himself via his previous care co-ordinator (the mental health nurse). When he assessed Mr SR some four days after the incident (two days after he was referred), there was *"no suggestion that he [Mr SR] was psychotic ... [he was] not deemed to pose a risk to others or self-necessitating hospital admission."*

The Independent Team accepts the consultant psychiatrist's viewpoint. However, the record of the consultant's assessment of Mr SR does not indicate a structured mental state examination. Consequently, based on records analysis alone, the Independent Team has no insight as to what features led the consultant to determine that Mr SR was not a risk and was *"attention seeking"*. As previously stated in this report, it would have been better practice for the consultant to have set out what the doctor's assessment revealed, including the exploration of the issue of intent (or otherwise), than to use emotionally-laden language which does nothing to describe the quality of the assessment conducted.

The first care co-ordinator to Mr SR told the Independent Team that the fire-setting “*was a historical risk as far as I was concerned*”. There was no contemporary evidence of it having occurred in the period prior to his transfer to the assertive outreach team or in the 12-plus months that he had been Mr SR’s care co-ordinator.

The Independent Team’s mental health nurse asked Mr SR’s mental health nurse specifically about Mr SR’s reported behaviour of “*painting out his windows black*”. Mr SR’s mental health nurse recalled that this actually occurred just prior to his admission in December 2007, and was not a feature earlier. He also reported to being completely unaware that Mr SR used to place his hands around his mother’s neck.

When asked to draw a picture of how risk was assessed, he reported: One takes into account “[Mr SR’s] *actions and things he said, and completing Forms 3A and 3B, which are Risk Screening and Assessment Forms. ... 3A is a tick-box form with areas where you can expand on it and 3B is a summary of that and you can add more detail on of specific/critical events.*”

The individual providing interview support added: “*you could put in what actually happened, then you form an agreement of whether high or low risk. Then there is a contingency plan*” and the nurse completed with “*where you can show relapse factors and things to do, things that have worked in the past*”.

Unfortunately for Mr SR, the Independent Team did not find any evidence of a ‘Form B’, a contingency plan, or a risk plan.

The second care co-ordinator to Mr SR (the social worker) told the Independent Team that:

“*With regards to his fire-setting behaviours, I considered this to have served a secondary purpose in so far as [Mr SR] set those following arguments with his mother, and with the desire to move premises. I attended a diversion panel meeting held at MDO,⁸ and I strongly advised that he should be prosecuted for his actions since he had pre-planned his actions and acted with full capacity. Regarding his potential risks to others by his fire-setting behaviours, I felt, following the above discussions, that his risk would be inadvertent. In regards to the risk to his family, I perceived them to remain unchanged; he had a documented history of volatile relationships with them and had often been threatening towards them for both money and to get his perceived needs met.*”

Care co-ordinator [2] also told the Independent Team that:

“*Risk management plans and risk assessment formulations as documented give the broad outline of risks; however, the day-to-day management of risks can fluctuate and our joint working with [Mr SR] was a response to the situation rather than a permanent fixture, since we did not know how he would eventually respond to more structured interventions.*”

⁸ Mentally Disordered Offenders Team.

The Independent Team found the above helpful, specifically the impetus behind the fire threat in July 2007, which it had not deduced from the clinical record.

Although the Independent Team has noted that overall there was a lack of formalised risk assessment and risk planning documentation for Mr SR, it does wish to highlight that care co-ordinator [2], following a further unsuccessful attempt to assess Mr SR on 19 December, set out a succinct summary of events leading to her decision that a s.135 warrant was necessary. This summary, set out in letter format, identified that the assertive outreach team had attempted to meet with Mr SR on 14 separate occasions between 8 August 2007 and 19 December 2007 and on all 14 occasions they were unable to assess Mr SR. The letter states that: *“On several of these dates, including today, [Mr SR] has been in the property; he has either not opened the door but could see us from the window, or opened the door and immediately shut it, not allowing us to speak with him.”*

The letter also set out briefly the situation that confronted the housing officer and police constable who entered Mr SR’s flat under warrant the week previously to serve notice of eviction, *“due to [Mr SR’s] anti-social behaviour and vandalism”*.

The Independent Team is of the opinion that the actions of Mr SR’s care co-ordinator [2] were timely and appropriate and enabled the much-needed assessment of Mr SR and his detention in to hospital.

Overall opinion

It is clear to the Independent Team, as previously highlighted in this report, that Mr SR was exceptionally difficult to meet with and assess. This was confirmed via the staff’s supervision records, the assertive outreach team minutes, and the clinical records. It is also clear that, when there were sufficient concerns about Mr SR and sufficient indicators to progress an assessment of him under the Mental Health Act, then this action was achieved using section 135 of the Act when he persisted in not allowing the consultant psychiatrist or an approved mental health practitioner over his threshold.

The above being said, the documentary evidence of good practice in relation to risk assessment, risk planning and contingency planning was insufficient and local policy expectations were not adhered to.

In addition, the Independent Team could not see any clinical benefit of the zoning/traffic light system. Generally speaking, there is strong clinical leadership around a zoning system, with clearly stated guidelines regarding how a service user is moved down the traffic lights once escalated. Such systems often also identify the frequency of medical review if a person is in a particular zone. The system used by Mr SR’s assertive outreach team did not have clear and auditable criteria associated with it, and neither is there any evidence to show that there was strong clinical leadership around it. This the Independent Team attributes to the lack of dedicated medical sessions.

Following all of its analysis, the Independent Team is also concerned that there was an over-reliance on past electronic CPA documentation and thus the retrospective review of records not covered by such systems did not and does not occur. In this

case, it meant staff were unaware of salient features of Mr SR that could have informed their overall picture of him. These features may not have impacted on his overall risk rating between 2006 and 2008, but may have prompted the assertive outreach staff to communicate better with Mr SR's family and the housing provider. The lack of detailed conversation with family and housing, the Independent Team considers to have been a significant lapse in the assertive outreach team's exploration of risk. It is the contention of the Independent Team that it would have been entirely reasonable for the assertive outreach team to have conducted a risk management assessment with Mr SR's family after the fire threat incident of 3 July 2007, and included them in the risk management plan. Regardless of Mr SR's feelings, his behaviours constituted a clear public safety risk, and his increasingly volatile outbursts, coupled with alcohol misuse, meant an unpredictable risk for all persons having contact with him. Under these conditions, the confidentiality the assertive outreach team owed to Mr SR, in the opinion of the Independent Team, took second place to the safety of the public and his family.

4.5 In December 2007 Mr SR's diagnosis was changed from one of Schizo-affective Disorder to Personality Disorder with Alcohol Abuse.

- ❑ **Was this change in diagnosis based upon an appropriate assessment and understanding of him?**
- ❑ **Was a reasonable plan devised regarding his ongoing management within the assertive outreach team?**

Summary opinion

The Independent Team can understand why Mr SR's consultant psychiatrist and the team of mental health professionals working with him considered that a change in diagnosis was appropriate. In their experience of Mr SR, there were no signs of psychosis or treatable mental illness. However, the Independent Team is not satisfied that there was sufficient consideration of the length of, and detail of, Mr SR's history with mental health services, collateral information obtained from family members, or evidence of a sufficiently detailed mental state examination on which to base a change in diagnosis. However, the Independent Team also accepts that for the consultant psychiatrist and care co-ordinator [2] the diagnosis was anything but clear and that the impetus for referring Mr SR for a forensic psychiatric opinion was to try and obtain further clarity regarding diagnosis and management. In view of this, the Independent Team suggests that it may have been prudent to have deferred documenting a categorical change in diagnosis until after further specialist assessment had been achieved.

Mr SR had a 20-year history of mental illness. It was clear to the Independent Team that he had always been challenging, prone to non-engagement and that difficulties with medication compliance were persistent. However although the assertive outreach team, notably his care co-ordinator [2], an experienced Approved Social Worker, reported detecting nothing suggestive of schizophrenia, or of a treatable mental health illness, and that this perspective was validated during Mr SR's hospital stay between 20 December 2007 and 9 January 2008, it is the perspective of the Independent Team that not all of his behaviours could be explained or attributed to a diagnosis of personality disorder. Some of his behaviours were reflected by past behaviours and also associated with previous staff's documented observations of Mr SR appearing to respond to auditory and/or visual hallucinations.

The key factors that seem to have led Mr SR's consultant psychiatrist to have changed the diagnosis of Mr SR were:

- ❑ The persistence of his medication non-compliance in hospital, the discovery that he had probably been medication non-compliant for eight months pre-admission, and the lack of any clear signs of psychosis as a consequence of this.
- ❑ Reports received from the professionals working with Mr SR in the community illustrating a frequency of manipulative behaviour. For example:
 - The fire threat incident in July 2007 was reported to have occurred as a consequence of an argument Mr SR had with his mother.
 - The reported behaviour of Mr SR when visited by the assertive outreach team where he seemed to undertake activities to

provoke a response, and then behaving more normally when this strategy was unsuccessful. For example, when he made a point to care co-ordinator [2] and his community psychiatric nurse that he was fixing himself a pint of cold coffee, and then having a coke when they did not respond to this.

- When he was an in-patient it was reported that Mr SR would wear a pair of cut-off jeans on his head, and when, believing he was out of sight of the hospital when on unescorted leave, he would take them off, putting them on again to re-enter the hospital.
- ❑ At least one report from Mr SR's sister that she believed her brother knew what he was doing.

This background history was further endorsed by the observations of the in-patient nursing staff.

On 20 December, after he had been admitted to hospital under section 2 of the Mental Health Act (1983), he was interviewed by a staff-grade doctor. This individual's assessment set out the following:

- ❑ an overview of Mr SR's history and behaviours in the preceding five months;
- ❑ that Mr SR denied any auditory or visual hallucinations;
- ❑ that Mr SR was not at all co-operative and was therefore difficult to assess;
- ❑ that there were clear signs of self-neglect;
- ❑ that Mr SR was shouting and aggressive;
- ❑ that there was some pressure of speech, but that Mr SR was coherent and relevant;
- ❑ Subjectively Mr SR was not depressed;
- ❑ Objectively Mr SR was mildly elated;
- ❑ That there was no suicide ideation, no thoughts of harm to self or harm to others, but that he could harm if intimidated;
- ❑ That Mr SR believed that he was 'all right'; and
- ❑ That Mr SR lacked insight.

In the first instance the management plan was:

- ❑ for 10-minute checks of Mr SR;
- ❑ to medicate him;
- ❑ to further assess the following day; and
- ❑ to ensure a full physical examination occurred.

The next documented medical assessment/input was on 2 January 2008, during the ward round. The record of this stated:

"Discussed presentation and how no overt evidence of any psychosis". It also reported Mr SR's behaviour during the assessment and how he wished for total

privacy and asked to move. The record stated: *“however, [Mr SR] appears to want the [consultant psychiatrists] or seniors to do it for him – advised to contact housing and begin starting the process of moving etc ... discussed [Mr SR’s] refusal of medication, but he insists that he does not need them.”*

The record noted that Mr SR’s consultant psychiatrist reiterated the recommendation that Mr SR take his medication, and that Mr SR again reported not needing it.

The documented plan following the ward round was:

- ❑ Quetiapine and Sertraline stopped;
- ❑ Advised to take medication for physical health;
- ❑ To have 8 hours’ leave as per section 17;
- ❑ To be reviewed next week with a view to discharge planning and decision regarding future treatment.

All of the daily records entered by ward staff between 20 December and 2 January report that Mr SR refused medication on every occasion, that he was verbally abusive and racially abusive to the extent that staff reported his offensive comments to the police, advising Mr SR that this was their intention if he continued, which he did. He was noted to walk around with a blanket on, to kick doors. Then, from the afternoon of 27 December, he was noted to be appropriate in mood with no outbursts; the only notable feature was his persistent pacing around the ward. He was also noted to have denied any problems (1 January 2008).

The improvement in Mr SR’s behaviour continued between 3 and 9 January 2008, except for an isolated incident of verbal racially-orientated abuse on 4 January following unescorted leave home.

The ward round of 9 January 2008:

Present on this ward round were Mr SR’s consultant psychiatrist, a Psychiatric Senior House Officer, Mr SR’s care co-ordinator and other ward staff.

The record of this ward round said:

“[Mr SR] does not appear to have a mental illness. No formal thought disorder evident. Social worker believes that [Mr SR] is responsible for his serious offence, e.g. setting fires. He was racially abusive on the ward. However, there is no evidence of this in keeping to any abnormal communication to people ... he has demanded Halal food and urinated on the floor; he has also demanded a skip.

He may need to be assessed by a forensic psychiatrist. There is no evidence of treatable mental illness. The social worker states that when he is ill he contacts [her] and when his problem is solved he disappears for a period of time.

INTERVIEW:

[Mr SR] says that everything has been OK, apart from some situation on the ward. Two things happened. [The consultant psychiatrist] clarified so-called offensive remarks towards some of the nursing staff and that the police had been informed.

[Mr SR] has got angry and left the interview room. Said that 'I don't want to discuss police ...'. However, this diagnosis will be changed from psychosis to Personality Issues.

Plan:

- ❑ *Diagnosis will be changed from Psychosis to Personality*
- ❑ *He'll be discharged today*
- ❑ *A letter will be sent to police regarding the offensive remarks towards some members of staff on [the ward].*" The record looks to be signed by the SHO.

The above has been discussed with Mr SR's care co-ordinator [2]. She reflected that she had not been accurately quoted by the junior doctor. It was clear to her that Mr SR contacted the assertive outreach team only when he wanted something; when he was ill he would not contact anyone.

There is a second record of the interview and the ward round written by one of the nursing staff. It is more comprehensive and sets out more clearly the rationale for discharge and other important features:

- ❑ No behaviours observed other than maladaptive behaviours;
- ❑ Mr SR is not gaining any benefit from being an in-patient and has an address;
- ❑ That there was a discussion about his existing diagnosis and "*? Personality disorder as opposed to psychotic disorder*". And that the consultant psychiatrist was to seek a second opinion from forensic psychiatry.
- ❑ The record also stated that when Mr SR left the interview room a nurse and the consultant psychiatrist did go after Mr SR to persuade him to return, but that he firmly told them to go away. The approved mental health practitioner did manage to speak with him and is noted to have told him that his detention under the Mental Health Act had been rescinded and that he was discharged from hospital.
- ❑ It was noted that Mr SR was to be seen in seven days by care co-ordinator [2] for his '7-day' discharge visit.

The plan documented by the registered mental nurse mirrored the features recorded by the SHO, but in addition noted that:

- ❑ Mr SR was to remain on enhanced CPA;
- ❑ Mr SR was to be referred to forensic psychiatry; and
- ❑ "*7-day follow-up to be completed by [care co-ordinator [2]] next Tuesday (15 January 2008)*".

Comment by Independent Team

The decision to alter Mr SR's diagnosis on the basis of his 20-day stay in hospital was significant. Based on Mr SR's reported behaviours, the Independent Team can understand why a clinical team might question the validity of the existing diagnosis of

schizo-affective disorder. However, the longevity of this diagnosis and the reports of auditory hallucinations as late as 2005 suggest that the clinical team could have taken a more 'belt and braces' approach to the assessment of Mr SR before committing themselves to a diagnostic change.

The independent consultant psychiatrist, also having experience as the lead professional of an assertive outreach team, considered that he would have expected to have seen documentary evidence of:

- ❑ A detailed mental state examination soon after Mr SR was admitted and again prior to discharge. If this was attempted but not possible due to the lack of co-operation from Mr SR, then this should have been documented.
- ❑ Documentary evidence of a careful exploration of Mr SR's previously reported voices.
- ❑ Efforts to seek collateral history from Mr SR's family, who were clearly involved in trying to support him.

In addition to the Independent Team's thoughts regarding the change in diagnosis, it was concerned that there was little apparent discharge planning for Mr SR. When he was assessed under the Mental Health Act in December, the notes suggest a flat barely habitable. However, there was no evidence in the records of any check undertaken to ensure the flat was in a suitable state of repair for Mr SR to return to. Furthermore, Mr SR was unequivocally a fire risk. There was evidence of at least five fires that he had started in his flat at the time of his admission. The mental health service had a public safety duty to advise the housing provider that Mr SR was being discharged home. This action should have been taken on or soon after 2 January 2008, so that any problem in relation to this, i.e. the tenancy provider considering Mr SR too high a risk, could have been addressed.

The lack of communication with the housing provider, given the type of accommodation in which Mr SR was a tenant, the Independent Team considers to have been a serious lapse in safe standards of practice.

Note: Individuals suffering from a severe mental illness can show behaviour that can appear to be wilful, manipulative or 'childish'. However, on receiving appropriate treatment, this behaviour can be resolved. An explanation is that a mood disorder can lead to disinhibited behaviour that breaks social norms, leading a patient to be rude, aggressive, sexually inappropriate, or racist. The patient does not always show classical manic symptoms such as pressure of speech or flight of ideas, which make the diagnosis more obvious. Such behaviour can also be as a consequence of auditory hallucinations that a patient may not admit to having. Accurate diagnosis in such cases can be very difficult, especially as sometimes the only way to differentiate these states from personality disorder is by trial of medication. In many cases, including with Mr SR, this is precluded by refusal of medication. However, in the case of Mr SR there was a very long history of contact with services and assessment by different professionals that should have been taken into account when making a change of diagnosis.

Schizo-affective disorder is a condition with both a mood component (hypomania or depression) and non-mood congruent psychotic symptoms (such as delusions or auditory hallucinations).

On the basis of the above, although the Independent Team considers that it should have been stated more plainly in the clinical records that the change in diagnosis was a 'working diagnosis', to have considered a change in diagnosis was in itself not unreasonable. Mr SR's consultant psychiatrist planned to obtain a second opinion from a forensic psychiatrist which was, and remains, a prudent precaution.

4.6 On the basis of what is recorded in Mr SR's clinical records and the memory recall of:

- ❑ **staff engaged in his care and treatment; and**
- ❑ **the family of the deceased,**

is the Independent Team satisfied that the level of communication and support provided to Mr SR's mother and sister was appropriate?

Summary opinion

It is clear from reading the records, and on the basis of what the care co-ordinator [2] to Mr SR can recall, that there was some interaction with Mr SR's sister. There is less information to show that there was effective communication with Mr SR's mother. This contrasts sharply with the clinical records of 2004 and 2005, when Mr SR was under the care and management of the community mental health team, where there is evidence of frequent communications between the health professionals and the family. On balance, it is the perspective of the Independent Team that the assertive outreach team did not engage with Mr SR's family as proactively as they could and should have done.

Occasions where the Independent Team considers contact and information-gathering from Mr SR's family should have been achieved has already been highlighted within the report, and it is not necessary to repeat the information here. This section of the report will concentrate specifically on the contact the assertive outreach team had with Mr SR's family.

Between January 2006 and February 2008 there were nine contacts between the assertive outreach team and Mr SR's family. The majority of these contacts were telephone calls to Mr SR's mother to locate him. However, on 3 July his sister was present at a home visit made by the assertive outreach team. There is, however, no record of her view or perspective at this visit.

Information provided by Mr SR's care co-ordinator [2] revealed that she had in fact had some detailed communications with Mr SR's sister. This professional told the Independent Team that:

"[she] told me of several incidents of [Mr SR] undertaking behaviours with secondary gains; for example, he threatened to throw himself out of his window as he lent dangerously through it in order to obtain money from his mother. On another occasion, his mother had brought herself a new bed and [Mr SR] jumped up and down on it, threatening to break the bed base, until his mother gave in to his demands for money. On all of the reported occasions from [the sister's] accounts, her mother conceded to [her son's] demand to placate this behaviour."

Care co-ordinator [2] also told the Independent Team that she felt she had:

"empathy with [Mr SR's sister] and listened to her when she was expressing her thoughts, feelings and perceptions of [her brother]; I also validated some of her concerns and tried to empower her in her choices. Whilst doing this, [Mr SR's sister]

felt able to be open with her inability to be as supportive of [her brother] or as supportive of her mother, due to her life circumstances.”

Care co-ordinator [2] also confirmed to the Independent Team that she and her colleagues were reliant on information from Mr SR's family about his medication compliance and other features, as they so frequently could not achieve a face-to-face meeting with him.

Another issue that arose from the Trust's internal investigation report was that Mr SR's sister appears to have been informed about her brother's change in diagnosis before he was. Care co-ordinator [2] confirmed to the Independent Team that she did share the information with Mr SR's sister, believing that Mr SR had been informed. She told the Independent Team that she was aware that Mr SR had left the interview at his discharge from the in-patient psychiatric ward as she had been present and had tried to encourage him to return. Mr SR's sister was informed by care co-ordinator [2] via a telephone conversation she had with her. She was not aware what information Mr SR's mother was privy to.

Care co-ordinator [2] also told the Independent Team that:

“[Mr SR] fluctuated in his desire for his family's involvement and at this time his family were actively involved in his life and care management; therefore this was not a breach of confidentiality. At no stage did [Mr SR] make a formal record of his intent that his family should not be informed.” Consequently, she did not consider that a breach of confidentiality had occurred.

Other than contacting Mr SR's mother to determine whether she knew the whereabouts of her son, the only contact the assertive outreach team had with her was via written correspondence. Mr SR's mother wrote two letters, one in July 2007 and one on 24 December 2007. Historically, Mr SR's mother had attended at the relevant community mental health team offices if she had specific concerns, and records in 2004, in particular, confirm that staff at Sunshine House spent time with her, listening to her concerns. However, by 2007 the Independent Team believes that she was incapacitated due to poor physical health and was not as able to get about as she once was. However, letter-writing for Mr SR's mother had also been a preferred mode of communication in the past.

The letter written by Mr SR's mother on 19 July 2007 spans five typed pages and conveyed:

- ❑ a deep sense of frustration about the situation of her son;
- ❑ some of the social prejudice she believed he was experiencing; and
- ❑ anger at the suggestion that her daughter could act as a carer for her son when she had family commitments and study commitments of her own.

Reading the letter carefully, it is clear that:

- ❑ Mr SR's mother did not believe that her son copes well in independent living;
- ❑ she believed he did not take his medication because he did not feel it provided improvement;
- ❑ she knew that, although intelligent, her son was affected by anger, thoughts, impulsiveness, and *"changing schemes is so dominant he cannot do anything"*.

She ended her letter: *"but I as his mother and a psychiatrist have been unable to change it for him"*.

The assertive outreach team responded to Mr SR's mother via letter on 15 August 2007. The formulation of the letter is akin to what one might expect following a letter of complaint. The letter was cold, officious and lacked any sense of compassion. The impression on reading it is that the professionals did not 'hear' any of the mother's pain and frustration, or her sense of helplessness. She was known to be a significant person in Mr SR's life, providing support to him over many years. It was also known that she was the subject of verbal and psychological abuse from her son.

Consequently, it is the strongly held opinion of the Independent Team that Mr SR's care co-ordinator [2] should have contacted Mr SR's mother on receipt of the letter and offered to meet with her, and her daughter, to talk about the letter, her concerns, frustrations, fears and anxieties. This would have been the right thing to do. Such a meeting could then have been followed up with a letter summarising all of the issues they had discussed and any actions and/or agreements made. It would have been a more appropriate and professional response. The Independent Team has discussed this matter with care co-ordinator [2] and, with the benefit of hindsight, she agrees that a face-to-face meeting would have been a better approach. With regards to the formulation of the written response to Mr SR's mother, care co-ordinator [2] was inexperienced at this type of letter-writing and at the time felt she had done her best to respond to the issues Mr SR's mother had raised. The Independent Team accepts this.

The second letter Mr SR's mother wrote was on 24 December. This letter was sent via her son's consultant psychiatrist. The document sent included a note highlighting that she would attend a meeting if she knew in advance when it was, because her mobility was poor; it also highlighted that she knew the good side of her son and felt helpless and very sad.

There is no evidence that any attempt was made to contact any of Mr SR's family to invite them to the discharge planning meeting, or to communicate with them in any way. This remains an unacceptable lapse by in-patient services and the assertive outreach team.

The letter Mrs SR wrote to her son tried to set out for him what he had done, what he had lost, and the danger he posed to others by his behaviours. She also tried to set out for him the limitations of the responsibility of his care team:

“Doctors, health workers, housing association, police are responsible for the welfare of you and others. They have to take action to keep safety for everyone. Liberty is [the] opposite of anarchy. Anarchy is irresponsible liberty. You are losing the liberty to live as everyone else.”

The second page of her letter ends with her thoughts about what treatment was required: *“section 3, secure unit, controlled care, parental medication”*.

There is no evidence that the mental health staff sought to communicate with Mr SR’s mother or his sister as a consequence of this letter. The Independent Team considers that such communication, particularly with the benefit of hindsight, may have been prudent. The real tragedy here is that the thoughts of the mother about what was needed for her son is precisely what has happened for him after her and her daughter’s deaths.

Subsequent communication between the Independent Team and care co-ordinator [2] revealed that she had spoken at length with Mr SR’s mother following his detention into hospital, as she was the ‘nearest relative’; and care co-ordinator [2], as the Approved Social Worker involved in the administration of the Mental Health Act, had a legal duty to contact her. Care co-ordinator [2] revealed that Mrs SR was very frustrated at the apparent inaction by mental health services in relation to her son and that she was relieved and grateful that he had been detained under the Mental Health Act.

Care co-ordinator [2] also revealed to the Independent Team that she had spoken many times with Mr SR’s sister, but that many of these conversations were undocumented. His sister had taken over the role of lead communicator for Mr SR’s family in 2007, when his mother became too unwell to continue in this role. Furthermore, it is the recollection of care co-ordinator [2] that she was specifically asked not to communicate with Mrs SR because of her poor state of health.

4.7 Was the incident in which Mr SR was involved predictable and/or preventable on the basis of information the assertive outreach team could or should have known about?

The Independent Team is confident in saying that the deaths of Mr SR's mother and sister were not predictable. Mr SR had a long history with the mental health service and a long history of verbal aggression and intimidating behaviour towards his mother, and was psychologically abusive to get his own way. However, there is nothing in his known history that would have caused anyone to consider him a risk of deliberate intent to harm another, and nothing to suggest that he would have been so calculating as he is reported to have been in the planning of the deaths of his mother and sister.

With regards to preventability, but for Mr SR's admission to hospital on 20 December 2007 under section 2 of the Mental Health Act, and the opportunity to have observed him at close quarters for 20 consecutive days, the question of preventability would be more challenging than it is. On balance, and after much deliberation, the Independent Team has concluded that, although it considers:

- ❑ the medical input to the assessment and treatment planning for Mr SR to have been lacking owing to the non-provision of medical sessions to the assertive outreach team;
- ❑ that it was premature to have changed Mr SR's diagnosis from schizo-affective disorder to personality disorder;
- ❑ that there was insufficient collateral history obtained from Mr SR's family throughout;
- ❑ that there was a lack of exploration about Mr SR's contemporary behaviours towards his mother and sister;
- ❑ that there was a lack of joint planning with the housing provider about how to manage the fire risk Mr SR posed to other residents,

on balance it is difficult to conclude that the incident as it occurred was preventable. There was simply no evidence known to the mental health services that could or should have prompted them to warn Mr SR's mother and sister that Mr SR posed a serious risk of harm to them and that they should avoid contact with him. To suggest otherwise is unrealistic.

Mr SR had not displayed any behaviour known to the mental health services where his family considered themselves to be at serious risk of harm from him. Following discharge from hospital, at his 7-day discharge meeting he was noted to be appropriate and polite by care co-ordinator [2]. A plan was made with him on 15 January to order a skip for 29 January to clear his flat. A further appointment was also made with him for 25 January. This did not occur until 29 January, owing to other pressing concerns. Nevertheless, on this day, although Mr SR was noted to be in his flat at the time, and knew that his care co-ordinator was knocking, he would not let her or the housing officer in. Mr SR was observed to have a sheet over his clothes.

The final clinical entry was on 31 January, when Mr SR was to attend for a medical review, which he did not do. The records of this day show that Mr SR was a fire risk and was unpredictable. It was also noted that his consultant psychiatrist and care co-ordinator [2] considered him responsible for his actions and fit for interview, should

the police require it. It was again confirmed that Mr SR's consultant would refer him for a forensic psychiatric opinion, and the referral letter was sent that same day.

The only caveat the Independent Team places on its overall conclusion is as follows. It cannot be predicated what difference it would have made to Mr SR's treatment plan or its execution, nor of his overall engagement, had there been dedicated medical sessions to the assertive outreach team. Furthermore, it cannot be predicated retrospectively whether or not an earlier forensic psychiatric referral would have occurred with more frequent medical in-put to the team. The Independent Team has a sense of a lack of clear clinical leadership for the assertive outreach team, with no one person qualified or empowered to take that lead and provide direction where it was required in the clinical management of a difficult patient. Care co-ordinator [2] for Mr SR said: *"There was very limited expertise within the team; there was never any input from psychology, RMOs [i.e. medical staff], or other agencies pertinent to the discussion."*

The Independent Team therefore reasserts its overall perspective that, on the balance of probabilities and taking into account the recorded behaviours of Mr SR over a four-year period pre-dating the incident, it cannot be said with confidence that had his care and treatment been different then the incident would not have occurred as it did.

5.0 What has changed in Mr SR's assertive outreach team and for assertive outreach services in 5 Boroughs Partnership NHS Foundation Trust since February 2008?

There have been significant changes in the Trust since 2008.

The Trust's own internal investigation noted the following local actions completed by Mr SR's assertive outreach team at the time of their investigation:

- ❑ Monitoring of the frequency of visits occurs on a monthly basis when samples of 10 case files are audited.
- ❑ The assertive outreach team had been accommodated in new premises in Claire House, which removed the obstacles to effective team communications caused by the team being on split sites.
- ❑ The management supervision system within assertive outreach had been reviewed. Consideration was given as to how to address difficulties experienced by the team manager in supervising such a large team. A consequence of this was that some of his supervision responsibilities for junior staff had been delegated to band 6 practitioners within the team. This emulated a commonly used cascade model used in other mental health trusts.
- ❑ The Assertive Outreach Team Managers Forum had been strengthened. The meetings were now on a monthly basis, with the focus of the forum being the sharing of best practice and service development.
- ❑ The Eligibility Criteria for acceptance into the Assertive Outreach Team had been reviewed as part of a complete review of the Trust's Assertive Outreach Operational Guidance.
- ❑ The criteria by which a service user is ready for transfer back to the community mental health team had been clarified.

Recommendations subsequently made by the Trust's investigation team were:

1. *The AOT members should receive monthly supervision and this should be recorded within the service user case file to show supervision is taking place. This will aid care co-ordinators with case management of complex cases. The review recommends that this is a model for the Trust.*

The contemporary situation:

The Trust has completed a review of Management Supervision and has developed an audit process to determine compliance which Adult Services is required conduct. Assurance of procedural compliance is assessed by the Clinical Advisory Group for Adult Services. This group is chaired by the Director of Nursing and Governance.

2. *The mechanisms for recruitment to AOT care co-ordinator posts should be reviewed to ensure selection of appropriately skilled and experienced staff.*

The contemporary situation:

The Trust has developed a recruitment and selection policy and procedure that outlines the mechanism for the recruitment and selection process for staff. Compliance with this is monitored by the human resources department.

3. *The training made available to AOT practitioners should be reviewed to establish if it adequately meets the needs of the AOT.*

The contemporary situation:

All staff employed by the Trust has an individual training and development need plan that is reviewed as part of their professional development review. This occurs at least annually. It is the responsibility of all staff managers to complete a professional development review form and to provide it to the Trust's education department. Non-compliance with this expectation is monitored by the education manager and reported to the responsible Assistant Director.

4. *There should be dedicated Consultant Psychiatrist time within the Assertive Outreach function to allow appropriate access to Consultant opinion.*

The contemporary situation: Fully achieved.

5. *The Trust should review how the Zoning Model is operated within this AOT and that the Zoning Model should be operated via the white board system.*

The contemporary situation:

The Wigan assertive outreach team has reviewed the IT mechanisms of how it operates its zoning system; however, there appears to have been no review of how it is used as a clinical management tool, or the effectiveness of how the outreach team currently applies zoning principles. The Independent Team acknowledges that the Wigan assertive outreach team has attended to how it reviews and discusses complex cases. Mr SR would have constituted such a case. The 'strategic assertive outreach meeting' minutes of 22 September 2009 clearly state that, where a complex case is presented, the following must be included:

- Full case summary;
- What works and what does not;
- The Crisis and Home Treatment – contingency plan;
- Ongoing issues;
- Recommendations for current management.

However, there is no evidence that the system has been audited for standard compliance.

6. *There should be a mechanism in place where external/expert review of complex cases can be undertaken in order to support AOT members.*

The contemporary situation:

The assertive outreach team now has a 0.8WTE (whole time equivalent) consultant psychiatrist. Consequently, this recommendation is no longer relevant.

7. *Protocols should be developed within the AOT to alert the supervisor/manager when there have been lengthy periods of non-engagement. This needs to be done via review of the Zoning Model.*

The contemporary situation:

This recommendation is addressed by the development of the assertive outreach team's development of a clear process for the discussion of complex cases. Ideally, the zoning model used should trigger a clear and auditable action plan where a service user disengages. There remains a lack of clarity around this.

8. *The mechanism and systems for sharing risk assessments with other key workers/agencies involved in the patient's care needs to be reviewed.*
- and
9. *That all information gathered upon a screening/assessment of risk must be transferred on to the service user's Risk Management plan.*

The contemporary situation:

The Care Programme Approach (CPA) Policy (2010) describes the responsibilities and mechanisms for multi-disciplinary review, and sharing risk management plans with relevant agencies. CPA describes the process for risk assessment and development of risk management plans based on the identified risks.

The Information Sharing Policy (2008) describes the model protocol for information sharing to be adopted across all services in the Trust. Local Authority staff have access to the Trust internal patient record system to ensure central integrated care records are available.

During 2010 the Trust reviewed the systems in place for management supervision. The review focused on the quality of caseloads with attention on supervision and quality of care plans, risk assessments and risk management plans.

The Management Supervision Quality Checklist was developed in 2010 and rolled out. The checklist is utilised through supervision where random case notes are selected and the quality checklist completed.

10. *The AOT needs to have very clear and defined protocols/procedures for arranging clinical cover for annual leave and sickness within the team. All of the team must fully sign up to these arrangements and the team manager must monitor and review the efficiency of the system.*

The contemporary situation:

The Trust managers have a contractual responsibility to ensure clinical and managerial cover for their service area. This is monitored corporately through management supervision.

- 11. The Trust should consider a process of shadowing where in-patient staff and community staff have periods of exposure to the other services roles. This would develop understandings of each specialism's role and would serve as a learning and developmental process. Also, this may assist in identifying gaps in training that need to be considered for in-patient staff moving out in to community work and vice versa.*

The contemporary situation:

The Trust now has a personal development review (PDR) programme in place that considers shadowing as part of each individual's personal development programme. This is recorded and reviewed on a quarterly basis. Completed PDRs are submitted and audited annually to ensure completeness and identification of training and development needs. All staff that transfer between departments or teams within the Trust are subject to the Trust Induction Policy and must receive local induction. This is monitored by the HR departments and followed up with responsible line managers.

- 12. The impact of the ASW role needs to be fully considered within the AOT model. There needs to be clear agreements between the Trust and the Local Authority in terms of how contributing to the ASW rota is equitably managed so as not to adversely pressurise the individual staff member, but which also takes into account the needs of the AOT.*

The contemporary situation:

The ASW is no longer a post within the AOT team. Work is allocated to Social Workers that are part of the Leigh locality team. This recommendation is no longer valid.

- 13. All staff within the AOT need to be educated and reminded of issues of confidentiality and information sharing.*

The contemporary situation:

All staff in the Trust are now required to undertake information governance training. This training is mandatory for all staff. Breaches of confidentiality are reported through the incident reporting system (DATIX) and investigated by the head of information governance. Breaches are dealt with by disciplinary procedures where required.

Other changes which have occurred that are of relevance to the findings of this investigation are set out below and relate to changes that have occurred within the Wigan Assertive Outreach Service itself and changes in how the Trust now plans for

and implements new services, including how it evolves existing services to meet new or different criteria.

With regards to the Wigan assertive outreach team, the most important change is that this team now has a dedicated consultant psychiatrist. The Trust undertook a review in 2007 and 2008, a consequence of which was a decision that the lack of dedicated medical sessions to assertive outreach could not continue. Since June 2010, with a change to the 'New Ways of Working', the Wigan assertive outreach team has a dedicated consultant input at 0.8 whole time equivalent. The consultant psychiatrist for the Wigan assertive outreach team told the Independent Team that 0.8 whole time equivalent is more than sufficient to provide adequate medical input to the assertive outreach team, including emergency cover. He also told the Independent Team that, in addition to this, 0.2 sessions were provided for the Criminal Justice Liaison Team from the whole time post, and this is provided on the same premises as the assertive outreach team and that this allows improved accessibility throughout the working week.

With regards to how the Trust now plans for service implementation and service change, the system is not recognisable to the situation in 2004 when the then Intensive Support Team was evolved into an assertive outreach team. In 2004 the approach, although considered, did not give the level of attention required to assessing risk and conduct of robust option appraisals as occurs today. Furthermore, at that time there was not the emphasis on medical leadership and 'doctors in management' as there is today.

6.0 CONCLUSIONS

The deaths of Mr SR's mother and sister were deeply shocking, and none more so than to the children of Mr SR's sister, who were in the home when the attack on their mother occurred.

Mr SR himself has been determined to suffer from a severe mental illness of paranoid Schizophrenia. As a consequence of this and the incident in which he was involved, he is now cared for in a high-security hospital.

With regards to the predictability of what happened on 19 February 2008, the Independent Team does not believe that the act of violence carried out by Mr SR was predictable. His immediate antecedent behaviours in the months prior to the incident were mostly associated with fire-setting risks and anti-social behaviour. With respect to his fire-setting risk, he did represent a risk of harm to others, but this was more than likely to have been accidental rather than purposeful. The Independent Team is mindful that Mr SR had a history of unacceptable behaviour towards his mother, a history the assertive outreach team was not as mindful of as it could and should have been. However, his behaviours were not of the magnitude where one would reasonably have considered Mr SR to have been a homicide risk.

With regards to the preventability of the incident, because Mr SR had been admitted under section 2 of the Mental Health Act on 20 December 2007 and observed by nursing staff between that date and 9 January 2008, when he was discharged, to display no signs of psychosis or treatable mental illness, observations which were endorsed by Mr SR's consultant psychiatrist, it is difficult to suggest that, after his discharge, Mr SR's management plan should have been any different to that which it was. This included a 7-day follow-up visit on 15 January, an outpatient appointment on 17 January (which Mr SR did not attend) and a second outpatient appointment on 31 January, which he again did not attend.

Mr SR was not on any medication during or after his discharge from hospital. Although treatment with a depot antipsychotic was considered at the time of admission (Section 2), during the period of inpatient assessment there was insufficient clinical evidence to enforce treatment with a depot antipsychotic. Mr SR was prescribed oral antipsychotic medication but he consistently refused to take this and the prescription was formally discontinued as there was no objective evidence of a psychotic illness during the course of the assessment period.

Mr SR had been referred for a forensic psychiatric opinion on 31 January, but this appointment had not been offered at the time of the incident. With Mr SR's history, even had this appointment been offered earlier, it is unlikely that Mr SR would have received an appointment for assessment prior to the incident. Furthermore, if an appointment had been offered, noting Mr SR's history, it is completely uncertain as to whether he would have attended.

Based on the above, and on the balance of probabilities, it is unlikely that the attack Mr SR made on his mother and sister was preventable on the day on which it occurred.

The above being stated, the Independent Team considers that the care and treatment of Mr SR could have been improved in the following respects:

- ❑ Easier and more regular access to a medical opinion may, in the opinion of the Independent Team, have resulted in more structured assessments of Mr SR (where possible) and in a more robustly formulated management plan.
- ❑ The hand-over between the community mental health team and the assertive outreach team in January 2006 did not meet any of the CPA standards in place at the time.
- ❑ The assertive outreach team was not as aware as it could and should have been about Mr SR's considerable history with mental health services. Had it been more aware, the Independent Team considers that the team's risk formulations would have been more robust.
- ❑ The assertive outreach team should have communicated more proactively with the community pharmacist with regards to how Mr SR's medicines were dispensed to determine if this could be achieved in a manner that would have made the monitoring of Mr SR's compliance more achievable.
- ❑ Mr SR's family (his mother and sister) could and should have been utilised more effectively as informants for the assertive outreach team.
- ❑ When it was determined in July 2007 that a more intensive service was required for Mr SR, how this was to be achieved should have been indicated in his care plan. Furthermore, obstacles to achieving this should have been noted and communicated to Mr SR's consultant psychiatrist once it was clear that delivering more intensive support to Mr SR was not achievable. The Independent Team did not see any evidence of an increase in the intensity of service offered to Mr SR.
- ❑ The assertive outreach team could and should have helped a planning meeting with the housing provider for Mr SR in view of his fire-setting behaviour, because of the risks this posed to other tenants. At the very least, the housing provider should have been involved in the discharge planning for Mr SR. The situation where housing was not advised of his discharge on 9 January should not have occurred.
- ❑ More complete documentation regarding the assertive outreach team's assessment of Mr SR's mental state would have better enhanced the effort his care co-ordinators put into trying to deliver an effective service to him.
- ❑ When Mr SR was an in-patient, there was no evidence in the clinical records of a detailed mental state examination performed at any time after 20 December. This lack of documentation concerning the process by which Mr SR's diagnosis was changed was not acceptable.

The Independent Team knows that it is being exacting in stating the above and it recognises that Mr SR was a particularly challenging service user. It is therefore satisfied that:

- ❑ Mr SR's care co-ordinators undertook a frequency of visits that they believed Mr SR had agreed to and would tolerate.

- ❑ Mr SR's care co-ordinators utilised their observational skills appropriately to determine whether or not he was frequenting his flat, even when he would not open the door to them.
- ❑ His care co-ordinators engaged appropriately with the mentally disordered offenders service when they were determining the extent to which Mr SR should be held responsible for his fire-setting behaviour.
- ❑ Mr SR's care co-ordinators were responsive to Mr SR's neighbours when they approached them directly. The clinical records also show that appropriate advice was always provided.

In addition to the above, the Independent Team particularly wishes to note the actions of Mr SR's care co-ordinator [2] in December 2007. When she, her community psychiatric nurse colleague, or Mr SR's consultant psychiatrist was unable to achieve a face-to-face assessment of Mr SR, between 14 and 18 December, she undertook to obtain a warrant under s.135 of the Mental Health Act to enable an assessment of Mr SR to occur. Her decisive action, the Independent Team believes, should be appropriately acknowledged. Her actions at this time and during the conduct of the assessment undertaken were central to securing a period of in-patient care and treatment for Mr SR in December 2007.

7.0 RECOMMENDATIONS

As stated in section 5.0 of this report, the situation in the Trust is very different to that which prevailed when the assertive outreach team was formulated and that which prevailed when Mr SR was a patient of the Trust.

Because of the changes implemented, recommendations the Independent Team may otherwise have made are no longer necessary.

However, the following recommendations have retained their currency:

Recommendation 1: The assertive outreach teams at the Trust should review their current approach to the traffic light system used to zone clients on the caseload. The model used when Mr SR was a patient did not set out a robust and clear management framework for each zone. For example, for service users in the RED zone, it did not set out the maximum gap between medical assessments or the frequency of care co-ordinator assessments. Neither did the tool set out the rules by which a service user could be moved from the RED zone to the Amber zone and so on.

Because in Mr SR's assertive outreach team the traffic light system was used as a clinical management rather than workload management tool, it is essential that the tool is designed in such a way that its efficacy and reliability of use can be subjected to periodic audit.

It is therefore recommended that the assertive outreach service managers, team leaders and clinical leads explore:

- ❑ the range of approaches currently in use across all Trust assertive outreach teams;
- ❑ approaches in other mental health trusts and other teams, such as early intervention services;
- ❑ the range of criteria that might constitute a robust framework for dictating the necessity for clinical discussion of a service user at the weekly clinical team meeting, and/or the service user's escalation up the zoning system;
- ❑ the process by which service users, once escalated up the zoning system, can be 'de-escalated'.

In conjunction with the above, it is recommended that:

- ❑ clear guidelines are developed for the zoning system agreed;
- ❑ documentation standards around clinical decision-making are agreed;
- ❑ the way the zoning system is to be audited, including audit criteria, and the frequency of audit is agreed and planned for.

In formulating an appropriate audit process, the Independent Team recommends that at least the following factors are incorporated:

- ❑ The appropriateness of the traffic light level/zone;

- ❑ The quality of documentation when a decision is made to manage a service user outside of the protocol guidelines;
- ❑ The quality of documentation when a decision is made to move a service user to a lower-risk tier of the traffic light system;
- ❑ Whether the documented frequency of medical review shows protocol compliance, and where the frequency does not meet this, do the notes provide a reasonable explanation as to why? (E.g. a decision has been made for less frequent reviews and is a documented component of the management plan, or the service user has not attended for appointments);
- ❑ Appropriateness and frequency of medication review;
- ❑ Appropriateness of actions planned, following consecutive periods of non-attendance for planned contacts, that the traffic light system says requires action.

Target audience: The Director of Nursing and Governance, the service managers and the clinical leads and team managers for all assertive outreach teams.

Timescale: It is anticipated that the Trust should be able to have developed a project management and commenced the delivery of this within six months of the publication of this report.

Recommendation 2: This investigation identified a lack of knowledge about Mr SR's past history in the professionals directly engaged in his care and treatment. There was at the time an over-reliance on the information stored on the electronic record-keeping system. Had a comprehensive and thorough chronology of his past contacts with mental health services been complied with, it is less likely that these knowledge gaps would have occurred.

The Independent Team acknowledges that now most records are made electronically; however, it is not tenable to rely only on the CPA documents to provide complete information. It is therefore the recommendation of the Independent Team that for all new assertive outreach clients an integral component of the activities undertaken when a service user is accepted on to the caseload is a comprehensive case history that sets out clearly the service user's:

- ❑ Contact with mental health services, the circumstances of this and diagnostic history, in a clear, chronological order;
- ❑ Historical risk behaviours and the context of these;
- ❑ Contemporary risk behaviours and known context;
- ❑ Physical health history;
- ❑ Current medication;
- ❑ Known vulnerabilities.

Where feasible, it will be advantageous if information from the family/known carer(s) is a key component of this process.

Target audience: The Director of Nursing and Governance, the service managers and the clinical leads and team managers for all assertive outreach teams.

Timescale: The Independent Team is aware that this recommendation will require an investment of time, and therefore the Trust will want to consider the principles of this recommendation within its governance forums before committing to an action implementation plan. Consequently, the Independent Team suggests that the Trust should be able to provide NHS North West with its response to this recommendation within three months of the publication of this report, aiming for an action implementation plan within six months.

APPENDIX 1: INVESTIGATION METHODOLOGY

The methodology employed for this investigation was structured and embraced the key phases detailed in the National Patient Safety Agency's root cause analysis e-learning toolkit. Key activities were:

- ❑ Critical appraisal of Mr SR's clinical records and the creation of a structured (tabular) timeline.
- ❑ The identification of areas that the Investigation Team needed to understand better.
- ❑ Critical appraisal for the Trust's own internal investigation report and the original internal investigation interview records to determine the extent to which the information already gathered answered the Independent Team's questions.
- ❑ Face-to-face and telephone interviews and discussions with staff working in the Wigan assertive outreach service.
- ❑ Face-to-face meeting with Mr SR's consultant psychiatrist.
- ❑ Face-to-face meetings with a range of assertive outreach and business managers working within the Trust.
- ❑ Face-to-face meeting with the current Director of Nursing, Trust Risk Manager, Assistant Director Adult Services, Assistant Director of Governance and Patient Safety, Business Manager, Wigan Adults.
- ❑ Liaison with Assistant Director Commissioning NHS Ashton, Leigh and Wigan.

The investigation tools utilised were:

- ❑ Structured timelining.⁹
- ❑ Triangulation and validation map.
- ❑ Investigative interviewing.
- ❑ Affinity mapping.
- ❑ Qualitative content analysis.

Documentary information:

- ❑ Volumes of Mr SR's clinical records, 1986-2008.
- ❑ 5 Boroughs Partnership Internal Investigation Interview records.
- ❑ 5 Boroughs Partnership internal investigation report.
- ❑ Pre-interview information provided by:
 - Mr SR's consultant psychiatrist;
 - Care co-ordinator [1], assertive outreach 2006-2007;
 - Care co-ordinator [2], assertive outreach 2007-2008;
 - Assertive outreach team manager (January 2006 to date).
- ❑ Independent Team interview records:
 - Mr SR's consultant psychiatrist;
 - Care co-ordinator [1], assertive outreach 2006-2007;

⁹ M. Dineen (2004). *Six Steps To RCA*, 2nd Edition.

- Care co-ordinator [2], assertive outreach 2007-2008;
 - Assertive outreach team manager (January 2006 to date);
 - Assertive outreach team managers meeting;
 - Business managers meeting;
 - Senior managers meeting (8 September 2011).
- Assertive outreach team weekly team meeting minute book, 2007.
 - One-page Traffic Light Protocol (replicated in this report).

NHS North West
4 Floor
Piccadilly Place
Manchester
M1 3BN

Consequence UK Ltd
392 Pickersleigh Road
Malvern
Worcester
WR14 2QH

www.northwest.nhs.uk

www.consequence.org.uk