

Independent Investigation
into the
Care and Treatment Provided to Mr. Y
by
Pennine Care NHS Foundation Trust

Commissioned by
NHS North West
Strategic Health Authority

Authored By: Mr. Alan Watson

Investigation Led By: the Health and Social Care Advisory Service

Contents

1. Investigation Team Preface	Page 4
2. Condolences to the Family and Friends of Mr. A	Page 5
3. Incident Description and Consequences	Page 6
4. Background and Context to the Investigation	Page 7
5. Terms of Reference	Page 9
6. The Independent Investigation Team	Page 11
7. Investigation Methodology	Page 12
8. Information and Evidence Gathered	Page 21
9. Profile of Pennine Care NHS Foundation Trust	Page 23
10. Chronology of Events	Page 28
11. Timeline and Identification of the Critical Issues	Page 43
12. Further Exploration and Identification of Causal and Contributory Factors and Service Issues	Page 50
- 12.1.1. Diagnosis	Page 51
- 12.1.2. Medication and Treatment	Page 56
- 12.1.3. Management of the Clinical Care and Treatment of Mr. Y	Page 63
- 12.1.4. Use of the Mental Health Act (1983 & 2007)	Page 70
- 12.1.5. The Care Programme Approach	Page 74
- 12.1.6. Risk Assessment	Page 83
- 12.1.7. Referral, Transfer and Discharge	Page 89
- 12.1.8. Carer Assessment and Carer Experience	Page 93
- 12.1.9. Service User Involvement in Care Planning	Page 100
- 12.1.10. Documentation and Professional Communication	Page 102
- 12.1.11. Clinical Supervision	Page 107
- 12.1.12. Adherence to Local and National Policy and Procedure	Page 108
- 12.1.13. Organisational Change and Professional Leadership	Page 111
- 12.1.14. Clinical Governance and Performance	Page 114

13. Findings and Conclusions	Page 120
14. Pennine Care NHS Foundation Trust Response to the Incident and the Internal Investigation	Page 131
15. Notable Practice	Page 135
16. Lessons Learned	Page 140
17. Recommendations	Page 143
18. Glossary	Page 147
Appendix One. Timeline	Page 153
Appendix Two. Pennine Care NHS Foundation Trust Performance on Carers' Assessments	Page 162

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. Y was commissioned by NHS North West Strategic Health Authority pursuant to *HSG (94)27*¹. This Investigation was asked to examine a set of circumstances associated with the death of Mr. A who was found killed on the 1 June 2008.

Mr. Y received care and treatment for his mental health condition from Pennine Care NHS Foundation Trust. It is the care and treatment that Mr. Y received from this organisation that is the subject of this investigation.

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

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's senior management who have granted access to facilities and individuals throughout this process. The Trust's senior management team has acted at all times in an exceptionally professional manner during the course of this investigation and have engaged fully with the root cause analysis ethos.

We would like to thank the family of Mr. A who offered their support to this process and who worked with the Independent Investigation Team. We acknowledge their distress and we are grateful for the openness and honesty with which they engaged with the Investigation. This has allowed the investigation to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

1. Health Service Guidance (94) 27: Guidance on the discharge of mentally disordered people and their continuing care in the community: Department of Health 1994

2. Condolences to the Family and Friends of Mr. A

The Independent Investigation Team would like to extend their condolences to the family and friends of Mr. A.

It is the sincere hope of the Independent Investigation Team that this investigation process has addressed all of the issues that Mr. A's family have sought to have examined and explained.

3. Incident Description and Consequences

Incident Description and Consequences

On the morning of Sunday 1 June 2008, Mr. A left home to visit a local shop in the Cheetham Hill area of Manchester. He was approached by Mr. Y in the street and stabbed twice by him. Mr. Y had never met Mr. A before. Mr. A died from his injuries as a result of this attack.

From reports made after the incident it is known that Mr. Y left home that morning and drove to the Cheetham Hill area. The forensic assessment following the incident found that Mr. Y was acting directly as a result of a set of delusional beliefs. He said that he heard a voice telling him kill someone. He took a knife from his home and used this to stab Mr. A twice. He then returned to the family home and did not say anything about his actions to the family.

Mr. Y's actions were witnessed and captured by a Closed Circuit Television (CCTV) in the locality. Mr. Y was traced from the CCTV record, was arrested on 2 June 2008 and charged with murder. After remand at Strangeways Prison Manchester he was admitted to Ashworth Hospital Merseyside on 12 August 2008. He appeared at Manchester Crown Court on 9 October 2008 and was found guilty of the manslaughter of Mr. A. The Crown Court ordered him to be detained under the provisions of Section 48/49 of the Mental Health Act (2007). He was returned to Ashworth Hospital Merseyside, and was still detained there at the time this report was written.

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

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

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

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

- i) When a homicide has been committed by a person who is, or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.
- ii) When it is necessary to comply with the State’s obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.
- iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

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

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

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

5. Terms of Reference

The Terms of Reference for this Investigation were set by NHS North West Strategic Health Authority. Pennine Care NHS Foundation Trust was consulted regarding the terms of reference and did not wish to make any additions. The family of Mr. A were also consulted. The Terms of Reference were as follows:

1. To examine:

- The care and treatment provided to the service user, at the time of the incident (including that from non NHS providers e.g. voluntary/private sector, if appropriate);
- The suitability of that care and treatment in view of the service 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 assessments to support care planning and use of the care programme approach in practice;
- The exercise of professional judgement and clinical decision making;
- The interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical needs;
- The extent of services' engagement with carers; use of carer's assessments and the impact of this upon the incident in question;
- The quality of the internal investigation and review conducted by the Trust.

2. To identify:

- Learning points for improving systems and services;

- Development in services since the user's engagement with mental health services and any action taken by services since the incident occurred.

3. To make:

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

4. To report:

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

6. The Investigation Team

Investigation Team Leader and Chair

Alan Watson

National Development Consultant, Health and Social Care Advisory Service. Social Work Member of the Team.

Investigation Team Members

Dr Androulla Johnstone

Chief Executive of the Health and Social Care Advisory Service and nurse member of the team.

Dr. David Somekh

Consultant Forensic Psychiatrist Member of the Team.

Support to the Investigation Team

Christopher Welton

Investigation Manager, Health and Social Care Advisory Service.

Transcription

Fiona Shipley Transcription Services.

Independent Advice to the Investigation Team

Mr. Ashley Irons

Capstick's Solicitors.

7. Independent Investigation Methodology

On the 7 April 2010 NHS North West (the Strategic Health Authority) commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the terms of reference set out in Section Six of this report. The Investigation methodology is set out below. It was the decision of the Strategic Health Authority that full anonymity be given to Mr. Y and all witnesses to this Investigation.

Consent and Communication with Mr. Y

During the course of this investigation Mr. Y has been detained at Ashworth Hospital Merseyside. On the 15 June 2010 a letter was sent to him by NHS North West requesting his consent for the Independent Investigation Team to access his clinical records and a consent form was enclosed. Mr. Y did not respond. On the 9 July 2010 a second consent letter and consent form was sent to Mr. Y. Both of these letters set out the purpose of the Investigation and offered the opportunity of a face-to-face meeting so that any that questions Mr. Y had could be addressed directly.

Following this correspondence, liaison was established with the hospital clinical team. Mr. Y was offered the opportunity to meet with a Senior Officer from NHS North West and a member of the Investigation Team. On the 29 July 2010 this meeting took place at Ashworth Hospital. The Investigation process and *raison d'être* were discussed with Mr. Y and he refused to give his consent for his clinical records to be accessed and used. He also said that he wanted to play no part in the process of the investigation and did not wish to be interviewed by the Investigation Team or to offer his views on his care and treatment. Subsequently, an application was made to the Pennine Care NHS Foundation Trust Caldecott Guardian for the release of Mr. Y's case records in the public interest and this was granted. The Investigation Team therefore had full access to Mr. Y's notes held by the Trust. The Caldicott Guardians of NHS Oldham and Mersey Care NHS Trust were also written to in order to access his GP notes held by NHS Oldham, and his forensic records held by Ashworth Hospital.

Communication with the Victim's Family

On the 30 June 2010 an introductory meeting was held between the widow of Mr. A, a senior officer from NHS North West and a member of the Investigation Team. On this occasion the purpose and process of HSG (94) 27 was explained. The terms of reference were given to her together with an invitation to consider any additional issues that she required to have addressed. Mrs. A declined to meet the Investigation Team. The Team also made contact with Mrs. B, the victim's sister, who also represented other members of Mr. A's extended family, including his parents. Mrs. B met the investigation team on 21 October 2010. The investigation team met Mrs. B again on 17 December 2010 to discuss the main findings of the investigation.

Communication with the Family of Mr. Y

The Investigation Team Chair made contact with Mr. Y's father. Mr. Y was living with his parents at the time of the incident and they were significantly involved with his care and treatment over a number of years. Mr. Y's father was offered the opportunity to meet the Investigation Team and this meeting took place on 22 September 2010. With his consent the meeting was recorded and transcribed and a copy of the transcript was sent to him for factual accuracy checking.

Communication with the Manchester Coroner

The Manchester Coroner will be holding an Inquest into the death of Mr. A on the completion of this Independent Investigation. A meeting was held between the Coroner, a senior officer from NHS North West and the Independent Investigation Team Chair on the 30 July 2010. At this meeting timeframes were agreed, process was discussed and preliminary information was shared.

A further meeting with the Coroner was held on 25 January 2011 to discuss the preliminary findings from the Investigation.

Communication with Pennine Care NHS Foundation Trust

In June 2010 NHS North West wrote to the Pennine Care NHS Foundation Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. Y.

Following this correspondence the Independent Investigation Team Chair made direct contact with the Trust.

On the 4 August 2010 a meeting was held with the senior management team at Pennine Care NHS Foundation Trust. The Investigation process was explained and a liaison person identified by the Trust. An invitation was made by HASCAS for a workshop to take place within the Trust to provide a briefing opportunity for all those who would be involved with the Investigation.

On the 1 September 2010 a Trust workshop was held. Pennine Care NHS Foundation Trust senior personnel and employees were present. Each workshop attendee was given an information pack that described the HSG (94)27 process, gave witness advice and set out the draft terms of reference. The workshop provided each attendee with the opportunity to learn more about the forthcoming procedure and what would be expected of them.

Between the first meeting and the formal witness interviews (September 20-22) the Independent Investigation Team Chair worked with the Trust liaison person to ensure:

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

On 8 December 2010 a meeting was held between the Independent Investigation Team Chair and the Trust Senior Management Team. The purpose of this meeting was to inform the Trust of the headline findings of the Investigation and to provide the draft report to commence the factual accuracy stage of the process. On this occasion the Trust was invited to comment upon the recommendation section in the report and to contribute further after a period of reflection.

Communication with Primary Care Trust

Pennine Care Trust is commissioned by NHS Heywood, Middleton and Rochdale Primary Care Trust (PCT) on behalf of a commissioning consortium of five PCTs responsible for the localities covered by the Trust. A meeting was held on 22 November 2010 between the Investigation Chair and the lead commissioner from the PCT to discuss the investigation. A meeting was also held on the 24 February 2011 with NHS Heywood, Middleton and Rochdale to discuss the findings of the Investigation and to offer the organisation an opportunity to contribute to the recommendations.

Completion of the Process

A formal workshop was held with the Pennine Care NHS Foundation Trust. This workshop was to ratify the findings and recommendations and to ensure that an action plan was framed in readiness for implementation in the most timely manner possible.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an investigation briefing pack. The Investigation was managed in line with Scott and Salmon compliant processes.

During the period that Mr. Y received his care and treatment from Pennine Care services he was seen by a large number of health and social care professionals. It would not have been either practical or useful to have interviewed them all. The independent investigation team took the decision to interview each of the Responsible Medical Officers, Named Nurses and Care Coordinators that provided the principal aspects of Mr. Y's care and treatment over this period and who were responsible for the formulation of his care management. The total number of witnesses interviewed by the Independent Investigation Team was 22. The witnesses who attended for interview are set out in table one below.

Table One
Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
20 September 2010	Trust Chief Executive Trust Director of Operations and Nursing Deputy Director of Nursing and Integrated Governance Head of Corporate Governance Director of Finance Director of Planning Performance and Information Trust Secretary *** Member of the internal investigation team *** Consultant Psychiatrist *** Care Coordinator	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer
21 September 2010	Consultant Psychiatrist *** Care Coordinator *** Named Nurse *** Managers of in-patient services and the Crisis Resolution and Home Treatment Team *** Service manager *** Community Mental Health Team Manager	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer
22 September 2010	Care Coordinator *** Named Nurse *** Consultant Psychiatrist *** Consultant Psychiatrist *** Mr. Y's Father	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer

Salmon Compliant Procedures

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

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:
 - (a) of the terms of reference and the procedure adopted by the Investigation; and
 - (b) of the areas and matters to be covered with them; and
 - (c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and
 - (d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and
 - (e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and
 - (f) that it is the witness who will be asked questions and who will be expected to answer; and
 - (g) that their evidence will be recorded and a copy sent to them afterwards to sign; and
 - (h) that they will be given the opportunity to review clinical records prior to and during the interview.
2. Witnesses of fact will be asked to affirm that their evidence is true.
3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.
5. All sittings of the Investigation will be held in private.
6. The findings of the Investigation and any recommendations will be made public.
7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.
8. Findings of fact will be made on the basis of evidence received by the Investigation.
9. These findings will be based on the comments within the narrative of the Report.
10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

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

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

The Team Met on the Following Occasions:

6 September 2010. On this occasion the Team examined the timeline based on what could be ascertained from analysing the documentary evidence. The witness list was confirmed and emerging issues were identified prior to the interviews.

20-22 September 2010. Between these dates witness interviews took place. During this period the Investigation Team took regular opportunities to re-examine the timeline, re-evaluate emerging issues and to discuss additional evidence as it arose.

Between the 22 September and the 20 October 2010 each Team Member prepared an analytical synopsis of the identified subject headings in readiness to conduct an in-depth Root Cause Analyses process. The Team were also able to read transcriptions of interviews. Transcriptions were sent to interviewees for their further comment or amendment and these amended transcriptions were received back from Pennine Care NHS Foundation Trust on 26 October 2010.

21 October 2010. On this day the Team met to work through each previously identified subject heading utilising the ‘Fishbone’ and ‘Five Why’ process advocated by the National Patient Safety Agency. This process was facilitated greatly by each Team member having already reflected upon the evidence prior to the meeting and being able to present written, referenced briefings at the meeting.

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

Other Meetings and Communications

A member of the Independent Investigation Team met on a regular basis with NHS North West throughout the process. Communications were maintained between meetings by email, letter and telephone.

Communications also took place with Ashworth High Security Hospital and the Manchester Coroner in the pursuit of clinical records and access to Mr. Y respectively.

Root Cause Analysis

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

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

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

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

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

8. Information and Evidence Gathered (Documents)

During the course of this Investigation clinical records have been read and other documentary evidence was gathered and considered. The following documents were used actively by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. Y's Pennine Care NHS Foundation Trust records.
2. Mr. Y's Ashworth Forensic records.
3. Mr. Y's GP records.
4. The transcription of the Crown Court proceedings.
5. The Pennine Care NHS Foundation Trust internal investigation report and action plan.
6. Secondary literature review of the media reporting the death of Mr. A.
7. Independent Investigation witness transcriptions.
8. Pennine Care NHS Foundation Trust CMHT- trust wide service model and operational policy-version 0.4 draft (March 2009).
9. Pennine Care NHS Foundation Trust clinical risk assessment and management policy- version 2 (CL19) issued August 2007 reviewed August 2009.
10. Pennine Care NHS Foundation Trust Incident reporting and investigation policy- version 4 (CO10)-issued June 2007 and reviewed June 2009.
11. Pennine Care NHS Foundation Trust Crisis Resolution and Home Treatment Team policy- version 2 (draft).
12. Pennine Care NHS Foundation Trust CRHTT operational policy- revised version June 2009.
13. Pennine Care NHS Foundation Trust supervision policy-version 2 (HR23) issued October 2007.
14. Pennine Care NHS Foundation Trust integrated care pathway.
15. Pennine Care NHS Foundation Trust CPA policy- version 5 (CL3) - issued August 2008 and reviewed June 2010.
16. Pennine Care NHS Foundation Trust safer practice notice 10- Being Open.
17. Pennine Care NHS Foundation Trust records management policy- version 3(CO20) issued February 2009.

- 18.** Healthcare Commission/Care Quality Commission Reports for Pennine Care Trust services.
- 19.** Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm*: a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006.
- 20.** Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005.

9. Profile of the Pennine Care NHS Trust Services (Past, Present and Transition)

Profile of Pennine Care NHS Foundation Trust

Pennine Care NHS Foundation Trust was established in July 2008 as the 100th NHS Foundation Trust. The Trust provides mental health and specialist drug and alcohol services to a population of almost 1.2 million people throughout the boroughs of Bury, Rochdale, Oldham, Stockport, and Tameside & Glossop. The Trust is also commissioned to provide mental health services to parts of the High Peak, East Lancashire and North Manchester areas. Prior to becoming a Foundation Trust the organisation was known as Pennine Care NHS Trust and was formed in April 2002.

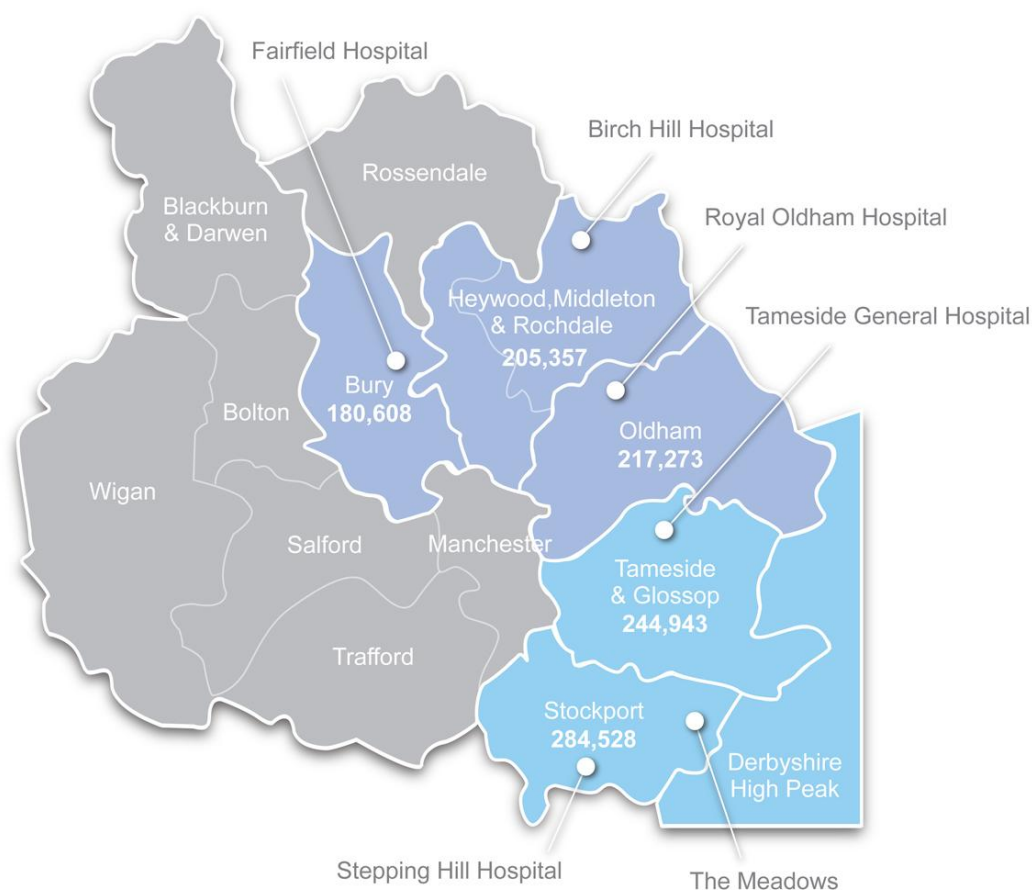
Table Two: Trust Services

Trust turnover:	Total £219m Bury community services £27m Oldham community services £30m Heywood, Middleton and Rochdale community services £34m Existing mental health £128m
Bed numbers	542 mental health beds 19 community beds
Boroughs	Bury, Oldham, Rochdale, Tameside & Glossop, Stockport
Chief Executive	John Archer
Chairman	John Schofield

In April 2010, in addition to the provision of mental health services, the Trust was selected as the preferred option for the provision of community services for Bury, Oldham and Heywood, Middleton and Rochdale (previously part of the respective Primary Care Trusts). The Trust commenced the management of these services from April 2011. These services consist of a wide range of health and allied healthcare professionals and disciplines who

support General Practitioners in the delivery of physical healthcare treatments and support, including Health Visitors, School Nurses, District Nurses, Dental services and Audiology.

Table Three: Trust Location



In the above map, the areas in darker blue represent those boroughs where Pennine Care NHS Foundation Trust provides both mental health and community services. The areas in light blue represent those boroughs where Pennine Care NHS Foundation NHS Trust provides mental health services. Grey areas show the boroughs next to the Trust's footprint.

As the map shows, acute mental health services are located on sites with three acute Trust providers, Pennine Acute NHS Trust (Bury, Rochdale and Oldham), Tameside Acute NHS Foundation Trust and Stockport Foundation Trust.

Community provider services are located in the geographical area covered by Pennine Acute NHS Trust, in the three boroughs in the north of the footprint.

The Trust also works in partnership with six local authorities in both community and mental health services. The Trust provides some joint mental health services with the local authorities.

Since 2002, the Trust has developed a range of ways to engage with service users and carers in mental health. It embarked on a significant expansion in community involvement when it became a Foundation Trust, recruiting over 11,000 members and electing a “Council of Members” from the wider membership. All three community service providers bring a culture of user and carer engagement which provide firm foundations on which to build on this work and increase Foundation Trust membership.

The Trust values the support it has from users and carers and looks forward to building on this through development of its membership and Council of Members in the new, expanded organisation.

In 2009, Pennine Care was rated “Excellent” in its Annual Health check by the Care Quality Commission – the health watchdog for England - for both its Quality of Services and its Use of Resources. This rating places the Trust amongst the highest performers in the country. The Annual Health Check assesses NHS Trusts on all aspects of the care that they deliver, including the quality of the services they provide to patients and the public, and how well they manage their finances and other resources such as their property and staff.

The Trust works in partnership with Local Authorities, Primary Care Trusts, Health Authorities and the independent sector. The Trust is committed to providing fully integrated, continually improving and locally accessible mental health services in a range of hospital and community settings. Users and carer involvement is a priority for the Trust, to facilitate the development of services that are appropriate, accessible and responsive.

The Trust vision is to “*‘improve the patient experience’ when patients come into contact with our services. Everyone working for the Trust, no matter what their role, has a part to play in improving the patient experience.*”

The Trust strategy is to *“provide high quality health and social care that improves an individual's opportunity for social inclusion and recovery. In partnership with the wider community, our care will improve mental wellbeing and drive out health inequalities.”*

The Trust Mission statement states the following:

“Our Trust, working in partnership with Local Authorities, Primary Care Trusts, Health Authorities and the independent sector, is committed to providing a fully integrated, continually improving and locally accessible specialist mental health service, in a range of hospital and community settings. We aim to involve users and carers, support staff and to maintain a high quality environment.”

Mental Health Service Provision

Mental health services are provided by staff from a range of clinical and non-clinical backgrounds (medical, nursing, technical, administration and management and social work).

The Trust provides a range of core services for people who have a serious mental illness (e.g. schizophrenia, bipolar disorder) and common mental health problems (e.g. depression, anxiety) and dementia. These services are covered by a block contract. The services provided are:

- primary care mental health services including Increasing Access to Psychological Therapies (IAPT);
- working age adult inpatient and community services, including Crisis Resolution and Home Treatment, Assertive Outreach and Early Intervention;
- older people's inpatient and community services;
- community- based Drug and Alcohol services;
- Child and Adolescent Mental Health Services (CAMHS);
- Psychiatric Intensive Care (PICU);
- Low Secure Rehabilitation and Step Down Rehabilitation services which are gender and age specific, designed to safely integrate individuals back into their local communities.

The Trust also works with specialist commissioners to develop new services to aid recovery and present a broader range of options for local people in need of mental health services within the NHS.

The Trust provides mental health services as follows:

Table Four: Detailed Breakdown of Trust Services

Borough	Site	Adult beds	Older people's beds	Rehab beds	CAMHS Beds	Total
Bury	Fairfield General Hospital (DGH)	44	16	0	22	82
Oldham	Royal Oldham Hospital (DGH)	44	22	0	0	66
Oldham	Rhodes Place	0	0	8	0	8
Rochdale	Birch Hill Hospital	40	25	0	0	65
Rochdale	Stansfield Place	0	0	12	0	12
Stockport	Stepping Hill Hospital (DGH)	46	22	25	0	93
Stockport	The Meadows	0	45	0	0	45
Stockport	Heathfield House	0	0	19	0	19
Tameside and Glossop	Tameside General Hospital (DGH)	45	38	69		152
Total		219	168	133	22	542

10. Chronology of Events

This Forms Part of the RCA First Stage

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

Background Information

Mr. Y was born in Oldham on 9 June 1976 and for most of his life lived at home with his parents. Following leaving school Mr. Y had a number of labouring jobs. He had a number of convictions for drink driving, street robbery and selling cannabis. When he was 21 he received a custodial sentence for driving whilst disqualified.

Clinical History with Pennine Care NHS Foundation Trust

9 December 2001. Mr. Y was brought to the Accident & Emergency Department of a local hospital by his sister because he had assaulted his father by punching him in the face. He was assessed and admitted to a psychiatric unit. He had been released from prison six months previously after a three-month sentence for driving whilst disqualified. His presentation included paranoid ideas and sexual delusions about interference from his family. He had a number of offences recorded including drink driving (2001), street robbery (1995) and selling cannabis (1994). He was known to the Probation Service as a result of sentences comprising a Probation Order and a Community Service Order. He was placed on 1:1 observation because of the potential risk of absconding.²

20 December 2001. Mr. Y was detained under Section 2 Mental Health Act (1983) after he had absconded from the ward.³

2 CCCN Vol.1 pp19-28

3 CCCN Vol 1 p35

11 January 2002. Mr. Y was assessed under Section 3 Mental Health Act (1983). He had delusions about his parents being responsible for Police harassment and there was an identified risk of harm to others. He had threatened his father the previous day. He was recorded as being guarded and unpredictable, he was also classified as homeless.⁴

1 February 2002. Mr. Y's sister contacted ward staff to say that Mr. Y had visited her with a replica gun. Ward staff confiscated a gun from him and he was later seen by a Police Officer and advised that he was putting himself at risk.⁵

20 February 2002. Records from the ward round noted that Mr. Y had disclosed to other patients that when he was discharged he intended to rape an Asian or black female. Mr. Y denied these allegations and said he would let his solicitor "*know about them*" (the ward staff). There was a plan to refer him to forensic services and to only allow him escorted leave with staff.⁶ At this point he was being seen by both Senior Registrar 1 (the Responsible Medical Officer) and Senior House Officer 1 (who was later to become Consultant Psychiatrist 6 in 2008).

5 April 2002. Mr. Y was assessed on the ward by Specialist Registrar 1 based with the Adult Forensic Services, Edenfield Centre, Prestwich Hospital. In his letter of 29 April 2002 to Mr. Y's Responsible Medical Officer (Consultant Psychiatrist 3) he noted that Mr. Y was reporting a number of symptoms that indicated ongoing mental illness. These included sexual ideas about having intercourse with schoolgirls. Specialist Registrar 1 recommended that "*any contact with his family must be very carefully supervised as he has had very concerning ideas about both assaulting and killing them. He clearly has a number of ongoing ideas about being sexually interfered with by his family...the ideas concerning sexual intercourse with schoolgirls are also of concern.*" Specialist Registrar 1 recommended that Mr. Y should be managed on the ward but that the Police should be involved if he absconded. It was decided that if Mr. Y's behaviour became difficult he should be referred to a Psychiatric Intensive Care Unit⁷.

4 CCCN Vol.1 p 41

5 CCCN Vol.1 p 44

6 CCCN Vol. 1 pp 46-47

7 CCCN Vol 1 p 493

Mr. Y was reviewed on 5 July 2002 by Senior Registrar 1 who noted some improvement in his mental state associated with a change of medication from Depixol (a depot injection) to Olanzapine. A trial of Clozapine had been discussed with Mr. Y but he was reluctant to accept the regular blood testing that would be required. He reported feeling better on Olanzapine. Senior Registrar 1 recommended that in relation to discharge a Care Programme Approach (CPA) package would be required and that any deterioration in mental state might be associated with sexual psychopathology and should be monitored carefully.⁸

Between February and August 2002. Mr. Y was regularly reviewed as an inpatient. He appealed against his detention under Section 3 of the Mental Health Act (1983) but the Tribunal on 10 July 2002 refused his appeal. His medication was changed to Clozaril and by August there was some improvement in his mental state. At a ward round on 8 August 2002 Consultant Psychiatrist 3 (Mr. Y's Consultant had changed) increased his dosage of Clozaril and noted that the long-term plan was for him to live with his parents. Detention under Section 3 was extended following the end of the six-month order but it was pointed out to Mr. Y that this did not imply that he would need to stay in hospital for the whole of the period. He was able to leave the ward and by 22 August Mr. Y's father requested that he could accompany the family on a holiday abroad.⁹ During this period medical responsibility transferred from Senior Registrar 1 to Consultant Psychiatrist 3 but it is not clear from the clinical notes why this occurred.

10 October 2002. It was recorded at Consultant Psychiatrist 3's ward round that Mr. Y was much better and that his father confirmed this. A plan for discharge was developed. Mr. Y's medication at this stage was Clozapine 150 mg twice daily and Hyoscine 300 micrograms at night. He was discharged from the psychiatric ward to a local rehabilitation unit.¹⁰ The case notes recorded that Mr. Y settled at the unit, he was allocated to a Care Coordinator who was a Community Psychiatric Nurse (Care Coordinator 1) and was also given an appointment for outpatient follow up.

18 October 2002. Mr. Y was discharged from the rehabilitation unit to his parents' home and followed up through visits from Care Coordinator 1.

8 CCCN Vol 1 p 490

9 CCCN Vol 1 pp 45-71

10 CCCN Vol 1 pp 76-78

29 April 2003. Mr. Y was reviewed at Cannon Street Clinic by Care Coordinator 1. He was living with his parents and receiving regular depot medication. His mental state was stable. There was a plan to introduce Mr. Y to a Community Support Worker to help with practical tasks and to increase social activity.¹¹

28 May 2003 to 18 August 2005. Community Support Worker 1 maintained regular contact with Mr. Y including visits at least once a week and accompanying him on community activities, particularly attendance at a local gym. The notes record 122 contacts during this period. In parallel there were regular reviews at the outpatient clinic at Cannon Street. The notes indicate this was a period of good progress when his mental state improved, his physical health and functioning improved and he was able to get his driving licence back (May 2005). He was taking Clozapine.¹²

5 August 2003. Mr. Y was reviewed at Cannon Street by Care Coordinator 1 who noted that Mr. Y's negative symptoms were lessening, that he had increased his social activity and was getting on better with his parents. At this stage Mr. Y was seeing Community Support Worker 1 regularly.¹³

9 December 2003. Mr. Y was reviewed at Cannon Street and it was noted that he was going out twice a week with Community Support Worker 1. He had also been on holiday in Greece with his family and there had been no reported problems with his medication.¹⁴

4 May 2004. Mr. Y was reviewed by Care Coordinator 1 at Cannon Street Clinic. He was described as "*warm and sociable*". He attended the clinic regularly and received Clozapine 250 mg daily. Work options were discussed and Mr. Y agreed that he would like to find employment as a driver.¹⁵

21 September 2004. Mr. Y was reviewed at Cannon Street Clinic and was recorded by Consultant Psychiatrist 3 as being very well. He had been to Cyprus with his parents, sister and her boyfriend.¹⁶

11 CCCN Vol.1 p78
12 PR Vol 1 pp 256-284
13 CCCN Vol 1 p79
14 CCCN Vol 1 p 80
15 CCCN Vol 1 p 80
16 CCCN Vol 1 p 81

1 February 2005. Mr. Y was reviewed by Care Coordinator 1 and was assessed as maintaining his progress. Mr. Y was still attending a local gym and trying to loose weight. The dosage of Clozapine was reduced to 200 mg daily by Consultant Psychiatrist 3.¹⁷

10 May 2005. Mr. Y was reviewed by Consultant Psychiatrist 3 who noted that he (Mr. Y) had been to see a doctor representing the Driver and Vehicle Licensing Agency (DVLA) who had recommended that he could get his driving licence back. He was maintaining exercise, enjoying swimming and going to the pub with his father.¹⁸

6 September 2005. Mr. Y had a clinic appointment but did not attend clinic due to a family holiday.¹⁹

11 October 2005. Mr. Y was reviewed at Glodwick Health Centre by Consultant Psychiatrist 3 and Care Coordinator 1. The case notes recorded that Mr. Y was “*doing very well*”. He had lost two stones in weight, enjoyed a family holiday and had his own car. He was maintaining social contacts and thinking about doing a college course.²⁰

25 October 2007 A letter was written to Mr. Y from Care Coordinator 2 to say that she had taken over the role. However Mr.Y continued to have contact with a number of community psychiatric nurses until the care coordination role transferred to Care Coordinator 2 in November 2007.

2 November 2005. Care Coordinator 1 made a home visit to complete the Care Programme Approach assessment.²¹ A home visit on **8 November 2005** recorded that Mr. Y’s mother said that he was making good progress and had no psychotic symptoms.²²

31 January 2006. Mr. Y was reviewed at Glodwick Health Centre by Consultant Psychiatrist 3 and Care Coordinator 1.²³

17 CCCN Vol 1 p 82

18 CCCN Vol 1 p 82

19 CCCN Vol 1 p 83/ PR Vol 1 p256

20 CCCN Vol 1 p 83/PR Vol 1 p 255

21 PR Vol 1 p 255

22 PR Vol 1 p 255

23 CCCN Vol 1 p 84/PR Vol 1 p 254

6 June 2006. Mr. Y was reviewed at Glodwick Health Centre by Consultant Psychiatrist 3. He noted that Mr. Y was going on holiday to Portugal shortly and that he was maintaining his gym attendance and social contacts.²⁴

1 June 2007 Care Coordinator 2 wrote to Mr. Y to say that she was leaving the service. Contact was largely maintained at this point through out-patient appointments with Consultant Psychiatrist 3 who knew Mr. Y well.

10 January 2007. Mr. Y was reviewed at Glodwick Health Centre by Consultant Psychiatrist 3.²⁵

From October 2002 to July 2007 (a five-year period). Mr. Y was maintained in the community and seen regularly by the clinical team. He had the same Consultant Psychiatrist (Consultant Psychiatrist 3) during this period. On 10 July 2007 Mr. Y was reviewed at Glodwick Health Centre by Consultant Psychiatrist 3's Senior House Officer (Senior House Officer 2). The notes recorded some concern from Mr. Y's father stating that he was drinking too much alcohol and was not taking his medication (Clozaril 150 mg). Mr. Y was advised about his alcohol intake and the next review was planned for two-month's time.²⁶

15 August 2007. A telephone call was received by Community Psychiatric Nurse 3 to say that Mr. Y was *"showing signs of relapse irritable and verbally aggressive towards his mum, not eating meals, not fully compliant with medication and increased alcohol use..."*.²⁷

16 August 2007. Community Psychiatric Nurse 3 met Mr. Y at the Phoenix Centre. There was a discussion about medication and Mr. Y complained about feeling drowsy. The Community Psychiatric Nurse suggested he took his medication at night to alleviate this side effect.²⁸

29 August 2007. A Community Psychiatric Nurse received a recorded a message from the Project Leader at an employment project (OPUS) attended by Mr. Y (PR1) concerning some difficulties in Mr. Y having his blood sample taken to monitor serum levels. The Community

24 CCCN Vol 1 p 84/PR Vol 1 p 254

25 CCCN Vol 1 p 84

26 CCCN Vol 1 p 85/PR Vol 1 p 249

27 PR Vol 1 p 248

28 PR Vol 1 p 248

Psychiatric Nurse spoke to Mr. Y's mother about the problem and arranged for blood to be taken at the walk-in centre.²⁹

10 September 2007. Following concern at the employment project attended by Mr. Y a Community Psychiatric Nurse recorded that his parents who were going on holiday the following week were concerned that he was not taking medication and that his mental state had deteriorated despite having a full time job as a car valet. The Community Psychiatric Nurse agreed to arrange a home visit.³⁰

11 September 2007. Community Psychiatric Nurse 4 liaised with Crisis and Home Resolution Treatment Team regarding the concerns raised by the family. The Community Psychiatric Nurse advised a home visit to investigate the concerns.³¹

12 September 2007. The Crisis Resolution Team visited Mr. Y at his home to discuss the concerns raised by his mother that he was not taking his medication. The outcome was that Consultant Psychiatrist 5 agreed that a Mental Health Act assessment was appropriate. A request was made to the Emergency Duty Team at Oldham Adult and Community Services for an assessment. There was also some concern that Mr. Y had an "*air rifle gun case*" in the back of his car. The Community Psychiatric Nurse rang the local Police to inform them of her concerns.

14 September 2007. Mr. Y was admitted to hospital following his arrest by the Police for pulling a telephone off a wall in a local massage parlour. It was noted that he was sexually disinhibited and believed that people had been talking about him. He had been non compliant with medication and was said to have had bizarre ideas about using a firearm on an animal.³² Mr. Y was assessed and following completion of a Mental Health Act Section 2 application he was taken to the psychiatric unit at the local hospital where he had previously been an in-patient.³³ It was recorded in the clinical records that Mr. Y's parents had been concerned about his deteriorating mental state throughout the previous three months. Prior to his admission he had assaulted his mother and had tried to force her to eat his prescribed

29 PR Vol 1 p 247
30 PR Vol 1 p 246
31 PR Vol 1 p 245
32 CCCN Vol 1 p 87
33 PR Vol 1 p 228

medication, and had also assaulted her with a knife.³⁴³⁵ It was noted that Mr. Y had a history of taking cannabis, crack cocaine, LSD and anabolic steroids. At this stage Consultant Psychiatrist 3 remained Mr. Y's Responsible Medical Officer.

11 October 2007. The notes written in the ward round at which Mr. Y's father was present recorded improvements in his mental state and a limited unescorted period of leave was agreed.³⁶

25 October 2007. Consultant Psychiatrist 3's Specialist Registrar (Specialist Registrar 2) reviewed Mr. Y and agreed to take him off his Clozapine which he disliked strongly. It was decided to try Mr. Y on Risperidone 2 mg at night and to reduce the Olanzapine 15 mg, that he had been commenced on shortly after his admission, to 10 mg.

19 November 2007. Specialist Registrar 2 agreed that Mr. Y could plan two overnight periods of leave at home the following week and it was recorded that Mr. Y's father was in agreement with this plan.³⁷

22 November 2007. It was agreed that Mr. Y could be discharged with follow up by Care Coordinator 2 (who was a social worker) and the Crisis Resolution Team, who would monitor his mental state and medication. Members of the Crisis Resolution Team initially maintained daily contact through home visits, then reduced visits down to alternate days. Mr. Y was making good progress but continued to go out drinking with friends and there were some concerns about his level of alcohol intake.³⁸

10 December 2007. Mr. Y was reviewed at the outpatient clinic with a Community Psychiatric Nurse and Care Coordinator 2. Good progress was noted but Mr. Y raised the issue of trying to get his gun back from the Police and was advised against this.³⁹

12 December 2007. Consultant Psychiatrist 2 wrote to the GP to say that Mr. Y had been formally discharged from the care of the Crisis Resolution and Home Treatment service and

34 CCCN Vol 1, p 241

35 CCCN Vol 1 p 95

36 CCCN Vol 1 p 95

37 CCCN Vol 1 p 105

38 CCCN Vol 1 p 107/PR Vol 1 p236

39 CCCN Vol 1 p 107/PR Vol 1 p 242

would be followed up by Care Coordinator 2 and Consultant Psychiatrist 3 who knew him well. Mr. Y had been supported by the service since 16 November 2007 to support leave and early discharge from the ward.⁴⁰

23 January 2008. Care Coordinator 2 had maintained close contact with Mr. Y and visited him several times a week. On this date she recorded some concerns about his alcohol and cannabis use. Mr. Y's parents were concerned because he was spending a lot of time away from home. Care Coordinator 2 discussed Mr. Y's management with Specialist Registrar 2, but it was decided not to refer him back to the Crisis Resolution and Home Treatment Team because it was thought that Mr. Y would not comply with this arrangement. It was agreed that Care Coordinator 2 would discuss hospital admission with Mr. Y.⁴¹

31 January 2008. Following a Mental Health Act assessment involving the GP, Specialist Registrar 2 and an Approved Social Worker, Mr. Y was admitted to the local psychiatric unit as a voluntary patient. It was noted that his relapse was due to non compliance with his prescribed Risperidone exacerbated by alcohol and street-drug misuse. It was decided that Mr. Y needed to be stabilised back onto a Clozapine regimen. In regular reviews at the ward rounds that followed the main issue was that Mr. Y did not wish to comply with the clinical view that he should take Clozapine. He said that there were unpleasant side effects.⁴²

12 February 2008. Mr. Y was placed on Section 3 of the Mental Health Act (2007).⁴³

27 February 2008. At a ward round with Consultant Psychiatrist 3, Specialist Registrar 2 and Care Coordinator 2 it was recorded that Mr. Y had assaulted (punched in the face) a member of staff "*over the weekend*". The Police had been informed but the staff member concerned had not wished to press charges. It was recorded that Mr. Y was impulsive, guarded and denying of symptoms. He had also been talking to other patients about being able to access guns. The care plan included discussion with the Psychiatric Intensive Care Unit about him.⁴⁴

40 PR Vol 1 p 631

41 PR Vol 1 pp 210-226

42 CCCN Vol 1 p 108

43 SP p11/CCCN Vol 2 p 109

44 CCCN Vol 1 p 128

2 March 2008. Mr. Y went absent without leave during an escorted visit to the shops to buy cigarettes. The Police and his parents were informed.⁴⁵

4 March 2008. Mr. Y was returned to the hospital by the Police and was taken to the suite used to detain people under Section 136 of the Mental Health Act (2007) after being found at a friend's address in Oldham.⁴⁶

5 March 2008. Following the agreed care plan, Mr. Y was assessed by staff from the Psychiatric Intensive Care Unit (PICU) and he was admitted to the unit. The PICU was located in another hospital, but was still part of the Pennine Care NHS Foundation Trust service.⁴⁷

Between 5-19 March 2008. Mr. Y was treated at the Cobden Unit (PICU) under the care of Consultant Psychiatrist 4.⁴⁸

19 March 2008. The final entry in the clinical notes from the PICU stated that Mr. Y had been settled, though guarded, on the ward and presented no problems in relation to violence or aggression. During his stay he was the victim of an attack by a fellow patient and did not retaliate. Mr. Y was considered suitable to be transferred back to the psychiatric unit at his local district general hospital.⁴⁹

27 March 2008. Specialist Registrar 2 noted in the ward round that Mr. Y was guarded with staff and denied psychotic symptoms. The care plan was to start Clozapine and that he was not to have Section 17 leave from the ward (Section 17 provides for leave under the Mental Health Act for detained patients).⁵⁰

2 April 2008. At a ward round that included Consultant Psychiatrist 3, Senior House Officer 2, Care Coordinator 2 and members of the Crisis Resolution Team, there was a decision that Mr. Y would be started on Clozapine "*from today*". It was also explained to Mr. Y that he would be moving to another ward in the same unit, remaining the clinical responsibility of

45 CCCN Vol 2 p134

46 CCCN Vol 2 p 136

47 CCCN Vol 2 p139/ SP p9

48 CCCN Vol 1 pp 131-145

49 CCCN Vol 1 p 145

50 CCCN Vol 1 p 147

Consultant Psychiatrist 3. However, Mr. Y objected to the move on the grounds that there was a patient on the new ward who he did not get on with. Consequently, Mr. Y remained on the present ward and consultant responsibility was transferred to Consultant Psychiatrist 6 who took over clinical responsibility for all patients on that ward.⁵¹

11 April 2008. There was a ward round during which Consultant Psychiatrist 6, Mr. Y's new Responsible Clinician, recorded that Mr. Y appeared to be better and had been taking Clozaril for ten days. Mr. Y's father was present and agreed that he could visit home for a few hours and that "*Clozaril suits him*".⁵²

16 April 2008. There was a ward round that included Consultant Psychiatrist 6 and a member of the Crisis Resolution and Home Treatment Team. The case notes recorded that Mr. Y had been re-started on Clozapine but staff were concerned that he would become non-compliant with oral medication. Mr. Y had spoken about his gun use on several occasions. He was very guarded and reluctant to discuss his symptoms. The role of the Crisis Resolution and Home Treatment Team (CRHTT) was explained to him and that he would receive support from them after discharge to his parents' home. There was also a reference made in the clinical record to a worker from housing support who had been asked to help Mr. Y find independent accommodation.⁵³

21 April 2008. At a review held by Consultant Psychiatrist 6 it was reported that home leave had been going well. However it was also noted that although Mr. Y's mother had reported that home leave went well, his father was concerned about medication compliance. Mr. Y said he was planning to go to the gym again and denied any paranoid thoughts. It was agreed that there would be a discharge meeting the following week (when Section 117 after-care would be discussed) and that leave would continue for the next week under the care of the Crisis Resolution and Home Treatment Team.⁵⁴

2 May 2008. There was a ward round to review treatment. This was attended by Consultant Psychiatrist 6, Care Coordinator 3 and Care Coordinator 4 (who were jointly taking over the Care Coordination role), Mr. Y's father and a worker from the Crisis Resolution and Home

51 CCCN Vol 1 pp 148,149

52 CCCN Vol 1 p 150

53 CCCN Vol 1 p151/CCCN Vol 2 p177

54 CCCN Vol 1 p153/CCCN Vol 2 p182

Treatment Team, (CRT Worker 1). It was agreed that Mr. Y would have a further two-week period of leave from the ward. Mr. Y said that he was capable of living independently and the view was that Mayall Street or Millview would be an appropriate “*step-down*” accommodation from the ward.⁵⁵

3 May 2008. Mr. Y was visited at home by a member of the Crisis Resolution and Home Treatment Team (CRT Worker 2). Mr. Y was said to be pleasant and welcoming and happy to view a supported housing project, although he was no longer in a rush to move from his parents’ at that time.⁵⁶

5 May 2008. There was a home visit by members of the Crisis Resolution and Home Treatment Team (Workers CRT3 and CRT4). Mr. Y had been on a shopping trip to Manchester. It was agreed that Mr. Y would pick up a ‘blood card’ for Clozaril the following day and go for a blood test. He was due to collect medication from the pharmacy on 9 May 2008.⁵⁷

7 May 2008. There was a home visit by the Crisis Resolution and Home Treatment Team (CRT Worker 5). No concerns were recorded.⁵⁸

10 May 2008. A home visit by the Crisis Resolution and Home Treatment Team (CRT Worker 5) reported a positive visit by Mr. Y to “*two new residences that Mr. Y and parents went to see*”.⁵⁹

12 May 2008. There was a further home visit by the Crisis Resolution and Home Treatment Team (CRT Worker 6). Mr. Y presented as “*warm and pleasant*”. There were no concerns recorded but Mr. Y said he would like to discuss his medication with Consultant Psychiatrist 6 at the ward round on 15 May.⁶⁰

15 May 2008. There was a ward round attended by Consultant Psychiatrist 6, Senior House Officer 3, Care Coordinator 3, Care Coordinator 4, three members of the Crisis Resolution

⁵⁵ CCCN Vol 1 p 153/CCCN Vol 2 p185

⁵⁶ CCCN Vol 2 p 186

⁵⁷ CCCN Vol 2 p187

⁵⁸ CCCN Vol 2 p 187

⁵⁹ CCCN Vol 2 p189

⁶⁰ CCCN Vol 2 p 190

and Home Treatment Team and a representative from the housing department (H1). During the ward round Mr. Y presented as slightly anxious and agitated but denied any paranoid ideas. He asked for procyclidine to help with his anxiety. Care Coordinator 3 reported that he had visited two supported housing facilities with Mr. Y. Mr. Y had not liked Mayall Street but had liked Millview and said he would be happy to move in. It was decided to “*take it to Panel on Monday*” (see directly below). The Crisis Resolution and Home Treatment Team reported no problems with Mr. Y. It was agreed that Mr. Y could have a further one-week period of leave and that his Clozapine dosage would be increased. It was agreed to review him again on 22 May.

19 May 2008. Care Coordinator 3 attended the VARSS Panel meeting. VARSS refers to ‘Vulnerable Adults Rehabilitation Support Services’. The VARSS Panel allocated supported housing resources to vulnerable people requiring a supported setting.⁶¹ The outcome was that Mr. Y could not be offered a place at Millview without being assessed at Mayall Street first. The reasons were that:

- he was unknown to the resettlement services and due to the low staffing levels at Millview it would not be possible to assess his capacity to live independently;
- he had a history of non-compliance with medication and assaultative behaviour when unwell and it was felt that this risk needed to be assessed.

It was agreed to offer Mr. Y one or two nights at Mayall Street to enable him to learn more about the service. It was possible he could be fast-tracked to Millview if all went well.⁶²

22 May 2008. There was a ward round where Mr. Y’s progress was discussed attended by Consultant Psychiatrist 6, Senior House Officer 3, Care Coordinator 3, Care Coordinator 4, and H1. Mr. Y reported feeling fine. Care Coordinator 3 reported back from the VARSS meeting but Mr. Y was not happy to spend time at Mayall Street and refused to consider this. A care plan was agreed:

- Mr. Y to be taken off his Section;
- support was to be provided by Care Coordinator 3 and Care Coordinator 4;
- bloods would be checked weekly in the community;
- medication to be supplied from the hospital pharmacy.

61 CCCN Vol 1 p 155/CCCN Vol 2 p153

62 CCCN Vol 2 p 236

No input from the Crisis Resolution and Home Treatment Team was identified as being required.⁶³

29 May 2008. Care Coordinator 3 (accompanied by Care Coordinator 4) recorded a home visit to Mr. Y after being contacted by Mr. Y's father. His father was concerned that Mr. Y was not taking Clozaril as prescribed, appeared agitated, pacing the house and was "off" with his parents. Mr. Y said that his "*brain was agitated*". Care Coordinator 3 advised that he had spoken to Consultant Psychiatrist 6 and that Mr. Y could take all his medication (325 mg Clozapine) at night if he felt that drowsiness was a problem. Mr. Y's parents thought that he had not been taking medication because of his behaviour but he denied this. There was discussion of the housing situation and Mr. Y said that he intended to present himself as homeless in order to be admitted to a hostel. He was advised against this course of action and advised to see a housing support worker. It was noted by Care Coordinator 3 that Mr. Y had attended Glodwick Health Centre on 28 May to give a blood sample for Clozaril monitoring and that his blood test had come back "*green*".⁶⁴

29 May 2008. There was a note on file recording a telephone call from Care Coordinator 3 to Consultant Psychiatrist 7's Secretary (PS) asking for an urgent clinic appointment, following their visit to Mr. Y. Mr. Y was booked into the Glodwick Clinic for 3 June 2008.⁶⁵ Following a discussion between the two Care Coordinators, the Community Mental Health Team Leader and the Consultant Psychiatrist 6 this was felt to be a sensible course of action to manage Mr. Y's medication issues. (Consultant Psychiatrist 7 was to take over as the responsible clinician from Consultant Psychiatrist 6 because Mr. Y had moved from in-patient to out-patient status).

30 May 2008. Care Coordinator 3 recorded that Mr. Y's mother had telephoned to say that she believed he was on his way to First Choice Homes to declare himself homeless. Care Coordinator 3 told Mr. Y's mother that he would contact the housing agency to let them know the background. Care Coordinator 3 also informed Mr. Y's mother that he had made an outpatient appointment for Mr. Y with Consultant Psychiatrist 7 for 3 June 2008.⁶⁶

63 CCCN Vol 1 p 155/CCCN Vol 2 p 237

64 CCCN Vol 2 p 237

65 PR Vol 2 p 5

66 CCCN Vol 2 p 239

Also on 30 May 2008. Care Coordinator 3, after discussion with Care Coordinator 4 and their Team Manager (TM1), telephoned First Choice Homes and spoke to a member of the housing support team (HS1) to express the view that Mr. Y should not be offered a hostel place. Mr. Y was with the housing officer but would not be offered hostel accommodation if his parents were willing to have him living with them. Care Coordinator 3 contacted Consultant Psychiatrist 6 at Cherrywood Clinic to tell them about recent developments.⁶⁷

30 May 2008. The Senior House Officer 3 wrote a discharge letter to GP1, Mr. Y's general practitioner.⁶⁸

2 June. Mr. Y was arrested on suspicion of murder.

3 June 2008. Mr. Y was interviewed at Ashton-under-Lyne police station and charged with the murder on 1 June 2008 of Mr. A.⁶⁹

⁶⁷ CCCN Vol 2 p 240

⁶⁸ PR Vol 2 pp 3,4

⁶⁹ CCCN Vol 2 p 251

11. Timeline and Identification of the Thematic Issues

Root Cause Analysis (RCA) Second Stage

11.1. Timeline

The Independent Investigation Team formulated a timeline and a chronology in a narrative format in order to plot significant data and identify the critical issues and their relationships with each other. Please see Appendix Material. This process represents the second stage of the RCA process and maps out all of the emerging issues and concerns held by the Independent Investigation Team.

11.2. Issues Arising from the Timeline

On examining the timeline, care pathway and chronology the Independent Investigation Team identified critical thematic issues that rose directly from analysing the care and treatment that Mr. Y received from Pennine Care NHS Foundation Trust. These critical thematic issues are set out below:

- carer assessment and involvement;
- care planning based on comprehensive risk assessment.

11.3. Issues Arising from the Review of other Data

The Independent Investigation Team found other critical issues that were not immediately apparent from analysing the timeline and the chronology. These issues are set out below under the Key headings of the Independent Investigation Terms of Reference.

1. Diagnosis

After Mr. Y's first contact with mental health services in 2001 there was consistency in the diagnosis of his mental illness. He was diagnosed as suffering from Paranoid Schizophrenia. When he was unwell he had delusional beliefs, many of which centred upon his family. He experienced auditory hallucinations. Sometimes Mr. Y was guarded about his symptoms and would deny his experiences. He was also impulsive and could be violent towards family members or others outside the family. He also used and abused a number of substances including alcohol. Some assessments of his mental state revealed that he had thoughts about

harming others. Assessments after the incident showed that he had delusional beliefs about people interfering with his medication.

2. Medication and Treatment

Mr. Y was treated with anti-psychotic drugs during his first admission to hospital and these were helpful in controlling the symptoms of his illness. When he took the medication prescribed for him, his thought disorder diminished and he was able to live with his family. He was also helped, by a Social Support Worker, to engage in activities in the community. He voluntarily maintained contact with mental health services for a number of years when he remained well, and would see his Consultant Psychiatrist regularly as an out-patient. This combination of anti-psychotic medication and social support worked well. In 2007 Mr. Y had his medication reduced to below a therapeutic level and this contributed to a breakdown in his health and subsequently led to inpatient readmission. Between 2007 and the incident Mr. Y became less compliant and did not take his medication as prescribed. He also took other substances, such as alcohol and cannabis. His treatment compliance varied and there was evidence that at the time of the incident he was not taking an effective level of medication. The Trust did not provide a full set of evidence-based care and treatment options in line with the National Schizophrenia guidance from the National Institute of Health and Clinical Excellence.

3. Management of the Clinical Care and Treatment

Between 2001 and most of 2008 the management of Mr. Y's care and treatment was good. After his first admission in 2001 Mr. Y was supported in the community by a stable clinical team for a number of years. He also benefitted from social support and was able to improve his personal and social functioning. He was known well to the clinical team and there was a good level of input to his care from in-patient services and community resources which included the Community Mental Health Team (CMHT) and the Crisis Resolution and Home Treatment Team (CRHTT). In the months before the incident there were a number of changes in the management of Mr. Y's clinical care due to organisational changes in the Trust. He became the responsibility of a different Psychiatrist and different Care Coordinators. When he was discharged from in-patient services shortly before the incident his clinical care also transferred to yet another Consultant Psychiatrist who had not met him before. On leaving hospital on the 22 May 2008 information relating to Mr. Y's risk did not translate well into

the care plan. This was made more problematic due to continuity of care issues and the changes made to his clinical team.

4. Mental Health Act (1983 & 2007)

The Act was used appropriately by the Trust at different stages of Mr. Y's treatment. He was admitted for assessment under the provisions of Section 2 of the Act and also detained for treatment under Section 3. He was informed of his rights under the Act and was assisted to appeal (unsuccessfully) against detention. When he was transferred to a psychiatric intensive care unit in another part of the Trust, appropriate Mental Health Act documentation was completed and procedures followed. At the time of the incident he was not subject to restriction under the Act. There was some evidence that the clinical team considered the value of using the supervised discharge provisions of the Act and decided that this would not be appropriate. There was no evidence of explicit consideration of the provisions of Section 117 of the Act when Mr. Y was discharged from hospital in May 2008.

5. Care Programme Approach (CPA)

Between 2001 and 2008 Mr. Y was allocated to the enhanced level of CPA and there was documentation to support the view that assessment and care planning took place, however on occasions this was found to be incomplete. This lack of thoroughness ensured that risk assessments were not always inclusive and that care plans did not always reflect the level of interventions required to maintain Mr. Y's safety and wellbeing and to mitigate against risk. On leaving hospital on the 22 May 2008 information relating to Mr. Y's risk did not translate well into the care plan. This was made more problematic due to continuity of care issues and the changes that had been made to his clinical care team.

Mr. Y had Care Coordinators allocated to him in accordance with Trust policy but there was some evidence that insufficient attention was paid to the risk presented by Mr. Y when a female Care Coordinator was allocated to him in 2007. Following Mr. Y's discharge on 22 May 2008 he was allocated to two experienced Care Coordinators.

6. Risk Assessment

There were formal risk assessments completed during the years of Mr. Y's contact with services. Risk was identified during routine assessment processes. The Trust utilised the Salford Tool for Assessment of Risk (STAR) and this was utilised by a range of clinicians

including forensic services. A number of risks were identified including that of violence to others, misuse of drugs, impulsivity, lack of insight, and non-compliance with medication. Over time there was evidence to show that risk assessments were not always based on a full understanding of Mr. Y's history and that risk assessments did not always feed into the care planning process. There was also evidence that the risks identified were not considered fully in the discharge plan when Mr. Y left hospital in May 2008, in addition the discharge meeting on 22 May 2008 gave insufficient weight to contingency planning for a relapse in Mr. Y's health.

There was insufficient weight attributed to the family view in the overall assessment of Mr. Y's risk. It was known to the clinical teams providing care and treatment to Mr. Y that he had harboured significant delusional thinking about his parents. As far as the documented evidence shows, the safety of his parents was never taken into account. Whilst this has no bearing on the death of Mr. A, it does represent a significant point of learning for the Trust.

7. Referral, Discharge and Handover Processes

Communication between clinical team members was generally good and the regular ward round meetings were used to share information about Mr. Y. When Mr. Y was discharged from hospital his GP was informed and kept up to date with treatment plans. Prior to Mr. Y's discharge in May 2008 clinical meetings were well attended by the Care Coordinators, the medical staff, and support workers which comprised representatives from the housing department and the Crisis Resolution and Home Treatment Team. However there was some discontinuity in Mr. Y's care caused by structural reorganisation within the Trust, which responded to requirements from the Department of Health. This meant that in the weeks before his last discharge, Mr. Y was transferred to the care of a Consultant Psychiatrist who knew him less well than the previous Consultant who had known him for some years. Following discharge, the role of Responsible Clinician passed to yet another doctor who by the time of the incident had not met Mr. Y.

At the point of his discharge Mr. Y met the referral criteria for the Assertive Outreach Service. Whilst referral to this service would not necessarily have altered the outcome of the incident it would have been good practice to have ensured that Mr. Y received a service that could have provided structured follow up and support that would have addressed both his health and social care needs in a holistic manner.

8. Carer Assessment and Experience

Mr. Y lived with his parents and they were an important part of his support network. When Mr. Y was unwell they were subject to threats from him and on one occasion he assaulted his father. He had delusional beliefs about his family. They attended ward rounds and were included by the clinical team in discussions about his care and treatment. However, they did not receive a formal carers' assessment although eligible to do so, and their views were undervalued by the clinical team. The parents thought that some of the support visits to Mr. Y were cursory and did not test his mental state to any degree. They were not present at the discharge meeting in May 2008 when it was agreed that Mr. Y could go to live with them after leaving hospital. Their views were not given sufficient weight by the clinical team and after the incident they were not well supported by the Trust.

9. Service User Involvement in Care Planning and Treatment

Efforts were made to include Mr. Y in discussions about his treatment but he was not well equipped to contribute to these. He remained guarded with staff about his mental state and in the later stages of his treatment he did not take medication as prescribed. He also undermined the efforts of the team by using alcohol and cannabis and taking the view that he did not need medication to control his illness. The attempts to involve him in planning for discharge were commendable but his underlying illness and non-compliance meant that these were fruitless. His refusal to engage with the Care Coordinators in planned activity towards greater independence from his family was symptomatic of his illness.

10. Documentation and Professional Communication

Documentation was of varied quality. There were some good assessments on file, but overall there was a failure to build on previous knowledge, particularly in relation to Mr. Y's compliance with medication and to risk. Some documents were completed only partially and some, although held on file, held no useful information about Mr. Y, for example the carers' assessment documentation which was blank. There was a lack of connection between some assessments, for example the risk assessments, and the care plans which did not contain reference to the risks identified. Professional communication was generally good and there were no resource issues of significance throughout the history of Mr. Y's care. There would be value in the Trust looking at the system for transfer of patients between consultants where a risk has been identified. Communication between professionals and teams working with

Mr. Y was satisfactory. Effective communication between the Trust and the family of Mr. Y was not always achieved.

11. Clinical Supervision

Care Coordinators working with Mr. Y were suitably qualified and worked within operational policies and procedures agreed by the Trust. They worked within a well-established clinical team structure in the Community Mental Health Team. The two Care Coordinators allocated to Mr. Y after his last discharge from hospital were very experienced and were supervised by an experienced and committed team manager. They were able to discuss the case with the manager and identified risks inherent in Mr. Y's mental state. Clinical Supervision was not an issue with the clinical witnesses who were interviewed as part of this investigation.

12. Adherence to Local and National Policy and Procedure

The Pennine Care NHS Foundation Trust operational policies and procedures were consistent with national guidance and good practice. There were departures from good policy adherence regarding:

- CPA documentation;
- Section 117 after- care;
- carers' assessments;
- the Trust response after the incident when its guidance under the Trust "Incident Reporting and Investigation Policy" could have been used to provide better support to the families of the victim and perpetrator. Local policy guidance was not followed in relation to the internal investigation after the incident, in that contact with the families of the victim and perpetrator was not made.

13. Organisational Change and Professional Leadership

There were organisational changes in 2008 to the Trust services which meant that Mr. Y had three Responsible Clinicians within a short period of time. These changes were in response to guidance from the Department of Health in the document *New Ways of Working*⁷⁰. Whilst it was noted that organisational change may have had a negative influence on the care and treatment of Mr. Y, the Trust was found to have implemented an innovative and highly effective *New Ways of Working* initiative.

⁷⁰ New Ways of Working for Everyone: a best practice implementation guide: Department of Health October 2007

14. Clinical Governance and Performance

At the time of the incident Pennine Care NHS Foundation Trust was rated as excellent by the Care Quality Commission (CQC), the external regulator for the health services. The Independent Investigation Team reviewed the present arrangements for clinical governance in the Trust and concluded that the systems now in place were strong and that the performance management framework was well established. This has been identified as an area of notable practice.

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

RCA Third Stage

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

1. Areas of practice that fell short of both national and local policy expectation.
2. Key causal, contributory and service issue factors.

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

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the independent investigation team have concluded had a direct causal bearing upon the significant deterioration of Mr. Y’s mental health and how it impacted upon the death of Mr. A. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide perpetrated by them.

Contributory Factor. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the independent investigation team to conclude that it made a direct contribution to the breakdown in Mr. Y’s mental health and/or the failure to manage it effectively.

Service Issue. The term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the death of Mr. A need to be drawn to the attention of the provider and

commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

This Investigation found no direct causal links between any act or omission on the part of the Pennine Care NHS Foundation Trust and the death of Mr. A. Whilst it was evident that some of the decisions made by the Trust had a detrimental effect on the maintenance of Mr. Y's mental health, these on their own could not be seen as causal factors. When assessing causality an Investigation Team has to take into account what was both known, and what should have been known, about a patient during the time that care and treatment was being given. An Investigation Team then has to consider whether the care and treatment provided was in accordance with the patient's presentation and national best practice guidance.

The standard of care and treatment that Mr. Y received over a seven-year period was of a generally good standard. In the days prior to the incident Mr. Y was described as being agitated by his parents. However following a comprehensive assessment by his Care Coordinators no signs of psychosis or imminent breakdown in the mental health of Mr. Y could be detected. The fact that someone was later killed by Mr. Y could not have been predicted, and in this case, without the benefit of hindsight, could not have been prevented.

12.1. Pennine Care NHS Foundation Trust Findings

12.1.1. Diagnosis

12.1.1.1. Context

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

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

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework that can allow conceptualisation and understanding of their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis should never take away from the treatment and management of the service user as an individual, but can provide a platform on which to address some care, treatment and risk management issues.

Paranoid Schizophrenia

The diagnosis of Paranoid Schizophrenia was given to Mr. Y during his care and treatment with the Mental Health Trust. The ICD 10 classification for paranoid schizophrenia is set out *verbatim* below.

“This is the commonest type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of affect, volition, and speech, and catatonic symptoms, are not prominent.

Examples of the most common paranoid symptoms are:

- *delusions of persecution, reference, exalted birth, special mission, bodily change, or jealousy;*
- *hallucinatory voices that threaten the patient or give commands, or auditory hallucinations without verbal form, such as whistling, humming, or laughing;*

- *hallucinations of smell or taste, or of sexual or other bodily sensations; visual hallucinations may occur but are rarely predominant.*

Thought disorder may be obvious in acute states, but if so it does not prevent the typical delusions or hallucinations from being described clearly. Affect is usually less blunted than in other varieties of schizophrenia, but a minor degree of incongruity is common, as are mood disturbances such as irritability, sudden anger, fearfulness, and suspicion. "Negative" symptoms such as blunting of affect and impaired volition are often present but do not dominate the clinical picture."

12.1.1.2. Findings

The diagnosis that Mr. Y received throughout his contact with Pennine Care NHS Foundation Trust was consistent after the formulation completed during his first period of in-patient treatment in 2001. He was classified as suffering from Paranoid Schizophrenia (ICD-10 F20.0).⁷¹Mr. Y's Ashworth reports (after the incident) give a textbook description of the diagnosis, which has never been in doubt. However, in order to provide care of a satisfactory standard, the reality of the diagnosis for the management of the patient involves unpacking the components of the condition so that the clinical team have a concept of the individual person who is affected by a chronic, disabling condition.

The carers of the service user are central to the process because they have a good sense of who this person was before the illness began affecting their behaviour and personal interactions. Schizophrenia is a spectrum of conditions, and there are some manifestations of the illness which allow an insight into the whole person, relatively free of the condition in the periods between phases of the illness (for example where affective or mood symptoms are a significant part of the clinical presentation as well as the diagnostic features of the schizophrenia, what is sometimes called schizoaffective disorder). For others, like Mr. Y, even when the condition has been successfully treated and between relapses of the illness, there is some residue of the illness which affects the personality, a so-called schizophrenic defect state, so that family members who knew the person before they became ill would recognise that their personality had suffered some permanent damage.

71 CCCN Vol 1 p 315

This formulation highlights how important it is, if there are caring family members available, to enlist their involvement at the start of engagement with the patient, so that they can assist the team in getting to understand who the person is that they need to build a working relationship with. This is the concept of the therapeutic alliance. As Mr. Y lived with his parents throughout his contact with mental health services it was particularly important to engage them in the diagnostic work that underpinned treatment.

In cases of long term mental illness, the therapeutic alliance may have to be sustained over long periods of time, and this in itself can bring challenges. Even when professionals appear caring, supportive and sympathetic to a patient they have got to know over years, there is a danger that such positive attitudes may slip into a kind of complacent, patronising tolerance of a familiar face. Clinicians may lose touch with the ultimate aim of the therapeutic alliance which is, where possible (and with schizophrenia it may not always be possible, if the illness is too severe), to help the patient to take equal responsibility with the team for their own care by learning to understand the implications of the illness for their future life and being helped to develop strategies to co-manage their condition.

The diagnosis for an individual then goes well beyond identifying the manifest symptoms which allow allocation of the correct diagnostic category, with implications for treatment and prognosis etc. To manage the case effectively, extremely detailed understanding of all of the manifestations of the illness is required.

The following are a few examples of features of illness that are generally relevant and many of these applied to Mr. Y.

- **Onset of illness** – are there characteristic symptoms with recognisable manifestations? For example, paranoid beliefs about being poisoned, resulting in refusing food prepared by others; sexual anxieties projected onto others, of homosexual assault, paedophile tendencies or promiscuity, resulting in physical aggression etc.
- **Evidence of significant withdrawal from normal interpersonal contact** (so-called autistic symptoms) resulting in stereotyped responses, physical withdrawal, inability to function, emotional flatness etc.

- **Motor symptoms** such as increased restlessness (in extreme cases the opposite, catatonia – now rare), sexual disinhibition, auditory hallucinations, abnormalities in use of language (so-called thought disorder) etc.
- **Particular factors** likely to contribute to the appearance of active illness, for example, the use of alcohol or certain drugs such as cannabis, life events such as break-up of relationships, over close family relationships or pressure of social circumstances.
- **Attitude to illness** – persistent denial of manifest symptoms including manifest hostility if challenged. Degree of ambivalence (strongly characteristic in some with schizophrenia – ‘I don’t believe I’m ill, but I agree to take the medication long-term’).
- **Response to treatment** - speed of response, type of medication that is effective if given with adequate dose and duration, proneness or otherwise to side-effects including sedation, sexual dysfunction or extra pyramidal symptoms (which might or might not affect compliance).
- **Attitude to medication** – ‘compliance’, manipulativeness (persuading staff to change medications repeatedly, not to use previously effective medication such as depot preparations etc.), projection of symptoms (for example, the belief that medication makes them feel weak), overt non-compliance for example, refusal of depot, concealing oral medication rather than taking it.
- **Differences in interpersonal style** when actively ill and after adequate response to treatment (flatness versus warmth, hostility or other manifestation of anxiety versus ability to cope with normal interactions).

These examples have been drawn out to illustrate that in order to effectively manage the person during all phases of their condition there is a significant learning curve for the clinical team. The knowledge that is accumulated about the individual case also has to be consolidated in order to ensure that this corpus of knowledge is readily transmitted, as changes of staff will inevitably occur (people move on), as will changes of responsibility between different settings (different teams take over).

If such knowledge is not passed on, and/or it is not looked for by those taking on the case anew, clinical judgements are inevitably not going to be as well informed as they might be.

12.1.1.3. Conclusion

In the case history of Mr.Y the diagnosis was never in dispute (not always the case in mental health) but the detailed knowledge that had accumulated about the patient over seven or more years of contact with mental health services was not utilised effectively at some key points during that period. The capacity of Mr. Y to hide symptoms was underestimated by the clinical team and the knowledge of his behaviour from the family, with whom he had more extended contact was undervalued. Some of the information from assessments relevant to diagnosis was not used effectively to plan care after he left hospital.

However it is the conclusion of the Independent Investigation Team that Mr.Y received a correct diagnosis from the Pennine Care NHS Foundation Trust.

12.1.2. Medication and Treatment

12.1.2.1. Context

The treatment of any mental disorder must have an approach which may include psychological treatments (for example, cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

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

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

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

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

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

The patient’s ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals for example, weekly / monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and / or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

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

12.1.2.2. Findings

In keeping with the comments made in the previous section, there was an absence in the case notes of information and analysis of Mr. Y's earlier life, prior to his presenting in late 2001 with all the signs and symptoms of a florid schizophrenic illness. There was then a ten-month admission, which allowed ample time to collect information from Mr. Y and his family, to try to understand who the person was who first presented to his GP in Spring of 1999 with symptoms which in retrospect can be recognised as early signs of his illness.

There are questions that arise from this period of in-patient treatment such as how does one understand Mr. Y's previous offending? Did his imprisonment in 1994 have any effect on his personality? How did his family deal with this? What were the circumstances surrounding the assault in 1996? How long did he remain living in the family home before moving into the council accommodation that he was reported to occupy in 2000? Did he have previous sexual relations prior to the live-in girlfriend, who he met that year?

It was recorded that there were several examples of chaotic offending in early 2001 leading to the four-month sentence in May 2001. His parents were reported as saying that his character appeared to have changed following his release from prison and in the build up to his first admission, but were the parents aware of any change in him during the earlier part of that year? These last questions are particularly relevant to what is commented upon in the Ashworth psychiatric report, namely a tendency to act in the context of his delusions.

It was such behaviour during his first, lengthy admission: for example bringing a replica gun to the ward, which led to his being referred for a forensic psychiatry assessment in 2002. Specialist Registrar 1, (a Forensic Psychiatrist) in fact made two assessments, in April and July of 2002. He highlighted particular concerns in addition to the acting out; the use of alcohol and cannabis, non-compliance with medication (it being reported by the team that they had in the previous weeks evidence of his hiding and not taking oral medication), lack of insight and the appearance of specific sexual elements in his ideas, all of which when present might indicate that further review of the case might be needed.

In his subsequent follow up in the community, particularly between his relapse in July 2007 and in the period before his third discharge from hospital in late May 2008, repeatedly there were calls to the service from his parents related to possible non-compliance and to use of

alcohol and/or cannabis. Mr. Y tended to deny these issues of non compliance and was not open with staff about his real behaviour.

The lesson here is a patient (not uncommon in young people with schizophrenia) will often deny symptoms in the face of evidence to the contrary. It shows itself in the outcome of the interview with him on May 29 2008 with two experienced community staff who could not detect a mental illness. During this interview Mr. Y denied having symptoms of illness. It must be noted also that directly after the incident he was found to have no symptoms of psychosis (it was only some time after the incident that florid symptoms appeared).

There appear to be two factors which contributed to his management by the mental health services, which inevitably led to three incidents of relapse of his illness due to non compliance that is, in July 2007, in January 2008 and in late May 2008.

The first was the patient's ability to persuade staff to change medication when clinical judgement might have counselled that this was unwise. Having carefully examined the in-patient records from late June 2002 it was evident that having been placed on Depixol as a depot injection on the 23 April 2002 because of an acute dystonic reaction to Amisulpride, he had made excellent progress with improvement in his mental state, willingness to discuss his diagnosis of schizophrenia and trips home to see his parents. The Olanzapine that he was receiving in addition was gradually being withdrawn.

However on the 14 June 2002 having been very settled he suddenly became restless and agitated and obviously deluded, for example believing that he had got Auto Immune Deficiency Syndrome (AIDS). He admitted that he had had some alcohol at home the previous day. He was given PRN Haloperidol and Lorazepam. When reviewed by Senior Registrar 1 on 26 June 2002 Mr. Y was asking to leave hospital and he was complaining of stiff muscles and possible akathisia (inner restlessness and a difficulty in keeping still) related to his depot medication.

The decision made on that day, not challenged by the Responsible Medical Officer who further reviewed him on 4 July 2002, was to stop depot medication at this point and to consider Clozapine. In other words rather than reduce his Depixol slightly or review his Anti-Parkinsonian medication (as these were chronic not acute symptoms) or to recognise that use of Haloperidol PRN could have contributed to the side effects, an effective treatment

of his condition was abandoned. The idea that depot medication either was ineffective or was too difficult for this patient became accepted during the course of his subsequent treatment, notwithstanding that non compliance with oral medication was an identified risk in his case.

The second factor was the evident successful use of oral Clozapine in stabilising Mr. Y and keeping him out of hospital for five years. This was obviously a powerful influence on the clinical team's thinking but the Independent Investigation Team raise the question of whether, during this period of relative good health, Mr. Y's motivation to cooperate with treatment was adequately explored. The same applies to the question of his insight into the need for him to contribute to the management of his long term condition and whether he had insight into the signs that might warn him that he was becoming ill again.

Finally in relation to prescription of medication, Consultant Psychiatrist 3 subsequently has explained that his primary criterion for judging the health of the patient over time was the degree of warmth he elicited at interview. He was also guided by the principle of trying to maintain the patient on the lowest amount of medication possible, both of which strategies are legitimate. Unfortunately this led to a reduction of dosage, at a routine outpatient appointment in January 2007 from 200 mg, a dose on which Mr. Y had been stable for the previous two years, to 150 mg which is on the borderline of Clozapine's clinical efficacy. Consultant Psychiatrist 3 did accompany this decision by advising him to make contact if he felt that this medication was not enough.

It is recognised well that patients whose schizophrenia is stable and who stop having adequate levels of (or any) medication, will take up to six months to break down and by July 2007 there were concerns that Mr. Y was drinking alcohol again, although when confronted, following expressions of concern from his parents, he denied it. No increase in his medication was proposed during the subsequent weeks even though very alarming reports about his behaviour were received. As before, despite very clear messages from his parents regarding relapse indicators, Mr. Y's assurances on face to face contact that all was in fact well, were accepted until the point that he appeared behaviourally, indeed sexually, disinhibited.

It was only then that re-admission was considered and even that did not take place until two days later, by which time the patient had committed an offence of criminal damage at a massage parlour. This last point will be returned to in the next section.

Further evidence of Mr. Y's ability to persuade staff to under-medicate him was evidenced by his discharge plan after this admission, whereby he had convinced them not to continue with Clozapine, but provide a modest dose of oral Risperidone (even though this medication is available in depot form). Like his denial of illness, this pattern of manipulation of staff in relation to medication, thereby compromising effective care of his condition, was simply not recognised. The lesson was not learnt.

Mr. Y relapsed again within two months of discharge, through non-compliance. There was a longer admission on the third occasion, as he was more obviously psychotic, but early on in this admission the plan was to reintroduce Clozapine, even though the patient was ascribing quite unreal side-effects to it, when he had been previously taking it, suggesting that it had made him feel twisted inside or had caused him to be socially withdrawn and had prevented him getting a job (having previously admitted that he was actually rejected because of his history of mental illness).

The Independent Investigation Team noted the speed with which Mr. Y was returned to the community (under Section 17 leave), while under the care of a new Responsible Medical Officer (Consultant Psychiatrist 6) who knew him less well, given he had returned from the PICU on 16 March and was restarted on Clozapine on 27 March 2008. Despite reservations being raised at the ward round about potential non-compliance, it was agreed that he would return home to his parents, with back-up support from the CRHT (Crisis Resolution Home Treatment Team) from 16 April. However well he seemed to have responded to the medication, this was a short period within which to fully assess the effects of reintroduced medication in a patient who was known to have a history of disguising his symptoms at interview with professionals. Nonetheless the clinical team were able to assess him in his home environment for a period of five weeks prior to his eventual discharge on the 22 May 2008. During this period Mr. Y was settled and presented with no psychotic symptoms.

Finally there is a general point that had been referred to in passing, related to the use of medication to prevent readmission to hospital. There were at least two if not three occasions when there were warning signs that the patient was not as well as he might be while in the community but somehow the obvious intervention, namely increasing his medication to stabilise his mental state, did not occur. This perhaps reflects two overlapping issues, first: that although there were crisis teams in place and CPA was being followed with an appointed Care Coordinator, medical intervention was not always apparent when the patient's mental

state was unstable as part of that community-based care. Second: that there appeared to be no clearly defined (and recorded) treatment plan, including contingency measures, agreed with all parties that might be involved in such measures, for managing fluctuations in the mental state, to prevent readmission. This is discussed in the next section.

Other Treatment Approaches

During the period when Mr. Y remained well in the community between 2002 and 2007 he received good levels of social support from Community Support Worker 1 and other non-medical staff. This enabled him to improve his social functioning. He was able to form a therapeutic relationship with social care staff when his illness was successfully treated.

During 2008 Mr. Y was visited regularly by the Crisis Resolution and Home Treatment Team when discharged from hospital but a decision was taken not to refer to this team at the discharge meeting on 22 May 2008.

The two Care Coordinators working with Mr. Y in May 2008 engaged in appropriate social care interventions, for example, referral to supported housing and encouragement towards Mr. Y's aspirations for independent living. However Mr. Y's non compliance with medication compromised the degree of cooperation that could be achieved.

12.1.2.3. Conclusion

The Independent Investigation Team concluded that Mr. Y was not taking therapeutic levels of medication at the time of the incident. There was evidence from his parents about this, however it has to be acknowledged that the information the parents did give was often contradictory, or minimised the situation. Mr. Y was able to mask his symptoms during the contacts he had from his two Care Coordinators during the discharge planning stage and also following discharge.

The clinical team should have considered a proactive monitoring of the therapeutic levels of medication in Mr. Y's blood at the same time blood serum levels were checked. Mr. Y received regular blood serum monitoring when he was on Clozaril. One side effect of this medicine is that it can occasionally cause a drop in the number of white blood cells. This may be referred to as neutropenia or agranulocytosis. As this could result in potentially serious infection, patients need to have regular blood tests whilst taking Clozaril, to make sure blood

cells are not affected. As Mr. Y was subject to this regular monitoring mechanism it would not have been intrusive to have checked medication compliance at the same time. When working with patients who are known to have history of non-compliance and are often guarded in their presentation a regular review of this kind would be seen as good practice.

Care and treatment is not about medication alone, it was the conclusion of the Independent Investigation Team that the work of the Community Support Worker was good and maintained Mr. Y in the community for a period of several years. This was an effective and patient-centred approach. The Independent Investigation Team noted that the national Schizophrenia guidelines were not implemented in full, in that Cognitive Behaviour Therapy, for example, (which is a recommended treatment for people like Mr. Y) was not offered. At no stage was psychological therapy considered for Mr. Y and this was an omission.

- *Contributory Factor One: the reduction of medication in 2007, and Mr. Y's later non-compliance in 2008 meant that he was not receiving a consistent therapeutic level of medication and this was a contributory factor to the breakdown of his mental health.*
- *Service Issue One. The Trust did not provide a full set of evidence-based care and treatment options in line with the National Schizophrenia guidance from NICE.*

12.1.3. Management of the Clinical Care and Treatment of Mr. Y

12.1.3.1. Context

The delivery of patient care and treatment in secondary mental health services is usually provided within a team context. People with mental health problems often require a high degree of case management in order to ensure that effective liaison between agencies takes place and that long-term treatment strategies are effective.

People with mental health problems can move between services on a frequent basis. Continuity of care and robust management is essential in order to ensure that professional

communication occurs in a timely manner. This is essential in providing a safe and effective level of intervention.

On the 17 October 2007 the Department of Health Published *New Ways of Working*⁷². This document advocated a change to traditional working practice. Historically the psychiatrist was seen as the senior professional leader of any clinical team. *New Ways of Working* set out a revised model of management. This revised model promoted the concept of the ‘democratisation of power’. A Team Manager would provide management, team leadership and service coordination. In addition professional leads were to be appointed on a patient-by-patient basis according to the individual needs of the person requiring the care and treatment. The professional lead role would no longer be allocated to a Psychiatrist as a default position as had been done previously. The purpose of introducing *New Ways of Working* was to provide a patient-centred ethos that provided a more bespoke model of care and treatment.

In Pennine Care NHS Foundation Trust *New Ways of Working* became operational in the Spring of 2008 in some parts of the Trust. As part of the new working arrangements consultant psychiatrists were allocated to either in-patient or community-based teams. This meant that patients would be allocated a different consultant psychiatrist each time they moved from one service to another, rather than remaining on the caseload of a single medical practitioner. This represented a large-scale level of organisational change within the Trust and to the experience of individual users of the service.

12.1.3.2. Findings

By the end of 2002 it was known that the appearance of certain indicators (referred to in a previous section), such as increased use of alcohol, would warn that the patient’s health might be at risk, i.e. that his mental state was deteriorating. Similarly it was known that if he was unwell, others might be at risk from him, his parents most obviously, clinical staff certainly and members of the public, possibly. There was evidence of past behaviour to support this analysis.

However there was a failure to recognise significant risk factors when they were present during the subsequent care of this patient, or if recognised, failure to take prompt action. Mr.

⁷² Mental health: New ways of working for everyone, Department of Health May 2007

Y's care and treatment also illustrates that although the extent of face to face involvement with this patient was more than adequate; the problem was in the quality of the clinical engagement. Recording that the patient has been seen and had denied that there were problems was not enough. The view of Mr. Y's parents was that Mr. Y was capable of masking his symptoms during these relatively short professional contacts.

From the latter part of 2007 (between 13 December 2007 and 25 January 2008) Care Coordinator 2 made regular visits and made entries in the records quite clearly reflecting her increasing concern about Mr. Y's mental state. She repeatedly had calls from Mr. Y's parents explaining why they felt that his mental state was deteriorating and indeed on occasions specifying that they were being bullied by him when they ventured to suggest to him that he might not be well. Yet the fact that they might be at risk, or rather that the risk to them needed evaluating via a carers' assessment did not surface in the collective mind of the Clinical Team. There was no evidence of this insight in the notes, or in the memory of staff that the Independent Investigation Team interviewed and questioned about this.

On 29 May 2008 a similar situation occurred again. Care Coordinators 3 and 4 made a home visit to assess Mr. Y. Having decided on the basis of their interview with him that he was not sectionable, it being immediately prior to a bank holiday weekend they made the arrangement for an urgent outpatient appointment at the earliest opportunity during the following week. The risk to the parents may have been minimised by Mrs. Y stating, whilst on the telephone on the 30 May that she thought Mr. Y's behaviour was improved with regards to his attitude towards her.

A similar failure to recognise the seriousness of the level of risk was when he was previously admitted in September 2007 and it was reported that he had had a gun in the back of his car. In keeping with the overall pattern of their behaviour, the staff took his explanation at face value, although the gun was confiscated, but no-one thought to consider that, given he had previously been assessed by forensic psychiatry, this event might prompt a specialist review of risk (especially as his behaviour immediately prior to admission included being violent to his mother, as detailed in the discharge summary to the GP dated 26 November 2007).

Mr. Y's parents had been extremely supportive to him. Unfortunately, because of the reliable way that they telephoned in when they were worried about him and his father's attendance at

some ward rounds, there is more than a hint that the staff team began to treat Mr. Y's parents in the same complacent way that such teams can start to treat long term patients as referred to above. There is considerable evidence to support this latter view.

The clinical team failed to perform a carers' assessment even though the parents had been carrying the responsibility for caring for him in the family home for several years and the Care Coordinator was seeing them often. It seems that no-one had talked to them separately about their perception of their son's problems, whether they had unmet needs or crucially, what the treatment plan was, particularly what plan of action was to be followed if he began to deteriorate. It was as if the parents' habit of ringing and expressing anxieties somehow prevented staff from carrying out the required actions in relation to his CPA, namely agreeing with the parents an explicit contingency plan which they were happy with, in the event of an emergency. However, the most recent community staff when interviewed expressed the view that communication with the parents was good.

Mr. Y senior commented that Mr. Y had been discharged to the parent's home at a ward round which also served as a Section 117 meeting which the parents had not attended. He said that he was surprised by this. However the clinical team had based their view about the family's willingness to have Mr. Y home on their recent previous contact with them during the visit to supported accommodation and on views expressed by Mr. Y's father at other ward round meetings.

The case records available to the Independent Investigation Team were variable in quality. CPA documentation was partially completed while Mr. Y was an inpatient and community staff admitted to us that conversations had gone on between them about him without being recorded in the case notes. When a Section 117 after-care meeting had been held prior to the last discharge, the nurse designated to make notes about the ward round had summarised key decisions in the case notes but no formal discharge plan was written down. At interview with a witness (in relation to Mr. Y's final discharge in May 2008) the Independent Investigation Team was told *'all I can say is that at the point of discharge there was a clear community plan. It wasn't written down at the time it would seem'*, but the plan was in effect to monitor him weekly and to address his accommodation needs. No mention was made of any contingency plan.

Finally, in relation to timeliness, this particular case suggests a potential problem in a much more worrying area, namely staff awareness of the issue of duty of care. If a patient's mental state is becoming significantly disordered to the extent that it is agreed that they need to come in to hospital, there is absolutely no excuse for admission being delayed for 24 hours or more, unless there are very significant extenuating circumstances. In September 2007 Mr. Y was manifestly ill, but after this being stated in the community notes, he was only admitted 48 hours later having been arrested following having damaged a telephone in a massage parlour. This meant that Mr. Y potentially had a criminal offence recorded against him directly as the result of the delay in admitting him. Worse still, the incident counted as a significant near miss (which went undetected by the clinical team) because it was known that he could be violent when sexually disinhibited.

Similarly, in late 2007, Care Coordinator 2 was concerned about Mr. Y's deteriorating mental state but things were allowed to continue until after Christmas, without significant intervention other than the promise of an earlier out-patient appointment. This was apparently due to a failure of adequate communication within the team (Care Coordinator 2 left messages for the team doctor which went unanswered and she did not then pursue the non-response), thus exposing the parents, and potentially others, to unnecessary risk. Again, this was a near-miss, which was not recognised within the service because no serious, i.e. formal, review of the events leading to either of his readmissions took place, in order that the clinical team might look at what lessons could be learnt from what had happened. It was the view of the Independent Investigation Team, that this lack of timeliness and its real or potential consequences, represented a significant neglect of the duty of care to the patient, to his parents, and potentially, to others.

The clinical team at the point of Mr. Y's last discharge formed a care plan that included follow up through out-patients and the allocation of two Care Coordinators. However, there was a case for a more assertive approach to have been used, underpinned by the Trust CPA policy. The guidance on the use of Assertive Outreach as an approach says that:

"The multi-disciplinary team should consider assertive outreach as an approach for service users with a severe mental illness who meet the following criteria:

- *A severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a high level of disability.*

- *A history of high use of in-patient or intensive home-based care (e.g. more than 2 admissions or more than 6 months of in-patient care in the past 2 years).*
- *Difficulty in maintaining lasting and consenting contact with services.*
- *Multiple complex needs including a number of the following:*
 - *History of violence or persistent offending*
 - *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 at least once in the last two years*
 - *Unstable accommodation of homelessness*⁷³

Mr. Y fulfilled most if not all of the criteria for referral to an Assertive Outreach Service and therefore seen in this context the more low key approach recorded at the ward round before Mr. Y's discharge was not sufficiently robust.

12.1.3.3. Conclusions

Over the period of Mr. Y's contact with mental health services there were examples of good management of clinical care and treatment. This was demonstrated in the period after his first in-patient admission when he was maintained in the community for several years. Clinical care during this period was facilitated through regularity of out-patient contact and enhanced by stability in the delivery of care by practitioners who were well known to Mr. Y. The most successful period of care combined medical and social care input with a supportive family environment. This demonstrated the therapeutic alliance working well.

When Mr. Y became an in-patient his care and treatment was managed well and the Trust was able to use its psychiatric intensive care provision effectively when Mr. Y was acutely ill and had assaulted a staff member. Mr. Y's transition between different parts of the Trust's range of services was smooth and the use of the Mental Health Act appropriate.

The clinical team managing Mr. Y's care during his last in-patient admission were less familiar with Mr. Y. The change of clinical leadership and Care Coordinator was due to the Trust's reorganisation of services to comply with national guidance about how services

73 Trust CPA policy: appendix B managing difficult patients p 35

should be delivered relating to *New Ways of Working*. They nevertheless had access to Mr. Y's clinical history and knew the risk factors clearly identified over the years of contact with Mr. Y.

The care plan agreed when Mr. Y left hospital for the final time did not reflect some of the risks identified in his historical presentations and there were no contingency plans other than follow up through out-patients (which would be by a different Consultant to the one who treated him as an in-patient, and who had not previously met him) and by visits from the Care Coordinators. The critical points of learning were therefore to build on previous knowledge of the patient, particularly in relation to relapse, and secondly to ensure that information was communicated fully to the clinicians taking over care and treatment in a timely way. The formulated plans, for example the Care Programme Approach care plan and the associated risk assessment, were only partially reflected in the recorded case discussion and care plan when Mr. Y was discharged from hospital on 22 May 2008. There was a strong case for Mr. Y to be followed up more assertively and he met the criteria for the assertive assessment service in operation at the time.

The weaker points regarding the overall management of Mr. Y's care and treatment over time were consistent. They were:

- comprehensive and holistic care planning;
- proactive crisis and contingency planning;
- carer assessments;
- Section 117 aftercare.

These themes are explored in more depth in the sections set out below.

- ***Contributory Factor Two: the care plan when Mr. Y left hospital on 22 May 2008 did not reflect the levels of risk assessed in the CPA risk assessment. The care plan was not sufficiently assertive in maintaining close contact and monitoring of his mental state. It did not build on the learning from Mr. Y's previous history.***
- ***Service Issue Two: changes to the organisation of service in response to Department of Health guidance led to more transitions in the care pathway. This in***

turn opened the possibility that information would not be successfully passed to the next stage of the treatment programme.

12.1.4. Use of the Mental Health Act (1983 & 2007)

12.1.4.1. Context

The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as ‘sectioning’. The Act has been significantly amended by the Mental Health Act 2007. Mr. Y was subject to action under Sections of the Act prior to the incident of the 2 June 2008. They are set out below.

Section 136 of the Mental Health Act (1983 & 2007) allows for Police Officers to take a person who is in a public place and who appears to be suffering from a mental disorder and to be in need of immediate care and control to a place of safety. The Act defines a place of safety as a police station, hospital, care home or any other suitable place. The person can be held under this power for up to 72 hours in order that he/she can be assessed by mental health professionals.⁷⁴

Section 2 of the Mental Health Act (1983 & 2007) allows for a 28-day period of compulsory detention in hospital for assessment purposes only. A patient has the right to appeal within 14 days of the section being ordered. Strict assessment criteria have to be used in order to detain someone. It has to be agreed that the person suffers from a mental disorder which requires assessment and that this needs to be given in hospital in the best interests of their own health and safety or that of other people.

Section 3 of the Mental Health Act (1983 & 2007) is an admission for treatment order for a period of up to six months. Strict assessment criteria have to be used in order to detain

⁷⁴ House of Lords Committee Briefing, Mental Health Alliance. www.mentalhealthalliance.org.uk

someone. It has to be agreed that the person suffers from a mental disorder which requires assessment and treatment and that this needs to be given in hospital in the best interests of their own health and safety or that of other people.

Section 117 of the Mental Health Act (1983 & 2007) provides free aftercare services to people who have been detained under Sections 3, 37, 45A, 47 or 48. It is the duty of the Primary Care Trust and the Local Social Services Authority to provide and pay for aftercare services. There is no definition of aftercare in the legislation, but services could include amongst others, psychological needs, crisis planning, accommodation and help with managing money. Aftercare lasts as long as someone needs it for their mental health condition, and it can only end when there is a formal discharge meeting.

12.1.4.2. Findings

The Independent Investigation Team found that the Mental Health Act was used appropriately throughout Mr. Y's history of contact with the Trust. After his first admission in December 2001 as a voluntary patient he became subject to Section 2 of the Act on 20 December 2001 after absconding from the ward. He was detained for assessment on 20 December 2001. Medical recommendations were completed by doctors with previous knowledge of Mr. Y and the application was made by an Approved Social Worker. Mr. Y appealed to the Mental Health Review Tribunal and at a hearing on 31 December 2001, the Tribunal rejected his appeal on the grounds that if discharged it was unlikely that Mr. Y would remain at the hospital for his assessment to be completed and that there were concerns for the safety of Mr. Y's father whom he had assaulted prior to admission.

Mr. Y remained an in-patient during the assessment period and was then detained for treatment under Section 3 of the Act on 4 February 2002. The application in this case was made by Care Coordinator 4 who was later to become Mr. Y's Care Coordinator after his discharge from hospital in 2008 shortly before the incident.

Mr. Y appealed against his detention and a Mental Health Review Tribunal hearing was held on 10 July 2002. In rejecting his appeal the Tribunal Chairman noted that Mr. Y had improved since his medication was changed to Olanzapine but that *"he is still guarded and*

access to any residual symptoms is difficult”⁷⁵. The Tribunal also noted that Mr. Y had only partial insight into his illness and did not accept the extent of his delusional ideas when ill. It accepted the view of the Responsible Medical Officer that there was a risk of non-compliance with medication if Mr. Y was discharged and that his mental health would deteriorate quickly. There would also be a concern for the safety of others as there had been a history of assaults when he was unwell. In the medical evidence to the Tribunal there were also some concerns about public safety because it was recorded that in his periods of leave from the ward under Section 17 of the Act, Mr. Y had approached several school children around the age of 15 or 16 years and had ideas of getting sexual favours from them in return for offering them drugs. He also disclosed that he had wanted to kill an acquaintance of his as he had suspicions that this man had slept with his ex-girlfriend.⁷⁶

Mr. Y remained a detained patient and the Treatment Order was renewed on 3 August 2002. In reports to the hospital managers in support of the renewal Mr. Y’s Responsible Medical Officer, Consultant Psychiatrist 3, noted that there had been significant improvement in Mr. Y’s mental state in the previous two months, however there were concerns that he had declared his intention of seeking sexual relations with teenage girls below the age of consent and his stated intention to kill a named individual. He had also brought a replica gun onto the ward. Mr. Y was discharged from his treatment order on 10 October 2002 and from in-patient care on 18 October 2002 and returned to his family home.

Mr. Y remained well for some years, as described in the case chronology above, but was admitted to hospital under the provisions of Section 2 Mental Health Act on 14 September 2007. This followed an incident when Mr. Y was arrested by the police for criminal damage. He had pulled a telephone from a wall in a massage parlour after having delusions that he was receiving a call from the ‘phone. He was sexually disinhibited and thought that people were talking about him. Mr. Y appealed to the Mental Health Review Tribunal and a hearing took place on 4 October 2007. The medical reports to the Tribunal recommended that he should remain a detained patient on the grounds that he had limited insight into his condition and did not see the need to take medication. The Tribunal rejected his appeal and he remained on the ward.

⁷⁵ PR Vol 1 p 658

⁷⁶ PR Vol 1 p 667

Mr. Y's mental health improved and after an extended period of home leave he returned to live with his parents. He was supported by the Home Treatment service. However he was re-admitted to hospital as a voluntary patient in January 2008. He was assessed at home by his GP and an Approved Mental Health Practitioner on 31 January 2007 after concerns that he was not taking medication and using alcohol and cannabis. The plan on admission was to start treating him with Clozapine. Mr. Y was then detained under Section 3 Mental Health Act on 12 February 2008.

Mr. Y was transferred to a psychiatric intensive care unit on 6 March 2008 after he had assaulted a member of staff on the ward. The transfer was authorised under section 19(3) Mental Health Act which provides for the transfer of detained patients between different units which are part of the same mental health trust. He returned to Royal Oldham Hospital on 19 March 2008, remaining a detained patient under Section 3 Mental Health Act.

Mr. Y was discharged from hospital on 22 May 2008 and discharged from his detention by his Responsible Clinician, Consultant Psychiatrist 6.

The case notes record a discussion at a ward round on 2 May 2008 of the merits of initiating a supervised discharge order under Section 25 Mental Health Act⁷⁷. It is noted that the Responsible Clinician was of the view that this would not add to the ability of the clinical team to achieve compliance with medication as Mr. Y *"had a high level of compliance when well"*.

As a patient detained under Section 3 of the Mental Health Act Mr. Y was entitled to after care under the provisions of Section 117 Mental Health Act. The Independent Investigation Team found that the ward round on 22 May 2008 was *de facto* the Section 117 after-care meeting. In other words, there was no separate and specific meeting to record Mr. Y's statutory after-care plans under Section 117.

12. 1.4.3. Conclusions

The Independent Investigation Team concluded that the Mental Health Act was, on the whole, used appropriately during the course of Mr. Y's contact with services. When necessary it was used to detain him for assessment and then for treatment. He had access to

⁷⁷ CCCN Vol 2 p 235

the appeals provision of the Act and was able to have his appeals heard in a timely way by the Mental Health Review Tribunal. Reports presented to the Tribunals by medical practitioners and Approved Social Workers set out clearly the evidence for detention and were completed within the required timescale. In the discussion by the clinical team leading up to Mr. Y's discharge from hospital on 22 May 2008, there was consideration of the merits of applying Section 25 of the Act.

The view of the Independent Investigation Team was that this would not have had a significant effect on the events leading up to the incident on 1 June and would have offered no more assurance that Mr. Y was being treated successfully. The discharge meeting on 22 May was *de facto* the Section 117 after-care meeting, but its significance as such was not recognised. The Trust CPA policy at the time did not offer guidance to staff on how Section 117 requirements in terms of process and outcomes should be incorporated into such a discussion.

- ***Service Issue Three: the Trust CPA policy did not make clear how the requirements of Section 117 Mental Health Act should be incorporated into discharge planning.***

12.1.5. The Care Programme Approach

12.1.5.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness⁷⁸. Since its introduction it has been reviewed twice by the Department of Health: in 1999 (Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach) to

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

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

70. Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH 1995

incorporate lessons learned about its use since its introduction and again in 2008 (Refocusing the Care Programme Approach)⁷⁹.

‘The Care Programme Approach is the cornerstone of the Government’s mental health policy. It applies to all mentally ill patients who are accepted by the specialist mental health services⁸⁰.’ (Building Bridges; DoH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients.

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

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and to maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

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

- ensuring regular review of the patient's progress and of their health and social care needs.

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

The Pennine Care NHS Foundation Trust CPA policy version 5 (CL3)⁸¹ summarises the Trust CPA policy. The Policy was written to ensure:

- *“consistent standards of assessment for all those accepted by the mental health service and their carers;*
- *coordinated and systematic care planning for all those with severe mental health problems and their carers;*
- *the identification of effective support to high risk service users;*
- *ensuring service user involvement as a continuous process during the provision of care;*
- *identifying unmet need.”*⁸²

The policy also stated that:

*“All service users admitted to hospital, irrespective of age or condition, will have their care managed in accordance with the Trust Hospital and Admission Policy”, and that “CPA applies to all those accepted by specialist mental health services irrespective of setting. All service users requiring care and treatment in hospital should have their admission and discharge managed in accordance with the procedures outlined in this policy”.*⁸³

The policy criteria for Enhanced CPA were:

- *“multiple care needs e.g. housing, employment, finances;*
- *require contact with, and cooperation between, a number of agencies or professionals but may be willing to cooperate with only one;*
- *be at risk of losing contact with services;*

⁸¹ Trust CPA policy in PD p 134 et seq

⁸² Trust CPA Policy version 3

⁸³ Trust CPA Policy. Version 3

- *pose a significant risk to themselves or to others or have a history of serious self harm or violence;*
- *lack an informal support network;*
- *have substance misuse difficulties in addition to their mental health problem(s).*⁸⁴

12.1.5.2. Findings

Main CPA Events

The Independent Investigation Team found that Care Coordinators were allocated appropriately to Mr. Y throughout his contact with the Trust. Care Coordinators were professionally qualified and typically came from a background in psychiatric nursing or social work. Analysis of case records showed that Care Coordinators carried out a range of tasks associated with their role including regular monitoring of Mr. Y's mental state when in the community, liaison with his parents (to varying effect), ensuring his attendance at out-patient appointments with his Consultant Psychiatrist, help with employment and advice on independent living. They operated within the Trust CPA policy and utilised CPA documentation at regular intervals, including formal risk assessments using the STAR risk assessment tool. However on occasions these assessments were found to be incomplete. Risk assessments were not always found to contain a cumulative set of information about Mr. Y and often did not translate into dynamic and comprehensive care planning.

Care Coordinators were supported in their role by other support staff, for example members of the Crisis Resolution and Home Treatment Team and community support workers. There was evidence to demonstrate that the Care Programme Approach was supported by a multidisciplinary team.

During the most successful period of treatment of Mr. Y's mental health, between his discharge from hospital in 2002 to his re-admission in 2007 Care Coordinators were in regular contact. During the first part of this period he received consistent support from Consultant Psychiatrist 3 who had been his Responsible Medical Officer during the last hospital admission, Care Coordinator 1, and Community Support Worker 1. Between May 2003 and August 2005, for example, Mr. Y was seen every few months as an out-patient, but he received a high level of social support from Community Support Worker 1 who had in the

84 Trust CPA Policy version 3

region of 120 contacts with him. His efforts helped Mr. Y to achieve better social functioning and to attain goals in the CPA care plan, including employment and the regaining of his driving licence.

This good progress was maintained throughout 2006 but in July 2007 there were concerns that Mr. Y was not taking medication as prescribed and had been using alcohol to excess. Those concerns culminated in Mr. Y's admission to hospital in September 2007 under the provisions of the Mental Health Act.

Following his discharge from hospital in November 2007 Care Coordinator 2 was allocated to Mr. Y. She visited regularly and made full recordings of her contact with Mr. Y and his family. She completed the Trust CPA initial assessment documentation which gave a full account of his history and identified the need for a carers' assessment⁸⁵. She sought to achieve the aims of the care plan and worked with Mr. Y to attend a supported employment project, helped him to resolve income support issues and visited him at home. During this period there were increasing concerns from Mr. Y's parents that he had been drinking heavily, smoking cannabis and staying with friends on several nights a week. They also found evidence that he was not taking medication. The Care Coordinator arranged a meeting with Mr. Y's father on 18 January 2008 at the mental health team base to discuss these concerns⁸⁶. She enabled Mr. Y's father to express his worries about Mr. Y's behaviour in a setting away from the family home. The Independent Investigation Team consider that this was good practice, and whilst falling short of a formal carer assessment, it did promote a fuller understanding of Mr. Y's mental state to set against the over optimistic view that he presented in interview and his denial of symptoms.

Mr. Y was admitted to hospital again in January 2008 and the focus of care was on in-patient services until his discharge from the mental health unit in May 2008.

The Independent Investigation Team's view was that Care Coordinator 2 made good efforts to fulfil the role of care coordinator in difficult circumstances during a period in which Mr. Y was likely to have been under-medicated and non compliant with advice on alcohol and substance misuse. The Independent Investigation Team did raise the question of whether the

85 PR Vol 1 p 70
86 PR Vol1 p 212

allocation of a female worker to undertake this role was appropriate, given Mr. Y's history of violence and sexual delusions.

After Mr. Y's period of treatment at the psychiatric intensive care unit in March 2008 and his return to the mental health unit, he was allocated to two new Care Coordinators. The rationale for the allocation of two workers was that Mr. Y posed some risk to staff and that it would not be appropriate for a lone worker to visit him. This reinforced that view that the allocation of Care Coordinator 2 (who was a lone female worker) was inappropriate. The two Care Coordinators also took the view that it would be wise to visit Mr. Y together until they had assessed him more fully and built up a rapport.

Care Coordinators 3 and 4 were both very experienced practitioners who had worked on the community mental health team for some time. Their initial contact with Mr. Y was on 29 April 2008 at his family home where he was on home leave from the ward. Their early work with him centred on finding suitable accommodation and they referred him to the Vulnerable Adults Rehabilitation Support Services (VARSS). They went with Mr. Y and his parents to visit a supported housing scheme in Oldham. Mr. Y declined the offer of supported accommodation. He would not agree to living in a supported housing unit as a step towards greater independence, wishing to move immediately into self-contained accommodation.

Care Coordinator 3 attended the VARSS panel meeting to discuss Mr. Y's application and views about the supported housing scheme. He recorded the panel's view that Mr. Y should be assessed at the scheme's supported unit on the grounds that:

- Mr. Y was not known to the resettlement service and it was therefore necessary to assess his capacity to live independently;
- Mr. Y had a history of non-compliance with medication and assaultative behaviour when unwell and it was felt that this risk needed to be assessed before he could be offered a place at the independent unit.⁸⁷

The Independent Investigation Team's view was that the referral to the resettlement unit was reasonable as part of Mr. Y's care plan and represented an opportunity for him to move from his parents' home to greater independence.

⁸⁷ CCCN Vol 2 p 236

The decision of the VARSS panel was discussed with Mr. Y at a ward round on 22 May 2008 and then again during a home visit by Care Coordinators 3 and 4 on 29 May 2008. The visit on 29 May was partly in response to concern from Mr. Y's father that he was not taking Clozaril as prescribed, appeared agitated and was irritable with his parents.

The visit to Mr. Y on 29 May 2008 was the last face to face contact between him and the Care Coordinators before the incident on 1 June 2008. The Care Coordinators recorded the substance of the visit and noted that there was discussion with Mr. Y about his housing application, about medication and the need to provide a blood test in relation to Clozapine medication. Mr. Y was said he wanted to sort out the housing problem himself and that his solution was to present himself as homeless and be allocated a place in a hostel. The Care Coordinators advised against this course of action. The following day (30 May 2008) Care Coordinator 4 recorded that Mr. Y did attend the hospital on 30 May and had a blood test showing that it was safe to continue Clozaril medication.

When the Independent Investigation Team interviewed Care Coordinators 3 and 4 they discussed the content of the last visit on 29 May 2009 and asked whether there was justification for a full assessment under the Mental Health Act. Both Care Coordinator 3 and Care Coordinator 4 recalled that the meeting with Mr. Y was relatively long, lasting an hour and that they felt they had tested his mental state during the interview and that no active features of mental illness (e.g. thought disorder) were present.

Care Coordinator 3 recalled that he was worried that he had been too rigorous in his questioning of Mr. Y and that he had pressed Mr. Y in order to be able to gauge his mental state. The view of care Coordinators 3 and 4, both experienced Approved Mental Health Practitioners, was that the threshold for an assessment under the Mental Health Act was not reached. They sought an early appointment with Consultant Psychiatrist 7 who was to take over Mr. Y's medical care in the community.

On 30 May 2008 Care Coordinator 3 had a telephone conversation with Mr. Y's mother because Mr. Y had gone to the local housing office to present himself as homeless. Care Coordinator 3 telephoned the housing office to give background information to the housing officer dealing with the case. Mr. Y's mother was said to have noticed a slight improvement in Mr. Y's attitude to her. The housing officer took the view that if Mr. Y was living with his

parents and they were willing to have him there, then he would not be deemed homeless. Care Coordinator 3 also recalled that Mr. Y's mother had said that he (Mr. Y) had been a bit better since the last home visit.

CPA Process

The Independent Investigation Team found that CPA documentation was used throughout Mr. Y's care and treatment, but that evidence gathered through this process was not always used to inform care plans. Information about risk, including relapse indicators, was not fully incorporated into the plans, this omission was of particular importance when Mr. Y was discharged. There was insufficient consideration of the degree of assertiveness required to follow up Mr. Y and contingency plans in the event of relapse. The Independent Investigation Team consider the issues of documentation *per se* more fully in a latter section of this report.

Whilst the Independent Investigation Team found that Care Coordinators worked in a reliable manner with Mr. Y over a seven-year period, and worked diligently to provide him with care and treatment, the Care Programme Approach delivered did not always fulfil the requirements set out in the extant Trust policy. The role of the Care Coordinator consists of more than making visits and coordinating team members and services. CPA requires that service users have a comprehensive and holistic plan of care based on sound assessment that:

- supports a recovery model;
- maintains individuals safely in the community.

The consistent failings with the CPA process over time were with regard to:

- comprehensive risk assessment based on Mr. Y's full psychiatric history;
- dynamic care planning;
- crisis and contingency planning;
- carer assessment;
- Section 117 aftercare planning.

12.1.5.3. Conclusions

The Independent Investigation Team concluded that the Care Coordinators allocated to Mr. Y during the period of his contact with Trust services were suitably qualified and experienced in the role. They operated within the Trust CPA policy which was consistent with the

requirements of national standards. There were no significant resource issues in the allocation of Care Coordinators and no delays. During the most successful period of care from 2002 to 2007 they were helped by the support of other community based staff who supplemented the care coordination role. After 2007 it is the view of the Independent Investigation Team that Mr. Y was less well maintained on medication. One consequence was that although Care Coordinators engaged in an appropriate range of activities with Mr. Y, his cooperation and compliance varied. There is some evidence that the allocation of Care Coordinator 2 to Mr. Y was unwise and contrary to the Trust lone worker policy. The allocation of Care Coordinators 3 and 4 was appropriate. They tried to engage Mr. Y in activity that would promote his greater independence from his parents. However the therapeutic relationship was compromised by the inability of Mr. Y to be an active partner in his care plan. His behaviour was impulsive and worked against the agreed goals of the plan, there was evidence that he was not taking medication as prescribed or that the dose he received was not therapeutic. The care coordinators considered that they had tested Mr. Y's mental state thoroughly in their last contact with him a few days prior to the tragic incident.

The Independent Investigation Team found that CPA tools, including risk assessment, did not lead to an assertive approach to aftercare and relied too heavily on Mr. Y's reports that he was taking medication. There was not a contingency plan in place to respond to deterioration in Mr. Y's mental state.

As has been mentioned above in the findings section, Care Coordinators worked in a reliable manner in providing care and treatment to Mr. Y over time. However activity alone (visits, liaison, medication monitoring) should not be regarded as the successful implementation of the Care Programme Approach *per se*. The Care Programme Approach requires a far more systematic approach to its successful implementation. Whilst it was evident that the care and treatment Mr. Y received was generally of a good standard and incorporated both a multidisciplinary and a holistic approach, it was not always delivered in a formal manner in accordance with Trust policy and procedure. Whilst this cannot be shown to have made a direct causal contribution to the death of Mr. A, it is a point of learning for the Trust. The Independent Investigation Team considered this factor to have made a contribution over time to the deterioration of Mr. Y's mental state in that his needs were not always assessed in a comprehensive manner that led to a proactive, long-term care and treatment strategy.

- ***Contributory Factor Three: the CPA process included assessment tools (including those for risk) but these were not always completed fully and were not reflected in care plans. Care plans did not contain contingency planning for relapse and relied upon the compliance of Mr. Y.***

12.1.6. Risk Assessment

12.1.6.1. Context

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

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

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

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

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

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

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed*⁸⁸.

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

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

12.1.6.2. Findings

The Independent Investigation Team found that a number of formal risk assessments had been made in the care and treatment of Mr. Y. These were underpinned by the Trust Clinical Risk and Management Policy⁸⁹. The policy stated that:

“Pennine Care has approved STAR as the standard tool for assessment of risk, which should be used for all service users. STAR is fully integrated into the Trust CPA process, and is the risk assessment component of the CPA documentation”.

⁸⁸ Best Practice in Managing Risk; DoH; 2007

⁸⁹ Clinical risk assessment and management policy: version 2 August 2007

The STAR (Salford Tool for Risk Assessment) risk assessment tool contained a number of screening tools in the domains of suicide and self-harm, risk to others, self neglect and vulnerability to exploitation. The risk formulation should lead to a Risk Management Plan.

In Mr. Y's clinical records, apart from the formal use of the risk assessment tool, there were also other references to risk, for example in the assessments completed by doctors who were the Responsible Medical Officers for Mr. Y, or those asked for an opinion, for example the forensic psychiatrist, Senior Registrar 1.

During Mr. Y's first admission to hospital in 2001 there was a risk assessment⁹⁰ using the Oldham NHS Trust and Social Services Department CPA/Care Management risk assessment tool. This identified that Mr. Y was suffering from delusions, had a low frustration threshold, was low in mood, had a history of violence or threats of violence, and had a history of alcohol and substance misuse. This assessment was repeated in February 2002 after Mr. Y had been treated and similar findings were noted with the additional comment that Mr. Y lacked insight into his illness and displayed inappropriate sexual behaviour which would put himself or others at risk. There was a risk management plan which was updated in April 2002.

After the relatively long period when Mr. Y remained well in the community, a risk assessment was completed in September 2007 following Mr. Y's admission to hospital and then updated in November 2007. This used the STAR tool and was completed by a member of the Crisis Resolution and Home Treatment Team⁹¹. It listed crisis indicators as:

- disinhibited behaviour;
- non-concordance with medication;
- violent behaviour;
- delusions- often with sexual content;
- sleep disturbance.

It was noted that Mr. Y had possessed weapons with possible intent to use them and that he had an interest in guns. The summary noted that Mr. Y:

90 PR Vol 1 part 2 p 487

91 PR Vol 1 p 9

- had a history of assaulting his girlfriend and father, had been found in possession of replica firearms, made sexually inappropriate comments to female members of staff, stated he wanted to rape an Asian female and had shot a firearm in the air;
- that family members and females may be at risk when Mr. Y was delusional or stressed;
- that there was a risk directly related to schizophrenia and that there was a risk of relapse due to non compliance with medication;
- that his parents were worried about him coming home if he was unwell;
- that risk was increased by disengagement, non compliance and substance misuse.

The Independent Investigation Team were surprised that a lone female Care Coordinator was allocated to Mr. Y at about this time, given the risks to females identified in the assessment.

A further risk assessment was completed on 31 January 2008 during Mr. Y's in-patient treatment.⁹² It noted that Mr. Y had become increasingly hostile and threatening towards his parents, and had made an unprovoked attack on a member of staff, punching a nurse in the face.

After Care Coordinators 3 and 4 took over there was a final risk assessment on 15 May 2008. The initial screening form identified that Mr. Y had a history of mental illness, a risk of relapse, a history of sexually inappropriate conduct, and a forensic history. Care Coordinator 3 went on to complete a more detailed assessment in the domains of self-harm and violence noting that Mr. Y had had a previous history of poor compliance with medication leading to relapse, that he had previously used cannabis and alcohol, that he had paranoid delusions when not medicated, that he had a previous history of aggression when unwell with a conviction for Actual Bodily Harm⁹³. Care Coordinator 3 also completed the domain relating to substance misuse, noting that:

- alcohol and cannabis use led to a deterioration in mental state;
- alcohol had featured in aggressive episodes;
- alcohol and drug misuse had led to violence;
- Mr. Y associated with friends who drank heavily;
- That substance misuse was associated with a relapsing mental state.

⁹² CCCN Vol 2 p 29

⁹³ CCCN Vol 2 p 47

In the summary of the domain relating to violence, Care Coordinator 3 noted that:

- Mr. Y had a past history of violence and aggression towards family and an ex-partner and that he had made sexually inappropriate comments to a woman in-patient;
- had been found in possession of firearms;
- that risks were greatly increased when he was non-compliant with medication;
- that he had assaulted a nurse on the mental health ward in February 2008;
- that his parents were concerned when Mr. Y was unwell because of the risk of violence.

Care Coordinator 3 noted that risk was increased by factors of stress, substance misuse and non-compliance with medication and that protective factors were Clozaril medication and engagement with mental health services, support from his family and stress reduction.

The Independent Investigation Team found that the Trust risk assessment tool had been used as part of the assessment process and that its conclusions were broadly consistent over the history of Mr. Y's contact with mental health services.

The Independent Investigation Team also found that the risk assessment was not reflected in the discharge plans for Mr. Y which did not contain references to risk factors. The discharge arrangements focused on continued contact and monitoring of Mr. Y by the Care Coordinators and reliance on his compliance with oral medication. We found that, in interview, those involved in Mr. Y's care were well aware of risk factors but that these were implicit in the discharge plan rather than explicitly acknowledged.

The specific risks to Mr. Y's parents are set out in section 12.1.8. below.

12.1.6.3. Conclusions

The Independent Investigation Team concluded that the Trust risk assessment tools were used throughout Mr. Y's treatment, however the resulting risk assessments did not always contain a cumulative set of information. The last such assessment was completed on 15 May 2008, a week before his discharge from hospital. This included a risk management plan as required by the Trust risk management policy.

Risks were identified and formed a consistent pattern. Those who worked closely with Mr. Y were clear about the risk of non-compliance with medication, his use of alcohol and cannabis and the incidence of violence in his past behaviour. The discharge plan on 22 May 2008 did not reflect the information contained in risk assessments and relied too heavily on Mr. Y's compliance with medication. Information gathered after the incident showed that he had been non-compliant with medication as prescribed and had therefore been under-medicated. When assessed directly after the incident, he remained guarded and suspicious, at this stage it still was not evident that he had psychotic symptoms. When assessed at Ashworth Hospital after the death of Mr. A he showed florid signs of psychosis. His rationale for killing Mr. A was associated with psychotic and paranoid beliefs held at the time which contributed to his actions.

Information about risk was not sufficiently captured in the plan for Mr. Y after his discharge from hospital in May 2008. The risk of Mr. Y not taking medication was underestimated and information about this risk from Mr. Y's parents was not given sufficient weight. However this being said, at the time of his discharge on the 22 May and during his final assessment in the community on the 29 May 2008 no psychotic symptoms could be detected. Whilst it was acknowledged that Mr. Y retained a potential for high risk behaviour, and that this would require careful monitoring, it was not evident that he had reached a stage of mental health breakdown that would have indicated that any such behaviour was imminent.

Whilst the risk management care plan was not comprehensive, this in itself cannot be said to have made a direct causal contribution to the death of Mr. A. There was ample evidence to suggest that care Coordinators 3 and 4 discussed the case, and recorded these discussions in the clinical record. They also discussed the case with their Team Manager, and with Consultant Psychiatrists 6 and 7.

- ***Contributory Factor Four: the assessment of risk at the point of discharge took insufficient account of cumulative evidence from Mr. Y's history of mental health care. In particular compliance with medication and the views of his parents were under-estimated.***

- *Service Issue Four. The significant risk to Mr. Y's parents was not taken into account. This was compounded by the lack of carer assessment made available to them.*

12.1.7. Referral, Transfer and Discharge

12.1.7.1. Context

Pennine Care NHS Foundation Trust policies in relation to referral, transfer and discharge were contained within the Care Programme Approach (CPA) policy. The policy included sections on:

- access to specialist mental health services;
- assessment;
- care planning and coordination;
- discharge;
- transfer of CPA responsibility.

Trust policies were compliant with requirements from the Department of Health.

12.1.7.2. Findings

The Independent Investigation Team found that the Trust was largely compliant with policy in relation to the referral, transfer and discharge of Mr. Y. In the history of his contact with the Trust, Mr. Y had contact with a consistent care team. Most of his in-patient treatment was on the same ward and after discharge he had contact with care coordinators and the Crisis Resolution and Home Treatment Team who knew him well. Contact with Mr. Y's GP was maintained by the clinical team. Referral processes worked well and there were no significant delays in Mr. Y receiving treatment when required.

The Independent Investigation Team reviewed the transfer of Mr. Y to the psychiatric intensive care unit (PICU) in March 2008 after he had assaulted a nurse and concluded that this transfer was appropriate and achieved the aim of establishing safer control of his

treatment in response to the incident.⁹⁴ He was able to return to the mental health unit after a few weeks. Clinical handover to the PICU unit was satisfactory and complied with the requirements of the Mental Health Act in relation to transfers between units that are part of the same mental health Trust.

In May 2008, Mr. Y started to have extended periods of home leave under Section 17 of the Mental Health Act. He was visited regularly by the Crisis Resolution and Home Treatment Team (CRHTT) who reported good progress. The record of the ward round on 22 May 2008 said that *“crisis resolution very pleased with Mr. Y- engaging well”*⁹⁵. The decision was made at this ward round for Mr. Y to be discharged and that there would be no input from the CRHTT. In the view of the Responsible Clinician when interviewed by the Independent Investigation Team, the feedback from the CRHTT reinforced the impression that Mr. Y was compliant with medication and ready to be discharged. In the discharge plan recorded in the case notes, there was no reference to the role of Mr. Y’s parents in the discharge planning process, and neither were they present at the meeting, although they were clearly important in giving feedback to the clinical team on Mr. Y’s mental state.

The Independent Investigation Team’s view is that Mr. Y should have been seen as a high risk patient, as defined by the Trust risk policy. As such the Trust policy on discharge would have been to follow him up within 48 hours of discharge⁹⁶. The Trust policy stated that:

“All service users assessed as being at high risk during their admission should be followed up within 48 hours of discharge. Arrangements for more intensive follow up and support within the first 3 months post-discharge should also be outlined in the care plan”.

The Trust Internal Investigation Review into the death of Mr. A concluded that Mr. Y posed a high risk to himself and others and the risk assessments completed by members of the clinical team supported this judgment.

Further support to this view came from the application of the Trust policy in relation to “difficult to engage service users- managing compliance”⁹⁷. This policy draws attention to the findings of *Safety First*⁹⁸.

94 CCCN Vol 1 p133 et seq

95 CCCN Vol 1 p155

96 TP p 167

97 TP p167

In particular Mr. Y fell within the definition of the small number of service users with severe mental illness and complex needs who have difficulty in engaging with services. The Trust policy suggested that “*assertive outreach is an effective approach to the management of this group*”.⁹⁹

The Trust policy stated that:

“The multi-disciplinary team should consider assertive outreach as an approach for service users with a severe mental illness who meet the following criteria:

- *A severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a high level of disability;*
- *A history of high use of in-patient or intensive home-based care (e.g. more than two admissions or more than six months of in-patient care in the past two years);*
- *Difficulty in maintaining lasting and consenting contact with services;*
- *Multiple, complex needs including a number of the following-:*
- *History of violence or persistent offending;*
- *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 at least once in the last two years;*
- *Unstable accommodation or homelessness.”*

The discharge plan for Mr. Y should also have included reference to Section 117 Mental Health Act, since, as a patient who had been treated under Section 3 Mental Health Act, he qualified for consideration under the duty of the Trust to provide statutory after-care.

The discharge plan did not therefore build on the risk assessment work completed by the team and did not give sufficient attention to the need to maintain close contact with Mr. Y. It did not contain contingency planning for any of the predictable problems in treating Mr. Y in the community, notably lack of compliance with medication.

98 Safety First: Appleby L et al: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness: London DoH
99 TP p168

A further complicating factor in the care and treatment of Mr. Y was the impact of the policy requirements of *New Ways of Working*. The implementation from April 2008 of this policy meant that Mr. Y was under the care of three Consultant Psychiatrists within a period of six weeks. Consultant Psychiatrist 3 had known Mr. Y well and had been his consultant during the years when he remained well, Consultant Psychiatrist 6 became his consultant and reviewed Mr. Y's care in a total of seven ward round meetings before discharge. Consultant responsibility then passed to Consultant Psychiatrist 7 who had not met Mr. Y. Consultant Psychiatrist 7 would have followed up Mr. Y routinely in the community but a few days after discharge had not had the opportunity to do this. Some witnesses told the Independent Investigation Team that the changes in practice from *New Ways of Working* acted against maintaining continuity of contact with patients.

However at interview with the Independent Investigation Team, Consultant Psychiatrist 6 felt that he did have a good working knowledge of Mr. Y upon which to base his decision-making in that he had worked with him several years before, during his first admission and had met him on many occasions since taking over lead consultant responsibilities for him in 2008. It must also be remembered that Mr. Y had been on extensive home leave prior to his discharge and it was the view of the clinical team that he was managing well. His parents were also on record during this period as being happy to have him at home.

12.1.7.3. Conclusion

The Independent Investigation Team concluded that although most episodes of treatment were conducted in accordance with Trust policies, there was, in the last discharge from hospital in May 2008, insufficient weight given to evidence from risk assessment and previous experience. There was a case for obtaining greater involvement by making a referral to the Assertive Outreach Team to monitor Mr. Y more closely.

That being said, it is acknowledged that the decision to discharge Mr. Y was made based upon a period of assessment during which time he appeared to be ready to go back into the community, albeit with significant support. The Independent Investigation Team concluded that some of the support mechanism options that should have been considered at this time, such as Assertive Outreach Services, were not made available to Mr. Y. It was also evident that a long-term proactive Care Programme Approach Care Plan, that addressed both risk and

recovery model issues, had not been comprehensively developed prior to his discharge. This could have been achieved better had Section 117 aftercare arrangements been in place.

It cannot be known whether a referral to the Assertive Outreach Service would have prevented the death of Mr. A. It is probable that any clinical input of any kind would have at this stage failed to detect the level of delusional thinking that Mr. Y had kept hidden from everyone. Whilst the Independent Investigation Team can find no contributory factors relevant to this section there are two relevant service issues set out below for Trust learning.

- *Service Issue Five: when service users meet the criteria for the assertive outreach service, as set out in Trust operational guidance, they should be considered for referral to that service as a preferred option.*
- *Please also see Service Issue Two.*

12.1.8. Carer Assessment and Carer Experience

12.1.8.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that *‘the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes’*. In particular the National Service Framework for Mental Health (DH 1999) states in its guiding principles that *‘People with mental health problems can expect that services will involve service users and their carers in planning and delivery of care’*. Also that it will *‘deliver continuity of care for as long as this is needed’*, *‘offer choices which promote independence’* and *‘be accessible so that help can be obtained when and where it is needed’*.

Carer involvement

The recognition that all carers, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and

Services) Act 1995 gave carers a clear legal status. It also provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensures that services take into account information from a carer assessment when making decisions about the cared for person's type and level of service provision required. Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to carers. It also gave carers the right to an assessment independent of the person they care for.

The Carers (Equal Opportunities) Act 2004 placed a duty on Local Authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. It also facilitated cooperation between Authorities in relation to the provision of services that are relevant to carers.

In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health stated that all individuals who provide regular and substantial care for a person on CPA should:

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

12.1.8.2. Findings

In this report Mr. Y's parents are identified as Mr. Y senior (father) and Mrs. Y (mother).

Mr. Y lived with his parents. He was the youngest of three children and had two older sisters who did not live at home at the time of the incident. Mr. Y senior and Mrs. Y were both very involved in Mr. Y's care. They often attended ward rounds and meetings where Mr. Y's care and treatment was being discussed. They were a valuable source of evidence to the clinical team about Mr. Y's mental state. This was particularly important later in Mr. Y's treatment when he characteristically became guarded with professional workers. This tendency was noted many times in observations of his behaviour.

When Mr. Y first came to the attention of mental health services in December 2001, this was as a result of an assault on his father. Investigation at the time showed that Mr. Y had many delusional beliefs centred on his family and in particular delusions about sexual interference from his parents. On 11 January 2002 Mr. Y was detained under Section 3 Mental Health Act (1983) after threatening his father.

Mr. Y senior and Mrs. Y maintained close contact with the clinical team during 2002 and on 18 October 2002 Mr. Y was well enough to be discharged to live with his parents.

In the chronology of Mr. Y's care and treatment the period from this discharge in 2002 to mid-2007 is established as a successful phase of treatment. Mr. Y was able to accompany his family on holidays and made good progress in education and employment and was able to work. Support from his parents was of great value to Mr. Y and although greater independence was a theme in his interviews with professionals monitoring his mental state, he derived positive support from family life.

By the middle of 2007, however there were concerns from Mr. Y's parents that he was not taking medication as prescribed and that his alcohol intake had increased. The view of Mr. Y's parents was that Mr. Y persuaded the doctors to change medication because he reported adverse side effects, such as weight gain, but that the new medication was less effective. The parents also reflected that after Mr. Y was discharged he received visits from the Crisis Resolution and Home Treatment Team but that these were brief in duration and did not test Mr. Y's mental state to any degree. Mr. Y was capable of being guarded and denying that he had not taken medication.

This was recorded at a routine visit to out-patients to see his Psychiatrist on 10 July 2007¹⁰⁰. Mr. Y senior recalled that Mr. Y had not been taking medication at that time:

"But I think he was taking it in dribs and drabs from, say, April 2007. You have to understand that we've lived with him for a long while and the wife was quite aware of all this, but by the time you got to 2007 you weren't getting the people coming round to your accommodation as much because they thought he was doing great now he's at home, so you don't see them for six months type of thing, and the contact gradually had gone really down,

100 CCCN Vol 1 p85/ PR Vol 1 p 249

it has to be said, notwithstanding he'd probably have to go to see possibly Consultant Psychiatrist 3 six-monthly. Having said that, we were where we are there, and we feel he was deteriorating."

This deterioration led to Mr. Y returning to hospital on 15 September 2007 under a section of the Mental Health Act. By 11 October 2007 he was able, with the agreement of his parents to come home for short periods. And on 19 November 2007 he stayed on overnight leave with the permission of Mr. Y senior.

In January 2008 the parents were concerned about Mr. Y's behaviour and Care Coordinator 2 arranged to see Mr. Y senior on his own to discuss the issues of concern. She saw him on 18 January 2008 at the community mental health team base¹⁰¹. Mr. Y senior reported familiar concerns that Mr. Y was not taking medication, drinking alcohol and spending more time away from the family home.

Mr. Y was admitted to hospital early in February 2008 and following an assault on a nurse was treated at the Psychiatric Intensive Care Unit before returning to the mental health unit.

By April 2008 Mr. Y was able to have home leave and the clinical team kept in touch with Mr. Y's parents to monitor the progress of those visits.

In April 2008 Mr. Y was being visited regularly by members of the CRHTT when at home and was reported to be doing well. However, Mr. Y senior expressed some reservations about the effectiveness of those monitoring visits:

*"these crisis teams came round, and I think a lot to be desired for these. They just came in the house for five minutes, 'How are you Mr. Y?' We all know what Mr. Y's going to say: 'I'm all right, how are you?' 'Are you taking your medication?' 'Yes.' This goes on. How do you get round this one when you know it's not right? The wife would be in the kitchen, 'No, you're not taking it.' 'He says he is.' I don't know how we get round this one, it is difficult."*¹⁰²

101 PR Vol 1 p 212

102 Transcript p 4

Mr. Y senior attended ward rounds with Mr. Y's new consultant, Consultant Psychiatrist 5, and was party to the discussions about referral to supported accommodation with Care Coordinators 3 and 4. He was in agreement with these plans and accompanied Mr. Y and the Care Coordinator on a visit to a supported housing project in Oldham. Mr. Y was present at the ward round on 15 May 2008 when these plans were discussed.

However Mr. Y senior was not present at the ward round on 22 May 2008 when it was decided to discharge Mr. Y and end his treatment order. Mr. Y senior recalled:

"We weren't expecting him to be home and we were gobsmacked".

Mr. Y senior and Mrs. Y thought that Mr. Y was not well and requested a visit from the Care Coordinators which took place on 29 May 2008. Their recollection of Mr. Y's behaviour at this time was that he showed overt signs of illness:

"We were frustrated big time, he was pacing about big time, he'd gone back on the cigarettes. I'm not kidding you, you really have to live with it, and it really got bad then. I was at my wit's end, me and the wife, and he was just pacing around the living room. That was on the Saturday."

The action agreed by the Care Coordinators after their visit on 29 May 2008 was to request an early appointment for Consultant Psychiatrist 7 to see Mr. Y as an out-patient on 3 June 2008.

In evidence given to the Independent Investigation Team, Mr. Y senior described the events of 1 June 2008. He confirmed that Mr. Y did not speak about his intention to carry out the fatal attack on Mr. A or his reasons for it. He left the family home and returned within a relatively short period of time, having driven to the Cheetham Hill area of Manchester and stabbed Mr. A. He then went to Manchester for a few hours by bus but did not tell his parents what he had been doing.

The Independent Investigation Team asked Mr. Y senior whether there had ever been a carer's assessment completed on his or his wife's behalf. He said that this had not been discussed with them. The Team found no record of a carer's assessment on the case files. As

part of the CPA documentation there was a carer's assessment form, signed by a nurse but not completed.¹⁰³

The Independent Investigation Team asked Mr. Y senior about the support he and his wife received from the Trust after the incident and he said that he had been visited by Care Coordinator 3 and by someone who had known Mr. Y at the employment scheme that he attended, but that there had been no contact with Trust Managers. The family would have welcomed contact with the Trust during this very difficult period.

12.1.8.3. Conclusions

The Independent Investigation Team concluded that Trust staff had regularly consulted with, and included Mr. Y's parents in, discussion about his care and treatment, but that their views were insufficiently valued. In particular they should have received a formal carer assessment as required by legislation and guidance. They were the primary carers for Mr. Y and at times the victims of his behaviour. Mr. Y senior and Mrs. Y had both been assaulted by their son and Mr. Y had made threats against his family when unwell. The family were at the centre of his delusional beliefs.

The parents were also a source of insight into the effectiveness of Trust care and treatment. The Trust Crisis Resolution and Home Treatment Team (CRHTT), for example visited frequently during periods of care and treatment in the community but the family viewed their involvement as unchallenging and cursory. A feature of Mr. Y's behaviour was that he was guarded about his experiences and denied active symptoms. His assurances that he was taking medication and that he was "*alright*" were taken at face value and not tested against the knowledge of his parents that he was, in fact, hoarding medication and non-compliant.

Mr. Y's parents' view was that Mr. Y remained well from 2002 to mid-2007 because he was willing to take medication. They felt that his mental health deteriorated because:

- he did not take oral medication as prescribed and persuaded doctors to change the dose;
- he began associating with friends who discouraged taking medication;
- he used alcohol and cannabis;

103 CCCN Vol 2 p 57

- he learned to hide his true thoughts and feelings from professionals to avoid going back to hospital.

Crucially, Mr. Y senior and Mrs. Y were not involved in the care plan when Mr. Y left hospital on 22 May 2008. Although their views and experience should have been a major theme of the plan, there was no reference to them in the notes.

In relation to the incident the Independent Investigation Team found that Mr. Y gave no warning to his parents about his intention to fatally attack someone. He had never met the victim, Mr. A, before and his attack was an unplanned, impulsive action.

We found that the Trust did not offer consistent support to Mr. Y senior and Mrs. Y after the incident and did not follow the practice recommended in the Trust policy,¹⁰⁴ which emphasises “*open and honest communication with patients and their relatives or carers is essential.*” A visit was made to them after the incident by Care Coordinators 3 and 4 but the Trust did not follow through with regular contact during the post incident processes.

We asked the Trust for information about carer’s assessments across all localities served by it and this data is included in this report in appendix 2. This shows that the Trust performance in relation to carer’s assessments was very poor in the locality where Mr. Y lived and variable across the borough served by the Trust.

Whilst the failure to provide a carer assessment to the parents of Mr. Y cannot be seen as a contributory factor to the death of Mr. A, it is a serious omission on the part of the Trust. The failure to involve the parents more fully in Mr. Y’s care and treatment and the failure to assess their needs and the risks presented to them placed them in a highly difficult and potentially dangerous situation.

- ***Contributory Factor Five: the views of carers are an essential part of the process of assessment and care planning, particularly when the carers live with the patient and have detailed knowledge of his mental state and behaviour. Their views were insufficiently weighted by the clinical team at the point of discharge in May 2008.***

104 Incident Reporting Management and Investigation policy : version 5

- *Service Issue Six: the performance of the Trust on completion of carers' assessments is very variable and in some localities poor. The parents of Mr. Y did not receive an assessment of their needs as principal carers and this placed them in a position of difficulty.*

12.1.9. Service User Involvement in Care Planning

12.1.9. 1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:

'the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes'.

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *'people with mental health problems can expect that services will involve service users and their carers in planning and delivery of care'*. It also stated that it will *'deliver continuity of care for as long as this is needed'*, *'offer choices which promote independence'* and *'be accessible so that help can be obtained when and where it is needed.'*

12.1.9.2. Findings

The Independent Investigation Team found that efforts were made to involve Mr. Y in his care and treatment at each stage of his contact with Trust services. During the most successful period of treatment from 2002 to 2007 he maintained regular contact with his care coordinator and responsible clinician through out-patient appointments. Mr. Y's self-reporting of his mental health was supplemented by views expressed by his parents to the care team. Care plans included some of the aims and aspirations expressed by Mr. Y for improvements to his social functioning including employment training and acquisition of a wider range of social skills. He also benefitted from the involvement of a community support worker who helped him to achieve a number of practical goals and a more engaged profile in the local community. When Mr. Y was well he was able to work and engage with family activities.

From his return to hospital in 2007 to the time of the incident, Mr. Y's compliance with treatment plans was variable. Care Coordinators worked with him to achieve goals that he had identified as important to him. His two care coordinators allocated in May 2008 tried to achieve the goals he had set for himself which centred on greater independence from the family home. The steps they took to achieve this aim were appropriate. The approach they took was inclusive of his views. Mr. Y's ability to work with professionals towards agreed goals was compromised by his non-compliance with medication. This meant that his increasing irritability and impulsiveness acted against the care plans that were made by the clinical team.

12.1.9.3. Conclusions

Mr. Y had contact with a wide range of Trust services including the psychiatric intensive care unit, the Crisis Resolution and Home Treatment Team and the Community Mental Health Team. The Independent Investigation Team found that individual professionals and teams working with Mr. Y sought to take his views into consideration at each stage of his care and treatment. This was evidenced by formal assessments and care plans using standard Trust assessment and planning tools, for example the Care Planning Approach documentation. The effectiveness of this approach varied over the course of Mr. Y's treatment from periods when he was compliant with medication and making good progress to the latter stages of his treatment when he was not taking medication as prescribed and masking his symptoms. At this point his capacity to work with the care team in an engaged and open effort towards the aims of the care plan was limited.

It is a point of good practice that the Trust engaged with Mr. Y by using a Community Support Worker to work with him for several years. It was evident that this intervention was meaningful to Mr. Y. The Community Support Worker encouraged Mr. Y to engage in positive recreational activities in the community, such as attending the gym and going swimming. This provided a positive example of a patient-centred approach. The Community Support Worker made some 120 contacts with Mr. Y and this played a significant part in keeping Mr. Y well for the five year period that he was maintained in the community prior to his health breaking down in 2007.

12.1.10. Documentation and Professional Communication

Documentation and use of records

12.1.10.1 Context

“The Data Protection Act gives individuals the right to know what information is held about them. It provides a framework to ensure that personal information is handled properly.

The Act states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- *Fairly and lawfully processed;*
- *Processed for limited purposes;*
- *Adequate, relevant and not excessive;*
- *Accurate and up to date;*
- *Not kept for longer than is necessary;*
- *Processed in line with your rights;*
- *Secure;*
- *Not transferred to other countries without adequate protection”.*¹⁰⁵

All NHS Trusts are required to maintain and store clinical records in accordance with the requirement of the Act. All records should be archived in such a way that they can be retrieved and not lost. All records pertaining to individual mental health service users should be retained by NHS Trusts for a period of 20 years from the date that no further treatment was considered necessary; or eight years after the patient’s death if the patient died while still receiving treatment.

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

¹⁰⁵ Information Commissioner’s Office Website 2009

The GMC states that:

*“Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off.”*¹⁰⁶

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

*“Records remain the most tangible evidence of a psychiatrist’s practice and in an increasingly litigious environment, the means by which it may be judged. The record is the clinician’s main defence if assessments or decisions are ever scrutinised”.*¹⁰⁷

12.1.10.2 Findings

The Trust had published a Records Management Policy containing standards for record keeping¹⁰⁸. It included minimum standards for record keeping. It also emphasised good practice in relation to clear and contemporaneous recording.

The Independent Investigation Team examined all case records held by the Trust about Mr. Y and also his GP record and forensic psychiatry records completed after the incident. Records were generally of good standard in recording the day to day contact with him by a wide range of professional workers throughout the duration of his care and treatment. Apart from the ‘running record’ of contact there were more formal recordings- for example the assessments and plans required by the Care Programme Approach (CPA) and the risk assessments that were part of that process. There were also reports prepared for the Mental Health Review Tribunal or Hospital Managers’ hearings which were of a good standard. Mr. Y had also been assessed by a forensic psychiatrist early in his contact with the Trust and the psychiatrist’s assessment gave a good account of the mental health problems that affected Mr. Y for the subsequent years.

The most common weakness of case records was that entries were not signed and dated clearly and that professional workers used first names to identify themselves- only identifiable at a later date to people who knew the workers concerned. Also some formal

¹⁰⁶ <http://www.medicalprotection.org/uk/factsheets/records>

¹⁰⁷ Pullen and Loudon, *Advances in Psychiatric Treatment*, Improving standards in clinical record keeping, 12 (4): (2006) pp 280-286

¹⁰⁸ Records Management Policy Version 3 March 2007, p 12

records were not completed fully. In the most striking example, a carers' assessment was held on file, which had been signed by a member of the nursing staff, but not completed.

The Independent Investigation Team found that there were two particular missed opportunities in recording. In the first, when Mr. Y had his first in-patient admission lasting several months, there was a good opportunity to complete a full assessment of his family background. His parents and siblings were available to the clinical team and would have been able to give a fuller account of his early years and family life. Since the family were at the heart of Mr. Y's delusions, this would have been of lasting benefit to those treating Mr. Y. Mr. Y, at this time had also had contact with the criminal justice system and that was not captured by the completed assessments.

The second opportunity was cumulative over the years of care and treatment. That is, although assessments were completed at intervals, they did not lead into a treatment plan that took account of everything that was known about Mr. Y. This was particularly clear in relation to his non-compliance with medication and impulsivity, both characteristics that were recorded by successive assessments. Yet when Mr. Y was discharged from hospital care in May 2008, his care plan did not address these issues fully. This reflected a tendency for documents to be completed for their own sake rather than used as a working tool by the clinical team. Had the accumulated knowledge about Mr. Y been used more effectively, a more assertive approach to his after-care would have been taken.

12.1.10.3 Conclusions

Clinical records were adequate in recording the contact between Mr. Y and the mental health service. They would have been improved by periodic summaries drawing together the strands of work, by more accurate attribution to workers through clear signing and dating, and by full completion of formal documents used in the CPA process.

- *Service Issue Eight: there is a need for the Trust to reinforce the importance of accurate record keeping to operational staff.*

Professional Communication

12.1.10.4 Context

‘Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion.’¹⁰⁹

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user centric manner.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and have a history of criminal offences cannot be met by one agency alone¹¹⁰. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticises agencies for not sharing information and not liaising effectively¹¹¹. The Department of Health *Building Bridges* (1996) sets out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required. This level of expectation was firmly in place during the time that Mr. Y first came to the attention of mental health services.

12.1.10.5 Findings

The Independent Investigation Team evaluated the quality of communication between professionals involved in the care and treatment of Mr. Y. In relation to the interface between primary and secondary care, we found that the GP was kept informed of developments in Mr. Y’s care through letters from the Responsible Medical officer (RMO). After his admission to hospital in 2001, his care was largely organised by the Trust and continuity maintained through Consultant Psychiatrist 3 who was Mr. Y’s consultant psychiatrist for several years. Internal Trust communication was good with evidence of multi-disciplinary working and care coordination through the CPA process.

In 2007, Mr. Y was referred to the Trust Psychiatric Intensive Care Unit (PICU) and this transition was managed well.

109 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) p 121

110 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999). p 144.

111 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

Liaison with agencies outside the Trust was also evidenced in case notes. For example, there were agencies involved in supporting Mr. Y to return to work and develop social skills. He had intensive support from a Community Support Worker who encouraged him to attend facilities in the local community like the gym. In the later stages of his care he was referred to a supported housing scheme and there was a housing support worker present at the ward round meetings when plans for his discharge were discussed.

Through the Community Mental Health Team (CMHT) Mr. Y had access to Care Coordinators who were from a nursing or social work background. They were appropriately trained and experienced practitioners. The CMHT combined both health and social care expertise and during the years of Mr. Y's contact with services this integration became closer as local authority and health services were aligned.

The Independent Investigation Team asked Trust doctors during interview about the implication of *New Ways of Working* for transfer of patients between in-patient and community services. There were systems in place for transfer of information following discharge and at the time of the incident this was largely through a discharge letter. Such a letter had been written by Senior House Officer 3, who was a junior doctor, to Consultant Psychiatrist 7 with details of Mr. Y's discharge arrangements. The Trust Internal Investigation report found that communication between consultants had not been a significant issue in this case but nevertheless made a recommendation that attention should be drawn to potential difficulties as a result of the implementation of *New Ways of Working*.

The Independent Investigation Team considered that transfer of consultant responsibility at the point of discharge on the 22 May 2008 placed a greater onus on the Care Coordinators to ensure continuity and monitor mental health during the transition.

12.1.10.6 Conclusions

The Independent Investigation Team found that professional communication was achieved successfully throughout Mr. Y's care and treatment. This was helped by continuity for several years in the individual practitioners looking after him. He was also well known to nursing staff on the in-patient unit who had contact with him for several months. Regular ward round meetings were used to inform members of the clinical team about progress. Mr. Y's parents attended many meetings with the clinical team. Towards the end of his contact

with the Trust there were changes to the delivery of services that led to a faster pace of change in those responsible for his care. This placed a greater responsibility on the care coordinators to provide continuity.

- *Service Issue Seven: when patients move from hospital to community based treatment they have a change of Responsible Clinician. This places a greater premium on the continuity provided by the care coordinator and the timely exchange of information between consultant psychiatrists.*

12.1.11. Clinical Supervision

12.1.11.1. Context

There has been a growing interest in and awareness of the importance of clinical supervision in all health and social care professions over the past two decades, particularly in mental health professions. There are guidance documents from registration and professional organisations¹¹² which stress the importance of supervision for clinical governance, quality improvement, staff development and maintaining standards.

The NHS Management Executive defined clinical supervision in 1993 as:

‘....a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations’¹¹³

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

¹¹² Nursing and Midwifery Council. (2008) Clinical supervision for registered nurses.

¹¹³ Nursing and Midwifery Council, Advice Sheet C. (2006)

12.1.11.2. Findings

Supervision arrangements in the Trust were set out in the Supervision Policy¹¹⁴. The policy set out the expectations for staff supervision and provides a framework for the activities to take place. The policy makes a distinction between management supervision and specialist supervision. All staff should have access to both forms and staff employed by the local authority should also benefit from the local authority's policies in this area.

The Independent Investigation Team found that staff working with Mr. Y had access to supervision and understood the place of both management and specialist supervision. The care coordinators for Mr. Y were very experienced and there was evidence that they had used professional and management consultation appropriately.

12.1.11.3. Conclusion

The Independent Investigation Team found that the Care Coordinators, and other clinical staff members responsible for Mr. Y's care, received good quality supervision in line with the Trust policy.

12.1.12. Adherence to Local and National Policy and Procedure

12.1.12.1. Context

Evidence-based practice has been defined as '*the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.*¹¹³' National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the

¹¹⁴ Supervision Policy Version 2 October 2007: PR p 109 et seq

capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of clinical governance which is explored in Section 12.1.14. below.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said policies or procedures or to raise any implementation issues as they arise with immediate effect.

12.1.12.2. Findings

The Independent Investigation Team found that the Trust operated within clear corporate policies. Of particular relevance were the Trust policies on clinical risk assessment and management, incident reporting and investigation, and operational policies for the Community Mental Health Teams and the Crisis Resolution and Home Treatment Team. Senior managers were committed to maintaining corporate standards across the disparate localities served by the Trust. They had developed more sophisticated systems for clinical governance since the incident and in response to the contemporary standards expected by regulators and the Trust Board. The Trust had achieved excellent ratings when assessed by the Care Quality Commission (CQC)¹¹⁵ in 2008/09.

At team level, the Community Mental Health Team that carried responsibility for Mr. Y's care was led by an experienced manager and the Care Coordinators allocated to Mr. Y were well qualified and experienced. The Independent Investigation Team was impressed by the Team Manager's commitment to the role and knowledge of both local and national good practice in mental health care. He had been fully engaged in discussion about the

¹¹⁵ NHS Ratings 2008/9 An Overview of the Performance of NHS Trusts in England: Care Quality Commission

management of the case with the Care Coordinators and had been involved in decision-making at the time of the incident. Although his direct knowledge of Mr. Y was limited he gave an account to the Independent Investigation Team of the operational challenges facing the Community Mental Health Team at the time of the incident. This included the reorganisation of teams to service geographical localities rather than being based on diagnostic categories (i.e. psychosis or non-psychosis). This organisational change had been disruptive to some extent as staff moved to new teams or were allocated according to the needs of the service. However, in relation to the delivery of care to Mr. Y, the Team Manager considered that this had not been affected adversely. The Team Manager was aware of national and local policies and their operational requirements.

Similarly we found that the individual practitioners involved in the care and treatment of Mr. Y were aware of Trust policies. The Trust Internal Investigation report made a recommendation that there should not be delays in the allocation of Care Coordinators—apparently this had been a problem in the locality served by the CMHT. However the Independent Investigation Team found that this was not an issue in this case and Mr. Y was not disadvantaged by delay in referral or allocation of a Care Coordinator. Both Care Coordinators allocated to Mr. Y were experienced and in interview demonstrated good knowledge of both national and local expectations in the delivery of mental health care.

What cannot be explained is why, over time, certain clinical policies were not adhered to appropriately. These policies and procedures included:

- CPA (with particular reference to care planning, crisis and contingency planning, and carer assessments);
- Section 117 after care arrangements;
- Clinical risk policy (with particular regard to care planning and managing the risk of potentially dangerous individuals on discharge).

12.1.12.3. Conclusion

Pennine Care NHS Foundation Trust had fit-for-purpose policies in place that reflected national best policy guidance. These policies and procedures were evidence-based and were considered by the Independent Investigation Team to be of a very high standard. What cannot be so easily understood is why certain clinical policies and procedures had not been adhered

to. It was made evident to this Investigation that audit systems are currently being developed, and that at the time of the incident may not have been sophisticated enough to determine non adherence issues. Whilst Investigations of this kind should not be tempted to make sweeping generalisations based on the examination of a single case, it was evident when interviewing many of the clinical witnesses that they were not aware of Section 117 aftercare obligations or carer assessment requirements. Many clinical witnesses when interviewed described processes that albeit thorough, were of an informal rather than formal kind. Documentation of assessment and care planning processes were not always embedded within the clinical culture.

Since the incident the Trust has continued to develop better governance systems to ensure compliance with policy throughout the Trust.

- *Service Issue Eight: the Trust policies and procedures were found to be of an excellent quality, however adherence to them was found to be poor with regard to CPA documentation, carers' assessments, Section 117, internal investigation process.*

12.1.13. Organisational Change and Professional Leadership

12.1.13.1. Context

In October 2007 *New Ways of Working for Everyone* was published. This document set out the national implementation guide for policy change that had been in development over a period of four years previously. The Department of Health stated that *New Ways of Working* “promotes a model where distributed responsibility is shared amongst team members and no longer be delegated by a single professional such as the consultant”.

The Department of Health also stated that “this cultural shift in services will mean that people with the most experience and skills will work face to face with people who have the most complex needs. More experienced staff will then support other staff to take on less complex or more routine work. All qualified staff will be able to extend the boundaries of what they do (i.e. non medical prescription) and there will be more chances for new roles

*such as support time and recovery workers (STR), primary care mental health workers and assistant practitioners to take their places within teams”.*¹¹⁶

Pennine Care NHS Foundation Trust implemented the changes required from the Department of Health during 2008. They had an impact on the organisation of services and the care delivered to Mr. Y.

12.1.13.2. Findings

Organisational Change

The Independent Investigation Team found that the implementation of *New Ways of Working* in the local context led to reorganisation of teams and responsibilities. Mr. Y had been cared for by Consultant Psychiatrist 3 for some years. This had included the period of five years when Mr. Y had remained well in the community and was willing to see Consultant Psychiatrist 3 regularly as an outpatient and take medication as prescribed. Consultant Psychiatrist 3 knew Mr. Y very well and had also had frequent contact with Mr. Y's parents. As a result of organisational change in the Trust, consultant responsibility was transferred to Consultant Psychiatrist 6 who took over Mr. Y's care because he was an in-patient. Consultant Psychiatrist 6 had a period of weeks as Mr. Y's consultant before the decision to discharge him to his parents' care on 22 May 2008.

Under the 'old' system Mr. Y would have remained the responsibility of the same consultant psychiatrist after discharge with the advantage of continuity of care. This would have been particularly helpful in Mr. Y's case because of the knowledge of Consultant Psychiatrist 3 of signs of relapse and his rapport with him and his family. Consultant Psychiatrist 6 in interview felt that he had a good knowledge of Mr. Y and indeed had been involved with him some years earlier when he was a junior doctor working with Consultant Psychiatrist 3. After the decision to discharge Mr. Y, responsibility for follow up in the community fell to Consultant Psychiatrist 7. This was as a direct result of the changes to the organisation of services as consultant psychiatrists were allocated to either in-patient or community-based teams.

¹¹⁶ http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_074106

When the Care Coordinators visited Mr. Y on 29 May 2008 and decided that an early assessment was required it was to Consultant Psychiatrist 7 that the referral was made. Consultant Psychiatrist 7 had never met Mr. Y and had no direct clinical knowledge of the case. An early out-patient appointment was offered to Mr. Y. At interview Consultant Psychiatrist 7 agreed that this was a typical response time for an urgent referral. If a patient needed to be seen more quickly, the consultant on call system was the appropriate route and this would ensure that the patient could be seen the same day.

New Ways of Working did affect the continuity of the care and treatment offered to Mr. Y. However it was evident to the Independent Investigation Team that services worked with Mr. Y in a sensible manner during this period. Whilst Mr. Y had been allocated to Consultant Psychiatrist 6 relatively recently prior to his discharge, consistent assessment was undertaken during this period by the Crisis Resolution and Home Treatment Team, the Community Mental Health Team and the Inpatient Team. Consultant Psychiatrist 6 met with Mr. Y at ward round seven times during this period, he also met with Mr. Y's parents on many occasions. Whilst it is acknowledged by the Independent Investigation Team that periods of transition often represent significant challenge, the organisational change brought about by *New Ways of Working* cannot be seen to have had a detrimental effect of any significant kind on the care and treatment that Mr. Y received.

Professional Leadership

Professional leadership has been assessed as good. This was evidenced by the clinical record over time that clearly documented the consistent availability of senior clinical managers and leaders. The clinical record bears testimony to the culture of advice seeking, enquiry and supervision (albeit sometimes informal). It was evident that concerns were discussed on a regular basis and that clinical staff understood clearly when to discuss difficult situations with their managers and senior clinical colleagues.

12.1.13.3. Conclusions

The Independent Investigation Team found that the Trust organisational changes regarding the delivery of services had an impact on the care received by Mr. Y, but that this was managed in a sensible manner by the clinical teams involved in providing his care and treatment. He came under the care of three different consultant psychiatrists within a period of two months as he made a significant transition from in-patient care to community living

with his parents. Reorganisation of Community Mental Health Teams also led to a transfer of care to new Care Coordinators. However all professionals concerned were qualified and experienced and their decision-making was informed by Mr. Y's presentation at the time. The Independent Investigation Team concluded that although organisational change was an important correlate in Mr. Y's care it could not be viewed as causal in the series of events that led to the killing of Mr. A. In reviewing the case of Mr. Y it was evident that strong clinical leadership ensured that services were maintained safely during this period.

12.1.14. Clinical Governance and Performance

12.1.14.1. Context

*'Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish'*¹¹⁷

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

During the time that Mr. Y was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation.

12.1.14.2 Findings

Independent Performance Ratings

In 2008/09 Pennine Care NHS Foundation Trust was rated amongst the 44 highest performing Trusts by the Care Quality Commission (CQC)

¹¹⁷ Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

Clinical Governance Review

As part of its terms of reference and in fulfilment of the requirement in HSG (94)27 to restore public confidence, the Independent Investigation Team asked Pennine Care NHS Foundation Trust to provide an up-to-date account of its clinical governance structure. The following is an extract from their statement to the team and represents the Trust view of current arrangements:

Ward to Board Culture

Pennine Care NHS Foundation Trust has embraced the ethos of a ward to board culture and has embedded Governance across the organisation. The Trust operates an integrated governance model to assure both quality and patient safety is maintained. The Trust has also adopted service line management models for service delivery and a key emphasis of this approach is clinical engagement and clinical leaders driving the Trust's strategy and care delivery.

The integrated governance model underpinning a ward to board culture includes the following notable best practice examples;

- A meeting structure from local services up to the Board with shared terms of reference and dashboard reporting;¹¹⁸ the Trust has local governance arrangements feeding into a Divisional Integrated Governance Group, these groups report into the Trusts Integrated Governance Group, which is chaired by the Chief Executive and is a formal sub-committee of the Board.
- The Integrated Governance Group oversees all corporate and clinical governance, bringing together safeguarding, serious untoward incident reporting, complaints, litigation, learning and development, risk management, risk register, health and safety, infection control and all relevant aspects and Care Quality Commission requirements to maintain patient safety. Non-executive directors attend the meeting and have open invitations to attend any of the feeder meetings or to scrutinise any aspects of governance.
- The Divisional Integrated Groups follow the same structure and its membership is made up of local service management and clinical leadership. This group ensures

¹¹⁸ 'dashboard reporting' refers to systematic reporting of key performance indicators and is a tool for senior managers to monitor performance

action is taken locally to address concerns, to drive service improvement and to ensure the Board is aware of issues of concern or risk.

- The Deputy Director of Nursing and lead for integrated governance co-ordinates all of the clinical governance activities and has a dynamic role working with service directors and local governance leads to ensure effective governance is in place. This role works closely with the Head of Corporate Governance to ensure complaints, litigation, legal and coroner inquests are linked to clinical governance in services.
- The Trust has developed a Patient Safety Improvement Group which has clinical and corporate membership and meets weekly to review all serious untoward incidents (grades 4 and 5). Its aim is to ensure that learning is identified to improve systems and the quality and safety of patient care.
- Learning points from SUIs are shared with the Integrated Governance Group, the Divisional Integrated Governance Group and wards/teams.
- A more detailed quarterly report is published and fed through the groups highlighted above and focuses on the lessons learnt, root cause analysis, complaints and audit reports.
- These themes are then incorporated into the training and development plan via the Educational Governance Group.
- The Trust has also developed and published its quality accounts which outline the key quality indicators to ensure continuous improvement within services. These indicators are prioritised around the key areas of safety, effectiveness and patient experience and improvements are monitored via the integrated governance group, the quality group, and the divisional governance groups in collaboration with the wards.

The Trust Board receives a monthly integrated governance dashboard and quarterly detailed reports. In addition the Board has development sessions and training on areas such as health and safety, child safeguarding, CQC standards and quality and patient safety. In addition to this the Board will have regular updates on the risk register and scrutinise items on this register. In 2010 the Board had two main development sessions focusing on the recommendations of the Francis Inquiry and agreeing an action plan to respond to those recommendations.

Finally, the Board (both Non Executive Director and Executive Director members) participate in a Trust-wide clinical presence programme. This coordinated programme timetables attendance by Board members to service visits and to spend time with clinicians. This is to ensure the Board is visible, meets staff regularly and hears direct accounts of the challenges clinicians face in practice. As a consequence these visits are discussed at Board and in Executive Director meetings and where needed actions are progressed as a direct response to issues raised by staff.

Staff Support: Pennine Care a Great Place to Work (GP2W).

Since 2006 the Trust has adopted an organisational development framework to ensure staff are supported, involved and engaged to ensure that the Trust has the best workforce possible to deliver safe and effective care. It is a fundamental belief of the Trust that the best supported staff deliver the best services.

The strategy for Organisational Development (OD) has followed an Appreciative Inquiry approach and is underpinned by the principles of Emotional Intelligence and Mindfulness. However, as a Trust these theoretical models sit behind actual implementation and action to support staff. The following are key features of the Trust's approach to OD;

- launching a strategy and making a clear 'pledge' to support and engage staff and to act upon their views and values to make the Trust a great place to work;
- taking action on a 'You said, We did' approach across a range of initiatives;
- the development and implementation of a health and wellbeing strategy to support and promote physical and mental wellbeing in work;
- setting up and running a professional coaching service for staff;
- developing a leadership development programme which has now provided support to over a 150 senior and middle managers;
- setting up an Education Governance Group and a Learning and Development department to provide education and OD services;
- delivering clinical skills training programmes;
- driving up access to University based education;
- running OD events, large and small, to engage staff and communicate widely on Trust business and strategy;

- running professional engagement events;
- hosting Chairman and Chief Executive lunches; inviting a wide range of staff to meet the CEO and Chairman to discuss challenges and celebrate success;
- celebrating success with a series of Trust awards and events to recognise outstanding contributions to patient care;
- being nominated and winning several nationally recognised awards.

These are just some notable examples of organisational development in Pennine Care NHS Foundation Trust. Importantly it is a core principle by which the Trust runs its NHS business; that the most effective outcomes are achieved through the close involvement of the workforce in developing strategy and delivering change. The best ideas and successes in Pennine Care NHS Foundation Trust have been generated by the clinical staff who are closest to the patient care pathway.

New Ways of Working

New ways of working has been adopted across the North Division which was facilitated by the adoption of the inpatient consultant and community consultant roles. This has led to a much more responsive model of care where tasks are delineated across the multi-disciplinary team and are reviewed on a daily basis. Individual members of the multidisciplinary team are held to account for their contribution at these daily meetings. This has replaced the traditional model whereby several consultants would each have a weekly ward round and hence decisions about patients care would predominately take place at that meeting. The result of this has been the adoption of a lean and high quality care pathway through the inpatient wards, characterised by a true multidisciplinary approach to the development and ongoing evolution of the inpatient environment, with meaningful patient and carer involvement.

12.1.14. 3. Conclusions

Pennine Care NHS Foundation Trust has well-developed systems of clinical governance which facilitate performance management. The Independent Investigation Team, whilst acknowledging that the Trust is still embedding their arrangements, observed that there was substantial evidence to demonstrate that the system, at the time of writing this report, was working well. There was evidence to suggest strongly that clinical staff within the Trust

understood clinical governance systems and performance management data. This area has been identified as one of notable practice.

13. Findings and Conclusions

Findings

Pennine Care NHS Trust

The following Findings, Contributory Factors and Service Issues were identified:

1. Diagnosis

After Mr. Y's first contact with mental health services in 2001 there was consistency in the diagnosis of his mental illness. He was diagnosed as suffering from Paranoid Schizophrenia. When he was unwell he had delusional beliefs, many of which centred upon his family. He experienced auditory hallucinations. Sometimes Mr. Y was guarded about his symptoms and would deny his experiences. He was also impulsive and could be violent towards family members or others outside the family. He also used and abused a number of substances including alcohol. Some assessments of his mental state revealed that he had thoughts about harming others. Assessments after the incident showed that he had delusional beliefs about people interfering with his medication.

2. Medication and Treatment

Mr. Y was treated with anti-psychotic drugs during his first admission to hospital and these were helpful in controlling the symptoms of his illness. When he took the medication prescribed for him, his thought disorder diminished and he was able to live with his family. He was also helped by a Community Support Worker to engage in activities in the community. He voluntarily maintained contact with mental health services for a number of years when he remained well, and would see his Consultant Psychiatrist regularly as an out-patient. This combination of anti-psychotic medication and social support worked well. In 2007 Mr. Y had his medication reduced to below a therapeutic level and this contributed to a breakdown in his health and subsequently led to inpatient readmission. Between 2007 and the incident Mr. Y became less compliant and did not take his medication as prescribed. He also took other substances, such as alcohol and cannabis. His treatment compliance varied and there was evidence that at the time of the incident he was not taking an effective level of medication. The Trust did not provide a full set of evidence-based care and treatment options in line with the National Schizophrenia guidance from NICE.

- ***Contributory Factor One: the reduction of medication in 2007, and Mr. Y's later non-compliance in 2008 meant that he was not receiving a consistent therapeutic level of medication and this made a contributory factor to the breakdown of his mental health.***
- ***Service Issue One: the Trust did not provide a full set of evidence-based care and treatment options in line with the National Schizophrenia guidance from NICE.***

3. Management of the Clinical Care and Treatment

Between 2001 and most of 2008 the management of Mr. Y's care and treatment was good. After his first admission in 2001 Mr. Y was supported in the community by a stable clinical team for a number of years. He also benefitted from social support and was able to improve his personal and social functioning. He was well known to the clinical team and there was a good level of input to his care from in-patient services and community resources which included the Community Mental Health Team (CMHT) and the Crisis Resolution and Home Treatment Team (CRHTT). In the months before the incident there were a number of changes in the management of Mr. Y's clinical care due to organisational changes in the Trust. He became the responsibility of a different psychiatrist and different Care Coordinators. When he was discharged from in-patient services shortly before the incident his clinical care also transferred to yet another Consultant Psychiatrist who had not met him before. On leaving hospital on the 22 May 2008 information relating to Mr. Y's risk did not translate well into the care plan. This was made more problematic due to continuity of care issues and the changes made to his clinical team.

- ***Contributory Factor Two: the care plan when Mr. Y left hospital on 22 May 2008 did not reflect the levels of risk assessed in the CPA risk assessment. The care plan was not sufficiently assertive in maintaining close contact and monitoring of his mental state. It did not build on the learning from Mr. Y's previous history.***
- ***Service Issue Two: changes to the organisation of service in response to Department of Health guidance led to more transitions in the care pathway. This in turn opened the possibility that information would not be successfully passed to the next stage of the treatment programme.***

4. Mental Health Act (1983 & 2007)

The Act was used appropriately by the Trust at different stages of Mr. Y's treatment. He was admitted for assessment under the provisions of Section 2 of the Act and also detained for treatment under Section 3. He was informed of his rights under the Act and was assisted to appeal (unsuccessfully) against detention. When he was transferred to a psychiatric intensive care unit in another part of the Trust, appropriate Mental Health Act documentation was completed and procedures followed. At the time of the incident he was not subject to restriction under the Act. There was some evidence that the clinical team considered the value of using the supervised discharge provisions of the Act and decided that this would not be appropriate. There was no evidence of explicit consideration of the provisions of Section 117 of the Act when Mr. Y was discharged from hospital in May 2008.

- ***Service Issue Three: the Trust CPA policy did not make clear how the requirements of Section 117 Mental Health Act should be incorporated into discharge planning.***

5. Care Programme Approach (CPA)

Between 2001 and 2008 Mr. Y was allocated to the enhanced level of CPA and there was documentation to support the view that assessment and care planning took place, however on occasions this was found to be incomplete. This lack of thoroughness ensured that risk assessments were not always inclusive and that care plans did not always reflect the level of interventions required to maintain Mr. Y's safety and wellbeing and to mitigate against risk. On leaving hospital on the 22 May 2008 information relating to Mr. Y's risk did not translate well into the care plan. This was made more problematic due to continuity of care issues and the changes that had been made to his clinical care team.

Mr. Y had Care Coordinators allocated to him in accordance with Trust policy but there was some evidence that insufficient attention was paid to the risk presented by Mr. Y when a female Care Coordinator was allocated to him in 2007. Following Mr. Y's discharge on 22 May 2008 he was allocated to two experienced Care Coordinators.

- ***Contributory Factor Three: the CPA process included assessment tools (including those for risk) but these were not always completed fully and were not reflected in***

care plans. Care plans did not contain contingency planning for relapse and relied upon the compliance of Mr. Y.

6. Risk Assessment

There were formal risk assessments completed during the years of Mr. Y's contact with services. Risk was identified during routine assessment processes. The Trust utilised the Salford Tool for Assessment of Risk (STAR) and this was utilised by a range of clinicians including forensic services. A number of risks were identified including that of violence to others, misuse of drugs, impulsivity, lack of insight, and non-compliance with medication. Over time there was evidence to show that risk assessments were not always based on a full understanding of Mr. Y's history and that risk assessments did not always feed into the care planning process. There was also evidence that the risks identified were not considered fully in the discharge plan when Mr. Y left hospital in May 2008. In addition the discharge meeting on 22 May 2008 gave insufficient weight to contingency planning for a relapse in Mr. Y's health.

There was insufficient weight attributed to the family view in the overall assessment of Mr. Y's risk. It was known to the clinical teams providing care and treatment to Mr. Y that he had harboured significant delusional thinking about his parents. As far as the documented evidence shows, the safety of his parents was never taken into account. Whilst this has no bearing on the death of Mr. A it does represent a significant point of learning for the Trust.

- ***Contributory Factor Four: the assessment of risk at the point of discharge took insufficient account of cumulative evidence from Mr. Y's history of mental health care. In particular compliance with medication and the views of his parents were under-estimated.***
- ***Service Issue Four: The significant risk to Mr. Y's parents was not taken into account. This was compounded by the lack of carer assessment made available to them.***

7. Referral, Discharge and Handover Processes

Communication between clinical team members was generally good and the regular ward round meetings were used to share information about Mr. Y. When Mr. Y was discharged from hospital his GP was informed and kept up to date with treatment plans. Prior to Mr. Y's discharge in May 2008 clinical meetings were well attended by the Care Coordinators, the medical staff, and support workers which comprised representatives from the housing department and the Crisis Resolution and Home Treatment Team. However there was some discontinuity in Mr. Y's care caused by structural reorganisation within the Trust, which responded to requirements from the Department of Health. This meant that in the weeks before his last discharge, Mr. Y was transferred to the care of a Consultant Psychiatrist who knew him less well than the previous Consultant who had known him for some years. Following discharge, the role of Responsible Clinician passed to yet another doctor who by the time of the incident had not met Mr. Y.

At the point of his discharge Mr. Y met the referral criteria for the Assertive Outreach Service. Whilst referral to this service would not necessarily have altered the outcome of the incident it would have been good practice to have ensured Mr. Y received a service that could have provided structured follow up and support that would have addressed both his health and social care needs in a holistic manner.

- *Service Issue Five: when patients meet the criteria for the assertive outreach service, as set out in Trust operational guidance, they should be considered for referral to that service as a preferred option.*
- *Please also see Service Issue Two.*

8. Carer Assessment and Experience

Mr. Y lived with his parents and they were an important part of his support network. When Mr. Y was unwell they were subject to threats from him and on one occasion he assaulted his father. He had delusional beliefs about his family. They attended ward rounds and were included by the clinical team in discussions about his care and treatment. However, they did not receive a formal carers' assessment although eligible to do so, and their views were undervalued by the clinical team. The parents thought that some of the support visits to Mr. Y

were cursory and did not test his mental state to any degree. They were not present at the discharge meeting in May 2008 when it was agreed that Mr. Y could go to live with them after leaving hospital. Their views were not given sufficient weight by the clinical team and after the incident they were not well supported by the Trust.

- ***Contributory Factor Five: the views of carers are an essential part of the process of assessment and care planning, particularly when the carers live with the patient and have detailed knowledge of his mental state and behaviour. Their views were insufficiently weighted by the clinical team at the point of discharge in May 2008.***
- ***Service Issue Six: the performance of the Trust on completion of carers' assessments is very variable and in some localities poor. The parents of Mr. Y did not receive an assessment of their needs as principal carers and this placed them in a position of difficulty.***

9. Service User Involvement in Care Planning and Treatment

Efforts were made to include Mr. Y in discussions about his treatment but he was not well equipped to contribute to these. He remained guarded with staff about his mental state and in the later stages of his treatment he did not take medication as prescribed. He also undermined the efforts of the team by using alcohol and cannabis and taking the view that he did not need medication to control his illness. The attempts to involve him in planning for discharge were commendable but his underlying illness and non-compliance meant that these were fruitless. His refusal to engage with the care coordinators in planned activity towards greater independence from his family was symptomatic of his illness.

10. Documentation and Professional Communication

Documentation was of varied quality. There were some good assessments on file, but overall there was a failure to build on previous knowledge, particularly in relation to Mr. Y's compliance with medication and to risk. Some documents were completed partially and some, although held on file, held no useful information about Mr. Y, for example the carers' assessment documentation which was blank, although signed by a member of staff. There was a lack of connection between some assessments, for example the risk assessments, and the care plans which did not contain reference to the risks identified. Professional

communication was generally good and there were no resource issues of significance throughout the history of Mr. Y's care. There would be value in the Trust looking at the system for transfer of patients between consultants where a risk has been identified. Communication between professionals and teams working with Mr. Y was satisfactory. Effective communication between the Trust and the family of Mr. Y was not always achieved.

- *Service Issue Seven: when patients move from hospital to community-based treatment they often have a change of Responsible Clinician. This places a greater premium on the continuity provided by the Care Coordinator and the timely exchange of information between consultant psychiatrists. This difficulty was in evidence in May 2008 when Mr. Y was discharged back into the community.*

11. Clinical Supervision

Care Coordinators working with Mr. Y were suitably qualified and worked within operational policies and procedures agreed by the Trust. They worked within a well-established clinical team structure in the Community Mental Health Team. The two Care Coordinators allocated to Mr. Y after his last discharge from hospital were very experienced and were supervised by an experienced and committed team manager. They were able to discuss the case with the manager and identified risks inherent in Mr. Y's mental state. Clinical Supervision was not an issue with the clinical witnesses who were interviewed as part of this investigation.

12. Adherence to Local and National Policy and Procedure

The Pennine Care NHS Foundation Trust operational policies and procedures were consistent with national guidance and good practice. There were departures from good policy adherence regarding:

- CPA documentation;
- Section 117 after care;
- carers' assessments;
- the Trust response after the incident when its guidance under the Trust "Incident Reporting and Investigation Policy" could have been used to provide better support to the families of the victim and perpetrator. Local policy guidance was not followed in relation to the internal investigation after the incident in that contact with the families of the victim and perpetrator was not made.

- ***Service Issue Eight: the Trust policies and procedures were found to be of an excellent quality, however adherence to them was found to be poor with regard to CPA documentation, carers' assessments, Section 117, internal investigation process.***

13. Organisational Change and Professional Leadership

There were organisational changes in 2008 to the Trust services which meant that Mr. Y had three Responsible Clinicians within a short period of time. These changes were in response to guidance from the Department of Health in the document *New Ways of Working*¹¹⁹. Whilst it was noted that organisational change may have had a negative influence on the care and treatment of Mr. Y, the Trust was found to have implemented an innovative and highly effective *New Ways of Working* initiative.

14. Clinical Governance and Performance

At the time of the incident Pennine Care NHS Foundation Trust was rated as excellent by the Care Quality Commission (CQC), the external regulator for the health services. The Independent Investigation Team reviewed the present arrangements for clinical governance in the Trust and concluded that the systems now in place were strong and that the performance management framework was well established. This has been identified as an area of notable practice.

Conclusions

The Independent Investigation Team found that the care and treatment provided by Pennine Care NHS Foundation Trust to Mr. Y was of an overall good standard over the seven-year period when he was in contact with service (from 2001 to 2008). After his first in-patient admission in 2001 he was able to live with his parents and the Trust provided health and social care services that supported him to remain in the community. There were adequate resources available to do this and he benefitted from continuity of care from the Trust staff who had most contact with him.

In 2007 Mr. Y's mental health deteriorated because he did not take medication as prescribed. He began to refuse the treatment offered and increased his use of alcohol and cannabis. This

¹¹⁹ New Ways of Working for Everyone: a best practice implementation guide: Department of Health October 2007

resulted in his admission to hospital under the provisions of the Mental Health Act. After an unsuccessful period at home he returned to hospital in 2008 and received further treatment, again under the provisions of the Mental Health Act.

After periods of home leave he appeared to be well enough to be discharged from hospital in May 2008. It became clear later that he had become more guarded in talking about his thoughts and had not been taking medication as prescribed. He was able to conceal this from the staff who worked with him and from his family. He made the fatal attack on Mr. A without warning. The mental health service could not have predicted that this would happen.

This Investigation found no direct causal links between any act or omission on the part of the Pennine Care NHS Foundation Trust and the death of Mr. A. Whilst it was evident that some of the decisions made by the Trust had a detrimental effect on the maintenance of Mr. Y's mental health these on their own could not be seen as causal factors. When assessing causality an Investigation Team has to take into account what was both known, and what should have been known, about a patient during the time care and treatment was being given. An Investigation Team then has to consider whether the care and treatment provided was in accordance with the patient's presentation and national best practice guidance.

It was unfortunate that Mr. Y's medication was reduced in 2007. This led to a gradual decline in his mental wellbeing. From that time on services found it difficult to help Mr. Y reach the same level of stability and wellness that he had enjoyed in previous years. It cannot be known with certainty whether this was a direct result of the changes made to his medication regimen or whether this formed a natural part of Mr. Y's psychiatric progression. However the Investigation Team concluded that Mr. Y's decline was probably influenced by his medication regimen being reduced below a therapeutic level. Once Mr. Y's medication regimen had been stabilised the issues of adherence became an ongoing issue. It was evident that Mr. Y complied with his medication in a sporadic manner and that his family was concerned about this. It cannot now be known exactly how much medication Mr. Y was taking prior to the incident however it would appear that he had been non compliant for a significant period of time.

The Independent Investigation Team found that risk assessment was not always documented well and that care planning did not always take risk assessment information into account.

However, Mr. Y's presentation was consistent over time and care teams were usually aware of most of the significant risk indicators pertaining to Mr. Y.

Shortly before the incident that was to lead to the death of Mr. A, Mr. Y had been subject to a series of in-depth assessments both as an inpatient and once again when discharged into the community. During this period Mr. Y did not appear to have any psychotic symptoms. He did not appear to be unwell and was assessed as being suitable for care in the community. The Care Coordinators in charge of his case following his discharge responded with immediate effect to concerns raised about Mr. Y by his father and made a protracted home visit. These two individuals were highly experienced and competent and after a rigorous assessment they agreed Mr. Y was not detainable and presented no immediate risk. However as a point of good practice they made an urgent appointment for Mr. Y to be seen by his new Consultant Psychiatrist which was scheduled to take place the following Tuesday, the 3 June 2008, the date of their assessment being Thursday the 29 May.

The Care Coordinators did not simply walk away from Mr. Y and his family following this assessment. They worked to support Mr. Y who was seeking a hostel place, (against advice) and took a telephone call from Mrs. Y who said that she thought she had "*detected a slight improvement in his (Mr. Y's) demeanour*".¹²⁰ At the time of the incident mental health services knew that Mr. Y would require a high degree of ongoing monitoring and support, but there was no indication to suggest that he presented either an immediate or significant level of risk to either himself or to another person.

In the days prior to the incident Mr. Y was described as being "*agitated*" by his parents. However following a comprehensive assessment by his Care Coordinators no signs of psychosis or imminent breakdown in the mental health of Mr. Y could be detected. The fact that Mr. Y was going to kill someone could not have been reasonably predicted, and in this case, without the benefit of hindsight, could not have been prevented.

The Independent Investigation Team reviewed the care and treatment given to Mr. Y and in accordance with the requirements of HSG (94)27 identified learning from this analysis. The recommendations in this report are based on the evidence collected by the Independent

120 Community File Vol 2. p 239

The Care and Treatment of Mr Y

Investigation Team and are intended to help the Trust develop better services and learn from this tragic event. Whilst no direct causality was found, the Independent Investigation Team did find factors that were contributory to the breakdown in Mr. Y's health and some service issues that require consideration by the Trust to ensure future safe service delivery.

14. Pennine Care Trust's Response to the Incident and Internal Investigation

The following section sets out the Trust response to the events of 2008. It also sets out the view of the Independent Investigation Team with regards to how effective the Internal Investigation Panel was in conducting its work. The Independent Investigation Team acknowledges the fact that Pennine Care NHS Trust has experienced few incidents of this kind before and that the requirement to manage an Internal Investigation of this nature was something that was largely outside of its experience. The following comments are intended to provide helpful feedback whilst offering a contextual background to assess the progress the Trust has made against the action plan developed from the findings of its own internal investigation.

14.1 The Trust Internal Investigation

The Internal Investigation Panel comprised the following personnel:

The Trust appointed an internal investigation panel chaired by MD, the Trust Medical Director, with DN, the Trust Director of Nursing, DO, the Trust Director of Operations and HCG, the head of clinical governance.

The Terms of Reference were as follows:

“the purpose of the review is to thoroughly and objectively examine the care and treatment of Mr. Y. This is to identify any shortfalls in his care, establish the lessons to be learned, to minimise the possibility of similar events and to make appropriate recommendations of improvements to the services.

The review will examine the serious untoward incident (SUI) by review and scrutiny of all written evidence and by interview of relevant clinical staff.

The review will specifically examine the circumstances surrounding the care, treatment and compliance of Mr. Y, paying particular attention to the history, quality, nature, scope and monitoring of his health, social and community care and risk assessment.

A report will be prepared, detailing the chronology of events, comprehensively scoping the incident and providing clear conclusions and recommendations. This will be achieved by:

- Reviewing both medical and nursing notes and commenting on the adequacy and appropriateness of their assessment, care and treatment;*
- Appraising the adequacy of the risk assessment and management plan undertaken by the multi-disciplinary team;*
- Will examine the adequacy of the operational policies, procedures and governance arrangements within the department;*
- Assess family carer involvement;*
- Consider any workforce, HR, training and supervision issues in relation to staff;*
- Consider any other issues relating to the public interest”;*

Methodology

The internal review team interviewed five members of staff and examined Mr. Y’s case notes.

Recommendations

The Trust internal review made two recommendations:

- The Trust needs to consider its handover arrangements , particularly when patients are changing consultants in the process of being discharged from the hospital to a community setting;
- The panel would like the Trust to consider its processes of allocation of care coordinators in Oldham to effectively manage waiting times and lists.

14.2 Findings of the Independent Investigation Team

The independent investigation team were asked to review the Trust internal investigation as part of its terms of reference. We asked staff involved in the care and treatment of Mr. Y about their participation in the investigation and also discussed the Trust response with Mr. Y’s parents and with the victim’s family. The Trust was not able to locate the archive material in support of their investigation. We interviewed one member of the internal investigation team about the process of the investigation. We also asked all interviewees about the findings of the investigation and their dissemination to staff.

The Trust policy and practice guidance was contained in the Incident Reporting, Management and Investigation Policy¹²¹. This included guidance about responses to a wide range of incidents but specifically referred to more serious incidents graded at 5, the upper point of a five point scale for incident analysis. The policy also included reference to HSG 94 (27) and the additional guidance published by the Department of Health in June 2005 on the management of homicide by people known to the mental health services. The policy document also referred to the National Patient Safety Agency guidance *Being Open*¹²².

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

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

The Independent Investigation Team found that the Trust had followed little of the policy guidance in its response to the incident. The internal investigation interviewed five members of staff. Those who were also interviewed by the Independent Investigation Team said that they thought this process had been conducted in a fair way and the chair of the internal review had a good understanding of the case. However no staff had seen a copy of the internal review until shortly before their interview with the independent team in 2010. Most surprisingly, the service manager responsible for the locality at the time of the incident had

121 Pennine Care Trust Incident Reporting, Management and Investigation Policy Version 5 2007

122 *Being Open: Communicating Patient Safety Incidents with patients, their families and carers*: National patient Safety Agency 2005, reissue November 2009

not seen the report and was not interviewed as part of the process. We found that the conclusions of the report had not been disseminated to staff and there had been no learning from the incident.

The most serious weakness of the internal investigation was that it had not followed Trust policy in communicating with family members, neither the perpetrator's or victim's family were contacted by the Trust. This had caused considerable resentment by the families of the Trust approach and feelings of being ignored and devalued. Part of the team's remit was to review carer involvement.

In relation to the findings of the internal investigation, we found that there was a lack of analysis of the care and treatment of Mr. Y and a failure to identify learning from the incident. For example, no positive conclusions were drawn from the period of several years when Mr. Y remained well. Similarly there was no reference to the impact of organisational change on working practices in the Trust. Of the two recommendations made in the report, one was not justified by the evidence from this case (there were no delays in the allocation of care coordinators to Mr. Y).

When the independent investigation team asked staff about the report we could register no changes to practice that had flowed from it.

14.3 Conclusion

The Independent Investigation Team found that the Trust Internal Investigation following the incident did not comply with Trust policy. The process and the conclusions of the investigation were very limited and failed to include the families of the victim or the perpetrator as they should have been in the spirit of the Trust policy statement. Managers who had accountability for the service at the time were not included in the investigation and had not seen the report. There had been no dissemination of learning from the incident.

Recommendation

The Trust should ensure that investigations following serious untoward incidents follow the Trust policy. In particular the Trust should ensure that staff and relatives are involved and informed in line with the principles of the policy and that learning is disseminated.

15. Notable Practice

15.1 Resources: use of a range of resources to provide long-term support

The Independent Investigation Team noted that through the history of Mr. Y's contact with services, he had access to a range of services, usually without delay, and provided in a timely fashion. These included:

- access to appropriate in-patient services;
- access to the psychiatric intensive care services when needed;
- well-managed in-patient nursing care;
- access to experienced care coordinators;
- support from community resources including employment and housing support;
- support when in the community to build social contact through use of a community support worker;
- more intensive support at times from the Crisis Resolution and Home Treatment Team;
- a dependable level of support that he could access when well. This is evidenced by his largely compliant contact with services even when unwell.

15.2 Professional input to care and treatment

Mr. Y had access to skilled professionals and although he suffered from a chronically debilitating illness, he was maintained in the community for an extended period when he thrived. Acting against this input was his increased tendency to mask the symptoms of his illness.

15.3 Trust Clinical Governance Structure

The Independent Investigation Team can verify that the corporate Trust Board vision was both understood and championed by all of the people that we met during the course of our work regardless of their grade or profession.

Pennine Care NHS Foundation Trust has embraced the ethos of a 'ward to Board' culture and has embedded governance across the organisation. The Trust operates an integrated governance model to assure both quality and patient safety is maintained. The Trust has also adopted service line management models for service delivery and a key emphasis of this

approach is clinical engagement and clinical leaders driving the Trust's strategy and care delivery.

The integrated governance model underpinning a ward to Board culture includes the following notable best practice examples;

- A meeting structure from local services up to the Board with shared terms of reference and performance reporting; the Trust has local governance arrangements feeding into a Divisional Integrated Governance Group, these groups report into the Trust's Integrated Governance Group, which is chaired by the Chief Executive and is a formal sub-committee of the Board.
- The Integrated Governance Group oversees all corporate and clinical governance, bringing together safeguarding, serious untoward incident reporting, complaints, litigation, learning and development, risk management, risk register, health and safety, infection control and all relevant aspects and Care Quality Commission requirements to maintain patient safety. Non Executive Directors attend the meeting and have open invitations to attend any of the feeder meetings or to scrutinise any aspects of governance.
- The Divisional Integrated Groups follow the same structure and their membership is made up of local service management and clinical leadership. This group ensures action is taken locally to address concerns, to drive service improvement and to ensure that the Board is aware of issues of concern or risk.
- The Deputy Director of Nursing and lead for integrated governance coordinates all of the clinical governance activities and has a dynamic role working with service directors and local governance leads to ensure effective governance is in place. This role works closely with the Head of Corporate Governance to ensure complaints, litigation, legal and coroner inquests are linked to clinical governance in services.
- The Trust has developed a Patient Safety Improvement Group which has clinical and corporate membership and meets weekly to review all serious untoward incidents (grades 4 and 5). Its' aim is to ensure that learning is identified to improve systems and the quality and safety of patient care.
- Learning points from SUIs are shared with the Integrated Governance Group, the Divisional Integrated Governance Group and wards/teams.

- A more detailed quarterly report is published and fed through the groups highlighted above and focuses on the lessons learnt, root cause analysis, complaints and audit reports.
- These themes are then incorporated into the training and development plan via the Educational Governance Group.
- The Trust has also developed and published its quality accounts which outline the key quality indicators to ensure continuous improvement within services. These indicators are prioritised around the key areas of safety, effectiveness and patient experience and improvements are monitored via the integrated governance group, the quality group, and the divisional governance groups in collaboration with the wards.

The Trust Board receives a monthly integrated governance performance report and quarterly detailed reports. In addition the Board has development sessions and training on areas such as health and safety, child safeguarding, Care Quality Commission standards and quality and patient safety. In addition to this the Board has regular updates on the risk register and scrutinises items on this register. In 2010 the Board had two main development sessions focusing on the recommendations of the Francis Inquiry and agreeing an action plan to respond to those recommendations.

The Board (both Non Executive Director and Executive Director members) participate in a Trust-wide clinical presence programme. This co-ordinated programme timetables attendance by Board members to service visits and to spend time with clinicians. This is to ensure the Board is visible, meets staff regularly and hears direct accounts of the challenges clinicians face in practice. As a consequence these visits are discussed at Board and in Executive Director meetings and where needed actions are progressed as a direct response to issues raised by staff.

Each ward and clinical area receives a regular report in relation to their clinical governance performance. This ensures that every clinical team has the information that it needs to improve local performance. It also ensures that staff feel connected into the clinical governance process.

15.4 Staff Support and Involvement

Since 2006 the Trust has adopted an Organisational Development framework to ensure staff are supported, involved and engaged to ensure the Trust has the best workforce possible to deliver safe and effective care.

The strategy for Organisational Development has followed an Appreciative Inquiry approach and is underpinned by the principles of Emotional Intelligence and Mindfulness. However, as a Trust these theoretical models sit behind actual implementation and action to support staff. The following are key features of the Trust approach to Organisational Development;

- Launching a strategy and making a clear ‘pledge’ to support and engage staff and to act upon their views and values to make the Trust a great place to work;
- Taking action on a ‘You said, We did’ approach across a range of initiatives;
- The development and implementation of a health and wellbeing strategy to support and promote physical and mental wellbeing in work;
- Setting up and running a professional coaching service for staff;
- Developing a leadership development programme which has now provided support to over a 150 senior and middle managers;
- Setting up an Education Governance Group and a Learning and Development department to provide education and Organisational Development services;
- Delivering clinical skills training programmes;
- Driving up access to University based education;
- Running Organisational Development events large and small to engage staff and communicate widely on Trust business and strategy;
- Running professional engagement events;
- Hosting Chairman and Chief Executive lunches; inviting a wide range of staff to meet the CEO and Chairman to discuss challenges and celebrate success;
- Celebrating success with a series of Trust awards and events to recognise outstanding contributions to patients care;
- Being nominated and winning several nationally recognised awards.

15.5 Support to staff during the Independent Investigation

The Trust continued to provide support and practical assistance to all witnesses during the Independent Investigation process. The Trust worked with the Independent Investigation Team to ensure that witnesses were prepared and supported throughout. It is to the credit of both the witnesses and the Trust that individuals were able to provide reflective witness statements and were able to engage in the interview process in a professional and honest manner during the Independent Investigation process. The Independent Investigation Team found that staff at all levels were able to give full and frank accounts of their involvement with Mr. Y and had been able to reflect on the lessons to be learned from the tragic events that led to the killing of Mr. A.

16. Lessons Learned

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Trust to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice has been identified: that the recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can further improve services and consolidate the learning from this inquiry process.

The Independent Investigation Team found that the Pennine Care NHS Foundation Trust worked within sound frameworks and procedures. However there are several lessons for learning that have been identified from the examination of the care and treatment that Mr. Y received. These lessons will have a resonance for all mental health Trusts across the country who are faced with similar issues. The principal lessons are set out below.

Medication and Treatment

Between 2007 and the incident Mr. Y became less compliant and did not take his medication as prescribed. He also took other substances, such as alcohol and cannabis. His treatment compliance varied and there was evidence that at the time of the incident he was not taking an effective level of medication. Although diagnosis was never in doubt, the capacity of the mental health service to achieve therapeutic results was limited by non-compliance. This emphasises the importance of achieving a measured outcome from therapeutic intervention by which to test efficacy.

Care Programme Approach

The case history of Mr. Y illustrates the importance of assertive and active case management by Care Coordinators. This includes full use of the elements of care planning to make an informed judgment about care plans. The purpose of care coordination is not to provide a commentary on the service user's mental health. It is required to be dynamic and forward

looking. The importance of systematic assessment of risk is central to the activity. The continuity provided by care coordinators is of critical importance, particularly when the responsibility for medical and psychiatric oversight of cases changes with the service user's status as an in- or out-patient.

Section 117 Mental Health Act

The Independent Investigation team found that the Trust had not given sufficient weight to the statutory requirements of this provision of the Act. Mr. Y was a very familiar service user to the clinical team. Nevertheless his discharge should have been accompanied by a formal discharge planning meeting where his main carers, his parents, were present to give their views.

Carer Assessments

The evidence from this case, and more generally in the Trust, is that carers' assessments are underused and undervalued. Mr. Y's parents had been the principal source of support to him throughout his life. Although there is a danger of making a hindsight judgment, it is clear that they were at least ambivalent, if not opposed to, his return home. They were in a unique position to give evidence about his mental state and they judged him to be unwell. Greater weight should have been given to their views. They became part of the accepted pattern of interaction between the Trust and the family and their views consequently were not always sought and not given any more than superficial consideration. Similarly, the risk posed to his parents by Mr. Y, who had strong delusional beliefs about them, was underestimated.

Trust Internal Investigation Process

Although witnesses seen by the Trust internal investigation were positive about the experience and complimentary about the Panel Chairman's grasp of the detail of the case, the findings and recommendation were very limited. The Trust could not locate the internal archive for the investigation. Witnesses had received little feedback about the findings and some managers knew little about the outcome of the investigation. There was a failure to identify the positive messages from the care and treatment of Mr. Y during the extended period of his good mental health.

Communication with relatives of the victim and the perpetrator

The Trust did not follow its own policies in relation to offering support to family members. The Trust Serious Untoward Incident procedure is described in its Incident Reporting and Investigation Policy. The Trust complied with none of the suggestions in the sections of the policy based on the NPSA *Being Open* guidance. All relatives interviewed by the Independent Investigation Team would have welcomed contact from the Trust and all were angry that they had received no communication for a period of years. The Trust senior management team are now better informed about the procedures to follow in incidents of this kind and more aware of the negative impact of not following their agreed good practice.

17. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Pennine Care NHS Foundation Trust and NHS Heywood, Middleton and Rochdale to formulate the recommendations arising from this inquiry process. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can further improve services and consolidate the learning from this inquiry process.

Each recommendation is set out below in accordance with the relevant progress that the Trust has already made since the time of the incident.

Medication and Treatment

1. The Trust should ensure that when a patient is suspected of not conforming with Clozapine treatment steps are taken to determine compliance. This should include:

- Serum/therapeutic level testing;
- carer involvement/consultation;
- service user engagement;
- clinical presentation;
- mental state examination.

2. The Trust should ensure that the care and treatment options for people with schizophrenia meet the expectations of the National Institute of Clinical Excellence (NICE) guidelines. The Trust should ensure that Cognitive Behaviour Therapy and appropriate psychological therapies are made available to all service users when clinically indicated.

Mental Health Act

3. The Trust should ensure that guidance on the requirements of Section 117 Mental Health Act are incorporated in the CPA policy and are both reviewed and audited within six months of the publication of this report.

Care Programme Approach (CPA)

4. The Trust should ensure that CPA processes are followed by care coordinators and that regular audit is completed to measure compliance with performance targets. This to specifically include:

- service user involvement;
- carer involvement (where appropriate);
- care planning as part of a dynamic risk assessment process;
- crisis and contingency planning.

Risk Assessment

5. The Trust should ensure that risk assessments are completed as part of the CPA process and that known risks are incorporated into the care plan. Processes should also be developed to ensure risk assessments are:

- dynamic and updated on a regular basis/as indicated by a change in presentation;
- formulated with the service user whenever possible;
- formulated and shared with the carer whenever appropriate;
- communicated to all of the service users' clinical network (GP etc.).

6. The Trust lone worker policy should be reviewed with immediate effect to ensure:

- that risks to workers are taken into account in the allocation of care coordinators.

Carer Assessment and Experience

7. The Trust should ensure that carers' assessments are offered and completed, particularly when service users rely on carers for daily support.

8. The Trust should complete regular audits of carers' assessments to enable managers to monitor compliance with Trust policy.

9. The Trust should ensure that carers, when included in the care plan for a service user, are aware of the plan, have a written copy of the plan and have a contingency plan if things go wrong.

10. The Trust should ensure that it complies with policy in relation to contact, information sharing and support to carers after a Serious Untoward Incident.

11. The Trust should review performance in assessing carers' needs and put forward plans for a more equitable service across the localities served by the Trust.

Documentation and Professional Communication

12. The Trust should undertake a review of communication systems and handover processes when transferring patients between services and clinicians. This recommendation should be accommodated within all service re-design plans.

Adherence to Policy and Procedure

13. The Trust clinical audit should incorporate into its regular audit cycle the monitoring and review of:

- CPA;
- carer assessments;
- Section 117.

14. The Trust should also provide regular training and practical guidance to all clinical staff on the implementation and importance of carer assessment requirements and Section 117 aftercare obligations.

Documentation and Use of Clinical Records

15. The Trust should complete a regular audit of the quality of case records to test timeliness and performance against quality standards in the Trust Records Management Policy.

The Trust Internal Investigation

16. The Trust should ensure that investigations following serious untoward incidents follow the Trust policy. In particular the Trust should ensure that:

- staff and relatives are involved and informed in line with the principles of the policy;
- and that learning is disseminated to both staff and relatives.

Glossary

Akathisia	Akathisia is a syndrome characterised by unpleasant sensations of 'inner' restlessness that manifests itself with an inability to sit still.
Approved Social Worker	A social worker who has extensive knowledge and experience of working with people with mental disorders.
Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user-centred manner.
Case management	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Clozaril	Clozaril (Clozapine): an antipsychotic drug used as a sedative and for treatment-resistant schizophrenia.
Delusional Disorder	Delusional disorder is a psychiatric diagnosis denoting a psychotic mental disorder that is characterised by holding one or more non-bizarre delusions in the absence of any other significant psychopathology. Non-bizarre delusions are fixed beliefs that are certainly and definitely false, but that could possibly be plausible, for example, someone who thinks he or she is under police surveillance.
Depot Injection	This is an intramuscular injection (an injection into the muscle) by which certain antipsychotic medication is administered, e.g. Clopixol.
Depixol	Depixol Injection belongs to a group of medicines known as antipsychotics (also called neuroleptics).

DNA'd	This means literally 'did not attend' and is used in clinical records to denote an appointment where the service user failed to turn up.
Enhanced CPA	This was the highest level of CPA that a person could be placed on prior to October 2008. This level requires a robust level of supervision and support.
Extrapyramidal	Extrapyramidal symptoms include extreme restlessness, involuntary movements, and uncontrollable speech.
Mental Health Act (83)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition.
Mental Health Act Managers Hearing	The 'Hospital Managers' are people from the community who act very much like school Governors and are non-Executive Directors of the hospital's Board of Directors. They act on behalf of the NHS Trust that runs the hospital. The managers have the power to discharge the patient (let the patient go) and a duty to refer certain cases to the Mental Health Review Tribunal. The Managers can also hold hearings at their own discretion for any reason.
Mental Health Act Tribunal	Mental Health Tribunals are judicial bodies that are independent of government. Their function is to determine the cases of mental health patients who have been detained under the Mental Health Act and decide whether or not they should be discharged from hospital. Mental Health Tribunals are normally heard in private, and therefore there are no members of the press or media at the hearings. They usually take place either in the hospital where the patient is detained, or community unit, if applicable.
Named Nurse	The 'Named Nurse' is a nurse designated as being responsible for a patient's nursing care during a hospital stay and who is identified by name as such to the patient. The concept of the named nurse stresses the importance of continuity of care.
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Olanzapine	A drug used for treating patients with schizophrenia and manic episodes associated with bipolar disorder.

Paranoid Schizophrenia	Paranoid schizophrenia is the most common type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a persons risk to both themselves and to others.
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.
Schizophrenia	Schizophrenia is a mental disorder characterised by a disintegration of the process of thinking and of emotional responsiveness. It most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganised speech and thinking, and it is accompanied by significant social or occupational dysfunction.
Schizoaffective Disorder	Schizoaffective disorder most commonly affects cognition and emotion. Auditory hallucinations, paranoia, bizarre delusions, or disorganised speech and thinking with significant social and occupational dysfunction are typical. The division into depressive and bipolar types is based on whether the individual has ever had a manic, hypomanic or mixed episode. Symptoms usually begin in early adulthood, which makes diagnosis prior to age 13 rare. Schizoaffective disorder is one of the more common, chronic, and disabling mental illnesses. As the name implies, it is characterized by a combination of symptoms of schizophrenia and an affective (mood) disorder. There has been a controversy about whether schizoaffective disorder is a type of schizophrenia or a type of mood disorder. Today, most clinicians and researchers agree that it is primarily a form of schizophrenia.

**Schizoid/Schizotypal
Personality Traits**

Individuals with *schizoid personality* are characteristically detached from social relationships and show a restricted range of expressed emotions. Their social skills, as would be expected, are weak, and they do not typically express a need for attention or approval. They may be perceived by others as sombre and aloof, and often are referred to as "loners." *Schizotypal personalities* are characterised by odd forms of thought, perception and beliefs. They may have bizarre mannerisms, an eccentric appearance, and speech that is excessively elaborate and difficult to follow. However, these cognitive distortions and eccentricities are only considered to be a disorder when the behaviours become persistent and very disabling or distressing.

**Section 2 Mental Health Act
(1983 & 2007)**

Section 2 of the Mental Health Act allows compulsory admission for assessment, or for assessment followed by medical treatment, for duration of up to 28 days.

**Section 3 Mental Health Act
(1983 & 2007)**

Section 3 of the Mental health Act is a treatment order and can initially last up to six months; if renewed, the next order lasts up to six months and each subsequent order lasts up to one year. It is instituted in the same manner as Section 2, following an assessment by two doctors and an Approved Social Worker. Most treatments for mental disorder can be given under Section 3 treatment orders, including injections of psychotropic medication such as antipsychotics. However, after three months of detention, either the person has to consent to their treatment or an independent doctor has to give a second opinion to confirm that the treatment being given remains in the person's best interests.

Section 12 Approved Doctors

A section 12 approved doctor is a medically qualified doctor who has been recognised under section 12(2) of the Act. They have specific expertise in mental disorder and have additionally received training in the application of the Act.

Section 17 Leave

Section 17 of the Mental Health Act 1983 & 2007 allows the Responsible Medical Officer (RMO) to give a detained patient leave of absence from hospital, subject to conditions the RMO deems necessary. These can include a requirement to take medication while on leave and to reside at a particular address, among others. Although the RMO can require a patient to take medication while on section 17 leave, treatment cannot be forced on the patient while they are in the community. There is no limit to the duration of section 17 leave provided the original authority to detain remains in force. Section 17 leave is not

required within the grounds of the hospital. (Code of Practice 20.1). However, the decision to allow the patient to leave the ward area should only be made at the formal multi-disciplinary review and/or following consultation with all involved in the patient's care and following a comprehensive risk assessment. It must be part of a plan and not a response to a patient's request, although the patient should be fully involved in the decision to grant leave.

Section 117 Aftercare

Section 117 of the Mental Health Act 1983 & 2007 (MHA) provides free aftercare services to people who have been detained under sections 3, 37, 45A, 47 or 48. It is the duty of the Primary Care Trust and local social services authority to provide and pay for aftercare services. There is no definition of aftercare in the legislation, but services could include amongst others, psychological needs, crisis planning, accommodation and help with managing money. Aftercare lasts as long as someone needs it for their mental health condition, and it can only end when there is a formal discharge meeting.

Section 136

Police Officers have the power, under Section 136 of the Mental Health Act, to take a person who is in a public place and who appears to be suffering from a mental disorder and to be in need of immediate care or control to a place of safety. The Act defines this place as being a police station, hospital, care home or any other suitable place.

Service User

The term of choice of individuals who receive mental health services when describing themselves.

SHO (Senior House Officer)

A grade of junior doctor between House officer and Specialist registrar in the United Kingdom.

Specialist Registrar

A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant.

Staff Grade Doctor

In the United Kingdom, a staff grade doctor is one who is appointed to a permanent position as a middle grade doctor.

Thought Disorder

This is one of the symptoms of psychotic illness where thoughts and conclusions do not follow logically one from the other.

TTOs

A prescription which is prepared for a patient to take out or away. Literally medication 'to take out'.

APPENDIX ONE: MR. Y TIMELINE

Mr. Y was born in Oldham on 9 June 1976. He had two older sisters and for most of his life lived at home with his parents. According to medical history notes he had some delay in speech development and some difficulties in primary school, getting into fights. At secondary school he often truanted and was bullied. He was expelled aged 14 due to fighting. He later attained some GCSEs and attended college for 12 months to study mechanical engineering but left before completing the course. He had a number of labouring jobs. He lived at home with his parents. He had a number of convictions for drink driving, street robbery and selling cannabis. When he was 21 he received a custodial sentence for driving whilst disqualified.

DATE	EVENT
9 December 2001	Mr. Y was brought to the Accident & Emergency Department by his sister because he had assaulted his father, punching him in the face. He was assessed and admitted to Northside Ward Royal Oldham Hospital. He had been released from prison six months before after a three month sentence for driving whilst disqualified. His presentation included paranoid ideas and sexual delusions about interference from his family. He had a number of offences recorded against him, including drink driving (1998), street robbery (1995) selling cannabis (1994). He was known to the Probation Service as a result of sentences of probation supervision and a community service order. He was placed on 1:1 observation because of the risk of absconding.
20 December 2001	Mr. Y was detained under Section 2 Mental Health Act after he had absconded from the ward.
11 January 2002	Mr. Y was assessed under Section 3 Mental Health Act. He had delusions about his parents being responsible for police harassment and there was a risk of harm to others. He threatened his father the previous day. He was said to be guarded and unpredictable and was also homeless.
1 February 2002	Mr. Y's sister contacted ward staff to say that he had visited her with a replica gun. Ward staff confiscated a gun from him and he was later seen by a Police Officer and advised that he was putting himself at risk.
20 February 2002	Senior Registrar 1's ward round noted that Mr. Y had disclosed to other patients that when he was discharged he would rape an Asian or black female. Mr. Y denied these allegations and said he would let his solicitor know about them. There was a plan to refer him to forensic services and to only allow him escorted leave with staff.
5 April 2002	Mr. Y was assessed on Northside ward by Specialist Registrar 1 (based at the Adult Forensic Services, Edenfield Centre, Prestwich Hospital). In his letter of 29 April 2002 to Senior Registrar 1 (Mr. Y's Responsible Medical Officer) Specialist Registrar 1 noted that Mr. Y was reporting a number of symptoms that indicated on-going mental illness. These included sexual ideas about having intercourse with schoolgirls and he recommended that <i>"any contact with his family must be very carefully supervised as he has had very concerning ideas about both assaulting and killing them. He clearly has a number of on-</i>

	<p><i>going ideas about being sexually interfered with by his family...the ideas concerning sexual intercourse with schoolgirls are also of concern”</i> the doctor recommended that Mr. Y should be managed on the ward but that the Police should be involved if he absconded. If his behaviour became difficult he should be referred to a psychiatric intensive care unit.</p> <p>Mr. Y was reviewed on 5 July 2002 by Specialist Registrar 1 who noted some improvement in his mental state associated with a change of medication from depixol to Olanzapine. A trial of Clozapine had been discussed with Mr. Y but he was reluctant to accept the regular blood testing that would be required. He reported feeling better on Olanzapine. Specialist Registrar 1 recommended that in relation to discharge a CPA package would be required and that any deterioration in mental state might be associated with sexual psychopathology and should be monitored carefully.</p>
February- August 2002	<p>Mr. Y was regularly reviewed as an inpatient. He appealed against his detention under Section 3 Mental Health Act but the tribunal on 10 July 2002 refused his appeal. His medication was changed to Clozaril and by August there was some improvement in his mental state. At a ward round early in August (8 August 2002) Consultant Psychiatrist 3 increased his dosage of Clozaril and noted that the long term plan was for him to live with his parents. Detention under Section 3 was extended following the end of the six month order but it was pointed out to Mr. Y that this did not imply that he would need to stay in hospital for the whole of the period. He was able to leave the ward and by 22 August Mr. Y’s father requested that he could accompany the family on a holiday abroad.</p>
10 October 2002	<p>Consultant Psychiatrist 3’s ward round noted that Mr. Y was much better and that his father confirmed this. A discharge plan was agreed with follow up at out-patients’. Medication was Clozapine 150 mg twice daily and Hyoscine 300 micrograms at night. He was discharged from Northside Ward to Greenacre Lodge.</p>
14 October 2002	<p>Mr. Y settled at Greenacre Lodge and allocated to Care Coordinator 1 (a Community Psychiatric Nurse) for follow up.</p>
18 October 2002	<p>Mr. Y was discharged from Greenacre Lodge to his parent’s home and followed up through visits from Care Coordinator 1 until 19 May 2003 when he was introduced to a Community Support Worker 1.</p>
29 April 2003	<p>Mr. Y was reviewed at Cannon Street Clinic by Care Coordinator 1. Mr. Y was living with his parents and receiving regular depot medication. His mental state was stable. The plan was to introduce Mr. Y to a Community Support Worker to help with practical tasks and to increase social activity.</p>
28 May 2003- 18 August 2005	<p>During this period Community Support Worker 1 maintained regular contact with Mr. Y including visits at least once per week and accompanying him on community activities- particularly attendance at a local gym. The notes recorded 122 contacts during the period. In parallel there were regular reviews at out-patients’ clinic at Cannon Street. The notes indicated this was a period of good progress where his mental state improved, his physical health and functioning improved and he was able to get his driving licence back in May 2005.</p>

	He was taking Clozapine.
5 August 2003	Mr. Y was reviewed at Cannon Street by Care Coordinator 1 who noted that negative symptoms were lessening, that Mr. Y had increased his social activity and was getting on better with his parents - Mr. Y saw the Community Support Worker regularly.
9 December 2003	Mr. Y was reviewed at Cannon Street and the notes indicated that he was going out twice a week with Community Support Worker 1. Mr. Y had been on holiday to Greece with family and there were no problems with medication.
4 May 2004	Mr. Y was reviewed by Care Coordinator 1 at Cannon Street Clinic. Mr. Y was described as “ <i>warm and sociable</i> ”. He attended the clinic regularly and received Clozapine 250 mg daily. Mr. Y discussed work and agreed that he would like to find employment as a driver.
21 September 2004	Mr. Y was reviewed at Cannon Street clinic and said to be very well. He had been to Cyprus with his parents, sister and her boyfriend. He was reviewed by Consultant Psychiatrist 3.
1 February 2005	Mr. Y was reviewed by Care Coordinator 1 who noted that Mr. Y was maintaining progress. He was still attending gym and trying to loose weight. Clozapine was reduced to 200 mg daily by Consultant Psychiatrist 3.
10 May 2005	Mr. Y was reviewed and it was noted that Mr. Y had been to see a doctor representing the Driver and Vehicle Licensing Agency (DVLA) who had recommended getting his licence back. He was maintaining exercise, enjoying swimming and going to the pub with his dad.
6 September 2005	Mr. Y did not attend clinic due to family holiday.
11 October 2005	Mr. Y was reviewed at Glodwick Health Centre by Consultant Psychiatrist 3 and Care Coordinator 1. The case notes recorded that Mr. Y was “ <i>doing very well</i> ”. He had lost two stone in weight, enjoyed a family holiday and had his own car. He was maintaining social contacts and thinking about doing a college course.
25 October 2006	Care Coordinator 2 wrote to Mr. Y to say that she was taking over the role from Care Coordinator 1.
2 November 2005	Care Coordinator 1 made a home visit to complete the CPA.
8 November 2005	Home visit. Mr. Y’s mother reported that he was making good progress and had no psychotic symptoms.
31 January 2006	Reviewed at Glodwick Health Centre by Consultant Psychiatrist 3 and Care Coordinator 1.
6 June 2006	Reviewed at Glodwick Health Centre by Consultant Psychiatrist 3. Mr. Y reported that he was going on holiday to Portugal shortly and that he was maintaining his gym attendance and social contacts.
10 January 2007	Reviewed at Glodwick Health Centre by Consultant Psychiatrist 3.
1 June 2007	Care Coordinator 5 wrote to Mr. Y to say that she was leaving. Care Coordination appeared to be largely undertaken by Consultant Psychiatrist 3 with input from a number of Community psychiatric Nurses until the appointment of Care Coordinator 2 in November 2007.
10 July 2007	Reviewed at Glodwick Health Centre by Senior House Officer 2. The notes recorded some concern from Mr. Y’s father that he was drinking

	too much alcohol and not taking his medication (Clozaril 150 mg). He was advised about his alcohol intake and the next review planned for 2 months' time.
15 August 2007	Community Psychiatric Nurse 3 recorded that she had received a phone call to say that Mr. Y is <i>"showing signs of relapse and was irritable and verbally aggressive towards his mum, not eating meals, not fully compliant with medication and increased alcohol use..."</i> .
16 August 2007	Mr. Y met Community Psychiatric Nurse 3 at the Phoenix Centre. There was a discussion about medication and Mr. Y complained about feeling drowsy. The nurse suggested taking the medication at night to alleviate this side effect.
29 August 2007	Community Psychiatric Nurse 5 recorded a message from the Employment Project Manager (the Opus Project) concerning some difficulties in Mr. Y having his blood taken to monitor medication levels. (The Opus Project provides guidance, support and assistance to individuals who have long-term mental health problems. The Mental Health Employment Service will try to find employment and/or identify training for employment based on individual need.) The nurse spoke to Mr. Y's mother about the problem and arranged for blood to be taken at the walk-in centre.
10 September 2007	Following concern at OPUS project attended by Mr. Y, Community Psychiatric Nurse 4 recorded that Mr. Y's parents who were going on holiday next week were concerned that he was not taking medication and that his mental state had deteriorated despite having a full time job as a car valet. She agreed to arrange a home visit.
11 September 2007	Community Psychiatric Nurse 4 liaised with Consultant Psychiatrist 5 regarding the concerns raised by the family. Consultant psychiatrist 5 advised a home visit to investigate the concerns. A visit was arranged for 12 September 2007 but there is no record on file of contact with Mr. Y.
12 September 2007	The crisis resolution team visited Mr. Y at home to discuss concerns raised by his mother that he was not taking his medication. The outcome was that Consultant psychiatrist 5 agreed that a Mental Health Act assessment was appropriate. A request was made to the Emergency Duty Team at Oldham Adult and Community Services for an assessment. There was also some concern that Mr. Y had an <i>"air rifle gun case"</i> in the back of his car. The Community Psychiatric Nurse rang the local Police to inform them of her concerns. Mr. Y was later assessed and following completion of Mental Health Act section 2 application he was taken to Northside Ward at Oldham Royal Hospital.
15 September 2007	Mr. Y was admitted to hospital following arrest by Police for pulling a telephone off a wall in a local massage parlour. It is noted that he was sexually disinhibited and believed that people have been talking about him. He was also non compliant with medication. He was said to have bizarre ideas about using a firearm on an animal.
11 October 2007	A ward round with Mr. Y's father present recorded improvements in his mental state and limited unescorted leave was agreed.
19 November 2007	A ward round with Specialist Registrar 2 agreed that he can plan two overnight leaves in the next week and Mr. Y's father was in agreement with this plan.

22 November 2007	Discharge was agreed with follow up by Care Coordinator 2 (who was a social worker) and the crisis resolution team monitoring Mr. Y's mental state and medication. Members of the crisis resolution team maintained daily contact through home visits, then visits on alternate days. Mr. Y was said to be making good progress but continued to go out drinking with friends and there were some doubts about his level of alcohol intake.
10 December 2007	Mr. Y was reviewed at out-patient clinic with Specialist Registrar 2 and Care Coordinator 2. They noted good progress but Mr. Y raised the issue of trying to get his gun back from the Police and was advised against this.
12 December 2007	Mr. Y was formally discharged from the Crisis Resolution and Home Treatment service by Consultant Psychiatrist 2 with follow up by Care Coordinator 2 and out-patient appointments with Consultant Psychiatrist 3.
23 January 2008	Care Coordinator 2 maintained close contact with Mr. Y and visited him several times a week. She recorded some concerns about his alcohol and cannabis use. His parents were concerned because he was spending a lot of time away from home. The Care Coordinator discussed the management of the case with Specialist Registrar 2 but it was decided not to refer him to the crisis resolution team because Mr. Y would not comply- it was agreed that the Care Coordinator would discuss hospital admission with Mr. Y.
31 January 2008	Following a Mental Health Act assessment involving GP 1 and an Approved Social Worker Mr. Y was admitted to Northside ward as a voluntary patient. It was noted that his relapse was due to non compliance with prescribed risperidone associated with alcohol and drug use. In regular reviews at ward rounds the main issue was that he did not wish to comply with the clinical view that he should take Clozapine. He said that there were unpleasant side effects.
12 February 2008	Mr. Y placed on section 3 Mental Health Act. The application for this treatment order was made by an Approved Mental Health Practitioner (AMHP 1) signed on 12 February 2008.
27 February 2008	There was a ward round with Consultant Psychiatrist 3, Specialist Registrar 2 and it was recorded that Mr. Y had assaulted (punched in the face) a member of staff "over the weekend" The Police had been informed but the staff member did not wish to press charges. It was noted that Mr. Y was impulsive, guarded and denying of symptoms. He had also been talking to other patients about being able to access guns. The care plan included discussion with the Cobden Unit about him.
2 March 2008	Mr. Y became absent without leave during an escorted visit to the shops to buy cigarettes. The Police and parents were informed.
4 March 2008	Mr. Y was returned to the section 136 suite by the Police- after being found at a friend's address in Oldham. (Section 136 of the Mental Health Act gives the police power to detain a person found in a public place who appears to be mentally ill and remove them to a place of safety).
5 March 2008	Following the agreed care plan, Mr. Y was assessed by staff from the Cobden Unit (the Cobden Unit is a Psychiatric Intensive Care unit

	located at Cheadle Royal Hospital, part of Pennine Trust). He was admitted to the Unit. Form 24 Mental Health Act was completed (giving authority for transfer from one hospital to another under different managers).
5-16 March 2008	Mr. Y was treated at the Cobden Unit under the care of Consultant Psychiatrist 4.
7 March 2008	The case notes recorded that Mr. Y was assaulted by a fellow patient who head-butted him. Mr. Y did not retaliate.
19 March 2008	The final entry in the Cheadle Royal notes said that Mr. Y had been settled though guarded on the ward and presented no problems in relation to violence or aggression. He was suitable to be transferred back to the Royal Oldham Hospital.
27 March 2008	Specialist registrar 2 noted in a ward round that Mr. Y was guarded with staff and denied psychotic symptoms. The care plan was to start Clozapine and that Mr. Y was not to have Section 17 leave from the ward.
2 April 2008	At a ward round with Consultant Psychiatrist 3, Specialist Registrar 2, Care Coordinator 2 and ward staff it was noted that Mr. Y would be started on Clozapine from that day. It was also explained to him that he would be moving to another ward-Southside. This was not welcomed by Mr. Y who said that he did not get on with another patient there. (This change was prompted by changes to the organisation of services in the Trust- it also meant that the role of responsible clinician passed from Consultant Psychiatrist 3, who had known Mr. Y for several years, to Consultant Psychiatrist 6, who had known him some years earlier when the latter had been a junior doctor to Consultant 3).
11 April 2008	At a ward round with Consultant Psychiatrist 6 it was noted that Mr. Y seemed better and had been taking Clozaril for ten days. Mr. Y's father was present and agreed that Mr. Y could visit home for a few hours and that " <i>Clozaril suits him</i> ".
16 April 2008	There was a ward round on Southside ward that included Consultant Psychiatrist 6 and a member of the crisis resolution and home treatment team. It was noted that Mr. Y had been re-started on Clozapine but staff were suspicious that he would become non-compliant. Mr. Y had spoken about his gun use on several occasions. He was very guarded and reluctant to discuss his symptoms. The role of the Crisis Resolution and Home Treatment Team was explained and that he would receive support from the team after discharge to his parents' home. There was also a reference to a person from housing support who would help him to find independent accommodation.
21 April 2008	Mr. Y was reviewed in a business meeting by Consultant psychiatrist 6. Home leave had been going well. It was noted that Mr. Y's mother had reported that home leave went well but his father was concerned about compliance. Mr. Y said he was planning to go to the gym again and denied any paranoid thoughts. It was agreed that there would be a discharge meeting next week (Mental Health Act Section 117 aftercare) and that leave would continue for the next week under the care of the crisis team.
2 May 2008	There was a ward round attended by Consultant psychiatrist 6, Care Coordinator 3, Care Coordinator 4, Mr. Y, Mr. Y's father and Crisis

	Resolution Team Member 1. It was agreed that Mr. Y would have a further period of two week's leave from the ward. Mr. Y said that he was capable of living independently and the view was that " <i>Mayall Street/Millview</i> " would be an appropriate 'step-down' from the ward. (this was a supported accommodation facility that enabled service users to move from a staffed unit to more independent living as their ability to live independently developed).
3 May 2008	There was a home visit by a member of the Crisis Resolution Team. Mr. Y was said to be pleasant and welcoming and happy to view the supported housing project, although not in a rush to move from his parents' at the moment.
5 May 2008	There was a home visit by members of the Crisis Resolution Team (CRT 3 and CRT 4). Mr. Y had been on a shopping trip to Manchester. It was agreed that Mr. Y would pick up a 'blood card' for Clozaril tomorrow and go for a blood test and collect medication from the pharmacy on 9 May 2008.
7 May 2008	There was a home visit by a member of the Crisis Resolution Team (CRT 5) who recorded no concerns.
10 May 2008	During a home visit by CRT 5 Mr. Y reported a positive reaction to his visit with his parents to the supported accommodation units previously discussed in the ward round.
12 May 2008	Home visit by the CRT (CRT 6 and CRT 7). Mr. Y presented as " <i>warm and pleasant</i> ". There were no concerns at present but Mr. Y said he would like to discuss medication with Consultant Psychiatrist 6 at the ward round on 15 May.
15 May 2008	There was a ward round attended by Consultant Psychiatrist 6, Senior House officer 3, Care Coordinator 3, Care Coordinator 4, members of the Crisis Resolution Team and Housing Worker 1. In interview Mr. Y presented as slightly anxious and agitated but denied any paranoid ideas- he asked for procyclidine to help with anxiety. Care Coordinator 3 reported that he had visited two supported housing facilities with Mr. Y. He did not like Mayall Street but did like Mill View and said he would be happy to move in. The Care Coordinator said he would " <i>take it to Panel on Monday</i> ". The Crisis Resolution Team reported no problems with Mr. Y. It was agreed that Mr. Y could have a further week's leave and that Clozapine dosage would be increased. It was agreed to review again on 22 May 2008 on Southside ward after the Panel meeting (this refers to the VARSS [Vulnerable Adults Rehabilitation Support Services] Panel that allocated supported housing resources).
19 May 2008	Care Coordinator 3 attended the VARSS Panel meeting at Rock Street. The outcome was that Mr. Y could not be offered a place at Millview without being assessed at Mayall Street first. The reasons were that <ul style="list-style-type: none"> • Mr. Y was unknown to the resettlement services and due to the low staffing levels at Millview it would not be possible to assess his capacity to live independently; • Mr. Y had a history of non-compliance with medication and assaultative behaviour when unwell and it was felt that this risk needed to be assessed. It was agreed to offer Mr. Y one or two nights at Mayall St to enable

	him to learn more about the service. It was possible he could be fast-tracked to Millview if all went well.
22 May 2008	<p>There was a ward round on Southside ward attended by Consultant Psychiatrist 6, Senior House Officer 3, Care Coordinator 3, Care Coordinator 4 and Housing Officer 1. Mr. Y reported feeling fine. Care Coordinator 3 reported back from the VARSS meeting but Mr. Y was not happy to spend time at Mayall Street and refused to consider this. A care plan agreed</p> <ul style="list-style-type: none"> • Mr. Y was to be taken off section today; • Support to be provided from Care Coordinator 3 and Care Coordinator 4; • Bloods would be done weekly in the community; • Medication to be supplied from the hospital pharmacy; • No input from Crisis Resolution Team. <p>Mr. Y was discharged on this day to the care of the Community Mental Health Team.</p>
29 May 2008	<p>Care Coordinator 3 (accompanied by Care Coordinator 4) recorded a home visit to Mr. Y after being contacted by Mr. Y's father. Mr. Y's father was concerned that Mr. Y was not taking Clozaril as prescribed, appeared agitated, pacing the house and was "off" with his parents. Mr. Y said that his "brain was agitated". Care Coordinator 3 advised that he had spoken to Consultant Psychiatrist 6 and that Mr. Y could take all his medication (325 mg Clozapine) at night if he felt that drowsiness was a problem. Mr. Y's parents thought that he had not been taking medication because of his behaviour but Mr. Y denied this. There was discussion of the housing situation and Mr. Y said that he intended to present himself as homeless in order to be admitted to a hostel. He was advised against this course of action and to see a housing support worker.</p> <p>It was noted by Care Coordinator 4 that Mr. Y had attended Glodwick Health Centre on 28 May to give a blood sample for Clozaril monitoring but had been told that no information had been passed to the clinic from the ward. Mr. Y attended the hospital and his blood test had come back 'green'.</p>
29 May 2008	<p>There was a note on file recording a telephone call from Care Coordinator 3 to Consultant Psychiatrist 7's secretary asking for an urgent clinic appointment, following their visit to Mr. Y. Mr. Y was booked into the Glodwick Clinic on 3 June 2008. Consultant 7 had taken over as the responsible clinician when Mr. Y was discharged from hospital in line with the Trust policy in response to <i>New Ways of Working</i>.</p>
30 May 2008	<p>Care Coordinator 3 recorded that Mr. Y's mother had telephoned to say that she believed Mr. Y was on his way to First Choice Homes to declare himself homeless. The Care Coordinator told Mr. Y's mother that he would contact the housing agency to let them know some background to Mr. Y's request. He also informed Mr. Y's mother that he had made an out-patient appointment for Mr. Y with Consultant Psychiatrist 7 for 3 June 2008.</p>
30 May 2008	<p>Care Coordinator 3, after discussion with Care Coordinator 4 and their</p>

The Care and Treatment of Mr Y

	<p>Team Manager 1(TM1) telephoned First Choice Homes and spoke to a member of the Housing Support Team to express their view that Mr. Y should not be offered a hostel place. Mr. Y was being interviewed by the Housing Officer but would not be offered hostel accommodation if his parents were willing to have him living with them (that is, he was not technically homeless).</p> <p>Care Coordinator 3 contacted Consultant Psychiatrist 6 at the Cherrywood Clinic to tell him about recent developments.</p>
30 May 2008	<p>A discharge letter from Senior House Officer 3 was sent to Mr. Y's GP summarising recent treatment and future plans.</p>
2 June 2008	<p>Mr. Y was arrested on suspicion of killing Mr. A.</p>
3 June 2008	<p>Mr. Y was interviewed at Ashton-under-Lyne Police Station and charged with murder on 1 June 2008 of Mr. A.</p>

APPENDIX TWO: PENNINE CARE NHS TRUST PERFORMANCE ON CARERS' ASSESSMENTS

	July 08	Oct 08	Nov 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	June 09	Jul 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	June 10	Jul 10	Aug 10	Sept 10	Total
Bury				3									2	3		9	18	10	49	42	65	27	40	11	279
Oldham	1			2		4	12	17	11	6	8	16	9	11	9	7	6	6	4	9	22	14	15	14	203
Rochdale					1			2	1			1						2	1	8	5	10	4	1	36
Stockport		1				1	2	2	6	5	8	12	6	13	9	10	19	14	18	10	17	12	5	1	171
Tameside			3	24	6	101	9	2	26	12	15	15	18	27	19	24	26	51	139	46	79	64	45	23	794
Total	1	1	3	29	7	106	23	43	44	23	31	44	35	54	37	50	69	83	211	115	188	127	109	50	1483

Note: This table contains all carer assessment activity.