Central Liverpool NHS
Primary Care Trust

Independent Review

into the care and treatment of Mark Corner

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Cheshire and Merseyside Strategic Health Authority

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ECRI
A NONPROFIT AGENCY

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Acknowledgements

The investigative team wishes to extend its deepest sympathy to all those affected by the incidents that led to this investigation.

We would also like to acknowledge Steve Morgan, who acted as the Inquiry Co-ordinator at Mersey Care NHS Trust, for his administrative assistance during the investigative process leading up to the publication of this report.

Finally, ECRI would also like to take the opportunity to thank all those who participated in and contributed in a full and frank manner to this process. Their input is valued and appreciated. It is sincerely hoped that the issues identified in this report result in lessons being learned.

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1.0 Summary

The external investigative team was appointed by the Cheshire & Merseyside Strategic Health Authority on 18th December 2003 to investigate the healthcare and treatment of MC and to prepare a report and make recommendations. The review commenced three months later following completion of the Trusts internal investigation.

The investigation, based on root cause analysis methodology, was established under the terms of the Health Service Guidance HSG (94) 27 – 'Guidance on the discharge of mentally disordered offenders', Department of Health. The investigative process was progressed in accordance with national and international best practice guidelines in this area.

The investigative terms of reference were as follows:

Terms of Reference

1. To independently examine all the circumstances surrounding the care and treatment of MC.

2. To establish the facts regarding the mental health care of MC up to the date of the offence.

3. To consider and comment on the appropriateness or otherwise of the care and treatment and supervision of MC including:
    - ∞ the assessed health and social care needs
    - ∞ the assessed risk of potential harm to himself or others

- ∞ Any previous psychiatric history (including any drug and alcohol abuse)
- ∞ the number and nature of any previous contacts with the criminal justice system

4. To consider any specific issues which the family of MC and or the family of the deceased may wish to raise, with due regard to confidentiality.

5. Determine the extent to which the services adhered to statutory obligations and local policies.

6. To examine the quality of the risk assessment undertaken.

7. Establish what action has already been taken.

8. Draw conclusions and make recommendations for any further action.

MC – aged 26

On 21st July 2003, MC a mental health service user at Mersey Care NHS Trust was arrested on suspicion of murder. On 23rd July 2003 MC was arrested in connection with a second murder. Police investigations revealed that MC had killed two women at his flat. MC was sentenced to indefinite detention under section 37/41 of the Mental Health Act (1983) on 10th December 2003.

Prior to the offences MC was in contact with mental health services under the care of Aintree Hospitals NHS Trust. At the time of the offences he was under the care of adult mental health services at Mersey Care NHS Trust and his General Practitioner. He had a history of contact with services dating back to 1994 and had a previous history of a range of symptoms: depression, anxiety, alcohol and substance misuse, suicidal thoughts, self harm and a range of psychotic thoughts.

The management of mental health services providing care to MC was reorganised during the period April 2001 to April 2002. The in-patient unit, Stoddart House was previously managed by Aintree Hospitals NHS Trust which became part of the newly created Mersey Care NHS Trust in April 2001.

The investigative team have reviewed evidence from a number of individuals, read substantial documentation from the relevant agencies involved including the report of the Trusts internal inquiry into the care and treatment of MC by Mersey Care NHS Trust.

All of those interviewed who provided information have had the opportunity to amend and approve the information they have provided. All agencies involved have replied in a punctual and efficient manner in regards to requests made for information.

Whilst there appears to be an extensive history of contact with mental health services, the key period of interest in relation to this investigation occurs subsequent to August 2002. MC had been escorted by Police and detained under Section 2 of the Mental Health Act (1983) at the Stoddart House Inpatient Unit, Mersey Care NHS Trust, Liverpool after thoughts of harm to others.

Three months prior to the murders he had repeated episodes of self harm, self reported substance misuse, failure to attend out-patient appointments and in addition to reporting the fact he was non-compliant with prescribed medication.

The clinical and service delivery issues considered by the external review and identified as pertinent to the incidents include:

- The lack of an implemented Care Programme Approach (CPA) process following MC's discharge into the community subsequent to his in-patient stay in August 2002. This finding should be considered in conjunction with the existence of published national guidance on the implementation of CPA and the published Effective Care Co-ordination (ECC) process within the Trust.
- A reliance by Trust services placed on MC, immediately following his in patient stay, and in the absence of formalised community support, to be able to self report any deterioration in his own mental health
- Following discharge from his in-patient stay a subsequent lack of assertive follow up by mental health services after a number of non-attendances for pre-planned out-patient appointments.

- ∞ The lack of availability of clinical information to the Community Mental Health Team and the Accident and Emergency Department during key periods of contact with MC.
- ∞ The method of communicating the Care Plan and Risk Assessment to the wider multi-disciplinary Team.
- ∞ The effectiveness of multi-disciplinary working and associated distribution of MC's clinical care documentation, including communication with MC's General Practice
- ∞ The assessment skills and in particular, supervision of junior medical staff assisting with the management of mental health service users.
- ∞ The overall lack of formal community support provided to MC following discharge into a community setting

The lack of a formalised CPA is seen as a significant feature in the care of MC. As required by the National Service Framework for Mental Health, (and indeed the Trusts own policy in existence at the time of these events) service users admitted to hospital with a severe and enduring mental illness are to have their aftercare systematically managed and supervised using the Care Programme Approach (CPA). It is noted that Mersey Care NHS Trust published an Effective Care Coordination Process (ECC) in March 2002 that described the need to integrate CPA with Care Management including the need to provide integrated health and social cares needs assessment and the identification of a Care Coordinator.

The investigative team have reviewed the Trust Internal Inquiry documentation and are satisfied that the actions proposed demonstrate that much has been learned. The Trusts Internal Inquiry is a robust and thorough consideration of the events. The investigative team noted that the internal review appears to have identified the primary causation issues related to these incidents.

Whilst it is acknowledged that service provision has significantly altered and community care provision appears more cohesive, it is strongly recommended that an audit be undertaken to ensure CPA processes are available to those service users who need it. A further audit should also be considered relating to the involvement and contributions of relatives of service users who are subject to detention under the Mental Health Act (1983). This review and any associated findings should be considered by officers from the Liverpool Primary Care NHS Trust and the provider of mental health services in this case: Mersey Care NHS Trust, to ensure wider NHS learning takes place.

It is recognised by the investigative team that MC was a service user with a long and complex history of mental health issues. These were further complicated by a background of substance misuse, non-compliance with prescribed medication and difficulties with engaging with the service. The diagnosis of MC was, in the opinion of the team, accurate and appropriate. A key feature of this investigative analysis remains however that a formal plan for the delivery of care following discharge into the community was significantly lacking.

2.0 Investigative Methodology

1.1 Root Cause Analysis is a retrospective systematic process of analysis of an incident conducted according to guidelines published at both national and international levels. Its purpose is to identify what, how, and why a particular event occurred. The output from such an analysis is then used to identify areas that require change and provide recommendations and sustainable solutions, in order to minimise the chance of re-occurrence of the incident.

1.2 The process consists of six main activities:

- data gathering
- information mapping
- identifying issues
- analysing issues for contributory factors
- agreeing the root causes
- recommendations and reporting

1.3 The government Chief Medical Officer's report *'An Organisation with a Memory'* (2000) presents the results of findings by an expert group reviewing adverse incident management and the options for learning from such events. This and subsequent publications have identified significant opportunities and benefits that exist to reduce unintended harm to patients in NHS care.

1.4 In practice with Root Cause Analysis procedures, and in order to encourage an uninhibited contribution by those involved, individuals are not identified by name.

3.0 Sources of information

3.1 Clinical notes and nursing Notes, MC, Mersey Care NHS Trust

3.2 Effective care coordination in Mental Health Services in Liverpool and Sefton, Mersey Care NHS Trust dated March 2002

3.3 Risk assessment guidelines, document no. AH/RISK/002, Mersey Care NHS Trust, dated January 2001

3.4 Senior House Officer induction programme, induction timetable, Mersey Care NHS Trust, dated 7th August 2002

3.5 Guidelines for the observation of patients, Mersey Care NHS Trust, dated 18th May 1992

3.6 Discharge procedure, Mersey Care NHS Trust, dated 10th August 1992

3.7 Bed management policy, Mersey Care NHS Trust, dated May 1998

3.8 Admissions procedure (managerial), University Hospital of Aintree, dated 1st July 1992

3.9 Policy and procedure for the reporting, management and review of adverse incidents, Mersey Care NHS Trust, undated

3.10 Post Incident Internal Trust Review – adverse incident MC, Mersey Care NHS Trust, dated July 2004

3.11 Press material provided by Mersey Care NHS Trust, various dates

3.12 Court Psychiatric Report, MC, dated 22 October 2003

3.13 Psychologist Report - Detailed assessment on the use of alcohol and drugs, by MC, Ashworth Hospital, dated 21st November 2003

3.14 Psychiatric Report, MC, Kemple View Psychiatric Services, dated 8th December 2003

3.15 Clinical Notes, Aintree Hospitals NHS Trust

3.16 General Practice Notes, Walton Medical Centre

3.17 Interviews conducted with:

- Team Co-Coordinator, Walton Team
- GP6, General Practitioner
- Victim relative and legal representative
- CP2, Consultant Psychiatrist
- CPN2, Community Psychiatric Nurse
- MC's current Consultant Forensic Psychiatrist
- MC's current, Clinical Psychologist
- Community Psychiatric Nurse
- Victim relative
- Approved Social Worker

3.18 Department of Health, National Service Framework for Mental Health. Modern Standards and Service Models, dated September 1999

3.19 The Royal College of Psychiatrists, Clinical Assessment and Management of Risk of Harm to Other People. CR 53 dated April 1996.

3.20 Cross referenced detailed tabulated chronology of events.

4.0 Narrative Chronology of Key Events

This section of the report provides a chronological review of the significant events entered within the clinical documentation reviewed in relation to the care and treatment of MC.

4.1 **October 1989.** MC's first contact with Mental Health Services following a referral by his General Practitioner to the Department of Psychological Medicine. He presented as a depressed and unhappy person who had frequent absences from school. A future plan was discussed to support the family in order to overcome these difficulties.

4.2 **December 1989.** MC was admitted to hospital with a physical illness. The duty medical team diagnosed a factitious illness and arranged a further follow up with Mental Health Services. No further medical follow up was deemed necessary.

4.3 **November 1990.** Aged 13 years, MC was referred to Mental Health Services due to a possible depression. He was seen on four occasions and also interviewed by an Education Welfare Officer due to his failure to attend school. The possibilities of establishing home teaching and applying for an education supervision order were discussed.

4.4 **December 1992.** Aged 15 years, MC was provided an emergency admission as a residential pupil to a special school. He was deemed to have emotional and social vulnerability and failed to attend school for prolonged periods of time. On one occasion it was noted that he admitted to taking a knife into school and was also alleged to have just shot a friend in the leg with an air pistol. MC was regularly body building as he felt it was the only thing that calmed him down. Four days after this admission he elected to live at home and become a day boy at school.

4.5 **June 1993.** MC was referred for counselling by a community paediatrician. He had difficulties attending school and was deemed to be suffering from low esteem and an inability to mix in addition to a tendency towards violence. Since his admission to special school staff felt there was a pent up anger and this was causing some concern.

4.6 **October 1994.** Aged 17. MC was seen by his GP and complained of depression, hearing whispers and of thoughts of self harm. He was referred for further assessment in a week's time. During the second assessment it was noted the symptoms remained and he was referred for a mental health assessment.

4.7 **November 1994.** MC was seen by a Consultant Psychiatrist at home following a referral by his General Practitioner. He was assessed as being fairly inactive and had not left the house for the previous two months due to the fact that he felt that people were looking at him. On examination he was assessed as depressed. He expressed thoughts of suicide and there was no evidence of thought disorders or hallucinations. The psychiatrist opinion was that MC was suffering from agoraphobia consequence upon long standing depression and social difficulties. The long term plan considered for him was attendance at the Oakdale Unit for help with his agoraphobia.

4.8 **February 1995.** MC as admitted under the care of the mental health team at Fazakerley Hospital, via the accident and emergency department. He presented as feeling low with a disturbed sleep, aggression and irritability. He reported paranoid thoughts regarding people being in the house at night and claimed to hear voices of people talking in the house. He indicated that he had not been taking his prescribed Prozac medication. A care plan was completed. MC was reported be suffering from regular mood swings and suicidal ideation. The short term goal established was to stabilise his mood in order to reduce the onset of aggression and thoughts of self harm with the long term goal to establish a network of support to improve MCs coping skills.

4.9 **March 1995.** MC was discharged from Fazakerley Hospital with a working diagnosis of a depressive illness. He had made some improvement on the ward but remained very low. He was given an appointment to attend the Oakdale Unit and prescribed Dothiepin 75mg nocte.

MC attended the Oakdale Unit later that month and his medication was changed to Thioridazine 50mg nocte and Dothiepin 75mg nocte. No evidence of harm to himself or others was observed or of neglect and there no risk was identified.

4.10 **April 1995.** MC failed to attend a scheduled appointment at the Oakdale Unit. He was asked to arrange a further appointment. Later that month following three further separate appointment offers he was contacted but indicated he no longer wished to attend the Unit.

4.11 **July 1995.** MC was admitted to the observation ward in accident and emergency following an overdose of Dothiepin. He admitted this was due to strange thoughts and reported homicidal ideas during this time. He appeared withdrawn with no auditory hallucinations and no clear defined symptoms of depression.

A psychiatric review whilst on the ward elicited hatred towards other people and a sense of frustration. MC indicated his hatred was great enough to harm others. The clinical impression was one of possible incipient schizophrenia or schizoid personality disorder.

He was discharged to the care of his General Practitioner and a follow up outpatient appointment with mental health services was arranged later in August.

4.12 **August 1995.** MC did not attend his scheduled out-patient appointment and did not contact the clinical psychology department where he had been referred.

4.13 **September 1995.** Following a GP attendance it was noted MC still felt depressed and indicated a non-compliance with prescribed medication. No thoughts of self harm were noted but motivation appeared poor with limited eye contact during this attendance. MC indicated he was willing to try a different antidepressant and was prescribed Lofepramine 70mg.

4.14 **October 1995.** His GP had referred him for community psychiatric nurse support. However, his engagement was not forthcoming and the case was frozen awaiting his agreement to re-engage with services.

4.15 **March 1996.** MC was re-referred to the community mental health team due to depression and self harm. He indicated that he felt that his previous exposure to mental health services had not been productive. It was noted during a community visit that he enjoyed reading books concerning murder. However, he had no thoughts of self harm but indicated if he tried to take his own life again he would use great violence. He refused any further offer of help including prescribed medication.

4.16 **April 1996.** Aged 19 years, he was re-referred to mental health services by his general practice.

A further visit that month to his GP indicated he was drinking heavily but refused a referral to the Windsor Clinic for assessment for this problem. He was prescribed Chlordiazepoxide 10mg for one month.

4.17 **March 1997.** MC attended his general practice and indicated that he was unable to go out. He denied thoughts of self harm and refused a referral to mental health services.

4.18 **January 1998.** MC was seen by his general practitioner who observed he had lost four stone in weight due to dieting and exercising. He had also stopped drinking.

4.19 **August 1998.** MC attends his general practice and he was perceived to be suffering from anxiety, depression and suicidal thoughts. However, he refused a mental health referral.

Later that month he was referred for a medical review urgently due to excessive weight loss (13 stone in two years). He refused a referral for any mental health symptoms at that time.

4.20 **October 1998.** Following the referral in August, MC was noted to have failed to attend his outpatient appointment and this is rescheduled for later in the month. Later that month he failed to attend a further two outpatient appointments to deal with the weight loss and, due a lack of engagement, no further appointment is made.

4.21 **January 1999.** Aged 21 years: GP review visit. MC is currently prescribed Paroxetine. He indicates that this drug helps his anxiety but not his depression and complains of erratic sleep patterns.

4.22 **February 2002.** MC is seen by his GP and observed to be in employment as a security worker. He reports it's a stressful job due to the need to interact with people. He reports a disturbed sleep and appetite with subsequent weight loss. Increasing levels of aggression are reported since ceasing Paroxetine which he had stopped taking. It was suggested that he recommenced this and was given a further prescription.

4.23 **May 2002.** MC reported to his general practitioner on a follow up visit that he had stopped taking Paroxetine as he felt it was not helping. He reported his symptoms to be worsening with increasing aggression. He was asked to re-attend at a later date.

4.24 **August 2002** It was noted during a GP visit on 6th August that MC had been smoking cannabis and had increasing paranoid thoughts and hearing voices through the walls.

On 18th August 2002 MC was admitted to the Ferndale Unit, Merseycare NHS Trust via the accident and emergency department. MC had indicated he could hear the neighbours talking about him through the walls of his property and he was taken into police custody after an apparent attempt to remove a kitchen knife and move towards the neighbours' house. On admission with a Police escort he was not able to speak and could not be assessed for purgative function. He was prescribed Lorazepam 4mg.

Subsequent clinical consultations revealed a long standing history of cannabis misuse and concurrent cocaine and heavy alcohol consumption. He reported the fact that he was a body builder and was on regular steroids but self admitted to administration of more than the recommended doses. He further reported auditory hallucinations and discussed the ideas that his neighbours were talking about him and thought that cameras were spying on him. He had been suffering from poor sleep, had lost significant weight and further had been terminated from his employment.

He was detained under Section 2 of the Mental Health Act (1983) under the care of a Consultant Psychiatrist.

During this admission a risk assessment was conducted which indicated the following:

- **Suicide = 48 (moderate/severe)**
- **Violent aggression = 53 (moderate/severe)**
- **Neglect = 1 (low)**

4.25 **19th August 2002.** It was noted that during this admission MC had been hostile towards members of staff and reported the fact that neighbours had been speaking about him. He had admitted that he may have used the knife. He reported that his family couldn't hear the voices but he clearly can.
MC was given a diagnosis of schizophrenia and started on an antipsychotic medication: Olanzepine.

4.26 **23rd August 2002.** It is reported that MC was much more settled on the ward although quiet and subdued. No thoughts of harm to himself or others were expressed. During this time it was noted, from a previous set of clinical notes, that MC had had thoughts of harm towards others and a morbid fascination with people who had died after they were mutilated. However, it was recorded that during this assessment MC had not indicated thoughts of this nature. MC was reported not to engage with a new risk assessment although there were no obvious signs of hostility or threats of violence since his admission. He was re-graded to level 2 (intermittent) observations with a long term goal of discharge from the unit with relevant community after care.

4.27 **27th August 2002.** MC's Consultant Psychiatrist presented a report to the Mental Health Review Tribunal. He was of the opinion that MC was suffering from a psychotic illness which required further assessment and treatment. He acknowledged that the incident leading to MC's admission was a very serious one and that there will be a risk to himself and other people if he were to be discharged prematurely.

4.28 **28th August 2002.** The Mental Health Review Tribunal's decision was that MC was not to be discharged. This decision records no discharge *"in the interests of his own mental health and the protection of others"*. It was deemed MC was suffering from schizophrenia with a continuing evidence of psychosis and a lack of insight into his condition. He was thought not stable enough for discharge.

Following the decision MC was subdued but settled with no obvious abnormal perceptions. He agreed that he should stop cannabis as this clearly added to his paranoia but continued to believe that his neighbours were talking about him but admitted that this feature had become to bother him less. He was allowed to have Section 17 leave for the weekend and one hour of unsupervised leave on the grounds.

4.29 **2nd September 2002.** His weekend leave was uneventful with no problems reported. He did not experience any problems with his neighbours and began to question whether or not he had actually heard any voices at all. He was granted more weekend leave and six hours leave per day.

4.30 **3rd September 2002.** A detailed past medical history was taken by a Senior House Officer in Psychiatry. He described a difficult childhood with frequent absences from school with infrequent alcohol consumption, cannabis, with LSD and "downers" taken infrequently. He disclosed that he had been once remanded into custody for a few hours for having a modified powerful airgun.

4.31 **10th September 2002.** MC returned from leave with no reported problems. He appeared compliant with his medication and denied using cannabis. He indicated he was keen to be discharged.

4.32 **11th September 2002.** MC was re-graded from Section 2 Mental Health Act (1983) to informal status. He was discharged from hospital with no psychotic phenomena and a good insight into his illness.

In a discharge letter to his General Practitioner, the Senior House Officer reported that his progress on the ward was rapid and that it was thought that his psychotic phenomena could have been induced by cannabis. He had been discharged and prescribed Olanzepine 10mg with a working diagnosis of paranoid schizophrenia. The Senior House Officer assessed his risk as low to himself and others and of neglect low. He indicated that MCs prognosis was good if he remained cannabis free and remained complaint with his medication. He was to be reviewed again in outpatients in three weeks time.

4.33 **11th September 2002.** A note is made in the Care Programme Approach documentation that indicates a diagnosis of '?depression' (of note to the investigative team: CPA documentation including risk assessment and required level of CPA not completed). Relapse markers noted included increased use of cannabis and cocaine abuse and increased levels of paranoia.

Nobody is listed under the persons present at the care meeting review.

Medication prescribed Olanzepine 10 mg nocte.

No date for CPA review was set and an outpatient appointment was fixed for 7th October 2002.

4.34 **12th September 2002.** MC was referred for a Community Psychiatric Nurse visit by his Consultant Psychiatrist.

Later that month, although the date is not clearly identified, MC was visited by the Community Psychiatric Nurses (CPN's) following this request. No risk assessment was conducted. The CPN's reported to be not aware that MC had previously been the subject of detention under Section 2 of the Mental Health Act (1983).

4.35 **21st September 2002.** MC was seen in the accident and emergency department by a duty psychiatric Senior House Officer. He had taken an overdose of Paracetamol, the aim of which he indicated was to aid his sleep. It is noted that he had been diagnosed the week before with paranoid schizophrenia. He self reported a non-compliance with his prescribed Olanzepine medication and reported heavy alcohol consumption in the previous few days.

He also reported to be feeling isolated and lonely. He was given a four day course of Zopiclone and discharged. A member of his own family phoned shortly afterwards to express concerns that he was not fit to be discharged. He was referred to the Crisis Management Team of Mental Health Services and for review in outpatients.

4.36 **23rd September 2002.** MC was contacted by the Crisis Management team. He reported feeling much the same and denied any suicidal thoughts and indicated that a prescription was waiting for his anti-psychotic medication at his GP's surgery.

4.37 **24th September 2002.** The Crisis Management Team contacted MCs Consultant Psychiatrist. They discussed recent events and MCs family's concerns regarding the need for Community Psychiatric Nurse visits and an urgent outpatient appointment. It was noted that his consultant would liaise with the CPNs and arrange for an outpatient appointment.

4.38 **7th October 2002.** MC was assessed by a Senior House Officer in Psychiatry in outpatients. Since his discharge from the Ferndale Unit it was noted he had stopped taking his prescribed Olanzepine and resumed significant consumption of alcohol and cannabis. The paranoid thoughts and auditory hallucinations had returned. It was noted that he had started hearing voices again indicating that the neighbours were talking about him, despite the fact he had moved into a new flat. He mentioned he had threatened a neighbour with a knife who had called the police who gave him a verbal warning. He had moved back home because he was feeling lonely and had restarted his Olanzepine. However, he thought his paranoid thoughts had remained.

He was prescribed Venlafaxine 75mg od. His General Practitioner was requested to prescribe these as required. It was planned to review him in four weeks time. A risk assessment conducted indicated a categorised risk to himself and others as 'low' with a 'moderate' risk of neglect.

4.39 **25th October 2002.** MC failed to attend his outpatient appointment.

4.40 **7th December 2002.** MC was admitted to the accident and emergency department, Aintree Hospital with injuries sustained during an assault. It was noted that he was intoxicated and admitted he was drinking considerably. He was observed for a while on the short stay ward and discharged to the care of his parents.

4.41 **13th January 2003.** MC failed to attend his scheduled outpatients appointment. The Senior House Officer had noted that the matter should be discussed with the Community Psychiatric Nurses before making a further appointment.

4.42 **21st January 2003.** MC was seen by his General Practitioner and he was noted to be drinking significantly. He reported he had stopped his prescribed medication three months ago.

4.43 **31st March 2003.** MC failed to attend a scheduled outpatient appointment. His case was to be discussed.

4.44 **18th April 2003.** Aged 26 years, MC was admitted to the observation ward via accident and emergency department at Aintree Hospital following an overdose of a mixture of drugs: Largactil, Ecstasy, Paroxetine and Dihydrocodeine. He indicated he had been using 60 to 70 Ecstasy tablets per week for the previous six months. Following some time on the observation ward, he was discharged on the 19th April 2003 to the care of his General Practitioner.

4.45 **21st July 2003.** MC was arrested by police on suspicion of murder.

4.46 **23rd July 2003.** MC was arrested again on suspicion of a second murder.

4.47 **13th October 2003. MC** was assessed by a Consultant Forensic Psychiatrist. He expressed the following opinions:

- ∞ MC was not under disability with respect to court proceedings.

- ∞ MC did not satisfy the criteria for "insanity" as he clearly recognised that his actions were wrong.

- ∞ MC described symptoms suggesting an underlying psychotic illness. Such symptoms were consistent with the diagnosis of schizophrenia.

- ∞ There was also evidence of early conduct disorder. He had met the criteria for both paranoid and schizoid personality disorders.

- ∞ MC gave a history of alcohol and illicit substance abuse. The symptoms of his mental illness persisted in the absence of drugs and alcohol thus indicating that his psychotic symptoms were a product of an underlying mental illness rather than as a result of intoxication.

- ∞ MC suffered from an abnormality of mind caused by the presence of both mental illness and psychopathic disorder.

5.0 Examination of Chronology

MC was admitted to a ward in Aintree Hospitals NHS Trust, prior to the incidents, between 18 August 2002 and 11 September 2002.

A Worthing Risk Indicator Assessment was conducted on the day of this admission on the 18th August 2002. This is a well validated and recognised approach to risk assessment. This risk assessment showed MC was a moderate to severe risk to both himself and to others. The assessment of the risk of harm to others was partly based on the following historical information:

- Age 15 yrs he had admitted to taking a knife into school with the intention of stabbing someone if they got in his way.

- Age 15 yrs he had shot a friend and his brother in the leg with an air pistol to prove that he could do it.

- Age 17 years he had first complained of paranoid ideas and auditory hallucinations

- Age 17 yrs he admitted to homicidal thoughts and said that thought he might act upon them one day. He hated everyone and thought that his hatred might be enough to kill someone. He had ideas of not wanting to be alive and wanting everyone else dead.

- Age 17 yrs he was arrested and cautioned for going out with a modified airgun. He was threatening to commit a crime and not co-operating with help. He was expressing a great deal of emotional drive and anger.

- ∞ Age 18 yrs he stated that he enjoyed reading books about murder and would do anything to go to prison even if it meant killing someone. He admitted to alcohol abuse and to mugging and stealing to obtain money.

- ∞ In August 2002 (aged 24 years) he was increasingly paranoid, he was hearing voices and was regularly using cannabis.

- ∞ On 18 August 2002 he was held in police custody after an attempt to harm his neighbour with a kitchen knife.

MC was admitted under Section 2 of the Mental Health Act (1983) on 18th August 2002. Section 2 admission is primarily used for assessment purposes and allows a detention period for up to 28 days. The diagnosis of a schizophreniform psychosis[1] was made by the admitting team and he was treated with oral anti-psychotic medication.

From the initial assessment on 18th August 2002, it was clear that without treatment or while using illicit drugs MC was likely to present an ongoing risk to the public. In answer to questions presented by ECRI the admitting Consultant agreed that MC was a moderate risk to others if not treated with anti-psychotic medication (letter dated 27 June 2005).

[1] On 13 October 2003, after MC was detained in custody, a forensic psychiatric assessment confirmed the diagnosis of Schizophrenia and Psychopathic Disorder.

A subsequent appeal by MC on 28th August 2002, to the Mental Health Tribunal, failed. In a report to the Tribunal his Consultant noted that MC was suffering from a psychotic illness, which required further assessment and treatment. He stated that the incident leading to MC's admission was serious and that there would be a risk of harm to himself and other people if he were discharged prematurely.

MC was removed from the Section 2 of the Mental Health Act (1983) and became an 'informal' patient. He was considered fit for discharge by his Consultant, on oral anti-psychotic medication, on the 11th September 2002, 14 days after the tribunal decision.

MC's general practice representative reported, at interview, that the practice was not notified of the outcome of the Mental Health Tribunal during his in-patient stay and therefore were unaware of the comments made concerning risk. In addition, they were not informed of his subsequent failure to attend outpatient appointments following discharge.

The discharge letter to the GP was dated 18 September 2002 and was signed by the SHO in psychiatry. It stated that his risk to others was low. This was an inaccurate and misleading comment. His risk to others was probably low while he was complying with medication but, if he was non-compliant or using illicit drugs, his risk to others was at least moderate or high (See Worthing risk indicator form completed on 18 August 2002). His GP indicated at interview that the risk assessment in the discharge letter was misleading and the GPs would have dealt with MC differently if they had known the true risk (ECRI interview dated 11 February 2005).

A Care Programme Form was partially completed prior to discharge and did not record the level of risk or designate a key worker. The admitting Consultant had no knowledge of the CPA form or of a pre-discharge CPA meeting (letter to ECRI dated 27 June 2005). The multidisciplinary and community/GP teams were not invited to a CPA meeting. Whilst it is recognised MC was admitted under Section 2 of the Mental Health Act (1983), it is acknowledged 'good practice' to assess service users for community based service provision following an admission of this nature.

The Trust had a detailed Care Programme Approach Policy implemented at the time (Ref: Aintree Hospitals. The Care Programme Approach/Care Management. January 1998). This policy conformed to nationally recognised guidance.

CPA policies are an integral part of the National Service Framework for Mental Health. In particular Standard Four of this document states:

"All mental health service users on the Care Programme Approach (CPA) should:

- ∞ *receive care which optimises engagement, prevents or anticipates crisis, and reduces risk*
- ∞ *have a copy of a written care plan which:*
- *includes the action to be taken in a crisis by service users, their carers, and their care co-ordinators*
- *advises the GP how they should respond if the service user needs additional help*
- *be able to access services 24 hours a day, 365 days a year."*

There is no evidence to suggest that CPA processes were applied yet MC would have met the criteria for continued management under CPA. If the policy had been utilised MC would have been allocated to an enhanced level of the CPA/ECC process because he was diagnosed with a severe and enduring mental illness and had at least one risk factor identified with the Worthing Risk Indicator (See January 1998, CPA policy. page 8). This would have resulted in a full multidisciplinary assessment and meeting.

This would also have enabled a decision to be made as to whether MC should have been allocated to the Supervision Register during the course of his outpatient management when non-compliance with anti-psychotic treatment and illicit drug use rapidly occurred.

The subsequent problems in his care were due to a failure to implement the recognised CPA and adjunctive Trust guidance (and also national guidance) as follows:-

- A lack of information passed to clinical staff concerning his level of risk to himself and others that was provided to the multidisciplinary team and community/GP carers.
- A failure to assign and communicate the correct CPA level to ensure the proper level of monitoring and review.
- The lack of designation of relapse indicators and identification of an appropriate plan of action for each indicator (eg non-compliance with his medication or illicit drug abuse).
- A failure to involve his family in his after-care and monitoring.
- A failure to involve a social worker in his care and provide an ongoing social needs assessment following discharge[2]

[2] The Royal College of Psychiatrists Clinical Assessment and Management of Risk of Harm to Other People. CR 53. April 1996.

The day after discharge on the 12 September 2002, at a referral meeting, MC was assigned a CPN. The manner in which the details of the case were communicated to the CPN's is not clear and could not be established by the interview team. There is no record of any formal CPN assessments post discharge. The CPN team leader at interview (dated 11 February 2005) indicated that they had minimal information about MC. They were asked to visit by MC's Consultant as MC had failed to attend a follow up outpatient appointment and the objective was to re-engage with MC in order to support him. When visited, MC did not want further involvement by the CPN service and no further proactive follow up action was taken and no further follow up request was received from MC's Consultant. This issue reflects the failure to follow formal, established, Trust ECC/CPA processes.

MC was due to be assessed in outpatients by a Senior House Officer in Psychiatry on 7 October 2002 in outpatients. However, before then, on the 21 September 2002, he was admitted to Accident & Emergency having taken an overdose of Paracetamol. He was assessed by a Senior House Officer in Accident & Emergency and an SHO in Psychiatry. MC admitted to having a diagnosis of paranoid schizophrenia and to non-compliance with his anti-psychotic medication and to be abusing alcohol.

Despite this self report there is no evidence of a formal risk assessment being conducted. Due to MC's remorse at the overdose and his findings during the examination the SHO commented that he was a low risk to himself and others. MC was discharged with a short term night-time hypnotic and Crisis Management Team follow up. A relative of MC later contacted the SHO and expressed concern regarding this discharge as it was felt that MC was not at all well. At this point and being only ten days post discharge, consideration of re-admission of MC should have taken place but no such discussion appears to have been recorded.

The Crisis Management Team followed up MC via telephone on five separate occasions following discharge from A&E and CPN involvement and the families concerns were discussed. No follow up assertive action by the CPN's could be identified. It is known that staff resources were reduced at that point but it is also possible they were never informed of the need for their further involvement.

On 7 October 2002 MC attended his booked appointment and was assessed by a Senior House Officer in Psychiatry. The SHO noted that he had stopped taking his Olanzepine medication and was abusing alcohol and cannabis following his discharge from hospital. He was suffering paranoid ideation and auditory hallucinations. He had again threatened a neighbour with a knife. The SHO asked his GP to prescribe Venlafaxine and recorded the risk assessment to others as low. He arranged for a further review in 4 weeks.

This risk assessment and management plan were incorrect. Based on his recent self harm episode, substance misuse and a possible lack of compliance with prescribed medication (and his observed risk levels when not compliant with such) all tend to indicate the fact that the risk to others was moderate or high as discussed previously. The observations recorded during this assessment should have resulted in a readmission to the ward, as a place of safety, for assessment, detoxification and treatment with anti-psychotic medication.

On 25 October 2002 he failed to attend a second outpatient assessment. He was offered a new appointment by the SHO in writing and an entry is made in the notes to make contact with the CPN's. No contact could be established by the investigative team to have taken place. Against the previous background of non-engagement and enhanced risk during non-compliance this appears to be an inadequate response.

On 7 December 2002 he was admitted to the Accident and Emergency department minor injury unit intoxicated with alcohol. He admitted to drinking over 100 units alcohol per week. He was discharged the following day. There is no evidence that his psychiatric history was known to the Accident & Emergency Department.

On 13 January 2003 he failed to attend a further outpatient appointment. The SHO decided to discuss the case with the CPNs before making a further appointment. But as shown above, the CPNs knew almost nothing about MC's case and no communication of this nature can be traced. Any further action is not recorded.

On 21 January 2003 MC reported to his GP that he had stopped the Olanzepine 3 months ago and was abusing alcohol and cannabis.

MC's GP was unaware of the risk this caused (see interview dated 11 February 2005) and so no action was taken to refer him back to the psychiatric team. It is reported that at this time MC requested a further prescription for medication. No written communication between the GP practice and the Trust can be found that reflect the contents of this consultation.

On 31 March 2003 he failed to attend the third consecutive outpatients appointment and the SHO recorded that the case was to be discussed. No further action is noted.

On 18 April 2003 he was admitted to A&E having taken an overdose of ecstasy and prescription drugs. He admitted to using 60-70 ecstasy tablets a week for the previous 6 months. He was discharged the following day. There is no evidence that the admitting Casualty Officer was aware of his psychiatric history. No referral to Mental Health Services is recorded.

During July 2003, MC was arrested for murder.

6.0 Clinical Care Provision

1. MC was admitted under Section 2 of the Mental Health Act (1983) on the 18th August and discharged on the 11th September 2002. MC's Consultant Psychiatrist, who was responsible for his care whilst an inpatient, did not implement or activate the CPA/ECC process, according to existing Trust policy, or as required by nationally recognised guidance at the time of his discharge from hospital into the community on 11 September 2002. This was considered by the RCA team to be the root cause of this incident.

2. The psychiatric SHO was on a 6 months GP rotation (a training position) and had been in post for less than 2 months in September 2002. The SHO was relatively inexperienced in psychiatry. Following discharge from his in-patient stay there is no evidence that MC's supervising Consultant checked the discharge letter for accuracy or reviewed the risk assessment provided by the SHO. This was a contributory factor.

3. The psychiatric outpatient SHO did not correctly assess the risk presented by MCs paranoid ideation, non-compliance with prescribed oral medication treatment and illicit drug abuse in outpatients on the 7 October 2002. The SHO allowed MC to remain in the community without active community support being available. This was a contributory factor.

4. MC's Consultant did not directly supervise the SHO in the outpatient management of MC and the SHO did not appear to discuss the case with the Consultant. This was a contributory factor.

5. The psychiatric SHO allowed consecutive non-attendances at outpatients by MC to occur and no assertive outreach process appears to have been considered. The SHO did not seek advice about this non-compliance from the team Consultant. This was a contributory factor.

6. The CPN's tasked with monitoring MCs care (on the one identifiable occasion) in the community were not provided with the inpatient risk assessment and a discharge care plan by the inpatient team. This was a contributory factor.

7. The CPN's tasked with monitoring MCs care in the community did not proactively request information from the inpatient team prior to visiting MC, including the inpatient risk assessment and the care plan. This was a contributory factor.

8. The supervising consultant's patients were distributed across four separate wards during MC's in-patient stay. This may have hampered communications and, additionally, there was a reported lack of community nursing staff. Community staff, as a result of these resourcing difficulties, reported not have the time to attend ward rounds. This was a contributory factor. It is noted that the community services have now restructured within a new Community Mental Health Team and staffing levels have improved.

7.0 Service Delivery Provision

1. The Accident and Emergency Department did not appear to have information systems available, which could quickly flag up the recent psychiatric history and risk assessment of patients receiving psychiatric care as in-patients who had been subsequently discharged into the community[3]. They were reliant on the past medical history self reported by MC. This may be related to the lack of an implemented CPA process for MC. This was a contributory factor.

2. The Accident and Emergency Department did not appear to have a policy, or care pathway, to assist the casualty officer with regard to requests for referral for psychiatric liaison assessment[3]. This was a contributory factor.

3. A social worker was not involved in his ongoing needs assessment/management following discharge into the community because there was no implementation of the CPA/ECC policy, no multidisciplinary CPA meeting and no nominated key worker in the CPA documentation. This was a contributory factor.

4. No contact between the GP and the mental health team could be established in relation to his visit during January 2003. At this time he was seeking further medication due to deterioration in his mental health. This was a contributory factor.

[3] Royal College of Psychiatrists. Psychiatric Services to Accident and Emergency Departments. CR118. February 2004.

5. Due to the lack of an implemented CPA process for MC there was no on-going formal follow up in a community setting after he was discharged from hospital. This is where MC's clinical problems manifested themselves and the chronology illustrates that substance misuse, alcohol consumption and a lack of compliance with prescribed medication played a significant part in his illness.

   Other than one informal CPN visit following discharge no formal community CPN support was in place. This was a significant contributory factor as no monitoring of medication compliance or specialised mental health state examination was available following MC's discharge from a controlled, monitored in-patient setting.

8.0 Recommendations for Improving Safety

- Random audits of the Trust CPA/ECC policy should be conducted at intervals to ensure that it is being implemented correctly. It is noted that the Trust CPA/ECC policy is robust and compliant with all Department of Health guidance.

- The effectiveness of training in risk assessment for all clinical staff should be reviewed. This should include the need to adequately document risk in the clinical notes and communicate such to all those staff involved with the ongoing care of the service user (E.g General Practice clinical staff).

- The effectiveness of induction training for newly appointed SHO's in psychiatry should be reviewed. Induction training should include an emphasis on risk assessment processes and when to access and seek advice from senior clinical staff in particular during circumstances where service users are known to be at risk of harm to themselves and others during non-compliance with medication.

- A supervision policy for newly appointed SHO's in psychiatry by senior staff should be developed/reviewed. This should include supervision in outpatients and supervision of written communication, in particular during the management of patients with a severe and enduring mental illness.

- A liaison psychiatric referral policy or care pathway for use by A&E medical staff should be developed[4].

- A system for quickly flagging and updating risk information on psychiatric patients under community care, and assessed as emergency cases in A&E, should be developed and deployed[4].

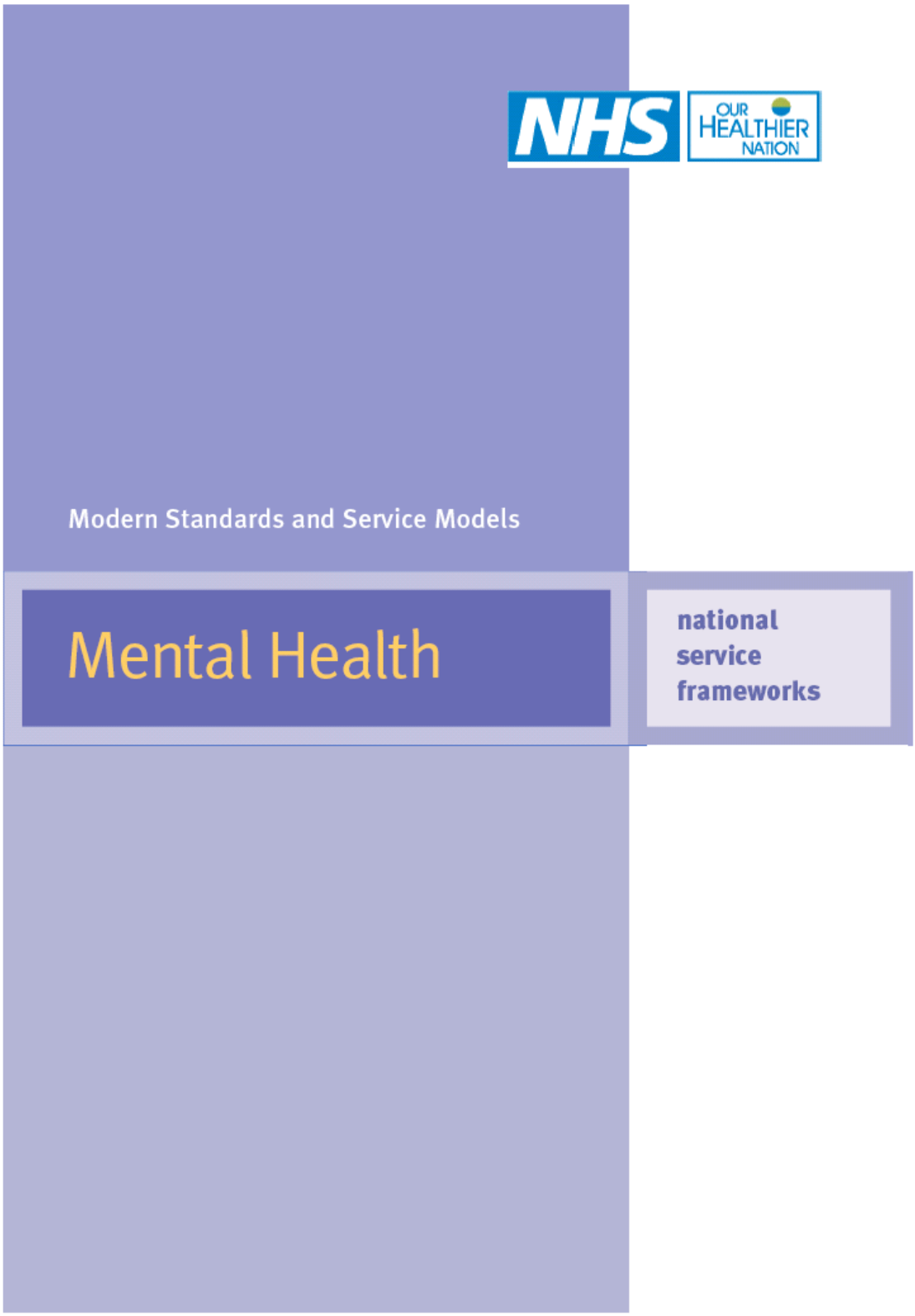
- In relation to any service user subject to in-patient care under the Mental Health Act (1983), it is essential to ensure that all correspondence, including that relating to the decision of Mental Health Tribunals and failure to attend routine out-patient appointments, be copied to the General Practitioner in order to advise them on the status and care requirements of the service user.

- The Primary Care Trust should emphasise to General Practitioners the importance of providing feedback should any concerns be perceived on the clinical status of service users who are known to be in contact with mental health care services.

- Where CPN's attend a service user in the community following discharge from hospital they should be empowered with the full clinical history in order to further establish an accurate assessment of their mental health.

[4] Royal College of Psychiatrists. Psychiatric Services to Accident and Emergency Departments. CR118. February 2004.

Appendix A – National Service Framework for Mental Health - Standards four and five.



Standards four and five

Effective services for people with severe mental illness

Aim

To ensure that each person with severe mental illness receives the range of mental health services they need; that crises are anticipated or prevented where possible; to ensure prompt and effective help if a crisis does occur; and timely access to an appropriate and safe mental health place or hospital bed, including a secure bed, as close to home as possible.

Standard four

All mental health service users on CPA should:

- **receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk**
- **have a copy of a written care plan which:**
  - **includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator**
  - **advises their GP how they should respond if the service user needs additional help**
  - **is regularly reviewed by their care co-ordinator**
  - **be able to access services 24 hours a day, 365 days a year.**

Standard five

Each service user who is assessed as requiring a period of care away from their home should have:

- **timely access to an appropriate hospital bed or alternative bed or place, which is:**
  - **in the least restrictive environment consistent with the need to protect them and the public**
  - **as close to home as possible**
- **a copy of a written after care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.**

Rationale

People with severe mental illness form a small proportion of those with mental health problems but have very high rates of psychological and physical morbidity. The WHO[124] (IV) has found that mental illness, including drug and alcohol misuse, accounted for almost 11% of the global burden of disease in 1990. This is expected to rise to 15% by 2020.

Worldwide, mental illness accounts for about 1.4% of all deaths and 28% of years lived with disability. In 1990, [124] (IV) five of the ten leading causes of disability were psychiatric conditions: unipolar depression, alcohol misuse, bipolar affective disorder, schizophrenia and obsessive-compulsive disorder. People with severe mental illness are also socially excluded, finding it difficult to sustain social and family networks, access education systems and obtain and sustain employment.

In a pooled analysis of 20 studies of 36,000 people, mortality among people with schizophrenia was found to be 1.6 times that of the general population; the risk of suicide nine times higher; and the risk of death from other violent incidents over twice as high [125] (IV).

Crises should be anticipated or prevented, with rapid intervention if necessary. Hospital admission, including secure mental health care, or the provision of a supported place may be required during the course of the illness.