NHS
East Midlands

An Independent Investigation into the Care And Treatment of a person using the services of LincoInshire Partnership Foundation NHS Trust

Undertaken by Dr. Geoff Roberts

Ref 2007/13278

November 2010

REPORT OF THE INDEPENDENT HOMICIDE INVESTIGATION

REFERENCE SUI 2007/13278

COMMISSIONED BY NHS EAST MIDLANDS

UNDERTAKEN BY DR GEOFF ROBERTS

Acknowledgements
The author thanks the staff at the Lincolnshire Partnership Foundation NHS Trust and the General Practitioner involved in this review for their assistance and very open approach. A consistently recurring theme in the review was the openness of staff to improvements in service quality.

The author gives his condolences to the mother of the victim and thanks for her assistance.

The author is also grateful to patient X and his parents for their assistance.

The author also thanks Professor Carolyn Steele, Professor of Mental Health, and Dr Alastair Thompson for their independent reviews of this report and their comments which have contributed to it.

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1.0 Executive Summary

The Department of Health issued guidance on 10 May 1994 on the care of mentally disordered patients discharged into the community in the circular HSG (94) 27, LASSL (94) 4. This included guidance on the conduct of external reviews where a patient has been convicted of homicide. This advice was modified in June 2005 and now allows for consideration to be given for a proportionate Independent Investigation and increasing the discretion of the statutory agencies in the format and nature of the Independent Investigation. This review was carried out in the context of these changes.

The review has been carried out in line with the Terms of Reference established by NHS East Midlands. This report is the result of the review.

Patient X was convicted in October 2008 of the murder of his girlfriend by stabbing. He was a patient of the Lincolnshire Partnership NHS Foundation rust (LPFT) at the time. The offence was committed on 4 December 2007 at which time patient X was an outpatient.

Patient X was referred to the sector consultant at Boston by the Peterborough crisis resolution home treatment (CRHT) team in August 2006. Peterborough CMHT is part of Cambridgeshire and Peterborough Mental Health Partnerships NHS Trust. This referral followed his admission to hospital in Peterborough on 10 August and assessment by the Peterborough CRHT Team following an overdose of aspirin and paracetamol. The referral was made directly to a locum consultant who saw the patient personally. All follow up care was provided by this consultant.

According to LPFT policies in place at the time, the initial assessment should have been carried out by the LPFT CRHT. Subsequent referral and follow up by the consultant may still have occurred, but patient X and his carer would have been known to LPFT CRHT service in case of crisis and would understand the access arrangements.

From the time of the initial referral to the time of the offence, X's patient journey fell outside the intentions of offering a CRHT assessment following all new referrals of deliberate self harm stated in the CRHT Operational Policy and the Care Programme Approach of LPFT. This meant that when he re-presented in early December 2007, again in crisis, LPFT did not respond in a timely or effective way to provide a therapeutic assessment or intervention. Had the Care Programme Approach been followed, the patient would have received a copy of his care plan; he did not.

This investigation makes no speculation as to whether the killing was avoidable. However, the opportunity to influence events was lost by failing to follow LPFT policies in respect of the CPA.

LPFT has conducted an internal investigation which has made

recommendations which are endorsed by this report.

NHS Lincolnshire also conducted a separate investigation into the actions of the General Practitioner (GP) who saw patient X on 3 December 2007. The report concluded that his actions were reasonable and that no further action be taken. This investigation endorses that view.

2.0 Terms of Reference

Independent Investigation into the Care and Treatment of Patient X under HSG (94) 27

Undertake a systematic review of the care and treatment provided to Patient X by Lincolnshire Partnership NHS Foundation Trust to identify whether there was any aspect of care and management that could have altered or prevented the events of 4 December 2007.

The investigation team is asked to pay particular attention to the following:

- To review the quality of the health and social care provided by the Trust and whether this adhered to Trust policy and procedure, including:
  - To identify whether the Care Programme Approach (CPA) level was appropriate and followed by the Trust with respect to Patient X.
  - To identify whether the risk assessments of Patient X were timely, appropriate and followed by appropriate action; specifically to include whether referral to appropriate services and the involvement of appropriate staff occurred.
  - To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;
  - The Mental Health Act assessment process (if appropriate)
- To examine any apparent confusion around the diagnosis of Patient X.
- To examine the appropriateness of medication prescribed to Patient X, his compliance with medication and the decisions taken relating to commencement or discontinuation of medication.
- To examine the events between 1st and 3rd December 2007; where concerns were raised by friends and relatives regarding the mental state of Patient X. Contact being made with mental health services, particularly the Crisis Team, requesting his earlier review; and Primary care review on 3rd Dec 2007.
- To establish whether the recommendations identified in the Trust's internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the Trust in response to these recommendations.
- To identify any learning from this investigation through applying Root Cause Analysis (RCA) tools and techniques as applicable.

- To report the findings of this investigation to East Midlands Strategic Health Authority.

3.0 Chronology of Main Significant Events

April 2001

Patient X was referred by his GP to psychiatric services at the Pilgrim Hospital. He had a long history of feeling inadequate and lacking in self confidence and was referred for counselling. He did not attend the initial assessment and was discharged. He was subsequently seen July 2001 for six sessions with the Counselling Psychologist.

The Consultant 1 (locum consultant) stated in his letter to the GP following his assessment in August 2006 that he had been seen by an SHO in psychiatry in 2001 and prescribed Escitalopram. This is not confirmed by any letter to the GP.

2003

In August 2003 he saw a registrar at his GPs who did prescribe Escitalopram for depression. The registrar noted a history of cannabis usage since the age of 17 and occasional ecstasy usage.

2005

Repeated presentation to the GP with depression. Again prescribed Escitalopram.

2006

At interview (conducted as part of this Investigation) Patient X stated that in May 2006 the local availability of cannabis resin had stopped. As a result he changed his usage to leaf cannabis which exposed him to higher doses of the drug. He then started to feel increasingly paranoid, particularly developing delusional beliefs about a former girlfriend and he also had a belief that a Lithuanian gang were going to cause him harm.

This caused sufficient concern to his mother that arrangements were made by his family for Patient X to stay at his aunt's house, close to Peterborough. This arrangement was made to try and ameliorate his persecutional delusional beliefs. It was whilst he was here on 9th August 2006 that Patient X took an overdose of Paracetamol and Aspirin and he was taken to Peterborough Hospital where he was seen by the Cambridge and Peterborough CRHT (Part of Cambridgeshire and Peterborough Mental Health Partnerships NHS Trust). The CRHT carried out an assessment and arranged follow up locally in Boston by Consultant 1. The referral was faxed through directly to the consultant's secretary on 10 August and an appointment was arranged for the 14 August 2006.

At that time he gave a history of multiple drug misuse including cannabis, speed, cocaine, ecstasy and magic mushrooms. The consultant's opinion was that Patient X had a drug induced psychosis.

The following chronology is quoted from the Trust's internal Investigation report. The accuracy has been confirmed during the independent investigation.

"This overview is constructed from health records, the review of the medical notes, interviews with key staff and the meeting with the patient's mother

There was no further known contact with mental health services until 2006. On the 10th August 2006 the Peterborough Mental Health Services Crisis Team saw the patient in A & E in Peterborough & Stamford NHS Foundation Trust Hospital. This was following an overdose of Paracetamol and Aspirin taken at 2300 hours on the 9th August 2006. The Peterborough Crisis Team fully assessed the patient in A & E and referred him on to Consultant 1[1] within Boston Community Mental Health Team (CMHT). This referral took the form of a fax, addressed to Consultant 1 directly.

Whilst in Peterborough on the 10th August, the patient was admitted following the overdose and was further assessed on that ward. The patient was assessed in the presence of his mother. He was described as "guarded and suspicious, convinced that people are after him and he attempted self-harm yesterday to prevent these people getting to him". There was a history of illicit drugs, including cannabis and cocaine (in the past), amphetamines, ecstasy and magic mushrooms. The mental health practitioner considered whether the diagnosis was drug induced paranoia. *(Independent Investigation author comment: He was only admitted overnight).*

On the 14th August 2006, Consultant 1 saw the patient in the outpatient clinic in Boston. The patient was interviewed at length and a detailed history taken. The health record noted his 'suspiciousness' and Consultant 1 formed the impression that it was a drug induced psychosis. The patient reported "feeling frightened from people out there who are not known to him but could have been known to his ex-girlfriend". He had complained to the police but found that they were not interested in his claim that people were trying to get him. He had been using illicit drugs including cocaine, ecstasy and amphetamines, and had tried magic mushrooms on two occasions. Consultant 1 obtained a detailed history and noted that there was no forensic background (specifically no problems with the police or the law). On Mental State Examination, Consultant 1 noted that the patient was guarded and fearful and had to be persuaded to come into the interview, feeling frightened that things might happen to him. His mother had confirmed his fearful behaviour, including hiding on the floor of the car on the way to the hospital. Consultant 1 offered a short admission, but this was declined. The patient was given the telephone number for the Crisis Resolution and Home Treatment Team. The patient was prescribed Lorazepam (an anti-anxiety drug) 1mg pm (as required) up to three times a day for two weeks. It was decided that he would be seen again in two weeks.

[1] The terminology for the locum consultant psychiatrist has been amended from the internal investigation report to be consistent throughout this report

Consultant 1 was aware that the patient slept with a knife under his pillow, but also states in the GP letter that "he denies carrying any weapon at any time". Consultant 1 considered that the primary risk was that of self-harm but on the basis of this interview and similar information faxed to him, concluded that this was not a current risk. This was expanded on in the interview with Consultant 1 on the 15th January 2008. Also Consultant 1 noted that the patient had experienced auditory hallucinations on two occasions in the past while taking ecstasy. Consultant 1 sent a detailed assessment letter to the GP. The GP letter was dictated on 14th August and typed on the 23rd August 2006.

On the 25th August 2006 Consultant 1 saw the patient with the patient's mother in outpatients. The patient appeared calmer, and had used only three of his Lorazepam tablets. The patient's mother felt there had been a slight improvement, although some suspicion was still noted. The outcome of this meeting was to continue Lorazepam and to review in two weeks. A letter was sent to the GP. The letter to the GP was dictated on the 25th August and typed on the 7th September 2006.

On the 4th October 2006 Consultant 1 reviewed the patient in the outpatient clinic, with the patient's mother present. The patient reported that "nobody believes me that definitely these people are out there trying to get me — nothing I can do". Indicated that he had not smoked Cannabis for two and a half months but was still hiding from other people. He did not have any reason to get up in the morning and reported receiving silly and strange messages from friends (for example, a girl who his mother used to teach inviting him out — despite him not having anything to do with her for the previous nine to ten months). Consultant 1 noted that the patient was low and looked "flat". He was anxious and angry, because he was not being believed and had no insight, "I am not imagining things", "I could be abducted with no evidence by those people .... killed", "I am not crazy, I am depressed". The plan following this meeting was to prescribe 1mg of Risperidone (an antipsychotic) and to add 20mg of Fluoxetine (an antidepressant). The patient was to be reviewed in one month, and a letter was sent to the GP. The GP letter was dictated on the 4th October and typed on the 9th October 2006. In this letter, Consultant 1 stated that the patient was not going out because he was worried for his safety. Consultant 1 concluded that he had a paranoid delusional system which was unshakable and was hiding and socially withdrawn.

On the 10th November 2006 Consultant 1 saw the patient in outpatients, together with his mother. His mood had lifted but he was having difficulties in the relationship with his father. He had had no Cannabis for the previous four months. Consultant 1 noted that the patient looked more relaxed and less paranoid, even though he remained convinced that people were out to get him. Consultant 1 gave him a further supply of medication and requested (in writing) that the General Practitioner continue to do so. The patient would be reviewed again in two months. A letter was sent to the GP. The letter to the GP was dictated on 10th November and typed on the 21st November 2006.

2007

On the 12th January 2007 Consultant 1 saw the patient alone in the outpatient

clinic. The patient's mother was in the waiting area but did not attend the consultation. He described feeling much more at ease in himself, although his sleep was disturbed. Consultant 1 noted that he was more reactive with more sensible thoughts and much less paranoia. The Risperidone was increased to 2mg, and the Fluoxetine was to continue at 20mg. The plan was to review the patient in two months, and a letter was sent to GP. The letter to the GP was dictated and typed on 12th January 2007.

On the 16th March 2007 Consultant 1 saw the patient alone in the outpatient clinic. The patient was making considerably better progress, although he was not happy to be on Risperidone. He reported that he was not feeling paranoid and felt that he may have over-reacted with some truth in his delusional system. Previously out of work, he was now completing the European Computer Driving Licence with Learn Direct and generally was more active. When his mother joined the interview, she confirmed that this was the case. She also felt that he was much better, although he had problems in the relationship with his father. In his letter to the General Practitioner, Consultant 1 noted that the patient had previously seen a counsellor and in these circumstances made a referral to LPFT Primary Care Team at Boston Community Mental Health Team for counselling and problem solving. Consultant 1 arranged to review progress in three months time. On the same day Consultant 1 wrote to the Primary Care Team asking for both a short intervention due to difficulties with interpersonal relationships with his father, and for guidance. Consultant 1 noted the previous overdose and the diagnosis of a drug induced psychosis, from which he was, by then, recovering. A letter was sent to GP. The letter to the GP was dictated on the 16th March and typed on the 20th March 2007.

On the 22nd March 2007 a letter was sent from Boston CMHT inviting the patient to opt into the service by the 5th April 2007.

On the 22nd June 2007 Consultant 1 reviewed the patient alone in the outpatient clinic. The patient reported feeling "all right" and said that he had tried Cannabis on a few occasions. He also described being occasionally "paranoid but tried to ignore it, but not worried". Consultant 1 confirmed the outpatient appointment with the Community Mental Health Team. Consultant 1 suggested decreasing Risperidone and stopping in one months time. He felt the patient should remain on the antidepressant. Consultant 1 wrote to the General Practitioner indicating progress. He noted that the patient denied any ongoing psychotic symptoms. The patient had been taking Risperidone 2mg, even though he had side effects from it and had no insight into the impact that Cannabis might have on his illness. Consultant 1 made an arrangement to review the patient in three months time. A letter was sent to the GP, which was dictated and typed on the 22nd June 2007.

On 27th July 2007 an appointment letter was sent from Primary Care offering an appointment on the 10th August 2007. This letter required a response from the patient by the 3rd August 2007.

On the 10th August 2007 the patient did not attend the appointment with the

Primary Care Community Mental Nurse. There was no notification or reasons given for this non attendance. The patient was discharged by Primary Care on the 13th August 2007. Also on the 13th August 2007 a letter was sent from Primary Care Community Mental Nurse to Consultant 1 notifying him of discharge. This letter was copied to the GP for information.

On the 21st September 2007 the patient did not attend the planned outpatient appointment with Consultant 1. The outcome of this was that Consultant 1 was to review in three months. A letter was sent to the GP. This letter was dictated and typed on the 21st September 2007."

[Comment by the external investigator: this 'discharge' of the patient without further Investigation can only be considered safe where the patient has established insight and capacity for the patient to choose. There is no evidence to suggest that this was pursued at the time by either the Primary Care Team or the consultant. The GP was informed of the failure to attend. An entry in the GP records dated 22 October 2007 stated 'doing ok off Risperidone and feeling more himself'. It therefore appears that this lack of follow up did not adversely influence the outcome of the case.]

Quote from Trust internal investigation continues: "The patient's mother told us her son's girlfriend attempted to contact Pilgrim Hospital on the weekend of the 1st and 2nd December 2007 to get an earlier appointment for him, and that she was told they could not do anything. We have not been able to verify this contact. We have been in touch with the Ward, but they do not keep a record of people contacting the Ward for help or advice.

On the 3rd December 2007 it is reported by the patient's mother that the patient made an appointment to see the GP as there was no surgery on the 1st December, which was a Saturday. The patient did not see his usual GP. He asked for a prescription but the GP did not provide one. It is reported by the patient's mother that the GP had denied the patient a prescription as the GP felt there was a risk of prescription abuse. It was reported by the patient's mother that the patient was upset when he left the GP surgery.

On the 4th December 2007 a deceased female member of the public, believed to be the patient's girlfriend was found at the home of the patient. The patient was arrested at the scene. In the medical notes this is recorded as an alleged homicide.

Also on 4th December 2007 the patient was assessed on a ward at Pilgrim Hospital in Boston following the incident in which he was alleged to have stabbed his girlfriend. Subsequently he harmed himself and suffered a neck and wrist injury. He was assessed by a Staff Grade Psychiatrist and a Community Mental Health Nurse. It was noted that the patient was sedated at the time of the assessment. The patient informed the Staff Grade Psychiatrist that he had initially "threatened his girlfriend with a knife to find out the truth about people" out to get him. The patient reported that he and his girlfriend ended up in a heated argument. The patient stated that "she had gone forever" and "she is behind everything". He denied other symptoms but

remained guarded during the interview and mute when questioned. Through an assessment of his mental health, the Staff Grade Psychiatrist noted that he showed continued paranoid preoccupations regarding his partner having contact with a gang of men who probably wanted to harm him."

The GP case note entry relating to the attendance on 3 December 2007 states:

> *'Declined to give him Lorazepam. Not suggested by psychiatrist. He is using less Cannabis but still feels his life is genuinely at risk but that he is not paranoid. Asking to XPD OPDA Consultant and reinstate CPN appt he DNA'd – OK E D Expedite appointment (9NK) P'*

Letters confirming the request to expedite the Consultant outpatient department appointment (XPD OPDA) and to reinstate the community psychiatric nurse (CPN) appointment which he had previously not attended (DNA'd) were sent by the GP next day.

4.0 Response to the Terms of Reference

Undertake a systematic review of the care and treatment provided Patient X by Lincolnshire Partnership NHS Foundation Trust to identify whether there was any aspect of care and management that could have altered or prevented the events of 4 December 2007.

This investigation makes no speculation as to whether the killing was avoidable. To do so would exceed the reliability of evidence in the days prior to the 4 December. However, the opportunity to influence events was lost. Individual matters of care and treatment have been considered.

To review the quality of the health and social care provided by the Trust and whether this adhered to Trust policy and procedure, including:

- To identify whether the Care Programme Approach (CPA) level was appropriate and followed by the Trust with respect to Patient X.

At the time of Patient X's treatment the CPA, version 3, used by the Trust had been in place since February 2007. Patient X was on a standard level of CPA which was appropriate to the clinical and future care management issues.

At 6.1.1, the policy states that a health and social care tool should be used appropriate to the area of use. Key standard 4 of the Trust's own CPA policy states that the service user must be given a copy of the care plan, but also states that this can be recorded on standard CPA paperwork or in a letter format. A 24 hour telephone number should be given for use in a crisis. No copies of the letters were given to Patient X. Although the letter prepared following the initial contact in August 2006 states that the telephone number of the crisis team was given to the patient's mother, there is no record that the patient was provided with this. At the time of the offence he was not living with his mother.

At the time although there was a requirement for patients on an enhanced level of CPA to be given a contingency plan for when matters deteriorated, there was no such requirement for patients on a standard CPA. This has changed following the new CPA procedure in 2009. The current policy mirrors national guidance and adherence to this policy is audited by the Trust.

- To identify whether the risk assessments of Patient X were timely, appropriate and followed by appropriate action; specifically to include whether referral to appropriate services and the involvement of appropriate staff occurred.

- To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;

The initial letter to the GP dated 14 December 2006 clearly indicates the matters of concern for clinical risk were considered. The CPA policy clearly states at 6.5.4 states that a HoNOS assessment should be carried out every six months as part of the review process. Such an assessment was not undertaken in this case. None of the documentation or letters states that a given consultation was a formal CPA review. That is a shortfall in standards in this case. Notwithstanding this observation, it is clear from the contents of the letters to the GP that consideration of risk issues were made at each appropriate stage. The external review agrees with the internal review root cause analysis and the PCT investigator on this point.-

Given the extent of Patient's X's engagement with the service it appears that the appropriate staff were involved. The internal Investigation speculated whether other services may have benefited the patient, but such consideration is speculative and would have needed the support and participation of the patient.

- The Mental Health Act assessment process (if appropriate)

Mental Health Act assessment processes were not relevant to this case.

- To examine any apparent confusion around the diagnosis of Patient X.

There appears consensus from the clinicians seeing Patient X, both clinically and in connection with the court proceedings that he experienced the effects of exposure to cannabis. The diagnostic difficulties have been in respect of the extent of any underlying mental illness. No assessment of underlying psychosis was made in the absence of antipsychotic medication. This makes the differentiation between psychosis and drug induced psychosis speculative.

- To examine the appropriateness of medication prescribed to Patient X, his compliance with medication and the decisions taken relating to commencement or discontinuation of medication.

It is the view of the Investigation that the medication prescribed to Patient X was appropriate for his clinical presentation and progression.

- To examine the events between 1st and 3rd December 2007; where concerns were raised by friends and relatives regarding the mental state of Patient X. Contact being made with mental health services, particularly the Crisis Team, requesting his earlier review; and Primary care review on 3rd Dec 2007.

According to the victim's mother, her daughter told her clearly that patient X had attempted to gain help from the psychiatric services. He had telephoned a secretary and was told to call the crisis team. He had rung the crisis team and they advised him to contact the GP. The victim had told her mother that she had rung the crisis team and was advised that he would be seen in three

days, but to see the GP. There is no documentary evidence of these phone calls, however the response is not adequate. An appropriate response would have been for the team member to have put themselves in a position to exercise clinical judgment at that time.

Patient X's recollection at interview was that he had spoken to a secretary at the hospital on the morning of 3 December requesting to be seen. His recollection was that he was advised to contact his GP. He saw his GP on the afternoon of the 3 December as an extra patient. The GP had refused to prescribe Lorazepam for him, but agreed to write to the consultant to expedite an appointment. The letter he sent was dated the following day.

It was the opinion of the PCT investigator that the actions of the GP were appropriate for the circumstances. This Investigation agrees with that conclusion.

At the time no records were kept at the hospital of requests for assistance which were not then acted on by way of clinical intervention. It is not possible therefore to bring this part of the investigation to a definitive conclusion. The situation has now changed and written records are kept of telephone conversations between service users or carers. The new system has been in place since May 2009.

- To establish whether the recommendations identified in the Trust's internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the Trust in response to these recommendations.

The recommendations of the Trust's internal Investigation were appropriate. As part of the Investigation the implementation of the actions plans has been assessed through the examination of appropriate records of implementation and reporting within the Trust. It is the view of the Investigation that these are adequately robust. See Appendix 3 for internal Investigation recommendations.

- To identify any learning from this investigation through applying Root Cause Analysis (RCA) tools and techniques as applicable.

Organisational Factors

It is essential that key clinical decision points are made by clinical staff, rather than non-clinical staff. The arrangements for the first appointment did not follow the single point of entry to services envisaged by the use of the CRHT. Subsequent events flowed from this decision. From this flows three points of recommendation:

1 Clinical pathways must be determined by clinicians; and agreed within Trust policy;

2 Staff need to be thoroughly trained as part of new policy introduction compliance with policy monitored through audit;

3 Locum staff need a thorough induction on taking up their appointment.

It is a matter of concern that the Trust's internal Investigation had not been distributed to the participants in the initial Investigation, either for comment on accuracy or in its final form. Neither the consultant involved nor the CHRT at Boston received a copy of the report. It is difficult to reconcile this with any concept of natural justice.

A further recommendation is that LPFT should demonstrate that it is a learning organisation by having robust arrangements in place to ensure a proper level of dissemination of the findings from internal Investigations.

Post Independent Investigation comment by LPFT: LPFT accept this recommendation but consider the dissemination of the findings and actions from internal investigation to staff now occurs through appropriate staff groups. This is evidenced by recent National Health Service Litigation Authority Assessment in September 2010.

Appendix 1 – Job titles of persons interviewed

Patient X
Patient X's mother and father

Victim's mother

Medical Director LPFT
Clinical director LPFT
Consultant 1 LPFT
Team leader CRHT

General Practitioner

Appendix 2 – Documentation reviewed in the preparation of this report

GP records
LPFT clinical records
Court Psychiatric Reports prepared for the criminal trial

Care Programme Approach OPR/14 14 February 2007
Assessment and Care Planning Policy (incorporating Care Programme Approach) OPR 14 July 2009
Crisis Resolution Home Treatment Operational Policy January 2005
Support and Treatment in Early Psychosis Policy February 2005

Minutes Risk Review Group19 December 2007
23 January 2008
6 February 2008
27 February 2008
26 March 2008
2 April 2008
23 April 2008
7 May 2008
21 May 2008
4 June 2008
18 June 2008
2 July 2008
16 July 2008
6 August 2008
20 August 2008
3 September 2008
17 September 2008
1 October 2008
22 October 2008
5 November 2008
19 November 2008
3 December 2008
17 December 2008

Appendix 3 - Internal Investigation Recommendations

The internal Investigation report found:

1.3 Although the investigation team found none of the contributory factors were root causes of the incident, the following recommendations for service improvement were identified:

1.3.1 Review CPA Policy with regard to copying CPA care plans to service users;

1.3.2 Review the CPA Policy with regard to Standard CPA reviews by consultants in outpatients;

1.3.3 Review ward procedures for logging telephone calls from patients and carers;

1.3.4 Revise the Primary Care procedure for screening and allocating referrals;

1.3.5 Audit timescales between dictation and typing of GP letters and benchmark against best practice.

Appendix 4 – The author

Dr Geoff Roberts is Director of a consultancy firm specialising in patient safety since 1995. My particular interests are in governance and risk management. I am a former Medical Director of Mental Health NHS Trusts with 10 years experience. I was a medico-legal adviser to the Medical Defence Union for 10 years and was head of risk management for the Medical Defence Union. I specified, developed and introduced the risk management programmes in the acute hospitals in Holland and have worked in acute care and mental health risk management in England, Wales, Northern Ireland and the Irish Republic. I am an Assistant Deputy Coroner for Cheshire.

I have been the lead examiner in health sector risk management for the Institute of Risk Management since 1996 and am an Honorary Senior Lecturer with a special interest in Risk Management and Governance for the University of Central Lancashire. I have been external assessor for NHS Scotland for the Certificate in risk management and governance of the Glasgow Caledonian University.

As a Lead Commissioner for the Mental Health Act Commission I reviewed the deaths of over 100 patients between 1999 and 2004. This has involved reviewing the legal and care aspects of health care provided, as well as attending inquests as a Properly Interested Person.

I have chaired a large number of external inquiries on behalf of Statutory Authorities (HSG 94(27) and PCT Performer Reviews) to review the standards of care of patients as well as undertaking, as independent author, Serious Case Reviews for Local Authorities in respect of the deaths of children. I am an adviser on the list of recommended experts of the National Police Improvement Agency and advise on offending by health care professionals, including gross negligence manslaughter and corporate manslaughter.

I am the Chairman of a community interest company which provides primary care for patients in the Wigan area. The organisation works with a mental health third sector provider and trains the provider staff to become health care assistants. A key value is the active ‘seek and treat’ of physical illness in people with mental health problems.

My formal qualifications are: M.B, Ch.B. – University of Manchester, (1972), MFFLM (Member, Faculty of Forensic and Legal Medicine, Royal College of Physicians), MCMI, (Member of the Chartered Management Institute), (1979) FIRM, Fellow of the Institute of Risk Management (2003, member 1998). I am a qualified assessor for Deprivation of Liberty Safeguards (2009). I am a qualified practitioner in Advanced Trauma and Critical Care and am an instructor for ATACC (2009) and BTACC, accredited by the Royal College of Anaesthetists. I have been the Medical Director and Deputy Team Leader for the Cheshire Search and Rescue Service.

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