Independent Investigation

into the

Care and Treatment Provided to Mr. X

by the

Solent NHS Trust

Executive Summary

Commissioned by

South Central
Strategic Health Authority

Independent Investigation: HASCAS Health and Social Care Advisory Service

Report Author: Dr. Androulla Johnstone

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1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. X was commissioned by South Central Strategic Health Authority pursuant to *HSG (94)27*.[1] This Investigation was asked to examine a set of circumstances associated with the death of Mr. Y who was found killed on the 2 August 2011.

Mr. X received care and treatment for his mental health condition from the Solent NHS Trust. It is the care and treatment that Mr. X received from this organisation that is the subject of this Investigation.

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

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

We would like to thank the mother of Mr. X (Ms. X Senior, who was also the sister of Mr. Y) who offered her full support to this process and who worked with the Independent Investigation Team. We acknowledge Ms. X Senior's distress and we are grateful for the openness and honesty with which she engaged with the Investigation. This has allowed the Investigation to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

1. Health service Guidance (94) 27

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

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

It is the sincere hope of the Independent Investigation Team that this investigation process has addressed all of the issues that Mr. Y's and Mr. X's family have sought to have examined and explained. We would like to thank the family of Mr. Y and Mr. X for their assistance to this Investigation.

3. Incident Description and Consequences

Background

In September 2007 Mr. X was admitted to a psychiatric inpatient unit in Portsmouth following a first episode of psychosis. At this time he was 27 years of age. Over the next three years Mr. X received care and treatment from the Headspace Early Intervention Service and was to experience two further psychotic episodes. During this period, whilst he did not receive a specific diagnosis, he was treated with antipsychotic medication and received psychological therapy interventions.

In the summer of 2010 a decision was taken by the Early Intervention Service, in conjunction with Mr. X and his family, to undergo a planned medication cessation and to discharge him from secondary care. Mr. X was ultimately discharged from the service on the 5 January 2011. His medication had ceased on the 28 December 2010. At this time Mr. X appeared to be free of all psychotic symptoms. The plan had been to discharge him back to primary care. However on the 5 January 2011 it was noted that Mr. X had not yet registered with a GP in the Havant area, to where he was planning to move, and so discharge information was not sent on this occasion to the new surgery. It would also appear that no letter was sent to the GP surgery with whom he was then still registered in Portsmouth.

On the 10 March 2011 Mr. X attended his Portsmouth-based GP Surgery. The GP was not aware that Mr. X was planning to move out of the area. The GP referred to a letter sent to him by Mr. X's Consultant Psychiatrist in August 2010 suggesting that as Mr. X was symptom free, and had no specific diagnosis, he could be weaned off his medication. Mr. X stated that he had ceased all medication seven months previously and that he was well, had a relapse plan, and knew what to do if his mental health deteriorated. His mood appeared to be stable.

In March 2011 Mr. X moved with his parents to a house in the Havant area. On the 31 March 2011 Mr. X registered with the Bosmere Practice in Havant and attended a new patient medical. Shortly after this he went to stay with his uncle and aunt (Mr. and Mrs. Y) who lived in Camberley, Surrey.

On the 15 April 2011 Mr. X's Care Coordinator wrote a letter to his new GP at the Bosmere Practice. The letter stated that Mr. X had been a patient with the Headspace Early Intervention Service in Portsmouth for a period of three years being treated for *"a Psychosis"*. Mr. X had recovered and it had been decided to cease his medication in December 2010 following a slow and supervised reduction. The Care Coordinator explained that she had continued to work with Mr. X until his discharge and she enclosed the care plans that had been developed. The GP was advised to contact the Care Coordinator in the future if needed. The new GP Practice received Mr. X's clinical records from the Portsmouth-based GP Practice on the 27 May 2011.

On the 1 June 2011 Mr. X received a letter from his GP Practice inviting him to attend for a medical check up as he had been placed on the mental health register (for an annual check up). He was seen on the 13 June by one of the Practice Treatment Nurses who also undertook a mental health review. Mr. X was found to be in good health on this occasion. There was *"no indication noted of any abnormal affect of psychological presentation"*.[2]

On the 1 August 2011 a telephone call was received from Mr. X's uncle, Mr. Y, by the Duty Doctor saying that his nephew was hearing voices. Mr. X's thoughts were racing and he was not sleeping well. This situation had been going on for between two to three days. It was arranged for Mr. X to be seen at the Surgery that same afternoon.

Later that day Mr. X was seen in the emergency surgery. He was accompanied by his aunt, and then later on during the consultation, by his mother. Mr. X said that his sleep had been disturbed for the past three to four nights. He said that he had experienced a psychotic episode some four years previously and had been treated with Olanzapine, which had been ceased Christmas the previous year. On this occasion it was noted that Mr. X was well dressed and did not appear to be agitated. Mr. X was *"pleasant, responsive and his speech was appropriate, there appeared to be no evidence of thought disorder at that time and ... [Mr. X] mentioned only that he was suffering from auditory hallucinations in that he felt his grandfather spoke to him at times"*.[3] The GP spent some time reading through Mr. X's past clinical records and decided, in collaboration with Mr. X, to follow the relapse prevention plan that had been sent to her by Mr. X's former Care Coordinator. Mr. X was therefore

[2]. DHR Clinical Record Archive P. 39
[3]. DHR Clinical Record Archive P. 41

prescribed Diazepam 5mg at night to establish his sleep pattern. The GP explained how Mr. X could access the Surgery through both the same day walk in service and also via the Out of Ours 'urgent appointments' service.

Incident

On the 2 August 2011 Mr. Y, the uncle of Mr. X, was stabbed to death at his home by Mr. X. Mr. Y was pronounced dead at the scene and Mr. X was arrested by the Police. Mr. X is currently detained in a medium secure hospital facility under a Section of the Mental Health Act (1983 & 2007).

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

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

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

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

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

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

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

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

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

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

5. Terms of Reference

The Terms of Reference set by the Strategic Health Authority are as follows:

1. *"To examine the care and treatment provided, including risk assessment and risk management;*
2. *Provide a chronology of the events leading up to the incident;*
3. *Identify care or service delivery issues, along with the factors that might have contributed to the incident;*
4. *Identify underlying causes, specifically to examine:*
    - *discrepancies in relation to the discharge process and handover of care to the GP;*
    - *the validity of the relapse plan;*
    - *discrepancies in the discharge letter between the Consultant and the Care Coordinator relating to diagnosis;*
    - *gaps between medical reviews;*
    - *the patient did not appear to be under the Care Programme Approach (CPA) although this would have been in keeping with national guidance;*
    - *the patient's diagnosis.*
5. *Make clear, implementable recommendations for the local health community:*
    - *hold a briefing meeting for those participating in the investigation to outline the process and address their concerns;*
    - *arrange a meeting between the investigation team, Trust representatives, the Police and representatives from any other agencies who have agreed to participate in the investigation;*
    - *to ensure victim and perpetrator families are informed about the investigative process and understand how they can be involved;*
    - *obtaining fully informed consent from the service user involved in the incident for the release of their medical records to the investigation team, and agreement that any personal details can be included in a public report;*
    - *agreeing the timescale for the investigation, timings and setting a date for receipt of the final report".*

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of Solent-based Mental Health Services. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation and Inquiry work of this nature. The individuals who worked on this case are listed below.

Investigation Team Leader and Chair

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

Investigation Team Members

Mr. Jonathan Allen	HASCAS Health and Social Care Advisory Service Associate and Nurse Member of the Team.
Dr. Elizabeth Gethins	HASCAS Health and Social Care Advisory Service Associate and Consultant Psychiatrist Member of the Team

Support to the Investigation Team

Mr. Greg Britton	Investigation Manager, HASCAS Health and Social Care Advisory Service
Fiona Shipley	Transcription Services

Independent Advice to Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

7. Findings and Conclusions Regarding the Care and Treatment Mr. X Received

1. Diagnosis

Mr. X was not given a definitive diagnosis. This would not be unusual when someone presents acutely to services for the first time, there is an argument that patients should not be 'labelled' at this early stage, particularly if the aetiology of their presentation is unclear. As an in-patient Mr. X had two negative urine drug screens, ruling out the possibility of a drug-induced psychosis. A very detailed history taken on the 3 September 2007 suggested a one year prodromal period which in turn should have suggested to the team that they and Mr. X were dealing with a schizophreniform psychosis. In the discharge letter sent from St. James Hospital Mr. X is referred to as having a *"first episode of psychosis".* This 'label' continued to be used throughout the next three years despite the fact that Mr. X clearly relapsed when off his antipsychotic medication, and the team considered him to have a severe and enduring mental illness of some kind.

At Outpatient Clinics in August 2009 and August 2010 the family raised questions about the nature of Mr. X's mental illness. Consultant Psychiatrist 3 declined to give a definitive diagnosis on the grounds that he did not know the patient well enough, although he did advise on reducing and stopping medication. It is unfortunate that this opportunity to confirm the enduring nature of Mr. X's illness was lost. Whilst the Independent Investigation Team can understand the debate that might have been had around whether Mr. X had Schizophrenia or a Schizoaffective Disorder (given his manic-type symptoms during relapse in June/July 2008), this Investigation concluded that Mr. X and his family should have been given a working diagnosis that would allow them to begin to accept that Mr. X had an enduring mental illness of some kind and would probably need mental health input for years to come.

Mr. X was not understood in the context of a diagnostic formulation. Consequently all care planning and relapse prevention work could not be said to be optimal as it failed to recognise Mr. X's longer-term needs and potential risks. It is the conclusion of the Independent Investigation Team that the three-year delay in providing Mr. X with a diagnosis contributed to Mr. X and his family's limited insight, thus influencing how they viewed his presentation and their subsequent acceptance and management of his illness. A diagnosis would also have flagged up to the new GP in the spring and summer of 2011 the potential seriousness of any

subsequent relapse that Mr. X experienced and she may have been able to work with the available relapse plan more effectively.

- ***Contributory Factor One. The failure to provide Mr. X with a diagnosis compromised the effectiveness of his short term, medium term and long term care and treatment programme. The lack of a diagnosis also meant that neither Mr. X, his family, nor his new GP understood him in the full context of his mental illness which meant that they were not able to respond to his relapse in August 2011 in an effective and timely manner.***

2. Medication and Treatment

The Independent Investigation Team found that the medication prescribed for Mr. X was appropriate, it was well monitored and issues regarding side effects were recognised, discussed and acted upon in a collaborative way with Mr. X. The Investigation Team understood the rationale for a trial off antipsychotic medication after one year and in the case of Mr. X this appears to have been managed well over all, even though his mental health relapsed rapidly as a result. However the Independent Investigation Team concluded that it was regrettable that Mr. X discontinued his medication again in December 2010. This ultimately led to a relapse of his mental health with devastating consequences for him and for his family. There was little evidence upon which to suggest the withdrawal of medication at this stage was appropriate as it was evident Mr. X relapsed rapidly when he discontinued its use. This Investigation understands that both Mr. X and his family were ambivalent about his long-term usage of medication; however a more assertive conversation should have been had with both Mr. X and his family in order for them to have understood fully the reasons why a more extended period of medication use was indicated.

Once the decision to withdraw medication was made it was poor practice to coincide the final medication dosage with the date of discharge from the service as ongoing monitoring and review could not take place.

During the time that Mr. X spent with the Early Intervention Service he received an appropriate range of care and treatment which addressed both his psychological and social needs in accordance with national best practice guidance, with the exception of structured family-focused interventions.

- ***Contributory Factor Two. The cessation of Mr. X's medication regimen made a direct contribution to the deterioration of his mental health. This deterioration was rapid and followed the same progression as his two previous medication-related relapses. The breakdown in his mental health led to a state of psychosis and the subsequent killing of his uncle.***

3. Mental Health Act (1983 & 2007)

The Independent Investigation Team found this aspect of Mr. X's care and treatment to have been managed in an appropriate manner.

4. Care Programme Approach

When Mr. X was discharged from the inpatient unit in 2007 he was placed on Enhanced CPA and was allocated a Care Coordinator. Nowhere in the clinical record is the level of Mr. X's CPA made explicit (aside from a letter sent to the GP by Consultant Psychiatrist 3 when it was mentioned that Mr. X was on standard care). This Investigation was told that all service users were considered to require Enhanced CPA (CPA under the amended national guidance 2008) for their first six months with the Headspace Early Intervention Service. After Mr. X had been with Headspace for a year he was not considered to require CPA as his mental health was stable. Care plans, crisis plans and relapse plans continued to be developed and Mr. X continued to receive a full package of care and treatment. At this stage communication between the Early Intervention Service and the GP was maintained well.

The Independent investigation Team was not convinced that Mr. X's level of CPA should have been formally revised in 2008 as he went on to experience two more psychotic episodes and continued to require a high level of intervention from the service. The rationale and decision for downgrading Mr. X's CPA level was not recorded. It would appear that the ethos of CPA care provision was maintained, however there is always a risk to service users when practice sits outside of Trust policy and procedure. There is ample evidence to demonstrate that Headspace endeavoured to provide an evidence-based package of care which included Cognitive Behavioural Therapy.

However the main difficulty with the CPA process lay not with the provision of clinical care but with the lack of Care Coordination and case management. Only one formal CPA review was held during Mr. X's time with the Headspace Service, even though he relapsed on two

occasions. This single review was held at Mr. X's home and did not involve any other members of the multidisciplinary team. This, when combined with the lack of a dedicated Consultant Psychiatrist, served to disrupt the opportunity to hold a formal multidisciplinary planning meeting to which all members of the treating team, Mr. X and his family were invited in order to discuss his long term care and treatment strategy. No CPA discharge meeting was held and this served to impact upon the quality of the written documentation sent to primary care in April 2011. Whilst the initial care, crisis and contingency, and relapse plans were of a good quality, they were not substantially updated to take into account Mr. X's changing mental health presentation (his two psychotic relapses) or transitions on his care pathway (planned medication cessation and discharge).

- ***Contributory Factor Three. Deficiencies in the provision of the Care Programme Approach compromised communication processes between health care professionals. These deficiencies also prevented a long-term view of Mr. X's transition through the service being managed in a planned and effective manner that involved both him and his family in an informed way.***

5. Risk Assessment

During the time that Mr. X spent with the Solent NHS Trust he was deemed to present with no particular risk factors to self or to others. However when he was psychotic he had been known to become confused and this had led him to become aggressive. For example he had to be admitted as an inpatient in handcuffs as the Police had to restrain him for his own safety and that of others.

This Investigation found a risk assessment lacuna in the culture of the Solent NHS Trust services which provided care and treatment to Mr. X. The word 'risk' appears rarely within Mr. X's clinical records and it would appear that he did not receive a formal risk assessment at any point during his care and treatment with the Trust. The absence of risk assessment and formulation was regarded by this Investigation to be a serious omission in the care and treatment of a person with the tendency to experience psychotic episodes. This is probably due in part to the fact that the Trust does not have a dedicated clinical risk assessment policy to instruct practitioners. This is a highly unusual finding. Nearly all mental health Trusts in England have dedicated clinical risk assessment policies that set out the Department of Health *Best Practice in Managing Risk* (DoH June 2007) guidance. The guidance is

necessary reading for all mental health professionals and the Trust dependence upon the CPA policy to set out clinical risk responsibilities is not fit for purpose in this regard. The Independent Investigation Team also noted that no validated risk assessment tools are advocated by the Trust and that the use of the HoNOS scale is not an appropriate tool to be used when assessing risk.

Clinical witnesses told the Independent Investigation Team that they did not think Mr. X was a risk because he was a very nice person. The point of learning here is that whether a service user is well liked, as Mr. X was by his treating team, or not, or whether he is deemed to be a low risk, or not, risk assessment is a required part of clinical practice. This is of particular importance when a service user experiences a psychotic relapse. The Independent Investigation Team concluded that risk assessment practice could not have predicted Mr. X's risk of violence to another person, but should have been used at key points on his care pathway.

- ***Contributory Factor Four. Risk assessment and risk formulation practice within the Headspace Service was poor. This made a significant contribution to the manner in which Mr. X's case was managed. As a consequence the explicit risks regarding what could happen should Mr. X experience a psychotic relapse were never examined with either him or his family. This meant that once he was discharged neither Mr. X nor his family knew the importance of accessing timely help and advice. In addition the paucity of the relapse plan made a direct contribution to Mr. X's deteriorating mental health not being managed in an optimal manner by either himself or his family.***

6. Referral, Transfer and Discharge

- Referral: the Independent Investigation Team was told by Mr. X's family that the referral to the Early Intervention Team was made because they requested he was followed up by them. That Mr. X was referred to this team instead of to a CMHT at this stage can be clinically justified, however it was also apparent by this stage that Mr. X had probably experienced prodromal symptoms for at least a year and that he was possibly suffering from Schizophrenia. Following his first relapse in December 2008, which was his second psychotic episode, a diagnosis should have been made and a referral to the CMHT

considered as part of his progression on from the Headspace Service. This would have been in keeping with the EIS operational policy.

- Transfer: this Investigation was told by several witnesses that the Early Intervention Team had pressure placed upon them to keep the numbers on its caseload up to a certain level. It was suggested that individuals like Mr. X may have been held within this team despite clinical indications that he would have been best placed within a different secondary care provision at an earlier stage. The Independent Investigation Team concluded that plans should have been in train to eventually transfer Mr. X out of the Early Intervention Service to a CMHT following his second/third psychotic episode.
- Discharge: this Investigation was told that the Early Intervention Team kept individuals on the caseload for a maximum period of three years. It is unclear why individuals should be kept by a service for this period of time. It was difficult to understand the care pathway normally taken for service users out of the Early Intervention Service. In the case of Mr. X he went from receiving a fairly intensive level of care to discharge with no follow up strategy apart from an out of date relapse plan. The decision to take Mr. X off his medication and to discharge him appeared to be due in part to the fact that his allocated time with the service had come to an end; this rationale was suggested by some of the clinical witnesses interviewed by this Investigation as to why he was discharged at this stage. At the end of the three-year period the decision had to be taken whether Mr. X was transferred to Acorn Lodge (the CMHT) or discharged back to primary care. The decision was made by Consultant Psychiatrist 3, and the rest of the treating team, to take him off his medication and to discharge him from the service. This was based to a large extent on the premise that he did not have Schizophrenia and that Mr. X wanted this plan of action to be tried.

There were further problems that ensued regarding the discharge in that Mr. X and his family were planning to move out of the area. The Headspace Team were of the erroneous impression that Mr. X had already moved from the area by the date of his discharge on the 5 January 2011. This was incorrect. Mr. X did not in fact move until the end of March 2011. This erroneous thinking led to a delay in the discharge information being sent to primary care in a timely manner.

On the 1 August 2011 Mr. X was reviewed following a deterioration of his mental health by a GP who did not know him, and who worked to a relapse plan that did not recognise the severity of Mr. X's probable diagnosis. Another unfortunate aspect of the relapse plan was that it had not been updated sufficiently to support Mr. X after discharge from secondary care services. For example the plan suggested that at 'stage two' of a relapse he should take his prescribed medication. He was no longer on any prescribed medication. The plan sent to the GP and given to Mr. X also advocated that he contact the Care Coordinator that he no longer had. This relapse plan should have been revised with Mr. X and his family prior to his discharge. The letter to the new GP contained very basic information and did not follow the Headspace Operational Policy proforma GP discharge letter.

- ***Contributory Factor Five. The discharge process that Mr. X was subject to was not good practice. Policy and procedure was not followed and this contributed to the lack of understanding Mr. X and his family had about how to seek professional help should his mental health relapse. The absence of a structured Discharge CPA ensured that a plan was not constructed for Primary Care which could have provided guidance as to how to manage Mr. X, both in order to maintain his mental health, and to support him in crisis.***

7. Carer Assessment, Involvement and Communication

The extant clinical record would indicate that the level of communication and involvement with the family of Mr. X took place on a regular basis. It was evident that the family was met with and that all discussions held, when appropriate, regarding Mr. X's care and treatment involved them to a certain extent.

It was evident to the Independent Investigation Team that on occasions Mr. X's family were perceived by members of the treating team to be a little 'over involved'. Several attempts were made to maintain a distance between the concerns and needs of the family and concerns and needs of Mr. X. Clinical witnesses to this Investigation were of the view that Mr. X and his family wanted the medication to be withdrawn and for his discharge from secondary care services to take place. Mr. X was symptom-free and had capacity at this stage. This understanding was given as being the reason why the treating team ultimately decided that they had no option but to concede to the wishes of Mr. X and his family.

The family of Mr. X when interviewed by this Investigation stated that they were invited to attend a monthly family support group at Headspace, and whilst they were grateful for somewhere to go, would have preferred a more structured focus on Mr. X's problems in a different kind of forum. The family also felt that they did not have any idea about what Headspace was trying to achieve in the long term for Mr. X and that they wanted the opportunity to discuss this in more depth.

Following Mr. X's first relapse during the Christmas of 2008 the family wanted to discuss the possible reasons which may have led this to happen, but this did not occur. At no time did the family truly understand what was wrong with Mr. X, believing that he had merely had some kind of breakdown from which he would recover. They were not aware of the fact that he may have been suffering from Schizophrenia. When they met with Consultant Psychiatrist 3 in the Outpatient Clinic in August 2010 the possibility of taking Mr. X off his medication and discharging him from the service was discussed. As Mr. X had been symptom-free for a year they thought this was a good idea. The family are now of the view however that had Mr. X been advised at this stage to remain on his medication and to stay engaged with secondary care services he would have done so and the family would have supported this as they would have followed what the clinical specialists advised them to do. The family did not push for the cessation of medication and a discharge from the service, but welcomed this as an option when it was discussed. The family remain of the view that the relapse plan was not discussed with them in full and that when Mr. X's mental health began to deteriorate they did not know what to do.

The lesson here is that involvement with a family has to be meaningful to them. It was evident that regular contact was maintained with Mr. X's family over a three-year period, but that this activity did not assist the family in understanding the nature of Mr. X's mental illness and how best to support him. A great deal of reliance was placed upon the family to *"keep an eye on him"* in the arrangements made for Mr. X's discharge. However the family did not know the nature of what they were supposed to be 'keeping an eye on' and when Mr. X became unwell did not recognise the severity of his deterioration or the initial need to seek help in a timely manner.

- ***Contributory Factor Six. The failure to ensure that Mr. X's family understood Mr. X in the true context of his mental illness affected the manner in which they helped***

him to manage his condition. This lack of understanding, combined with the lack of a detailed and current relapse plan following his discharge, led to a significant delay occurring in getting Mr. X clinical support which in turn led to a serious relapse in his mental health.

8. Service User Involvement

Mr. X appears to have received care and treatment from a treating team that was sensitive to his needs and who worked with him in an open, honest and non-judgemental manner. It was evident that the Care Coordinator built up a good rapport with Mr. X and supported him in his recovery. It was also evident that the Care Coordinator had several 'courageous' conversations with Mr. X and worked with him in a professional manner in order to further his understanding of the nature of psychotic illness and the ongoing need for him to take his medication and comply with his care and treatment plan.

The treating team was to ultimately make the decision to take Mr. X off his medication and to discharge him from the service. It was known at this stage that Mr. X had a psychotic illness of some kind (since the killing of Mr. X's uncle the diagnosis of Paranoid Schizophrenia has been confirmed). It was evident that the treating team wanted Mr. X to realise his desire to be well and to live a normal life without medication. However the treating team had a duty of care to ensure that Mr. X's desires and wishes for his own future were set against a realistic long-term care and treatment plan. This plan needed to take into account the distinct possibility that Mr. X's recovery would probably not continue in the long term in a linear manner and that he would be prone to periodic relapse.

- ***Contributory Factor Seven. A more assertive management of Mr. X may have ensured that he remained in contact with secondary care services. It is probable that his levels of resistance to continued mental health inputs were overestimated by his treating team and that more could have been done to ensure that he received continued levels of support once he left the Headspace Service.***

9. Documentation and Professional Communication

The standard of clinical documentation was good as was the level of general professional communication. Three points of learning were identified by this Investigation.

First: CPA was not implemented in the true meaning of the sense in the case of Mr. X. This prevented the establishment of a formal discussion and planning forum which included all members of the treating team, Mr. X and his family. This meant that expectation and understanding did not always match, either within the treating team, or with Mr. X and his family.

Second: at the point of discharge communication with primary care was delayed for a four-month period. There was little communication or planning that took place prior to the discharge taking place and professional levels of communication with primary care were of a poor general standard during this time.

Third: the written communication to the GP at the Bosmere Medical Centre sent by the Care Coordinator was of a poor standard which did not reflect Mr. X's psychiatric history adequately and did not provide a useful or appropriate relapse plan in order to guide future working with Mr. X. This letter to the new GP contained very basic information and did not follow the Headspace Operational Policy proforma GP discharge letter. Had there been a dedicated medical input to the Early Intervention Team then a better standard of discharge summary would have been expected. However in the absence of medical input the responsibility fell to the Care Coordinator and this aspect should have been addressed better.

- ***Contributory Factor Eight. Whilst the standard of clinical documentation and professional communication was of a generally good standard at times it was inconsistent and failed to ensure that health care professionals engaged in providing care and treatment to Mr. X were provided with appropriate and full information. This was of particular note regarding the quality of the discharge information sent to Mr. X's Havant-based GP and influenced the approach taken with Mr. X on the 1 August 2011. Whilst the GP made sensible decisions based upon what she knew about Mr. X, and upon his presentation, a more detailed set of clinical information would have supported a timelier and more appropriate set of interventions for Mr. X who was experiencing a psychotic episode.***

10. Adherence to Local and National Policy and Procedure

The Trust has evidence-based operational and clinical policies that are fit for purpose with two exceptions.

First: whilst the fidelity of the Early Intervention service model was adhered to, general Trust-wide clinical policy and procedure was not. This was of particular note with regards to the Trust CPA policy. There were also significant departures from the Headspace Operational Policy in relation to discharge process. This impaired the quality of the care and treatment provided to both Mr. X and his family.

Second: the risk assessment and management lacuna in the approach taken to Mr. X's care and treatment was in part due to the fact that the Solent NHS Trust does not have a clinical risk assessment and management policy in keeping with the Department of Health 2007 guidance. This is a significant omission on the part of the Trust.

- ***Contributory Factor Nine. Failure on the part of the Headspace Service to adhere to policy guidance made a significant contribution to the failure to manage Mr. X's case in an evidence-based and professional manner to the detriment of his health, safety and wellbeing.***

11. Overall Management of the Care and Treatment of Mr. X

The clinical care and treatment that Mr. X received from Headspace over a three-year period was of a generally high standard. However, good clinical care can be compromised by poor clinical case management. The quality of the care and treatment delivered to Mr. X was impaired by the following factors:

1. Diagnostic ambiguity: this meant that Mr. X's care and treatment plan did not focus upon the long-term management issues that a severe and enduring mental illness, such as Schizophrenia, requires. This diagnostic ambiguity also obscured the need for Mr. X to continue with his antipsychotic medication, which was clearly indicated following his first major relapse and second psychotic episode during December 2008 after a supervised reduction in his antipsychotic medication had taken place.
2. Long-term planning and the care pathway: the Independent Investigation Team concluded that a plan to eventually transfer Mr. X to a Community Mental Health Team should have been put into train following his second/and/or third psychotic episode. By this stage it was evident that Mr. X was probably suffering from Schizophrenia. He was to experience two psychotic episodes whilst with the Headspace Service when he suffered from auditory hallucinations and bizarre thoughts. A discharge back to primary care did not factor in the likelihood that Mr. X

would relapse once off his medication and that Mr. X could not be managed and monitored appropriately in this clinical context.

3. Discharge planning: without a longer-term plan the intensive level of input that Mr. X received whilst with the Early Intervention Service came to an abrupt halt when he was discharged from the service. Without a diagnosis and a long-term evaluation of what his continuing needs were likely to be Mr. X was not considered for a referral to a Community Mental Health Service. It is not good practice for a service user to come off antipsychotic medication and be discharged from secondary care services at the same time, especially when it is known that the service user is due to move out of area. Despite a relapse plan being formulated this cannot be seen as a substitute for robust planning at the end of an episode of care.
4. Carer involvement and communication: it was evident from the discussions that this Investigation had with the family of Mr. X that neither they nor Mr. X were planning to disengage from the service and that they were not rejecting of it. Had they been told that Mr. X's diagnosis was Schizophrenia (or some such severe and enduring mental illness) and that medication and an ongoing contact with secondary care services was necessary they would have cooperated fully. Instead assumptions were made about what Mr. X and his family wanted, rather than what they needed, and Mr. X was discharged from the service and his medication stopped without the arrangements being made for ongoing monitoring and support in primary care.

There were other issues that impacted upon the effectiveness of the care and treatment offered to Mr. X by the Early Intervention Service. It was apparent that there was a minimal level of medical input to the team. This meant that medical inputs were not able to be given on a regular basis and that individual service users were not known well to medical members of the team.

In the case of Mr. X it would appear that he received a good general level of care and treatment. However from a relatively early point on his care pathway Mr. X was managed by a service which did not provide a diagnostic formulation which meant that his long-term needs were not understood appropriately. This served to minimise the seriousness of his mental illness and prevented a robust multidisciplinary approach to diagnosis, care and treatment. This made a significant contribution to the way in which his discharge was

managed and he did not graduate from the service in a manner which was appropriate to either his illness or long-term needs.

- ***Contributory Factor 10. Clinical activity, which was of a good standard, was provided outside of a structured management framework. As a result the integrity and long-term efficacy of the care and treatment that Mr. X received was compromised to the detriment of his ongoing health, safety and wellbeing.***

12. Clinical Governance and Performance

The Trust has robust clinical governance systems and is in the process of developing them further.

13. Internal Investigation Process (Individual Management Report MR)

The quality of the Trust IMR was deemed to be of a basic standard. Few of the relevant findings of the Domestic Homicide Review and Independent Investigation were found and this would have prevented timely changes to services from being made.

Summary

Positive features of the decision made to discharge Mr. X from the Headspace Service and stop his medication:

1. Mr. X appeared to have been free of major symptoms for 18 months at the point of his discharge.
2. Mr. X had a relapse plan that they were advised to adhere to.
3. Mr. X was leaving the area and was planning to register with a GP in the near future so he could not be kept by the Headspace Service.
4. Mr. X and his family were keen to follow the plan of medication cessation and discharge back to primary care.
5. Mr X had capacity and was able to make these choices.
6. Mr. X had a supportive family and his risk was deemed to be low (apart from two reported episodes of violence when psychotic).

Features of concern about the decision to discharge Mr. X from the Headspace Service and stop his medication:

1. Mr. X had experienced three episodes of psychosis and had also experienced a prodromal period of at least a year prior to his admission in 2007. The diagnosis of Schizophrenia/Schizoaffective Disorder would have been consistent with his symptoms. It would not be usual to discharge a person with this kind of diagnosis back to primary care with no follow-up plan after stopping his medication.
2. Mr. X's two previous episodes of psychosis had been linked to either a reduction or non-compliance with medication. The cessation of antipsychotic medication was therefore problematic.
3. Mr. X was moving out of the area at a time due to coincide with his medication cessation and discharge from secondary care services. This would make future follow-up difficult.
4. Mr. X still had no diagnosis and Consultant 3 did not have enough information available to him in August 2010 when he wrote that he thought Mr. X had a Mood Disorder rather than Schizophrenia. Mr. X received no diagnosis and no explanation had been formulated to explain his three psychotic episodes, prodromal period, and difficulties with every day living and social functioning.
5. The family has stated to this Investigation that they did not want Mr. X to be discharged and for his medication to be stopped if this was not in his best interests and that they would have supported a plan to continue the medication and for his referral to a CMHT had they known this was what he needed.
6. The relapse plan did not recognise the severity of Mr. X's underlying diagnosis and therefore could only have a limited efficacy in preventing any relapse from escalating into a full-blown psychotic episode. The relapse plan had not been updated prior to Mr. X's discharge and was predicated upon Mr. X remaining with a secondary care service; this was not helpful once he had returned to a primary care context.

Conclusions

The Independent Investigation Team concluded that the overall clinical care and treatment that Mr. X received was of a generally good standard, but that this was seriously impaired by the relatively poor case management that was deployed by the Headspace Service. It is a fact that care and treatment cannot be delivered in an optimal manner in the absence of a formal formulation of a case. In the case of Mr. X this led to a great deal of clinical activity over a

three-year period but this activity did not appear to be linked to any short, medium or long-term plan.

In real terms it would appear that Mr. X left the Headspace Service on the 5 January 2011 with exactly the same set of problems that he entered the service with. For example:

- it was evident that Mr. X was suffering from a mental illness of some kind even though no one was prepared to state what it was;
- Mr. X was not entirely symptom free; he had some residual bizarre behaviour and his mood was often observed to be slightly elevated;
- Mr. X had little or no insight into the fact that he had a mental illness; at the point of his discharge he was in denial about this altogether;
- Mr. X's social functioning was impaired; he was unemployed and found employment situations to be very stressful; he could not live independently and needed to reside with his parents;
- Mr. X remained socially isolated and the issues about his personal issues had not been resolved which continued to cause Mr. X a degree of anxiety and frustration.

Despite the levels of activity undertaken by the Headspace Service it is difficult to understand how effective any of these interventions actually were or what changes they were trying to effect.

The Independent Investigation Team reached the conclusion that the killing of Mr. Y could not have been predicted. It was evident that Mr. X did not appear to be a violent or aggressive person and that his demeanour had always been gentle. However that being said, any individual who suffers from psychotic episodes will experience a degree of confusion, delusion and paranoia. These experiences can lead to dramatic changes of behaviour and therefore there is always a risk that any individual when psychotic may act in an uncharacteristic manner, at times with tragic consequences.

On the issue of preventability the Independent Investigation Team concluded that a significant contribution was made regarding acts and omissions on the part of the Solent NHS Trust which led to the relapse of Mr. X's mental health which in turn led to him killing Mr. Y. It is probable that had Mr. X been maintained on his medication and received a continued

monitoring of his mental health then he would a) either not have experienced a psychotic relapse or that b) it would have been detected and treated at an earlier stage than it was.

However the Independent Investigation Team could not conclude that there was direct causal link between any act or omission on the part of the Solent NHS Trust and the killing of Mr. Y for the following reasons:

1. **Knowledge.** Whilst the Solent NHS Trust had a good day-to-day level of knowledge about Mr. X whilst he remained with the Headspace Service, once he was discharged this ceased. A seven-month interval occurred between Mr. X's date of discharge and the killing of his uncle, Mr. Y. No one at the Headspace Service was aware that Mr. X's mental health had begun to relapse and that he and his family were reaching a stage of crisis. The family of Mr. X did not contact Headspace and there was no awareness of Mr. X's change of condition.
2. **Opportunity.** Because Mr. X was no longer a patient with the Headspace Service which was 'out of area' there was no opportunity for the team to intervene, particularly as they were unaware of his relapse. The Headspace Service was in no way remiss in this respect.
3. **Means.** Even had the Headspace Team been told about the deterioration in Mr. X's mental health, as they were 'out of area' it would have been difficult for them to have been able to intervene and there was no facility for the team to arrange a Mental Health Act (1983 and 2007) if the requirement for one was indicated.

Mr. X received assessment at his Havant-based GP surgery on the 1 August 2011. Based upon what the GP undertaking the assessment knew at this time Mr. X's case appears to have been managed in a reasonable manner. However it would have been good practice for the GP to have made contact with the Care Coordinator within the Headspace Team (as suggested in the discharge letter should advice be required) as this may have been a way for a more detailed clinical management plan to have been instigated. This was an omission. However the information supplied by the Headspace discharge letter did not raise any sense of urgency should Mr. X become unwell and this seeming lack of urgency was also reflected in the available relapse plan. Mr. X did not appear to be floridly psychotic during the GP consultation and based upon this it is difficult to know what else the GP could have been expected to have done.

The Solent NHS Trust internal investigation processes and reflection found that the clinical care and treatment Mr. X received was of a high overall standard. The Independent Investigation Team acknowledges that the care and treatment was of a good quality but concluded that the overall case management was poor and lacked cohesion and that this made a direct contribution to Mr. X being discharged in an inappropriate manner which in turn contributed to him experiencing a relapse a few months following his discharge which went unmanaged and undetected.

8. Notable Practice

Systems

Since the time of this incident; the Trust has completed its community services transformation scheme. The new community services structure was designed by frontline staff, service users and commissioners together in 2010 and has been rolled out across two years, the final phase being completed as estates moves and refurbishments allowed. The transformation scheme has established a new Intensive Engagement Team, in a new purpose-built team base in St Mary's Hospital Portsmouth. The aim of establishing this team was to bring together the best practices of Assertive Outreach, Early Intervention and High-Intensity Borderline Personality Disorder services, in a team that was large enough to have a dedicated Consultant Psychiatrist lead. Headspace has met its targets for engagement of people with a developing psychosis, but the Trust was keen to offer some of the expertise of the team to a wider pool of service users. The IET will continue to meet fidelity to EI principles and activity targets, but will encourage the involvement of service users outside the narrow EI category in initiatives to prevent disability and promote social inclusion.

The IET will continue the award winning 'Back on Track' initiative; with Highbury College and is in advanced talks about extending the scheme to introduce a Recovery College opening the door to people with mental health problems taking an education-based approach to self-management and self-actualisation. The new Team also now has dedicated social care support.

The new IET had an away day on the 17 November to agree the format and content of their new Operational Policy and incorporate the recommendations in it from the draft external review report. All substantive improvements required to team processes, however are already in place and operational (as previously detailed). The IET Operational Policy will be ratified by the AMH Clinical Governance Group in January 2013.

The former Headspace Team will have the opportunity to learn about effective, assertive engagement from the members of the previous Assertive Outreach Team, who are now their colleagues in IET. The team approach will be focussed on individual needs – taking the best skills, interventions and processes from both previous treatment modalities.

Solent has used the SIRI process to good effect in improving care outcomes for patients. One example is how the Trust has successfully implemented and utilised a unique virtual approach to the first line review of Grade 3/4 Pressure Ulcers acquired in its care. This has resulted in a significant improvement with regards to the turnaround for pressure ulcer investigations, which in some cases can be a little as one week from logging on STEIS to submission for closure.

The process consists of a notes review undertaken in the service when the ulcer is identified, which then undergoes a virtual panel review and is deemed avoidable/unavoidable by majority consensus. At this point if the pressure ulcer is deemed unavoidable the notes review, panel feedback and any actions undertaken are submitted to commissioners for consideration to close. If deemed avoidable then the incident will undergo further analysis and a full RCA report delivered for review at SIRI Panel.

The process for pressure ulcers not only increases the speed of turnaround of these investigations and ensures a proportionate and more consistent response, it is also assists with early identification for any lessons learnt. The Trust partners in social care take part in the early review process and involvement in the virtual panel.

In respect of homicide-related SIRIs; the Trust has improved its processes, since this incident in a number of ways:

- Solent has taken a decision to interpret national guidance in relation to chronology and allocation of the lead for SIRI investigation in a way that ensures that the Trust would not be wrong-footed by any confusion over discharge dates. The Trust has increased the threshold of last contact with services to one year pre-event;
- The Trust has increased its scrutiny of internal assurance measures by introducing an Internal Management Review (IMR) process. The IMR is undertaken within 48 hours of the reporting of an incident to ensure that all immediate actions required to ensure safety and secure evidence have been undertaken.
- Progress of investigations is now reviewed during the course of the investigation through the SIRI Panel.
- All Senior Managers will now be supported by an Associate Director or Executive Director when contributing to a homicide review undertaken by external agency.

- All documentation will be reviewed and approved by the Medical Director or Director of Nursing & Quality prior to external circulation/submission.

Solent NHS Trust has an extensive audit and improvement programme within the Adult Mental Health division with over 40 annual audits on a rolling programme. This process is overseen by the Lead Consultant and led by the Nursing and AHP Lead for Mental Health. Any aspect of the audit programme that requires more detailed analysis or assurance is introduced into the standard clinical supervision template and evidence gathered during supervision sessions, with individual action plans made with practitioners. This has been effective in enabling fast improvements to be made to specific standards around the CPA process. The adherence to the supervision template is also audited to ensure that supervisors are using sessions effectively to enable quality improvement.

The Trust recognises that its mental health staff have a challenging role that will inevitably lead them to encounter highly distressing situations at times. As part of the SIRI Policy, staff are offered de-briefing, by a person trained in these techniques and access to the Trust's confidential employee assistance programme. All staff also have clinical and managerial supervision at which personal support needs are addressed. It would be usual also for staff to meet with a Service Head to ensure that they feel supported through any process and that they understand how a process will unfold. This would include accompanying them to inquests or inquiry interviews. In more serious incidents the Associate Director would usually discuss the incident with staff on an ongoing basis and facilitate staff learning and reflection in addition to formal SIRI processes including accompanying staff to inquests and giving personal support and advice. This is a function of the relatively small size of the mental health division, but also the clinical background of all Heads and the Associate Director and the Trust's preference for a style of management based on inter-personal relationships and knowing its staff well.

Professional Input

The Independent Investigation Team found the clinical care and treatment offered to Mr. X by the Care Coordinator within the Headspace Team to be of a high standard.

9. Lessons Learned

The lessons for learning set out below are generalised and should be considered by all Mental Health Trusts.

Adherence to Local and National Best Practice Policy Guidance

Local and national best practice policy guidance is evidence-based and ensures that care and treatment is delivered in a safe and effective manner. When practitioners deviate from policy guidance they risk compromising the safety and effectiveness of the care and treatment that they are providing. It is sometimes necessary for treating teams to take decisions contrary to what would normally be seen as best practice, however when this needs to occur treating teams should write the rationale clearly in the clinical record and ensure that Trust Governance Teams are made aware.

High levels of activity can sometimes be mistaken for meaningful engagement. Treating teams can be lulled into a sense of false security believing that a high standard of care and treatment is being provided. The culture within small, specialist teams can instil a belief that they are somehow exempt from best practice guidance. This kind of working should be discouraged because when clinical inputs are delivered outside of a systematic policy framework a departure from safe and effective practice can occur resulting in risks to the health, safety and wellbeing of service users.

Each Trust as a statutory body has a duty of care to ensure that all clinical staff adhere to both local and national policy guidance. Each individual practitioner and NHS employee has an individual duty of care to ensure that they also adhere to policy guidance.

Professional Communication

The failure of mental health professionals to communicate in an effective and timely manner has been a key finding of most *HSG (94) 27* Investigations since the inception of the process in 1994. Each mental health professional needs to ensure that all communication is clear, relevant and timely. Communication must be maintained within treating teams and also between the interface of primary and secondary care. With the introduction of *New Ways of Working* communication pathways, traditionally maintained doctor-to-doctor, are no longer

always possible. This means that the standard of professional communication, with particular regards to discharge summaries, must now be maintained and developed by other healthcare professionals. The role of Psychiatrists in the maintenance of robust professional communication cannot be underestimated, and as roles alter and merge within modern mental health teams this important function must become a part of multi-disciplinary practice. As a consequence training and supervision may be required in order to ensure that the necessary standard is upheld.

Carer and Family Involvement

The importance of carers and families can be paramount in the maintenance of a service user's health and wellbeing. When a family has been identified as being a key protective factor regarding health maintenance, relapse and crisis management, it is essential that they are involved in care planning and have access to advice and support that is meaningful to them. It is not unusual for families to appear to be ambivalent at times. For this reason it is important that communication is clear and consistently provided. Carer assessments should always be offered and support plans for carers and families should be developed. Mental health teams need to work in partnership not only with service users, but also with carers and families when they have been specifically identified as having a key role to play in the service user's recovery.

10. Recommendations

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

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

10.1. Recommendations for Solent NHS Trust

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

10.1.2. Diagnosis

- ***Contributory Factor One. The failure to provide Mr. X with a diagnosis compromised the effectiveness of his short term, medium term and long term care and treatment programme. The lack of a diagnosis also meant that neither Mr. X, his family, nor his new GP understood him in the full context of his mental illness which meant that they were not able to respond to his relapse in August 2011 in an effective and timely manner.***

Recommendation 1. The Trust must ensure that the diagnostic practice within the Early Intervention Service conforms to national best practice policy guidance. This to include:

- all patients will be held on CPA for at least the first six months to ensure multi-disciplinary input into formulation of diagnosis;

- consideration of diagnosis will be reviewed every six months by a Consultant Psychiatrist for all patients, within the Early Intervention pathway;
- differential diagnoses and implications will always be discussed with patients and carers;
- diagnostic ambiguity will be avoided where possible and will not be pursued as a policy;
- primary care will be provided with clear diagnostic information.

10.1.3. Medication and Treatment

- ***Contributory Factor Two. The cessation of Mr. X's medication regimen made a direct contribution to the deterioration of his mental health. This deterioration was rapid and followed the same progression as his two previous medication-related relapses. The breakdown in his mental health led to a state of psychosis and the subsequent killing of his uncle.***

Recommendation 2. When service users are ambivalent about their medication and also have a history of medication non-adherence then a medicines management plan should be developed with the assistance of a Pharmacist. This plan should also include:

- education of the service user and carer (where relevant);
- the use of service user-led medication assessment and monitoring tools.

Recommendation 3. All service users should be monitored for a two-year period following the cessation of antipsychotic medication in accordance with NICE best practice guidance. Secondary and primary care services should develop a protocol as to how this is best managed when service users are discharged back to the care of the GP.

10.1.4. Care Programme Approach

- ***Contributory Factor Three. Deficiencies in the provision of the Care Programme Approach compromised communication processes between health care professionals. These deficiencies also prevented a long-term view of Mr. X's***

transition through the service being managed in a planned and effective manner that involved both him and his family in an informed way.

Recommendation 4. All service users with the Early Intervention Service will receive a service in keeping with the Trust CPA policy. This to include:

- allocation to CPA or non-CPA in accordance with the Trust policy;
- CPA reviews to be conducted at the required six/12 months intervals or when the service user experiences a relapse/recurrence of mental illness or when a transition on the care pathway is planned;
- a discharge CPA should always be held in a timely manner and the consequent plans of care made available to primary care;
- formal Trust CPA documentation is to be used by the Early Intervention Service to record assessment of need, care, relapse, crisis and contingency planning;
- active involvement of both service user and carers (where appropriate) in the formal CPA process;
- CPA to be a multidisciplinary activity;
- CPA documentation to be sent in full to the GP.

Recommendation 5. Care Coordinators are to receive specific training for their role in keeping with the 2008 national CPA guidelines.

Recommendation 6. An audit should be conducted within the Early Intervention Service within a six-month period of the publication of this report to ensure compliance to the CPA policy and to also ensure that CPA is meeting the required quality standard within the service.

10.1.5. Risk

- ***Contributory Factor Four. Risk assessment and risk formulation practice within the Headspace Service was poor. This made a significant contribution to the manner in which Mr. X's case was managed. As a consequence the explicit risks regarding what could happen should Mr. X experience a psychotic relapse were never examined with either him or his family. This meant that once he was discharged neither Mr. X nor his family knew the importance of accessing timely help and***

advice. In addition the paucity of the relapse plan made a direct contribution to Mr. X's deteriorating mental health not being managed in an optimal manner by either himself or his family.

Recommendation 7. The Trust must develop a Clinical Risk Assessment and Management Policy that will apply to all mental health service users across the Trust as a matter of priority. This is in keeping with the practice of most, if not all, other mental health Trusts nationally. This policy should include:

- clear guidance to all clinicians regarding the Department of Health *Best Practice in Managing Risk* (June 2007);
- the identification of validated risk assessment tools in keeping with the recommendations from the DH guidance;
- clear guidance relating to the positive management of risk;
- clear guidance in relation to risk assessment, relapse, crisis and contingency plans;
- clear guidance in relation to risk assessment and management and the Care Programme Approach.

Recommendation 8. The Trust will develop the Clinical Risk Assessment and Management Policy within one month of the publication of this report. The Policy should be audited 12 months following its first implementation.

10.1. 6. Referral, Transfer, Discharge

- ***Contributory Factor Five. The discharge process that Mr. X was subject to was not good practice. Policy and procedure was not followed and this contributed to the lack of understanding Mr. X and his family had about how to seek professional help should his mental health relapse. The absence of a structured Discharge CPA meant that a plan was not constructed for Primary Care which could have provided guidance as to how to manage Mr. X, both in order to maintain his mental health, and to support him in crisis.***

Trust Progress since the Incident

The new Intensive Engagement Team (Early Intervention Service) produced a Standard Operating procedure on the 23 November 2011 including:

- The patient journey through services will be primarily based on need, not stage of mental health career. This will have the direct implication that any person requiring intensive elements of Early Intervention treatment will continue to stay with EIT, regardless of age or length of time in mental health services. Those requiring only primary care intervention or less intensive secondary care will be transferred to their GP or the Recovery teams as indicated.
- CPA Policy will be reviewed to include a new element of 'Discharge Relapse Plan'. A relapse plan will be agreed with any patient being discharged from secondary care services and written copies shared with them, their carers and GP. The plan will detail indicators of relapse and action to be taken, including who to contact if relapse indicators occur.
- Discharge will always be agreed as a multi-disciplinary decision.
- Discharge summaries will always be written by the Consultant or delegated medical staff in charge of the patient's care.

Recommendation 9. The new process should be audited within six months of the publication of this report to ensure effectiveness.

10. 1.7. Carer Assessment and Carer Experience

- ***Contributory Factor Six. The failure to ensure that Mr. X's family understood Mr. X in the true context of his mental illness affected the manner in which they helped him to manage his condition. This lack of understanding, combined with the lack of a detailed and current relapse plan following his discharge, led to a significant delay occurring in getting Mr. X clinical support which in turn led to a serious relapse in his mental health.***

Recommendation 10. The Early Intervention Service should ensure that all carers of young people have a carer's assessment offered to them and a suitable plan developed to support their needs if any are identified.

Recommendation 11. The Early Intervention Service should ensure that all carers of young people are involved in the development of relapse, crisis and contingency plans. These plans should make explicit which service should be contacted in a crisis on a 24/7 basis.

10.1.8. Service User Involvement

- ***Contributory Factor Seven. A more assertive management of Mr. X may have ensured that he remained in contact with secondary care services. It is probable that his levels of resistance to continued mental health inputs were overestimated by his treating team and that more could have been done to ensure that he received continued levels of support once he left the Headspace Service.***

Recommendation 12. Guidance should be provided to clinical staff as a part of the Clinical Risk and CPA policy documentation which sets out requirements for service user engagement in therapeutic work and long-term care planning. Guidance should be provided in the following areas:

- when taking positive risks;
- when balancing aspects of a recovery programme with an individual service user's choices and wants which may run counter to that person's best interests.

10.1.9. Documentation and Professional Communication

- ***Contributory Factor Eight. Whilst the standard of clinical documentation and professional communication was of a generally good standard, at times it was inconsistent and failed to ensure that health care professionals engaged in providing care and treatment to Mr. X were provided with appropriate and full information. This was of particular note regarding the quality of the discharge information sent to Mr. X's Havant-based GP and influenced the approach taken***

with Mr. X on the 1 August 2011. Whilst the GP made sensible decisions based upon what she knew about Mr. X, and upon his presentation, a more detailed set of clinical information would have supported a timelier and more appropriate set of interventions for Mr. X who was experiencing a psychotic episode.

Recommendation 13. The Early Intervention Service must ensure that when a service user is discharged back to primary care a full set of discharge CPA documentation is sent to the GP together with (as required):

- discharge care plans;
- medicines management care plans;
- discharge summary documentation.

10.1.10. Policy Adherence

- ***Contributory Factor Nine. Failure on the part of the Headspace Service to adhere to policy guidance made a significant contribution to the failure to manage Mr. X's case in an evidence-based and professional manner to the detriment of his health, safety and wellbeing.***

Recommendation 14. The Trust must ensure that an audit of CPA and clinical risk assessment processes takes place within 12 months of the publication of this report. This audit should address both compliance and quality issues in accordance with the recommendations set out above.

10.1.11. Overall Management of Care and Treatment

- ***Contributory Factor 10. Clinical activity, which was of a good standard, was provided outside of a structured management framework. As a result the integrity and long-term efficacy of the care and treatment that Mr. X received was compromised to the detriment of his ongoing health safety and wellbeing.***

Trust Progress since the Incident

The new Intensive Engagement Team (IET) which commenced full operation on the 26 September now has a 1.0 WTE Consultant Psychiatrist dedicated to the team. This is a single person, rather than the previous model of input from several medics. The Consultant is supported by two trainees. All significant care decisions including change to CPA level and discharge are discussed at weekly multi-disciplinary team meetings.

No additional recommendations are required here as recommendations 1-14 serve to address the issues raised under this contributory factor.

10. 1.12. Internal Investigations Following Homicide

Recommendation 15. In the future should the Trust experience another untoward incident constituting a homicide perpetrated by a mental health service user under its care then the National Patient Safety Agency Guidance 2008 should be applied. This should include:

- a full application of the national *Being Open* guidance with communication and support being offered by a Senior Officer of the Trust;
- a full root cause analysis approach being undertaken by a multidisciplinary team not directly involved in the service under investigation;
- consideration of Scott and Salmon compliant principles being upheld held in order to ensure support to clinical witnesses and the transparency of the investigation process.

10.2. Feedback from the Commissioners of Solent Mental Health Services

The Commissioners had the following to add:

"It is recognised that the report has been prepared at a time of considerable change within the NHS and in particular to commissioning arrangements. PCTs and/SHAs will come to an end in March 2013 as new parts of the commissioning architecture including Clinical Commissioning Groups(CCGs) and the NHS Commissioning Board take up their responsibilities.

PCTs and SHAs are currently preparing handover documents and arranging face to face meetings with receiving organisations including CCGs to ensure that all relevant information about the quality of local services is passed on to successor bodies.

It will be important that the findings and recommendations of the Independent Investigation of Mr X forms part of this handover so that there is continuity in the work to gain assurance in the areas highlighted for improvement within Solent NHS Trust.

It is understood that from 1st April 2013 Portsmouth CCG will be the lead commissioner for services provided by Solent NHS Foundation Trust and expects to commission an increasing range of integrated services including mental health services with Local Authorities.

The report highlights a number of areas of practice which have wider implications for patients accessing services from the Trust including the need for a robust clinical risk assessment policy and effective CPA arrangements. These are areas that commissioners may wish to seek further assurance on through regular reviews of key performance indicators, commissioning of clinical audits within the Trust, observational visits involving third sector organisations and reviews of patient/ advocate and staff feedback".