

VERITA

IMPROVEMENT THROUGH INVESTIGATION

**Independent investigation into the care and treatment of
Mr F**

A report for
NHS England, North Region

December 2013

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1. Introduction

Background to the independent investigation

1.1 Mr F, a 24-year-old service-user, under the care of Blackburn and Darwen complex care team attacked a 22-year-old man (an acquaintance) on 16 April 2011. The man died of his injuries on 21 April 2011.

1.2 Mr F was then remanded in custody at HMP Preston.

1.3 Mr F pleaded guilty to murder on 14 November 2011 and was sentenced to life imprisonment. He must serve a minimum of 13 years and 100 days.

1.4 Mr F's GP first referred him to East Lancashire Mental health services in February 2005 with symptoms of acute psychosis. By January 2007 he was diagnosed with paranoid schizophrenia by Dr SA, consultant psychiatrist.

1.5 Mr F's mental health deteriorated in October and November 2008 and in June 2009. On all three occasions the crisis resolution and home treatment team (CRHTT) helped care for him until his health stabilised and he was discharged back to the community mental health team (CMHT). His diagnosis remained paranoid schizophrenia, controlled by olanzapine.

1.6 Mr F was discharged from the CMHT back to the care of his GP in May 2010 because his consultant psychiatrist, Dr MA, considered his mental health was stable.

1.7 Mr F's GP referred him back to mental health services in January 2011 after his mental health deteriorated. The crisis nurse assessed Mr F at home and he agreed to home treatment.

1.8 Mr F was allocated a new care coordinator who he met on 7 April 2011. No concerns were raised during this meeting and it was agreed by the care coordinator that Mr F would next be seen for a CPA review on 28 April 2011. This review never happened because the incident occurred on 16 April 2011.

1.9 The chief executive of Lancashire Care NHS Foundation Trust commissioned a post incident review (PIR) into the care and management of Mr F immediately after the offence, which a service manager performed. She did not meet Mr F, his family or the victim's family in the process but she tried to engage Mr F's mother.

1.10 The service manager submitted the PIR report in June 2011 and made no recommendations. The panel did not share its findings with Mr F, his family or the victim's family.

1.11 NHS North of England¹, the responsible strategic health authority, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out this independent investigation in December 2012.

1.12 The independent investigation follows the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in section 2.

1.13 The purpose of an independent investigation is to discover what led to an adverse event and to audit the standard of care provided to the person involved. An independent investigation might not find root causes or aspects of the provision of healthcare that directly caused an incident but will often find things that could have been done better.

1.14 Chris Brougham and Amber Sargent, both senior investigators for Verita carried out the investigation with expert advice provided by Dr Douglas Gee, consultant general adult psychiatrist and medical director. Their biographies can be found at appendix A.

1.15 Derek Mechen, partner, peer-reviewed this report.

¹ During the course of our investigation NHS North of England ceased to exist as powers were transferred to NHS England. Throughout the report we still refer to NHS North of England as they were the commissioners of the review and the incident occurred while they were still in existence. The final report will be submitted to NHS England.

Overview of the trust

1.16 Lancashire Care NHS Foundation Trust specialises in inpatient and community mental health services. The trust serves the whole county. Community services include primary care mental health teams that offer assessment and short-term psychological treatment and support for adults. The trust also provides an early intervention service that promotes early detection of mental illness and provides education about psychosis.

2. Terms of reference

2.1 The terms of reference for the independent investigation, set by NHS North of England Strategic Health Authority (the SHA), in consultation with Lancashire Care NHS Foundation Trust, are as set out below.

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 judgment 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 health 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.

To identify:

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

To make:

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

To report:

- findings and recommendations to the NHS North of England Board, as required by the SHA.

3. Executive summary and recommendations

Executive summary

3.1 NHS North of England (now NHS England, North Region) commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of a mental health service-user (Mr F).

3.2 The independent investigation follows guidance published by the Department of Health in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33-36 issued in June 2005.

3.3 The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. The independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident but equally it may find elements of care that could have been better provided.

The incident

3.4 Mr F, a 24-year-old service-user, under the care of Blackburn and Darwen complex care team had been socialising with the victim (a 22-year-old man) and another young male on the evening of 15 April 2011. Late that evening Mr F and the victim were seen on CCTV entering a car park in Blackburn town centre. Nine minutes later Mr F was captured on CCTV leaving alone. The victim was found shortly after midnight by passers-by. He had suffered severe head trauma consistent with an attack. He was taken to hospital but died of his injuries on 21 April 2011.

3.5 Mr F was then remanded in custody at HMP Preston and pleaded guilty to murder on 14 November 2011. He was sentenced to life imprisonment and must serve a minimum of 13 years and 100 days.

Overview of care and treatment

3.6 Mr F was first referred by his GP to East Lancashire mental health services in February 2005 with symptoms of acute psychosis. He was treated as an informal inpatient and then under Section 2 of the Mental Health Act (1983) for about four weeks. At this time Dr MA, consultant psychiatrist, considered that Mr F had experienced an “*acute psychiatric episode*” that was possibly “*drug induced?*”

3.7 Mr F was admitted to hospital again in June 2005 after trying to assault his sister with a knife and a hammer. He was assessed by staff on Darwen ward and then discharged the following day.

3.8 Mr F was admitted to hospital early in January 2007 with recurring symptoms of paranoia and low mood. He admitted to not taking his medication and to smoking cannabis. He was diagnosed with paranoid schizophrenia by Dr SA, consultant psychiatrist. He was discharged back to the care of the crisis resolution and home treatment team (CRHTT) at the end of January. He was then discharged to the community mental health team (CMHT) on 7 February 2007.

3.9 Mr F’s mental health deteriorated in October and November 2008 and in June 2009. On all three occasions the CRHTT were involved in his care until his health stabilised and he was discharged back to the CMHT. His diagnosis continued to be recorded, by those involved in his care, as paranoid schizophrenia.

3.10 Mr F was discharged from the CMHT back to the care of his GP in May 2010 because his mental health was considered, by Dr MA, consultant psychiatrist, to be stable.

3.11 Mr F was referred again to mental health services by his GP in January 2011 after his mental health deteriorated. The crisis nurse assessed him at home and Mr F agreed to home treatment.

3.12 Mr F’s new care coordinator phoned Mr F on 29 March 2011 and Mr F said he was taking his medication. A CPA review was arranged by the care coordinator for 28 April 2011 and Mr F met his new care coordinator on 7 April 2011. No concerns were raised during the meeting and it was agreed that Mr F would next be seen for his CPA review on

28 April 2011. This appointment never took place because the incident occurred on 16 April 2011.

Overall conclusions of the independent investigation

3.13 Several important factors could have changed the way trust services understood and engaged with Mr F. Greater attempts to provide Mr F with appropriate treatment options could have given him a better understanding of his mental health condition and helped him manage it. However, nothing suggests the incident was predictable or preventable.

3.14 Most notably, there was a lack of recognition by staff involved in Mr F's care of the role drug use played in the deterioration in his mental health. This resulted in a disconnection between addiction and mental health services.

3.15 Mr F first came into contact with mental health services in February 2005. He was considered to have had an acute psychiatric episode and Dr MA, consultant psychiatrist, asked if it was drug induced. Drug use was recorded as an aspect of his presentation. From then on, throughout Mr F's contact with mental health services both in the community and as an outpatient, excessive drug use was a consistent feature of his presentation that preceded deterioration in his mental health.

3.16 Despite this, Mr F was never referred to the drug and alcohol service, and drug use did not feature as a risk factor or as an early indicator of relapse in his risk management plan. Staff inconsistently referred to the impact of drug use in Mr F's care plan documents and no action was taken when he started using drugs again.

3.17 Mr F's diagnosis was changed by Dr SA, consultant psychiatrist, from an acute psychiatric episode to schizophrenia following an inpatient episode in 2007. There were no subsequent attempts, by staff involved in Mr F's care, to re-evaluate the diagnosis despite evidence that some of his behaviour and symptoms may have been caused by something other than mental health problems.

3.18 Mr F's risk was regularly reviewed, by staff involved in his care, using safety profiles but information in these documents was often copied from previous assessments making it difficult to identify new or relevant information.

3.19 Mr F was predominantly managed in the community by the crisis team and once he stabilised, by the community mental health team (who became the complex care and treatment team). The focus of their intervention was to ensure Mr F take his schizophrenia medication. The approach seemed to have been purely medical rather than based on a biopsychosocial assessment of need.

3.20 Trust services have been reorganised since the incident to ensure a multidisciplinary team approach to assessment and management of service users. This includes introducing specialist practitioners to the complex care and treatment team. The specialist practitioners have post-graduate training in psychosocial type interventions or cognitive behavioural therapy. PH, acting assistant network director for step four services, told us that the trust recognised it needed to develop its psychological treatment teams for people with psychosis in the community. This features in their three-year business plan.

3.21 PH told us that the service has a plan to improve the risk assessment process. This will help ensure the assessment form is more dynamic and will be used as a tool to have a meaningful impact on the management of service users.

3.22 Someone presenting to the services with similar symptoms to Mr F would now be considered for formal work with the specialist practitioner or the team psychologist. One of the main changes in practice is the firm expectation that a standardised crisis and relapse prevention plan and a contingency plan will be made. The new crisis form differentiates between 'early indicators', 'medium term indicators' and 'acute indicators' of relapse.

3.23 These developments will help ensure that diagnosis is considered and reviewed on a regular basis and that appropriate interventions are applied. The development of crisis and relapse prevention plans will also help signs of relapse to be identified at the earliest opportunity.

3.24 Despite Mr F's mental health deterioration after heavy cannabis use (a feature reported in most of his A&E presentations) it was not considered, by staff involved in his care, a major risk factor for him. He was never referred to a drug worker for assessment and management. Throughout his engagement with trust services there was clearly a disconnect between addiction and mental health services. Now, substance misuse should be identified in the physical health assessment and a specialised practitioner has a dual diagnosis role in the team. The specialised practitioner can work with the care coordinator and the service user to discuss the best approach - including therapeutic interventions and/or education about the impact of substance misuse on mental health.

3.25 We were told by an interviewee that in 2006/7 all patient records were moved to the electronic system (EDMS) and paper copies were destroyed. However, some information was not uploaded properly and in the course of this investigation we found that important pages from Mr F's discharge letters were missing. Dr MA told us that important clinical information could be stored on two electronic systems (ECP and EDMS). Because of this, a staff member must look for information uploaded to EDMS that may be important.

Recommendations

R1 The trust should conduct annual audits of NICE quality standards. The board should be provided with evidence that all community mental health teams have access to specialist addiction practitioners and know how to refer to them. We recommend that the trust conducts annual audits to review patient pathways from referral to discharge.

R2 We recommend that within the next six months the trust review the process by which they decide whether someone should have a carers' assessment. This should be reviewed alongside adult mental health services to ensure that the process is systematic. A clinical audit of compliance with the set standards should be conducted and reported to the board as part of the trust's clinical audit plan.

R3 The trust should report on the implementation of their new risk assessment process and on the roll out of training to the board. The trust plans to commission an external review of the quality of the new process. These findings should be reported to the board for any necessary action.

4. Approach and structure

Approach to the investigation

4.1 The investigation was undertaken in private in the form of an expert panel review. It comprised a review of documents and interviews. We used information from Mr F's clinical records and evidence gathered from the internal investigation team. We sought only to interview staff to clarify information (see appendix B). As part of our investigation we interviewed:

- CJ, Mr F's care coordinator from 2005 - 2011
- RD, Mr F's care coordinator at the time of the offence
- Dr MA, Mr F's consultant psychiatrist between February 2005 - May 2010
- Dr GT, ST5 in psychiatry for the Blackburn crisis team (at the time), who reviewed Mr F twice in January 2011

4.2 We also met with PH, acting assistant network director for step four services (complex care and treatment teams and the recovery teams) about the progress of recommendations made in the internal report.

4.3 We had full access to trust papers produced at the time of the internal investigation. We met the lead investigator of the internal (PIR) investigation in order to understand the trust's investigation process and how the post-incident review was conducted in this case.

4.4 We wrote to Mr F at the outset of the investigation, explained the nature of our work and asked to meet him. We then met him at HMP Gartree. Mr F gave written consent for us to access his medical and other records. We told him that the report was likely to be published. We gave Mr F the opportunity to comment on a draft before it was finalised.

4.5 We met Mr F's mother and explained the purpose and process of our investigation. We also invited her to share her views on the care and treatment provided to her son.

4.6 We had no contact details for the victim's family, so the police victim liaison officer contacted the victim's mother and asked if she would meet us. She did not reply

but we gave her regular updates about the investigation through the victim liaison officer. We also wrote to the victim's mother at the end of the investigation to ask if she would like to hear our findings.

4.7 Our findings from interviews and documents are in ordinary text and our comments and opinions are in ***bold italics***. This does not apply in section 6, which consists largely of comment and opinion.

Structure of this report

4.8 Section 5 sets out the details of the care and treatment of Mr F. We have included a full chronology of his care in order to provide the context in which he was known to trust services.

4.9 Section 6 examines the themes arising from Mr F's care and treatment.

4.10 Section 7 reviews the trust's internal investigation and reports on the progress made in tackling the organisational and operational matters identified.

4.11 Section 8 sets out our overall analysis and recommendations.

5. The care and treatment of Mr F

Early years

5.1 Mr F was born and raised in Blackburn. His parents separated when he was a child and he grew up with his mother. He had little contact with his father. He has two younger half siblings on his mother's side.

5.2 Mr F attended mainstream school in Darwen. He left school with no qualifications when he was 14.

Forensic history

5.3 Mr F was convicted three times for five offences between 2001 and the end of 2004: twice for shoplifting, and three times for taking a vehicle without consent, driving without a licence and driving while uninsured. The sentences handed down included a three-month referral order, 24 hours at an attendance centre and disqualification from driving.

5.4 He was convicted of assault occasioning actual bodily harm and battery in May 2006. The police record describes this offence as sexual in nature. He was sentenced to 26 weeks in prison suspended for two years. He was given a two-year supervision order and a programme requirement of 100 hours. He was also given a four-month curfew between 8pm and 8am.

5.5 Mr F was convicted of driving while disqualified, with no insurance and without an MOT on his vehicle, also in May 2006. He was sentenced to a community order with a twelve-month supervision requirement.

5.6 He was sentenced to 180 days in prison suspended for two years in July 2006 for a dangerous driving offence that happened in November 2005. He was also convicted of driving without insurance and without a licence.

5.7 Mr F was convicted of going equipped for theft in January 2010. He was given an 18-month conditional discharge. Mr F was also charged with producing and supplying cannabis in 2010. He was sentenced for this offence at the same time as the murder conviction in November 2011.

Contact with mental health services

5.8 Mr F first came into contact with mental health services on 9 February 2005 when he was 18. His GP, Dr R, referred him with symptoms of acute psychosis and paranoid ideas. The referral form highlighted that Mr F had a history of aggression towards others.

5.9 Mr F was admitted informally to the inpatient unit at Royal Blackburn Hospital (RBH) and was later detained under Section 2 of the Mental Health Act (MHA) 1983 because he refused to stay on the ward voluntarily or take his medication (olanzapine 10mg daily).

5.10 Mr F's notes recorded by AG, care coordinator, on 15 March 2005 say that he was showing some improvement. Entries on 29 March include comments about him being intimidating to vulnerable patients and inappropriate to staff. It was noted he had been sexually disinhibited at times and had been heard whispering threats to other patients. It was recorded that his last drug screen was negative for cannabis. Mr F was recorded as being irritable and defensive when questioned about his behaviour.

5.11 Mr F was discharged on 12 April 2005 to the home he shared with his mother, stepfather, brother and sister. The discharge summary recorded his diagnosis as:

- 1) Acute psychiatric episode
- 2) Drug induced?

5.12 We found a handwritten correction of the diagnosis in the letter that appears to indicate that the first point was intended to be 'acute psychosis'. When we interviewed Dr MA, his recollection was that Mr F's symptoms were consistent with drug-induced psychosis. Dr MA told us that:

“...the impression was that he had been doing well and he will become paranoid when he starts taking cannabis again.”

5.13 His care programme approach (CPA) status was recorded as enhanced and the plan was for him to be reviewed in the outpatient clinic 4-6 weeks later. He was discharged under the care of the community mental health team (CMHT). AG, a CMHT worker, recorded in Mr F’s clinical notes that she did not feel that Mr F was particularly well; he was suspicious and paranoid. She advised Mr F’s mother to follow the crisis plan if she had any concerns.

5.14 Mr F was re-admitted to hospital on 7 June 2005 after he tried to assault his sister with a knife and hammer. Mental health services assessed him and decided that this was a social altercation and Mr F’s mental health had not deteriorated. He was therefore discharged. We found no indication that the police were involved on this occasion.

5.15 AG visited Mr F at home on 21 June 2005. Mr F disclosed that he had been driving without a licence or insurance. Mr F said that he *“can drive because he is important and only needs to show the police his welding shield”*. AG challenged this and Mr F laughed in response.

Comment

We think it reasonable to infer that the professionals treating Mr F did not consider mental illness was the cause of his actions on 7 June 2005. Comments Mr F made about being able to drive without a licence or insurance could appear, from the case notes, to have arisen as a result of disturbance in personality rather than clear mental illness.

5.16 Mr F was prescribed 10mg olanzapine daily throughout June 2005 and reported to AG, care coordinator, that he was compliant with this. He continued to engage with AG who found out that Mr F was driving without tax or insurance. AG reported this to a community police officer. No outcome is noted in Mr F’s clinical records but the police records suggest he was charged with driving while disqualified the following year.

5.17 An entry in Mr F's case notes in July 2005 says:

"It is not surprising that Mr F has had problems as he does not seem to have any clear guidance or boundaries set for him."

Comment

This could suggest a disturbance of personality rather than a mental health issue.

5.18 Mr F moved into his own flat provided by Stonham Housing Association in Darwen on 9 August 2005. Mr F stopped taking his medication in September and AG suspected that he was smoking cannabis and drinking alcohol. Mr F became difficult to engage. He was assaulted on 9 September and his arm was broken. The perpetrator was identified using CCTV at Stonham and was remanded in custody. The reason for the assault was not documented in Mr F's records.

5.19 Mr F's records report his behaviour was inappropriate in September 2005. He had been taking photos of AG, a care coordinator with his camera phone. AG documented that he was acting *"very immature"* and *"giggling although denies drinking and using illicit substances."*

5.20 Members of staff from the housing association were concerned on 14 October 2005 that Mr F was not attending the weekly meetings that were part of his tenancy agreement. He had also been arrested and charged with assault, sexual assault and harassment, but denied the last two charges. Mr F told AG, that he had weapons in his flat for protection but had been told to get rid of them. Mr F was not taking his medication but he engaged with staff.

5.21 CJ took over from AG as Mr F's care coordinator on 7 November 2005. This transfer was thought, by the team, to be in Mr F's best interest because he *"seems to respond to men better"*. A care programme approach review, attended by Dr MA, consultant, AG and CJ, care-coordinators, Mr F and his mother, took place on this date. Mr F admitted that he had not been taking his medication for some time but that he had started to take his olanzapine again in the past two weeks, although his mother disagreed. Mr F indicated

that the reason he stopped his olanzapine was because it made him drowsy. Dr MA tried to compromise with Mr F by suggesting he take 10mg dose instead of 20mg. Mr F made comments about being “*above the law*”. This was felt by the CPA review team to be in keeping with him not taking his medication. Dr MA warned Mr F of the dangers of his mental illness if he did not take his medication.

5.22 It was documented, on the CPA review form, that Mr F had problems with his tenancy because Stonham staff reported smelling cannabis in his flat and said they had received reports that he had been intimidating other residents. The diagnosis in Dr MA’s letter to the GP was “*psychotic episode - probably drug induced*”. The next CPA review was arranged for 8 February 2006.

Comment

This review did not appear to consider if Mr F’s difficulties were due to personality disturbance rather than or in addition to mental illness. The implicit message was that Mr F’s disturbed behaviour was a result of mental illness and that medication would be the appropriate treatment.

5.23 Mr F was stopped by police while driving on 17 November 2005. During questioning he drove away and nearly “knocked one of them down”. The police later visited Mr F at Stonham housing. A Stonham worker told CJ, care coordinator, that Mr F had found the situation amusing and had said, “*nothing will stop me committing crime*”. He was later charged with failing to stop and fined £500 for the traffic offences on 25 November.

5.24 Mr F went abroad with his family during December 2005 and remained settled. However, by 27 December, back in the UK, he had again become paranoid and asked a crisis team worker if he could be admitted to hospital. He was assessed by the on-call SHO at the Blakewater Unit who restarted Mr F on olanzapine 10mg daily and assessed him as suitable for home treatment.

5.25 CJ, care coordinator, spoke to a Stonham worker on 5 January 2006. She said Mr F had told her that he wanted to move from Blackburn/Darwen “*because he feels there are people after him*”. CJ discussed this with Mr F the following day. Mr F said “*it’s not*

because I'm paranoid but I just need to get away from these dickheads round here". The entry in Mr F's notes describes no evidence of paranoia or psychosis at that time.

Comment

Mr F's behaviour suggests that some of the features ascribed to mental illness may have been a function of personality and an understandable reaction to circumstances.

5.26 Mr F told CJ on 10 February 2006 that he was not taking his medication and that he was feeling paranoid. He agreed to start taking olanzapine 10mg daily again and was reported by CJ to be stable for the next few months.

5.27 Mr F's probation officer reported to CJ on 9 May 2006 that he had no major concerns but that Mr F had indicated to him that it would be better for him to be admitted to hospital rather than going to prison for his recent offences.

5.28 Mr F attended court on 18 May 2006 charged with assault occasioning actual bodily harm and battery. Police records show this offence was sexual in nature. He received a 26-week prison sentence suspended for two years, a two-year supervision order with 100 hours of community service and he was electronically tagged and put under curfew from 8pm to 8am for four months. He was ordered to pay compensation to the victim of the assault.

5.29 Mr F was settled during the summer of 2006 and said he was taking his medication. He was accepted onto an electrician's college course, which started in September 2006.

5.30 Mr F attended his college course between September and December 2006 and his care coordinator documented he seemed well but guarded at times. He denied paranoid ideation or intrusive thoughts and said he was not taking medication because he did not need it.

5.31 A member of staff saw Mr F outside Royal Blackburn Hospital on 2 October 2006 asking about a female ward clerk. Another female member of staff documented in Mr F's

notes that she felt intimidated by his behaviour. The next day Mr F told his care coordinator that he wanted a girlfriend and felt he would be able to find one through the mental health service. Mr F was noted to have *“minimised the seriousness of his actions and it became apparent that his actions were due to his lack of social skills and unrealistic expectations of mental health services.”*

Comment

At this time there was no evidence that Mr F was psychotic. The incident on 2 October 2006 is another example of how Mr F’s difficulties and behaviour appear to be a function of personality disturbance rather than mental illness.

5.32 Mr F was admitted to Darwen ward inpatient unit at Royal Blackburn Hospital (RBH) on 4 January 2007. He said he had not been taking his medication and had been smoking cannabis. The clinical records for that day say that Mr F had delusions of reference. Specifically, Mr F believed that his care coordinator was giving him messages. For example, if his care coordinator crossed his legs he was telling Mr F to go to hospital and two police cars passing his house was also a sign that he should go to hospital. However, these symptoms appeared to be fairly short-lived because the notes from the next day (5 January) say that Mr F had told staff he was not feeling paranoid. They also say that:

“He did not actually appear to be displaying any paranoia at the time or throughout the shift although it is difficult to ascertain for sure due to him remaining in his room.”

5.33 A primary nurse documented on 7 January 2007 that female staff should work in pairs and be careful around Mr F due to his history of sexually assaulting a female, which he denied. It was also documented on this date that Mr F appeared preoccupied but the next day he denied having psychotic experiences.

5.34 Mr F gave ward staff £4,640 cash to be placed in the night safe on 9 January. The notes do not say that staff asked Mr F why he was carrying such a large amount of money.

5.35 Mr F was seen by a member of ward staff rubbing himself through his pants while sitting in the ward lounge on 10 January. The nurse in charge told him that this was unacceptable behaviour.

5.36 Mr F's mother expressed concerns during Mr F's admission (4 - 24 January 2007) about his risk to others. She told CJ on 9 January that her son may have decided to harm his stepfather. She said on 17 January that she would not feel safe if Mr F came home and was specifically concerned about Mr F's younger brother. She appears to have based this concern on Mr F's apparent belief that she had had his younger brother so that he could grow up and kill Mr F.

5.37 A crisis and contingency plan was drawn-up on 9 January 2007 and a CPA review meeting took place on 17 January. The CPA meeting was attended by:

- Dr SA, consultant psychiatrist
- MA, generic base
- CJ, care coordinator
- AR, primary nurse, Ribble ward
- MD, home treatment team
- JA, Pendleview RBH
- Mr F
- Mr F's mother

5.38 Mr F's diagnosis was discussed during the CPA review; schizophrenia verses drug-induced psychosis. The consultant psychiatrist said if it was schizophrenia then depot injections should be considered. MD had undertaken a home treatment team assessment and reported that Mr F had delusional thoughts. Mr F's mother said Mr F had been smoking cannabis but he denied it.

Comment

There does not appear to have been a plan to resolve the uncertainty of Mr F's diagnosis. This was a critical issue to resolve. If the diagnosis was of a long-term psychotic condition such as schizophrenia, more robust attempts could have been made to ensure compliance with medication and follow-up. If however, the diagnosis

was more in keeping with drug induced psychosis, cannabis misuse or personality dysfunction, it would have been more appropriate for his care plan to include the need for setting boundaries, helping Mr F get support for his cannabis misuse, and dealing with issues of responsibility. Appropriate interventions could also have been put in place to help Mr F address any behavioural disturbance.

5.39 Another care plan was drawn-up on 18 January 2007. It recorded that Mr F presented a risk to female staff and they should work in pairs and take care when around him due to reports of him sexually assaulting a female, which he denied.

5.40 Mr F admitted on 20 January that he believed that some of his classmates are police and the cars going past the house have messages for him. However, it is recorded by a CRHTT worker that Mr F did not seem at all distressed by this or understand why staff might be concerned about it.

5.41 Mr F stayed in hospital until 24 January 2007. He was started on olanzapine 20mg daily and citalopram 20mg daily during his inpatient stay. He responded well to the medication and was able to attend college while on the ward. Mr F did not want to return to his flat upon discharge so it was agreed he would stay with his mother. A CPA review meeting took place before he was discharged. Mr F was showing no signs of psychosis or depression, his mood was better and he was described as “*relatively stable*”. There was no review of risk on the CPA form. The plan was for Mr F to be seen by the home treatment team with a follow up with the community consultant 4 - 5 weeks later.

5.42 Dr SA’s SHO wrote the discharge letter for this admission on 8 February 2007. A diagnosis of paranoid schizophrenia was recorded. It also records he had been diagnosed with paranoid schizophrenia before, but it is not clear when this statement refers to.

Comment

In an interview with Dr MA, he recalled that Mr F’s diagnosis was changed to paranoid schizophrenia in 2007 following assessment by Dr SA. This diagnosis was maintained throughout Mr F’s engagement with mental health services thereafter.

The basis for the diagnosis of schizophrenia instead of attributing Mr F's symptoms to drug induced psychosis from cannabis use is not clear from the notes.

On the basis of the evidence in the case notes, Mr F does not seem to have reached the threshold for the diagnosis of schizophrenia. The guidelines for an ICD 10 diagnosis of schizophrenia are given in appendix C. Dr MA recalls that Mr F originally presented with drug-induced psychosis and had a symptom profile after admission in 2007 consistent with ongoing episodes of drug-induced psychosis. Furthermore, the symptoms Mr F presented with in 2007 were similar to those outlined by Dr MA in his medical report from Mr F's admission in 2005. The diagnosis of schizophrenia was never formally reviewed after it was made in 2007. Whether this distinction had a bearing on clinical management is considered in section 6.

5.43 Mr F was under the care of the home treatment team for two weeks after discharge. He took his medication and attended college. A home treatment care plan was completed for him on 4 February. The assessment says Mr F was admitted to Ribble Ward, Royal Blackburn Hospital, after a relapse in his mental state. The plan was for Mr F to be supported in the community, with help to engage in community activities and to ensure he took his medication. He was then discharged into the care of the community mental health team.

5.44 Mr F was noted on 7 February 2007 to be *“bright, appropriate and optimistic...he appeared to realise that he had become unwell prior to his admission and is aware of things he did and said that were out of the ordinary.”*

5.45 A CPA review took place on 8 March 2007 after Mr F's follow-up appointment with Dr MA, consultant psychiatrist. Mr F denied hearing voices or thinking about self-harm and said he was taking his medication. He also said he felt fine but that he wanted to go to the ward. When Dr MA explored this, Mr F said it was because he felt stressed and wanted to come to the ward for relaxation. Dr MA found Mr F to be reasonably stable at this review. Another outpatient appointment was arranged for three months later.

Comment

Mr F's diagnosis was still paranoid schizophrenia at this time. His desire to be admitted to a mental health unit appears to be unconnected from symptoms of psychosis. There may have been a missed opportunity to explore this further because it would suggest psychopathology unrelated to psychosis.

Irrespective of the diagnosis, staff could have done more to focus on and treat Mr F's presenting symptoms - cannabis use and behavioural issues.

5.46 Mr F's clinical records say that he began smoking cannabis again in March 2007, and that this caused conflict with his family. The case notes also say there was no evidence that his mental health was deteriorating.

5.47 A group worker expressed concerns to CJ about Mr F's inappropriate behaviour in May 2007. He had to ask Mr F to take his hands from his pants during a group work session. The group worker told CJ that Mr F was not displaying any obvious symptoms of psychosis on this occasion.

5.48 A CPA meeting took place on 14 June 2007 and was attended by Mr F, Dr MA, consultant and CJ, care coordinator. Mr F said he had stopped smoking cannabis two weeks previously. He said he continued to be medication-free and that if he did not smoke cannabis, he did not experience mental health problems. Dr MA prescribed four weeks supply of 5mg olanzapine, to be taken daily. The plan was for CJ, the care coordinator, to continue to visit Mr F monthly and for Dr MA to review him six months later.

Comment

Mr F's observations about his own mental health problems appeared to be consistent with his presentation. Again, this link between cannabis use and a deterioration in Mr F's mental health should have raised questions about the validity of the diagnosis. The fact that, by Mr F's own admission, being symptom-free was associated with not

using cannabis rather than taking his antipsychotic medication, should have raised questions about his diagnosis/formulation.

5.49 Mr F moved out of his family home and into a flat on 7 July 2007. The CMHT supported him to take his medication during this time. He enrolled in an English course at college and continued the electrician's course he had started the previous year.

5.50 Mr F told CJ on 21 August 2007 that he had not been taking his medication, although he remained settled and was keeping alcohol and cannabis use to a minimum. He continued to go to college. The case notes show no evidence that Mr F's mental health had deteriorated. CJ noted that he appeared "*genuine and plausible*". He said he had not taken olanzapine for two months and felt he did not need it.

5.51 Mr F remained stable until 11 December 2007 when he again began to deteriorate. CJ agreed with Dr MA that Mr F should restart his medication, 10mg olanzapine, daily. There is little information recorded in the case notes describing the cause of the deterioration. CJ also completed a safety profile on this date.

5.52 The two entries in Mr F's clinical records on 14 December 2007 suggest that there were no overt signs of psychosis. However, on 23 December 2007, TC, a CRHTT worker noted Mr F appeared suspicious and guarded. His answers were short and precise; his eye contact was "*staring*". However, CP, another CRHTT worker reported three days later, on 26 December, that Mr F was "*quite warm in manner*" and "*had enjoyed the day yesterday*".

5.53 Mr F told a CRHTT worker on 6 January 2008 that he had not suffered from paranoid ideas for two years. Their discussion focused on his use of psychotropic medication. Mr F felt he did not need to take it and the CRHTT worker suggested he discuss this with the doctor at his review the next day.

5.54 Mr F was under the care of the home treatment team until 9 January 2008 when he was discharged to the community mental health team. Safety profiles were completed by SL, approved social worker and CJ, care coordinator on 9 and 15 January 2008 respectively. The risk Mr F posed to mental health workers visiting him at home was

recorded due to a criminal conviction for an assault against a female. No other risks were identified. His diagnosis was recorded as paranoid schizophrenia in remission at this point.

5.55 Mr F had stopped taking his medication by March 2008. CJ advised him to continue to take it but Mr F was adamant he did not want to.

Comment

We found no evidence that Mr F stopping his medication triggered a review of his risk or escalation to Mr F's consultant.

5.56 A CPA review took place on 10 April 2008 and was attended by Mr F, his mother, CJ and Dr MA. Mr F was described as anxious and suspicious during the meeting. He said he wanted to be admitted to Pendleview Hospital because there would be people around, and he was "*depressed in his own flat*". He said he was not taking his medication and appeared to lack insight about the need to do so in the long term. Mr F agreed to take 5mg olanzapine daily and the plan was for CJ to refer Mr F to the CRHTT. CJ also completed a safety profile. Convictions for violent/non-violent sexual offences were highlighted as a current risk. Illness related risks included failure to engage, signs of relapse, boredom and difficulty communicating his needs.

Comment

Reference is made to Mr F lacking insight about his condition but this is based on the assumption that he had a long-term psychotic illness such as schizophrenia. It could be argued that the evidence for this diagnosis is limited and we found evidence which points more strongly to an alternative diagnosis/formulation of a combination of drug induced psychosis, misuse of cannabis and some degree of personality dysfunction. More efforts could have been made to focus on Mr F's symptoms (cannabis use and behavioural issues).

5.57 Mr F was assessed by the CRHTT on 11 April 2008 when he was experiencing a relapse of paranoid symptoms and social isolation. He was restarted on 10mg olanzapine, daily. Safety profiles were completed on 20 and 28 April and 13, 19 and 22 May and 16 June 2008. Mr F's inability to self-medicate was highlighted as a current risk along with those noted in previous assessments, including the risk he posed to females. He remained under the care of CRHTT until 16 June 2008.

Comment

Staff make reference to Mr F losing interest in finding a job, going to college and in the activities of daily living. These were described as being his "usual relapse signature". These developments, however, are non-specific and could have been due to a number of different reasons not necessarily related to mental illness.

5.58 Mr F asked Dr MA on 28 April 2008 to arrange for him to be admitted to hospital for a few days. Dr MA did not find symptoms of mental illness that would make this appropriate. Mr F later said he wanted to go to hospital so he could befriend one of the ward nurses in the hope that he could move in with her. Mr F referred to a previous encounter with the nurse who said to him, "you can come and talk to me". He interpreted this to mean that he could talk to her about moving into her house.

Comment

Mr F denied stalking this nurse, however, his erroneous interpretation of what she said could be an example of personality dysfunction rather than clear mental illness. In the ICD 10 diagnostic criteria for dissocial personality disorder, criterion (b) refers to, "Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations." The misinterpretations and lack of normal social boundaries that Mr F displayed in this incident ought to have led to consideration of personality dysfunction/disorder. We found no evidence that this was ever considered.

5.59 A CPA review meeting between CJ and Dr MA took place on 10 July 2008. Mr F did not attend. The next review was set for November, four months later but did not take place. The next CPA review happened on 18 June 2009.

5.60 The CMHT saw Mr F monthly between July and September 2008. He remained well until he stopped taking his medication in September/October 2008. His mental health was thought to have deteriorated, he stopped attending college and isolated himself socially. He was assessed by the CRHTT on 29 October 2008. He told staff a man he used to know had chased him with a knife. Mr F said he had offered to fight him in a car park but the man failed to turn up. A safety profile was completed that day. A current risk was identified for violent convictions and risk to staff visiting Mr F at home. Illness-related risks included discontinuation of medication, failure to engage, difficulty communicating his needs and showing signs of relapse. We found an entry in Mr F's notes indicating that Mr F's description of events appeared to be plausible and there did not appear to be evidence of an acute mental illness at that time.

5.61 Mr F was prescribed 10mg of olanzapine daily and was to receive support from the CRHTT to ensure compliance with his medication. He was seen daily between 29 October and 4 November 2008 and responded well to medication. However, Mr F went to the in-patient ward at Royal Blackburn Hospital (RBH) on 5 November 2008 and asked to be admitted. He said he was paranoid but a member of ward staff (JH) reassured him that his treatment plan was working and Mr F agreed to go home. A safety profile was completed and no new risks were identified.

5.62 Another discussion took place between Mr F and CJ, care coordinator, on 29 October 2008 about Mr F's desire to be admitted to hospital to find a girlfriend.

Comment

During an assessment in November 2008 Mr F said feeling paranoid was his main stressor but he showed no evidence of psychosis, delusional beliefs or formal thought disorder. It was decided, by hospital staff, that admission was not appropriate. We found another reference in Mr F's case notes on 5 and 6 November to him wanting to be admitted in order to find a girlfriend. This pattern of behaviour, where Mr F did

not appear to think about social boundaries, is consistent with personality dysfunction.

5.63 Mr F engaged in home treatment with the CRHTT and apart from one evening on 11 November 2008 when he had been drinking, staff documented that there was nothing significant to report. A safety profile was completed on 13 November 2008. It recorded that Mr F had thoughts of harming others, specifically a man in Darwen he had recently argued with.

Comment

We found no information to suggest that anyone involved in Mr F's care explored his thoughts of harming others with him following this disclosure on 13 November 2008.

5.64 The CRHTT oversaw Mr F's use of medication. He was described as guarded and suspicious at times, although they considered Mr F well enough to be discharged to the care of the community mental health team by 15 December 2008. Mr F's care coordinator followed him up and reminded him of the importance of taking his medication. He also discussed his relapse signs of paranoid symptoms and wanting to be admitted to hospital. Mr F was keen to make plans for the future and wanted to get a job as an electrician's mate.

5.65 A health and social needs assessment was conducted by CJ, care coordinator, Dr S and a student nurse on 4 January 2009. The relevant form was only partially completed and did not identify risks or a plan for ongoing care.

5.66 Mr F improved throughout January and February 2009. His care coordinator documented he abstained from cannabis use, was taking his medication, was looking for a job and had good insight into his illness.

5.67 A Crimson Trial worker emailed Mr F's care coordinator on 26 February to tell him that Mr F had texted her asking her to go to his house for drinks.

5.68 Mr F had again stopped taking his medication by April 2009 but clinical records written by his care coordinator show that he was coping well. Mr F was reminded by his care coordinator of the risk that not taking his medication would cause him to relapse but both he and his family were happy with his progress.

5.69 Mr F began to relapse on 12 June 2009. He asked to be admitted to hospital but his care coordinator advised that home treatment would be more appropriate. CJ arranged a joint visit to Mr F with the CRHTT for 15 June.

5.70 Mr F's mother phoned CJ, care coordinator, on 12 June 2009 and raised concerns that Mr F was relapsing. She said he had shown the usual signs he demonstrated ahead of relapse. On 15 June CJ recorded in Mr F's notes that he was not detainable under the mental health act and there was no obvious evidence that he was experiencing psychotic symptoms. Mr F told staff on that date that he would only restart his medication if he was admitted to one of the units.

Comment

Once more, his behaviour could be described as a function of personality dysfunction rather than mental illness.

5.71 A CPA review meeting took place on 18 June 2009. Mr F, CJ, Dr MA and a staff member from Crimson attended. The CPA team documented that Mr F had been mentally stable for many months despite not taking medication. Cannabis was described as having a large impact on his mental health. CJ told Dr MA that Mr F was not willing to take his olanzapine 10mgs once a day unless he was admitted to hospital. The CPA team agreed that Mr F was slowly starting to relapse into schizophrenic illness but was not willing to take medication. The plan was for his care coordinator to refer him to the CRHTT for monitoring and support in the community. A safety profile was completed on this date. Current risks due to Mr F's conviction for a sexual offence were identified for mental health workers visiting Mr F at home.

Comment

Staff drew the link between Mr F's excessive cannabis use and deterioration in his mental health. Cannabis was described as "having a big impact on his mental health". Despite this recognition the diagnosis was considered to be a relapse of his schizophrenic illness. There was no consideration that psychosis was drug-induced or that he needed support from drug intervention services.

5.72 Mr F was described as engaging with the CRHTT by 20 June 2009 and agreed to take olanzapine 10mg daily. This was despite Mr F's GP phoning the CRHTT the day before expressing concerns about relapse of mental illness. When the CRHTT assessed him on 20 June, his presentation was described as *"visibly no different when I spoke to him on the joint visit with his care coordinator"*. Reference was also made to Mr F being lonely and wanting to be on the ward for company.

5.73 Mr F was discharged from the CRHTT on 20 July 2009. He did not take his medication after discharge. His care coordinator saw him every month and by 26 November 2009 Mr F was described by the care coordinator as coping well and having no relapse indicators. Mr F and his care coordinator agreed that if his recovery continued he could be discharged back to his GP.

5.74 Mr F attended an outpatient appointment on 6 January 2010 with his care coordinator. He appeared well despite not taking medication since July 2009. He was in regular contact with his family and agreed to be transferred back to the care of his GP. In his crisis and contingency plan on 6 January, documented by CJ, it is recorded that Mr F:

"Has recovered well from several episodes of illness induced by increased cannabis and alcohol use and social stressors...[Mr F] now understands that cannabis and alcohol don't agree with him..."

5.75 Early indicators of relapse were recorded in his crisis and contingency plan as:

*"[Mr F] isolating himself more than usual...
[Mr F] becoming more suspicious of people, and expressing ideas that people are after him.*

His sleep pattern may become more disturbed...may start to express paranoid beliefs and seeing special meanings in 'every day' things that occur around him. [Mr F] will also ask to be admitted to hospital but will not be able to explain exactly why."

Comment

Despite the crisis and contingency plan recording that Mr F's deterioration in mental health could be attributed to drug and alcohol use, neither was mentioned as early indicators of relapse.

Staff appear to have established a link between cannabis use and symptoms of psychosis. Interventions such as a referral to the drug worker should have been put in place to address Mr F's cannabis use as part of his treatment plan before he was discharged from the service.

5.76 Mr F was formally discharged from services on 6 May 2010 back to the care of his GP. CJ, care coordinator, completed a safety profile on this date. No current risks were identified in relation to the harm Mr F posed to others. The only current risks identified in relation to his illness were the risk of discontinuing his medication or failing to engage with mental health services.

5.77 Mr F had no further contact with secondary mental health services until 3 January 2011. Mr F was referred to mental health services by an out-of-hours GP (AH) on the evening of 3 January after his mental state deteriorated. The referral form showed that Mr F had a history of self-harm and aggression towards others. It noted that he presented a risk to others and himself because of his paranoid ideation. The form says that Mr F had been diagnosed with paranoid schizophrenia, it also said:

"Although after long periods of assessment it would appear he has suffered several drug induced psychosis, usually concurrent with social problems and getting involved with criminal element."

Comment

The out-of-hours GP concluded in the referral form that Mr F's diagnosis was drug-induced psychosis. He also highlighted social problems and getting involved in criminal activity.

5.78 Mr F's mother told the GP that Mr F was not taking prescribed medication, was irritable and spending long periods alone. The plan was for Mr F to be prescribed olanzapine, 10mg daily, and for the CRHTT to follow up Mr F the next day.

5.79 Mr F was assessed at home by PM, CRHTT and MW, CPN on 4 January 2011 and PM completed a safety profile. Threatening or intimidating behaviour was identified as a current risk of harm to others. PM documented in Mr F's clinical records that he was showing signs and symptoms of relapse - *"he feels there are ghosts in his loft"*. Mr F was described as being guarded, suspicious and reluctant to engage in the assessment. Mr F told PM that he had stopped taking his medication some time before. He agreed to take medication when prompted and agreed to engage with CRHTT.

5.80 Mr F went to Darwen ward inpatient unit on 5 January 2011 and asked to be admitted. He agreed to return home to be assessed by a CRHTT worker. Mr F later insisted to the CRHTT worker that he be admitted to hospital and despite PM, crisis practitioner, offering support and reassurance during the visit, he again went to the inpatient unit that afternoon asking to be admitted. He was advised to return home because the CRHTT were due to visit him that evening. He was seen by a CRHTT worker at home at 8pm and accepted 10mg of olanzapine. The plan was for Mr F to undergo a medical review the next day.

5.81 Dr GT, a staff-grade doctor, and PL from the crisis team, assessed Mr F at home on 6 January 2011. Dr GT noted Mr F had a diagnosis of paranoid schizophrenia. He was described as having a long history of cannabis use and poor insight into his mental health problems. Mr F had stopped taking olanzapine nearly 12 months before. He had been smoking cannabis regularly and binge drinking. Mr F said he had felt depressed for the last few months and had difficulty concentrating and sleeping. He had become increasingly paranoid during the last two months. He had also been arrested for cultivation and supply of cannabis.

5.82 Dr GT thought Mr F had suffered a relapse of paranoid psychosis caused by not taking his medication, substance misuse and social stressors. Dr GT found no evidence of clinical depression and Mr F's immediate risk of self-harm and harm to others was recorded as low. Mr F was advised to take his medication and engage with the CRHTT. There were no concerns noted, Mr F was willing to comply with the advice.

Comment

We found no evidence that Mr F's history of violence was considered during the review on 6 January 2011 or that his diagnosis/formulation was reviewed, despite the consistent impact of cannabis on Mr F's mental health. When we interviewed Dr GT he recalled that at the time of his assessment, Mr F already had an established diagnosis of paranoid schizophrenia. It was therefore reasonable for Dr GT to proceed on this basis and in terms of interventions that a crisis team would undertake, the diagnostic distinction issues outlined above would, in our opinion, have been less relevant.

5.83 PB, CRHTT worker, saw Mr F on 8 January 2011. Mr F denied having psychotic symptoms but was concerned that the police had frozen his bank account and he now had little money. He said he was taking his medication.

5.84 The CRHTT saw Mr F on 10, 11, 14, 15, 17 and 18 January to ensure he took his medication. CRHTT workers recorded no concerns and Mr F was noted to be socialising well.

5.85 The crisis team held a risk-rating meeting on 18 January 2011. The plan was for Mr F's care to be passed to the complex care treatment team after the review on 20 January 2011.

Comment

Mr F appeared to show no evidence of acute mental illness from 8-18 January 2011.

5.86 Dr GT, ST5 in psychiatry and PL, crisis practitioner, saw Mr F on 20 January 2011. Mr F said he had been taking his olanzapine, 10mg daily. He denied using drugs and was considered a low risk to himself and others. The plan was to discharge Mr F from home treatment to the complex care treatment team (previously known as the community mental health team). A safety profile was also completed by PL on this date. Mr F was identified as at risk of self-harm through misuse of drugs or alcohol. He was also assessed as posing a current risk to others because of his conviction for a sexual offence.

5.87 During a visit to Mr F's flat on 22 January 2011 PB, crisis practitioner, documented he could smell cannabis and Mr F was drinking alcohol with a friend. Mr F said he was taking his medication.

5.88 No concerns were recorded during a visit by PM, crisis practitioner, on 24 January 2011.

5.89 PB completed a home treatment plan on 26 January 2011 during which Mr F appeared drunk. He said he was fine and was taking his medication. He said he did not want further contact with mental health services although he agreed to the joint visit with the CMHT planned for 28 January.

5.90 PL, crisis practitioner, and NR, CMHT worker, went to Mr F's flat, as arranged, on 28 January 2011 in order to discharge him from home treatment and for his new male care coordinator, SC to follow him up in the community. Mr F did not answer the door so PL left a message for Mr F to say the visit would, instead, take place on 31 January 2011.

5.91 PM, crisis practitioner, and SC, care coordinator, visited Mr F on 31 January 2011. Mr F was reluctant to have further input from the CCTT and did not want further visits from SC. However, Mr F did agree that SC could contact him a few weeks later to arrange another appointment. PM completed a safety profile on this date and no current risks were identified.

Comment

No current risks were identified on the safety profile completed on 31 January 2011 despite cannabis use and poor engagement. These factors had been identified as risk factors in previous episodes of deterioration of his mental health.

5.92 Mr F's solicitor contacted CJ, Mr F's previous care coordinator, on 8 February 2011 to advise that Mr F was due in court on 11 February 2011 and that he might need support after his appearance. CJ passed the message to SC, care coordinator.

5.93 SC called Mr F on 11 February 2011. Mr F told him that his court case had been adjourned for six weeks while a psychiatric report was undertaken. Mr F agreed to meet SC on 24 February 2011.

5.94 Mr F called the complex care and treatment team on 24 February 2011 and spoke to CJ. Mr F said he thought he was due to be seeing his care coordinator, SC, that day. CJ explained that SC was not at work and that the duty team could provide support until his return.

5.95 The service's inability to pick up SC's caseload in his absence meant that they did not contact Mr F until 29 March 2011.

Comment

The service did not contact Mr F promptly but he had been assessed by the service as stable at this point and therefore they thought the delay was unlikely to have had a significant impact on his mental health.

5.96 Mr F's solicitor called RD, an agency female care coordinator, on 28 March 2011 asking for information about Mr F's care and treatment. He said Mr F was under a considerable amount of pressure because of the court case.

5.97 RD phoned Mr F on 29 March 2011. Mr F said he was taking his medication, olanzapine 10mg daily, and asked for a letter to support him at his court appearance. RD arranged a review with Mr F and Dr MA, consultant psychiatrist on 28 April 2011 to determine the content of the letter because she did not know Mr F. In the meantime, Mr F agreed to meet RD on 7 April 2011.

5.98 RD met Mr F for the first time on 7 April 2011. He told her he was taking his medication (olanzapine 10mg daily), but that he also smoked a few cannabis joints a day and drank beer occasionally. He said he felt paranoid when he went out and believed people were talking about him but he had insight that these thoughts were only in his mind. He denied having thoughts about harming himself or others. Mr F said he did not need another visit before his review on 28 April 2011.

5.99 The custody suite at Blackburn police station contacted the complex care and treatment team on 18 April 2011 asking for information. Mr F had been arrested on suspicion of attempted murder.

5.100 RD, Mr F's care coordinator, went to the police station the next day to act as an appropriate adult for Mr F while he was being questioned. RD also accompanied Mr F to the Magistrates court on 20 April as an appropriate adult.

5.101 Mr F was questioned under Section 18 of the offences against the person act and was remanded in custody on 21 April 2011. The charge of attempted murder was changed to murder after the victim died on 21 April 2011.

6. Arising issues, comment and analysis

6.1 In this section we review the policies and procedures in place in the trust when Mr F was known to the services. We also looked at the trust's current policies and procedures and other documentation to establish what improvements have been made since the incident in April 2011. We interviewed senior trust managers who gave us examples of how policies and procedures have been operationalised. A full list of the documents reviewed can be found in appendix D.

6.2 As this section mainly consists of comment and analysis we have not separated this out from the narrative and have not used *bold italics* in this section.

6.3 The trust's internal post-incident review (PIR) report does not highlight specific concerns about the care and treatment provided to Mr F and made no recommendations for service improvement. We therefore focus on the points identified in the terms of reference for our independent investigation and further areas that have emerged during our investigation. We have not undertaken an independent audit but rely on information provided by the trust about developments in the service.

6.4 The terms of reference for this investigation asked that we assess:

- 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 health needs
- the extent of services engagement with carers; use of carer's assessments and the impact of this upon the incident in question

The adequacy of risk assessments to support care planning and use of the care programme approach in practice

The use of care programme approach (CPA)

6.5 Mr F first came into contact with mental health services in February 2005 when he was admitted informally to the inpatient unit at Royal Blackburn Hospital (RBH) and was later detained under Section 2 of the Mental Health Act (MHA) 1983 because he refused to stay on the ward voluntarily or take his medication (olanzapine 10mg daily). He was discharged on 12 April 2005. The discharge summary recorded his diagnosis as:

*“Acute psychiatric episode
Drug induced?”*

His CPA status was recorded as enhanced and the plan was for him to be reviewed in the outpatient clinic in 4-6 weeks.

6.6 The trust’s 2006 CPA policy says that all service-users should undergo a primary assessment. When that assessment is completed and staff establish that the service user needs specialist mental health services, another decision must be made to determine their level of need and how best to match services to those needs:

“It is the combination of social functioning, risk and identification of a mental health disorder that must be weighted by the multi-disciplinary team, when determining if a service user should be placed on standard or enhanced CPA.”

6.7 In relation to CPA review, the CPA policy, June 2011 says:

“Reviews will be no more than 12 months apart and the expectation is that reviews, depending on need, will be more frequent as a result of higher level of need, presenting risks, clinical complexity and vulnerability.”

6.8 Mr F’s first CPA review took place on 7 November 2005. Enhanced CPA meetings also took place on:

- 17 January 2007

- 24 January 2007
- 8 March 2007
- 10 April 2007
- 14 June 2007
- 29 June 2007
- 10 April 2008
- 10 July 2008
- 12 March 2009
- 18 June 2009

6.9 Mr F's clinical records indicate Mr F's diagnosis changed from "1. *acute psychiatric episode 2. Drug induced?*" to paranoid schizophrenia in 2007.

6.10 The Department of Health published 'Refocusing the Care Programme Approach' in March 2008. This provided guidance to mental health trusts on the 'new CPA'. As a result of the guidance only those on enhanced level continued to be managed under the CPA.

6.11 Mr F continued to have CPA reviews after March 2008, which suggests that he was identified as suitable for management under the new CPA arrangements. He would have been eligible for the "severe mental disorder" diagnosis category because he had a diagnosis of schizophrenia.

6.12 Mr F was discharged back to the care of his GP on 6 May 2010 after improvement in his mental health and was therefore no longer under CPA. We found no risk or relapse plan completed at the time.

6.13 Mr F's clinical records do not explain why his CPA was not reviewed between November 2005 and January 2007, when he had regular contact with his care coordinator.

6.14 Mr F failed to attend a clinic appointment with Dr MA on 8 May 2006. He attended an outpatient appointment with CJ, care coordinator, on 3 July 2006. We do not know who else attended this meeting or whether it was a CPA review meeting.

6.15 The trust's CPA policy at the time Mr F was engaged with trust services stated that CPA reviews should take place, as a minimum, every 12 months. Between 2007 and 2009 Mr F's reviews were undertaken in line with trust policy. When Mr F was referred again to

mental health services in January 2011 CPA was not mentioned until 29 March, when RD was allocated as his new care coordinator. A CPA review was subsequently planned for 28 April 2011, although this appointment never took place because Mr F had already been arrested for attempted murder.

6.16 Throughout the majority of Mr F's care, the CPA requirements and interventions from services appear to have been in keeping with good practice. There was a delay in Mr F being allocated a care coordinator and in having a CPA meeting when he re-engaged with trust services in early 2011. However, it is our view that the delay in arranging a CPA meeting did not contribute to the incident.

Risk assessment and management

6.17 The trust's CPA policy, June 2011, says:

"A risk assessment must be completed and documented and inform the care planning process. Any new information gained which impacts on the assessment of risk must be identified and documented and will trigger a review of the care plan."

6.18 The trust's effective care-coordination policy, 2010 says that:

"Service users on CPA will have a care plan which includes...a crisis plan, which should include who the service user is most responsive to; how to make contact with that person; and previous strategies that have been successful in engaging the service user."

6.19 New evidence, such as concerns raised about Mr F's behaviour towards female staff or when he had clearly returned to heavy cannabis use, did not always trigger staff to review his care plan or risk.

6.20 Staff recorded in November 2008, on a safety profile, that Mr F had had thoughts of harming others. We found no evidence that this information led to a review of Mr F's care plan.

6.21 Between Mr F's first contact with mental health services in February 2005 and January 2011, his mental health was recorded to have deteriorated on nine occasions:

- June 2005 (admitted to hospital after violent altercation with siblings. Discharged to his mother's address the next day)
- December 2005 (assessed by SHO, crisis team involved)
- January 2007 (admitted to hospital informally 4 - 24 January)
- December 2007 (crisis team involved)
- April 2008 (crisis team involved)
- October 2008 (crisis team involved, had not taken medication for three weeks)
- November 2008 (presented to urgent care centre - discharged under crisis team)
- June 2009 (attended A&E but agreed to crisis team involvement instead)
- January 2011 (referred to crisis team by out of hours GP @ RBH, had not taken medication for 12 months)

6.22 Mr F generally presented to mental health services when he was in crisis. The crisis team regularly saw him following inpatient assessment. Once settled, he was then discharged back to the CMHT and the care of his care coordinator. Cannabis use was a regular feature in Mr F's presentation before his mental health deteriorated.

6.23 It appears from the records that crisis and contingency plans were completed on two occasions:

- 9 January 2007
- 6 January 2010

6.24 At the time Mr F was engaged with trust services staff completed 'safety profile' forms to record current and historical risks and identify his risk of relapse. Mr F's care coordinator primarily completed regular safety profiles for him.

6.25 The safety profiles do not allow the assessor to rank the risk of the service user as 'high, medium or low,' simply to record whether they present a current or historical risk in a number of areas.

6.26 Safety profiles generally identified that Mr F would be a risk to female staff who visited him alone. This was based on a police conviction for assaulting a woman in 2006. It is documented in Mr F's clinical notes that he received the conviction because he:

“Touched fellow resident [at Stonham housing] in an airing cupboard”.

6.27 However, the police conviction suggests that Mr F was convicted of assault occasioning actual bodily harm. The offence was described as sexual. Mr F's records neither indicate the severity of the offence nor that trust staff were aware of the details of the incident.

6.28 The most recent safety profile was completed by PM, CRHTT worker, on 31 January 2011. It recorded no current risks but noted a history of aggression towards others, a past risk of threatening behaviour and noted convictions for violent or non-violent sexual offences. It also recorded a past risk to staff conducting home visits.

6.29 Staff working with Mr F could have explored several incidents in Mr F's clinical records in order to better understand his behaviour and the risk he posed. These incidents include:

- inappropriately touching himself in public - this is recorded in his notes but not in his risk assessments
- being sexually inappropriate towards women - one conviction, several reports of inappropriate behaviour towards female staff
- violence towards siblings
- concerns he had weapons in his flat
- challenged acquaintance to a fight
- assaulted a male who was then present on the day of the homicide.

6.30 It does not appear from the records that the risk Mr F posed was given significant attention. It appears that trust staff managed Mr F's risks by managing his schizophrenia. In our opinion, this was incorrect, particularly because Mr F's symptoms and behaviour could have been caused by conditions other than schizophrenia. More attention could have been paid to the symptoms, other than psychosis, that were identified (cannabis and behavioural issues).

6.31 We saw no evidence that risk was considered other than in the completion of the safety profiles. The safety profiles appear to have been completed in order to “tick the box” rather than using them to develop a contingency and care management plan.

6.32 It was difficult to differentiate new or important information because many of the safety profile forms contain information copied from previous safety profiles.

6.33 Cannabis was rarely mentioned as a risk factor for Mr F’s mental health deterioration, despite using it before most presentations to mental health services.

6.34 We found no evidence that Mr F’s past violence was explored in detail by trust staff. The documentation suggests that staff did not try to fully understand his behaviour, the risks he posed and the impact drug misuse had on his mental health.

6.35 There does not appear to have been an attempt to evaluate the totality of Mr F’s risk indicators in terms of risk to others. The only time a change in management was introduced was after learning of his forensic history. This resulted in staff appropriately undertaking community visits to Mr F in pairs. A robust re-evaluation of diagnosis/ formulation might have led to a better understanding of why Mr F had a recurrent pattern of disturbed behaviour. Interventions could then have been offered as outlined above.

6.36 Management of Mr F’s risk appears to have focused on trying to persuade him to continue to take medication and engage with appropriate follow-up appointments with services. Not giving appropriate attention to Mr F’s probable personality dysfunction meant that they ascribed his behaviour to mental illness rather than helping him to take responsibility for his behaviour. Furthermore, dysfunctional aspects of the way Mr F engaged with mental health services appear to have been given only superficial attention and there does not appear to have been a plan to help Mr F address his behaviour besides telling him that his actions were inappropriate.

The exercise of professional judgment and clinical decision-making

Diagnosis

6.37 Mr F presented to mental health services with essentially the same symptoms on a number of occasions over five years. He was initially diagnosed by Dr MA, consultant psychiatrist, with psychosis with a query if it was drug-induced. His diagnosis was reviewed by Dr SA, consultant psychiatrist, after his inpatient admission in 2007 and changed to paranoid schizophrenia.

6.38 It is our opinion that diagnosing Mr F with schizophrenia rather than drug induced psychosis/cannabis use/personality dysfunction was clinically relevant to the management of his case in the sense that it resulted in a purely medical management of his care. The focus of staff involved with Mr F appeared to be to in getting him to take his medication. That said, irrespective of the diagnosis, his care plans should have reflected his presenting symptoms; psychosis, cannabis use and behaviour problems. Staff appeared to focus on the medical treatment of psychosis but insufficient attention was paid to his cannabis use or his behaviour.

6.39 NICE guidance on schizophrenia *“covers the treatment and management of schizophrenia and related disorders in adults (18 years and over) within established diagnosis of schizophrenia ...”* It contains a footnote clarifying that this also covers schizoaffective disorder, schizophreniform and delusional disorder but drug induced psychosis is not mentioned.

6.40 Within ICD 10¹, schizophrenia is given the diagnostic code F 20.0 and drug induced psychosis due to cannabis is code F 12.5.

6.41 ICD 10 and the classification system used by the American Psychiatric Association are internationally recognised. Page 55 of the desk reference to the diagnostic criteria, the current version, DSM-5 (APA, 2013) contains the following statement under the diagnostic criteria for substance induced psychotic disorder:

¹ The ICD-10 is a classification of mental and behavioural disorders developed by the World Health Organisation

“The disturbance is not better explained by a psychotic disorder that is not substance/medication induced. Such evidence of an independent psychotic disorder could include the following:

The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g. about one month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence of an independent non-substance/medication-induced psychotic disorder (e.g. a history of recurrent non-substance/medication-related episodes.)”

6.42 Mr F’s history would point to drug induced psychosis rather than schizophrenia under this guidance.

6.43 The management of Mr F’s case appeared to have been a “medical model” with an emphasis on Mr F adhering to his antipsychotic drug treatment regime in order to prevent relapses. We found little evidence of meaningful psychosocial interventions.

6.44 We do not make a retrospective diagnosis but we question the evidence Dr SA used to make the diagnosis in the 2007 admission. We think it is also noteworthy that no one tried to re-evaluate Mr F’s diagnosis since 2007, despite evidence that some of his behaviour and symptoms might have an alternative explanation. The ICD 10 diagnostic criteria for schizophrenia and the diagnostic criteria for dissocial personality disorder in appendix C.

6.45 We have not clinically assessed Mr F, but since conviction he reports not suffering mental disorder and is not receiving antipsychotic drug treatment. In appendix C, we have tried to show how the symptoms of dissocial personality disorder could have been applied to Mr F. We seek to show that details in Mr F’s history should have raised questions about his diagnosis/formulation.

6.46 Dr MA told us he thought Mr F’s psychotic episodes had mostly been drug-related. Dr MA said the diagnosis of paranoid schizophrenia was consistently used in his letters since 2007 because:

“My colleague changed the diagnosis.”

6.47 Dr MA was asked why the diagnosis was not reconsidered. He said it was because he had never seen Mr F when he was psychotic and also that:

“I see people in my clinic and, once they have been admitted, when they come out they have changed the diagnosis, and I respect that.”

6.48 We asked Dr MA if he thought the distinction was clinically relevant and he said:

“I don’t think the treatment or intervention would have been different...For somebody who was diagnosed with drug-induced psychosis or schizophrenia, the medical management or other interventions because we treat it as a psychosis, I think it would perhaps have been the same.”

6.49 We understand that this reply was made in the context of treatments available in the trust at the time. When asked about the availability of interventions for patients with personality disorder, Dr MA said:

“We now have specialist practitioners in our team who provide that intervention and support but I do not think we had one at that time.”

6.50 Irrespective of diagnosis, staff could have done more to ensure Mr F’s care plan reflected all of his presenting symptoms - not just medically addressing his psychosis.

6.51 Schizophrenia is usually a long-term condition needing a range of biopsychosocial interventions but drug-induced psychosis is associated with the misuse of substances. This is in turn influenced by the biopsychosocial reasons for substance misuse. A range of treatment options should have at least been considered to help Mr F address substance misuse.

6.52 We found no evidence that Mr F used his diagnostic label as a means of avoiding responsibility for his behaviour. However, the persistent use of this diagnosis reinforced by interventions based on Mr F suffering from a long-term mental illness would not have helped him take responsibility for his actions.

6.53 The records do not seem to show that psychological interventions were considered for Mr F. Mr F's unusual relationship with mental health services, in terms of his repeated requests for admission for inappropriate reasons, might have been made more understandable if a psychological formulation of his presentation had been made. A psychological formulation might not necessarily have resulted in specific psychological intervention but it could have guided clinical staff to help Mr F adopt more appropriate behaviours.

Medication

6.54 The premise behind mental health service involvement with Mr F was that he needed to take medication on a long-term basis. However, the evidence suggests that his psychosis was short-term and related to cannabis use rather than a long-term psychotic disorder such as schizophrenia. The consistent message from trust staff to Mr F was that he had an illness that needed long-term medication. This could have hindered him taking responsibility for his actions or engaging in therapeutic interventions to change his problematic behaviour.

6.55 Mr F's treatment focused on the premise that he was suffering from a long-term mental illness. We challenge this premise and consider that attention should have been focused on re-evaluating the diagnosis/formulation rather than the importance of Mr F taking his medication.

6.56 The post-incident review reports that Dr GT, ST5 in psychiatry, who reviewed Mr F twice in January 2011, told the PIR investigator that Mr F:

“Could just have an antisocial personality problem and the offences may not be linked to mental illness.”

6.57 We found nothing in Mr F's clinical records to suggest personality disorder was ever considered or excluded as part of an assessment or treatment plan.

6.58 A psychological formulation for Mr F's presentation could have informed the care plan and treatment strategies. All staff seem to have approached the case from a purist

medical model rather than on a biopsychosocial assessment of need. The latter should have happened regardless of the diagnosis.

Involvement of addiction services

6.59 Drug use was a consistent feature in Mr F's deteriorating mental health since his first presentation in early 2005. Cannabis use was frequently identified in Mr F's care plans and safety profiles as a risk factor in his mental health deteriorating but we found no mention of suggested interventions in the "*what actions are going to be taken?*" section of the care plan. We found no evidence that Mr F was ever referred to addiction services.

6.60 The role of cannabis was not appropriately explored. We found no referrals to services that could have helped Mr F take responsibility for his actions and to become more aware of the adverse impact of cannabis on his mental health.

Mr F's care coordinator (CJ) told us:

"We tried to refer him to drug and alcohol services but the problem with drug and alcohol services and cannabis is that it is just like smoking cessation. Service users don't value what is offered by the drug and alcohol services. We would benefit more from them going than they feel that they would benefit."

Dr MA, Mr F's consultant psychiatrist between February 2005 and May 2010, told us:

"...he would have been offered support from the drug team but I don't think he would have engaged... With the drug team, it is a self-referral".

6.61 There was a lack of consistent recognition of the detrimental impact drug use had on Mr F's mental health. Once trust staff identified the link between drug use and deterioration in Mr F's mental health, they took no action when he returned to heavy cannabis use. This indicates a disconnection between addiction and mental health services.

Recommendation

R1 The trust should conduct annual audits of NICE quality standards. The board should be provided with evidence that all community mental health teams have access to specialist addiction practitioners and know how to refer to them. We recommend that the trust conducts annual audits to review patient pathways from referral to discharge.

The interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs

6.62 Mr F was known to a number of services between February 2005 and April 2011:

- Blackburn Hospital, Darwen inpatient unit (mental health service)
- community mental health team (community mental health team/complex care team)
- crisis team
- primary care (through his GP)
- supported housing service (Stonham)
- probation service (through probation officer IP)
- police
- courts
- solicitors.

6.63 Mr F's clinical records show that his care coordinator frequently contacted other agencies involved in Mr F's care, including his probation officer, CRHTT and his solicitor.

6.64 We have not seen the trust's information sharing policy but Mr F's care coordinator, primarily CJ, appeared to engage appropriately with other agencies involved in Mr F's care. For example, whenever Mr F went to the A&E department seeking help, his care coordinator was alerted and the appropriate services were put in place to support him.

The extent of services engagement with carers; use of carer's assessments and the impact of this upon the incident

6.65 The trust's effective care coordination policy, February 2010, says that carers should be informed of their right to an assessment, have their needs assessed and have a care plan made for them that is reviewed at least annually.

6.66 Mr F's main support in the community was his mother. She tended to alert mental health services when Mr F's mental health deteriorated. We asked Mr F's care coordinator, CJ, whether Mr F's mother was ever given a carer's assessment and what support was in place for her. He told us:

"[Mr F's mother] would have been offered a carer's assessment, but she might not have considered herself to be a carer because [Mr F]...was extremely self-sufficient. He was really self-sufficient and he would only go to his mum's very infrequently, and he would only spend more time there if there was a problem... [Mr F's mother] always felt that... [Mr F's] needs would probably be best met elsewhere, although I am not really sure where that would be."

6.67 Mr F's mother played a role in Mr F's community care and his behaviour impacted on her and the family, particularly when his mental health deteriorated. Mr F was often discharged to her address or stayed there when he felt unwell. Given her involvement, more could have been done to support her and recognise her role in Mr F's care, even if not in a formal carer's capacity.

Recommendation

R2 We recommend that within the next six months the trust review the process by which they decide whether someone should have a carers' assessment. This should be reviewed alongside adult mental health services to ensure that the process is systematic. A clinical audit of compliance with the set standards should be conducted and reported to the board as part of the trust's clinical audit plan.

Predictability and preventability

6.68 We consider that the homicide would have been predictable if there had been evidence from Mr F's words, actions or behaviour that could have alerted professionals that he might become violent, even if this evidence had been un-noticed or misunderstood at the time it occurred.

6.69 We consider that the homicide would have been preventable if there were actions that professionals **should** have taken and which they were able to take to prevent it and which they did not take. Simply establishing that there were actions that **could** have been taken would not provide evidence of preventability.

Predictability

6.70 In the interviews that we have carried out and in our review of the clinical records there were no words, actions or behaviour that could have alerted staff that this tragedy may occur. Whilst there is some evidence that Mr F, at times, had acted aggressively and had difficulty with other young men in his neighbourhood, there was nothing to suggest that it would result in such an incident.

Preventability

6.71 Mr F was well known to a number of services including CRHTT and the CCTT. Several weeks before the offence he had been assessed by his new care coordinator and a plan was made for him to be reviewed by the consultant psychiatrist and for a CPA review meeting to take place. There was nothing about Mr F's actions or behaviour that led, or should have led, his new care coordinator to be concerned and based on his presentation there were no further actions that they should have taken. Therefore this tragedy was not preventable by actions that the NHS should have taken.

New developments or improvements in services since Mr F's engagement with mental health services

Risk management arrangements

6.72 National policy requires that risk assessment and risk management should be at the heart of effective mental health practice. The trust's policy says that all service-users should have a risk assessment completed as part of their assessment. Risks or safety issues identified should be incorporated into the service-user's care plan and reviewed as appropriate for up to 12 months.

6.73 We heard from staff that safety profile forms are still used to assess and record risk in the trust today. These forms can be completed by anyone involved in the service-user's care.

6.74 We told PH, acting assistant network director for step four services, that we found it hard to find new information in each of Mr F's safety profiles and that the information is repetitive. He said:

"... that probably reflects a concern that we have, and another priority within the next 12 months, which is reviewing our clinical recording system so it reflects the assessment process, rather than driving the assessment process. That is a real concern that we have, that we have reached this position with the introduction of the electronic recording systems, removing the old paper systems, but we need to revise that.

There is also a need to have the recording of that alongside the service user rather than away, as an intuitive part of the recording."

6.75 From documentary and interview evidence we are aware that the trust has a plan to improve the risk assessment process. The developments will help ensure the assessment form is more dynamic and used as a tool to have a meaningful impact on the management of service users.

6.76 Dr MA told us that in 2006/7 all patient records were moved onto the electronic system (EDMS) and paper copies were destroyed. However, some information was not

uploaded properly and we found as part of this investigation that important pages from discharge letters were missing. Dr MA told us that important clinical information could be stored on two electronic systems (ECP and EDMS). Because of this, a staff member must search for important information uploaded to EDMS.

6.77 At present there does not appear to be a link between the two electronic systems (ECP and EDMS) and staff are not alerted by ECP to important information that may be stored on EDMS about a client and vice versa. The trust told us that:

“Increasingly EDMS is of historical interest only - whilst staff are aware of it, it is extremely difficult to access as it contains massive amounts of unstructured photocopied information. In our view the implementation of our risk assessment process will solve this problem as it is designed to ensure that relevant past information is automatically carried into the data that are used to construct the current risk formulation.”

6.78 They also said that they are in the process of introducing a new risk assessment process and will roll out training to ensure staff are clear about the new system. The trust told us that they will commission an external review of the quality of the new process.

Recommendation

R3 The trust should report on the implementation of their new risk assessment process and on the roll out of training to the board. The trust plans to commission an external review of the quality of the new process. These findings should be reported to the board for any necessary action.

Diagnosis/management

6.79 The trust has introduced specialist practitioners with either a nursing or social work background into the complex care and treatment team. These practitioners have post-graduate training in psychosocial type interventions or cognitive behavioural therapy. These roles have only been fully operational for the last 12 - 18 months. PH told us that

the trust recognises that it still needs to develop its psychological treatment team for people with psychosis in the community. This features in their three-year business plan.

6.80 PH told us that, since Mr F was involved with trust services, they had introduced a “step-care model” designed to improve quality and deliver a service in line with NICE guidance. PH said this had resulted in real improvements, particularly in management of medication and the physical health of people with long-term psychosis. The next step is to develop psychologically minded care coordination.

6.81 Someone presenting to the services with similar symptoms to Mr F would now be considered for formal work with the specialist practitioner or with the psychologist in the team. One of the main changes in practice is an expectation that a standardised crisis and relapse prevention plan and a contingency plan be made. The new crisis form differentiates between ‘early indicators’, ‘medium term indicators’ and ‘acute indicators’ of relapse.

6.82 The trust has taken steps to ensure a multi-disciplinary team approach to the assessment and management of service-users. This will help ensure diagnosis is considered and reviewed regularly and that the appropriate interventions are used. The development of crisis and relapse prevention plans will also help ensure signs of relapse are identified as early as possible.

The role of the drug and alcohol services

6.83 Despite Mr F’s mental health deteriorating after heavy use of cannabis (a typical feature of his A&E presentations), the notes indicate that little consideration was given to this being a major risk factor for Mr F. He was never referred to a drug worker for assessment and management. Throughout Mr F’s engagement with trust services there was clearly a disconnection between addiction and mental health services.

6.84 PH told us:

“I would recognise the challenge that it presented to services and to care coordinators and to service users, but we introduced a specialist practitioner in a dual diagnosis role...What seems to work best around that role is the link to

relationship-building with substance misuse services, so that a conversation can occur around a specific case, and a plan can emerge around management of that substance misuse. There is a kind of judgment I guess around an educational approach, or whether a therapeutic approach would be appropriate...The approach that we have, the strategy document around dual diagnosis which has said 'It is not an either/or, it is both strands', and that has been particularly important."

6.85 He said another improvement to the service for people with substance misuse was the development of the physical health assessment:

"We use the physical health check tool with all our service users in the secondary care community teams, and that specifically asks them about both nicotine smoking but also recreational substance misuse, or any kind of substance misuse, so we are more explicit now in addressing that question on a regular basis and having that conversation. I wouldn't want to suggest that it is not an issue but it keeps it in the arena, if you will, with service users.

We are much more alert to having the conversation and recognising it is an issue, and ensuring that if it is identified as an issue when they have a physical health check that is then picked up by care co-ordinators. We also have the management of the link with the substance misuse services."

6.86 The trust has taken steps to ensure that patients with a dual diagnosis are managed in a more joined-up, coherent way with regular multi-agency meetings and a jointly reviewed care plan.

7. The internal review

7.1 The terms of reference for this investigation include assessing the quality of the internal investigation and review conducted by the trust.

7.2 In this section we examine the national guidance and the trust's incident policy to consider if the investigation into the care and treatment of Mr F met the requirements set out in these policies.

Detection of incident

7.3 The trust became aware of the incident because a medical examiner at Blackburn custody suite told Blackburn CCTT that Mr F had been arrested and that they needed information about his mental state.

7.4 Police asked the CCTT for an appropriate adult to accompany Mr F during an interview on 19 April 2011. RD, care coordinator, attended on this occasion and again on 21 April.

The trust's internal post incident review (PIR)

7.5 The good practice guidance 'independent investigation of serious patient safety incidents in mental health services' (NPSA February 2008) advises that after a homicide, an internal NHS mental health trust investigation should take place to establish a chronology and identify underlying causes and further action needed.

7.6 The trust introduced the procedure for the investigation of incidents, complaints and claims policy in February 2009. This policy was still in place at the time of the incident, and was due for review in February 2013.

7.7 The trust's policy says that unexpected deaths e.g. suicides and/or incidents where care or delivery issues may have contributed to the serious untoward incident (SUI) should be managed as a multi-disciplinary post incident review.

7.8 Trust policy also advises that an internal investigation should take place after a serious incident to determine if lessons can be learnt.

Comment

In this case the trust commissioned a PIR into the care and treatment of Mr F. A service manager for adult services undertook the investigation.

Investigation process

7.9 We asked the PIR investigator to explain the process of setting up a PIR. She said:

“You are allocated as a Lead...You get identified as the Lead and then it is basically up to you then to follow that policy procedure to undertake that investigation. It depends on what it is, how intense it is, the amount of information and the amount of people involved.”

7.10 In terms of gathering information, she said:

“We tend to do that one big meeting to try to ascertain what information we need, rather than individual interviews...I did not do any witness statements. It was a small meeting. Apart from what was written in his notes, limited information came from the group of people who were actually involved with... [Mr F] and I found that at the SUI meeting that I held...There was not a lot but there were some handwritten notes and there was some analysis of dates that I had done as well, to try to get a pattern of his relapses and his relapse indicators as well.”

7.11 The terms of reference for the internal review were:

1. To review the care and treatment of a service user
2. To develop a clear chronology of events
3. To provide a detailed narrative of events of the incident

4. To identify any care delivery problems that may have arisen in relation to the direct provision and process of care
5. To identify any service delivery problems associated with the process of service delivery, focusing particularly on the processes and systems in place within Blackburn with Darwen complex care and treatment team
6. To identify any factors contributing to the identified care of service delivery problems
7. To explore barriers that could be adopted to minimise the likelihood that such an incident would occur again under similar circumstances
8. To explore barriers and initiatives that could be adopted to improve the quality and safety of services for all in light of the review's more general findings
9. To make recommendations informed by the review in relation to improving the quality and safety of future care/service delivery.

7.12 The trust's policy provides guidance for conducting interviews. It says:

"Interviews should be conducted in private, and usually with two investigators (it is good practice for one person to undertake the interview, and the other to record the conversation). If a member of staff wishes to be accompanied, this should be permitted."

7.13 In this case no interviews took place. The investigator told us that, as part of the PIR process, investigators tend to hold a group meeting rather than individual interviews with staff. She said:

"There was not a lot more information that came from the staff that were involved, other than what was already in his notes. So there was no real need to do individual interviews or witness statements."

7.14 We asked the investigator how they access medical expert advice when carrying out investigations alone. She told us:

"We could get a view from other internal consultants and that is absolutely no problem. As part of an investigation I could have asked any consultant or gone for advice from one of the clinical directors to get an independent from another consultant if I thought that was necessary."

Recommendations from the trust's review

7.15 The investigation lead did not make recommendations in this case. She told us:

"I think the only thing that I found was the decision...not to follow KK up but I made a note of that in the report because I think there was a period of about four weeks before he was followed up. Then I went back to the manager and asked that question and it is noted in the SUI that she would not have made any decision otherwise. I think in all cases there are things that you could improve on but I don't think there was anything specific that I could find to say... I don't think seeing him any sooner we would have been able to predict what he was going to do."

Submission of report

7.16 The trust's procedure for reporting and management of incidents and serious untoward incidents, April 2011 says:

"All SUIs must be investigated using RCA and a post incident review report is to be completed within 45 working days"

7.17 The first draft of the PIR was submitted on 14 June 2011, in line with the trust's policy.

Comment

The trust commissioned an internal review into the care and treatment of Mr F in a timely way and in line with national and local good practice.

The review was led by an appropriate senior person in the trust with clear terms of reference. These were appropriate given the seriousness of the incident.

However, a single investigator conducted the PIR with no senior clinician formally providing advice to the investigation. Without such clinical input it would not have

been possible for the lead investigator to make clinical judgements about how appropriate Mr F's diagnosis and treatment were.

No interviews were conducted during the investigation. The investigator told us that it was normal for a group meeting to take place instead. She said the key staff involved in Mr F's care and treatment attended this meeting. However, we found no minutes for this meeting. No care or service delivery problems were identified with Mr F's care and treatment and no learning points were identified in the PIR report.

The PIR focused on process and procedural matters rather than reviewing whether the diagnosis of MR F was appropriate whether he was later managed was in line with his presenting symptoms.

The PIR report does not make clear what Mr F's diagnosis was, what treatment he received and whose care he was under.

We find that the PIR was not as robust as it could have been. This is not a criticism of the PIR lead but of the trust's process for conducting PIRs.

8. Overall analysis and recommendations

8.1 Several important aspects could have changed the way trust services understood and engaged with Mr F. Greater attempts to provide Mr F with appropriate treatment options could have given him a better understanding of his mental health and helped him to manage it. Despite this, we found nothing to suggest that this incident was predictable or preventable.

8.2 Most notably, there was a lack of recognition, by staff involved in Mr F's care, of the role drug use played in the deterioration of his mental health. This resulted in a disconnection between addiction and mental health services.

8.3 Mr F first came into contact with mental health services in February 2005. He was considered by Dr MA, consultant psychiatrist, to have had an acute psychiatric episode and Dr MA questioned whether this was drug induced. Drugs use was recorded as an aspect of his presentation. From then on, throughout Mr F's contact with mental health services both in the community and as an outpatient, excessive drug use continued to precede deterioration in his mental health.

8.4 Despite this, Mr F was never referred to the drug and alcohol service, and drug use did not feature as a risk factor or early indicator of relapse in his risk management plan. It was inconsistently referred to in Mr F's care plan documents and no action was taken when it became clear that he had returned to drug use.

8.5 Mr F's diagnosis was changed from an "*acute psychiatric episode*" to schizophrenia after an inpatient episode in 2007. There was no attempt by trust staff to re-evaluate this diagnosis despite evidence that at least some of Mr F's behaviour and symptoms may have had an alternative explanation.

8.6 Irrespective of the diagnosis, more could have been done to address his symptoms - other than to medically treat his psychosis. Consistent presenting symptoms included cannabis use and difficult behaviour, although these rarely featured in his care plans.

8.7 Mr F's risk was regularly reviewed by trust staff using safety profiles. However, information contained in these documents was often copied from previous assessments making it difficult to identify new or relevant information.

8.8 Mr F was convicted of an offence of a violent/sexual nature (ABH) in May 2006. We found no evidence in Mr F's clinical records that his motivation for the offence or the level of danger he posed was ever fully explored.

8.9 Mr F was largely managed in the community under the care of the crisis team and then when he stabilised, under the community mental health team (who became the complex care and treatment team). The focus of their intervention was to help Mr F take his schizophrenia medication. The approach seemed to have been on a purist medical model rather than a biopsychosocial assessment of need and did not address all of his symptoms.

Predictability

8.10 In the interviews that we have carried out and in our review of the clinical records there were no words, actions or behaviour that could have alerted staff that this tragedy may occur. Whilst there is some evidence that Mr F, at times, had acted aggressively and had difficulty with other young men in his neighbourhood, there was nothing to suggest that it would result in such an incident.

Preventability

8.11 Mr F was well known to a number of services including CRHTT and the CCTT. Several weeks before the offence he had been assessed by his new care coordinator and a plan was made for him to be reviewed by the consultant psychiatrist and for a CPA review meeting to take place. There was nothing about Mr F's actions or behaviour that led, or should have led, his new care coordinator to be concerned and based on his presentation there were no further actions that they should have taken. Therefore this tragedy was not preventable by actions that the NHS should have taken.

Recommendations

R1 The trust should conduct annual audits of NICE quality standards. The board should be provided with evidence that all community mental health teams have access to specialist addiction practitioners and know how to refer to them. We recommend that the trust conducts annual audits to review patient pathways from referral to discharge.

R2 We recommend that within the next six months the trust review the process by which they decide whether someone should have a carers' assessment. This should be reviewed alongside adult mental health services to ensure that the process is systematic. A clinical audit of compliance with the set standards should be conducted and reported to the board as part of the trust's clinical audit plan.

R3 The trust should report on the implementation of their new risk assessment process and on the roll out of training to the board. The trust plans to commission an external review of the quality of the new process. These findings should be reported to the board for any necessary action.

Team biographies

Amber Sargent

Amber joined Verita as a senior investigator in 2009. Previously she worked at the Care Quality Commission (CQC) where she led on several major investigations into patient safety, governance and concerns around performance. At Verita Amber has worked on a wide range of investigations and reviews, including those into the care and treatment of mental health patients convicted for homicide or murder. She specialises in patient safety systems and benchmarking.

Amber recently worked with a foundation trust to help it develop its care pathway for cardiology services and benchmark its services against national and international standards.

Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its most high-profile mental health reviews. In addition to her investigative work, Chris regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations. As head of training Chris has developed and delivered courses on different aspects of systematic incident investigation. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people. Chris heads up Verita's office in Leeds.

Douglas Gee

Douglas graduated from medical school in 1990 and after gaining membership of the Royal College of Psychiatrists (MRCPsych) in 1995, he obtained an MSc in advanced studies in clinical psychiatry. He took on clinical responsibility for adult mental health services for Humber NHS Foundation Trust in 2001 and became medical director in 2005. As well as being responsible for the professional leadership of medical staff, he leads the pharmacy team and on risk management and clinical governance within the trust. This includes

responsibility for complaints, serious untoward incidents and adverse incident management. Externally from the trust, Douglas is part of SHA wide mental health patient safety group, SHA Mental Health Darzi group and Clinical Policy Forum. He has also provided expert psychiatric advice to a number of mental health homicide investigations for Verita over the past four years.

List of interviewees

- CJ, Mr F's care coordinator from 2005 - 2011
- RD, Mr F's care coordinator at the time of the offence
- Dr MA, Mr F's consultant psychiatrist between February 2005 - May 2010
- Dr GT, ST5 in psychiatry for the Blackburn crisis team (at the time), who reviewed Mr F twice in January 2011
- PH, acting assistant network director for step four services (complex care and treatment teams and the recovery teams)

ICD10 diagnostic criteria

In order to assess Mr F's diagnosis we have used the ICD10 diagnostic criteria to assess his symptom and behaviour against. We acknowledge that this is done in retrospect using Mr F's clinical records, but all this information would have been available to the assessing clinician in addition to being able to assess Mr F in person.

In ICD-10 section F20.0 - F20.3, the general criteria for Paranoid, Hebephrenic, Catatonic and Undifferentiated type of Schizophrenia says that:

G1. At least one of the syndromes, symptoms and signs listed below under (1) should be present for most of the time during an episode of psychotic illness lasting for ***at least one month*** (or at some time during most of the days).

(1) ***At least one*** of the following:

- a) Thought echo, thought insertion or withdrawal, or thought broadcasting.
- b) Delusions of control, influence or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception.
- c) Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing him between themselves, or other types of hallucinatory voices coming from some part of the body.
- d) Persistent delusions of other kinds that are culturally inappropriate and completely impossible (e.g. benign able to control the weather, or being in communication with aliens from another world).

Comment

There was no evidence that Mr F experienced any of the above symptoms listed above maintained for the required minimum period of one month.

G1. At least two of the symptoms and signs listed under (2), should be present for most of the time during an episode of psychotic illness lasting for ***at least one month*** (or at some time during most of the days):

- e) Persistent hallucinations in any modality, when occurring every day for at least one month, when accompanied by delusions (which may be fleeting or half-formed)

without clear affective content, or when accompanied by persistent over-valued ideas.

f) Neologisms, breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech.

g) Catatonic behaviour, such as excitement, posturing or waxy flexibility, negativism, mutism and stupor.

h) "Negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses (it must be clear that these are not due to depression or to neuroleptic medication).

Comment

There was no evidence that Mr F experienced the symptoms and signs identified in points e, f or g. There were possibly some elements of apathy (as outlined in point h) but this could also be ascribed to other causes.

G2. Most commonly used exclusion criteria: If the patient also meets criteria for manic episode (F30) or depressive episode (F32), the criteria listed under G1.1 and G1.2 above must have been met before the disturbance of mood developed.

G3. The disorder is not attributable to organic brain disease (in the sense of F0), or to alcohol- or drug-related intoxication, dependence or withdrawal.

Comments: In evaluating the presence of these abnormal subjective experiences and *behaviour*, special care should be taken to avoid false-positive assessments, *especially where culturally or sub-culturally influenced modes of expression and behaviour, or a subnormal level of intelligence, are involved.*

An alternative diagnosis that could have been considered given Mr F's symptoms and presentation is personality disorder with drug induced psychosis.

The first issue here is that "*there is general agreement that Cannabis can cause acute psychosis*" as well as precipitating symptoms in someone with an established diagnosis of schizophrenia¹.

¹ Sham et al (2007), The Aetiology of Schizophrenia in Seminars in General Adult Psychiatry 2nd edition (eds - Farmer et al) p205. London: Gaskell

Mr F often reported that he was using cannabis in the lead up to his mental health deteriorating. It would therefore be a reasonable hypothesis to assume any episodes of acute psychosis displayed was a drug induced psychosis.

The ICD 10 diagnostic criteria for dissocial personality disorder are to have at least three of the following:

- (a) callous unconcern for the feelings of others;
- (b) gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations;
- (c) incapacity to maintain enduring relationships, though having no difficulty in establishing them;
- (d) very low tolerance to frustration and a low threshold for discharge of aggression, including violence;
- (e) incapacity to experience guilt and to profit from experience, particularly punishment;
- (f) marked proneness to blame others, or to offer plausible rationalizations, for the behaviour that has brought the patient into conflict with society.

Comment

Based on the reviewing the Mr F's clinical records we consider Mr F's symptoms against the criteria as the following:

Criteria	Presence of symptoms
A	Possible
B	Probable
C	Possible
D	Probable
E	Possible
F	Possible

It would be clinically unsound to retrospectively give a definitive diagnosis in particular without the investigating team conducting a detailed clinical assessment

of Mr F. However we found evidence that there were features consistent with a diagnosis of personality disorder and consideration of this alternative diagnosis ought to have taken place as it would have had a significant effect on management of both KK's condition and any associated behaviours displayed.

Documents reviewed

- Adult mental health network and early intervention services (EIS) joint Oxford model event report, May 2012
- Care programme approach policy, February 2006
- Care programme approach policy, June 2011
- Care programme approach procedures, October 2011
- Carers strategy
- Clinical risk assessment and management in mental health services policy, January 2012
- Complex Care and Treatment Team Operational Guidelines, November 2011
- Contact protocol between LCC customer service centre and adult mental health services, February 2010
- Effective care coordination policy, August 2008
- Effective care coordination policy, February 2010
- Incident reporting and management procedure including the management of serious untoward incidents, September 2008
- Mr F's clinical records
- Practitioners aide memoire for possible psychosis
- Procedure for reporting and management of incidents and serious untoward incidents, April 2011