Report prepared for:
NHS East of England

An Independent Investigation into the Care and Treatment of JMcF

Final Report: October 2011
Chair: Mr Len Wilson MA, DipClinPsychol AFBPsS
Report Author & Lead Investigator:
Mrs Siân Wicks.LLM, RGN. Deputy Director Patient Safety

CONTENTS

1.0 INTRODUCTION

1.1 Niche Health & Social Care Consulting was commissioned by the East of England Strategic Health Authority to conduct an Independent Investigation to examine the care and treatment of JMcF under HSG(94)27[1] (amended in 2005[2]). Under Department of Health guidance, Strategic Health Authorities (SHA) are required to undertake an independent investigation:

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

1.3 *When it is necessary to comply with the State's obligation 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 for 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.*

1.4 *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."*

2.0 PURPOSE AND SCOPE OF INVESTIGATION

2.1 Independent Investigations should increase public confidence in statutory mental health service providers. The purpose of this investigation is not only to investigate the care and treatment of JMcF, but to put into context the care and treatment that JMcF received in relation to the murder of MG and whether or not that could have been prevented; to establish whether any lessons can be learned for the future and to consider recommendations from similar independent mental health investigation reports so that any significant common factors can be identified.

3.0 SUMMARY OF INCIDENT

3.1 On 6th May 2009 JMcF broke into the house of MG and killed her with a bolt gun. He pleaded guilty to murder in November 2009. He was sentenced to life imprisonment and his tariff was increased to serve a minimum of thirty years. MG was known to JMcF and was a friend. In the days leading up to the offence, JMcF had made a suicide attempt and was assessed under the Mental Health Act 1983. He was not detained. He engaged with the crisis team and was visited at his place of residence. On the 5th May 2009 JMcF began to send a series of text messages to a number of people including MG and used a social networking site to post personal details about MG. MG reported the harassment to the police. A call was made by the police that evening to MG to ask her if they could visit her the following day. In the early hours of Wednesday 6th May 2009, JMcF broke into her house and killed her, an act which was witnessed by her children.

[1] Department of Health (1994) *HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care*
[2] Department of Health (2005) *Independent Investigation of Adverse Events in Mental Health Services*

4.0 CONDOLENCES TO THE FAMILY OF MG

4.1 The Investigation Team would like to offer our sincere condolences to MG's children, family and friends. This was a life changing event for them all. It is our sincere wish that this report provides no further pain and distress but addresses the outstanding issues and questions that were raised by some members of the family. We would like to acknowledge the contributions that they have made to this investigation.

5.0 ACKNOWLEDGEMENT OF PARTICIPANTS

5.1 We would like to acknowledge JMcF's participation in this investigation. We would also like to acknowledge all the friends, employers and the health and social care staff who provided statements and agreed to participate in the interview process. It is regrettable that the limited information that was provided by Suffolk Police very late in the process of this investigation, and the late response for further assistance, has delayed the reporting of this investigation.

6.0 TERMS OF REFERENCE

6.1 The East of England Strategic Health Authority (SHA) outlined the Terms of Reference, the expectations in regard to the Investigation Team, the proposed method of working, the output and reporting arrangements and the timetable. The Terms of Reference were divided into two stages.

6.2 **Stage One**

Following the review of clinical notes and other documentary evidence:

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the Trust has made in implementing the action plan.
- Agree with the Strategic Health Authority any areas (beyond those listed below) that require further consideration.

6.3 **Stage Two**

- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of his offence.
- Compile a comprehensive chronology of events leading up to the incident.
- Review the appropriateness of the treatment, care and supervision of the mental health service user in the light of any identified health and social care needs.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming himself or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and his family.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations, including the Mental Health Act assessment process where applicable.

- Examine the adequacy of the collaboration and effectiveness of communication between the service teams and other agencies who may have been involved in the care and treatment of the service user.
- Consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence.
- Provide a written report to the Strategic Health Authority that has clear implementable recommendations for the local health community.

6.4 The Investigation Team will conduct its work in private and provide a report with recommendations to the Strategic Health Authority on its findings.

6.5 The Strategic Health Authority will make the findings and the recommendations of the investigation public.

6.6 The full terms of reference are in Appendix one.

7.0 EXECUTIVE SUMMARY

7.1 JMcF had a difficult upbringing. His behaviour deteriorated in his teenage years and he went into care. He was largely placed in institutional settings until he was sixteen.

7.2 He was a farm worker most of his adult life and in the last decade before the offence. JMcF described a happy but solitary lifestyle as a farm worker with limited interests outside work.

7.3 JMcF had in the years before the offence developed a small circle of friends outside the farm whilst working part time as a fitness instructor. It was here that he met the victim, MG, who was also a fitness instructor. JMcF had interpreted the relationship with MG in a more romantic way. This was not reciprocated by MG. A short time before the offence she had made her feelings clear to him, which JMcF coped badly with.

7.4 At the time of the offence, JMcF had recently separated from his wife.

7.5 REVIEW OF THE APPROPRIATENESS OF THE CARE, TREATMENT AND SUPERVISION OF JMcF AND THE ACCESS TO MENTAL HEALTH SERVICES

7.6 JMcF had three discrete episodes of involvement with mental health services spanning approximately fifteen years. There was similarity in the episodes in that the key issues were around coping and self harm following stressful events.

7.7 JMcF did not have any relevant previous history of violence or offending.

7.8 **13th AUGUST 2008** in the months leading up to the offence he was referred by GP One as an urgent referral to a Consultant Psychiatrist at Suffolk Mental Health Partnership Trust. The referral came through the then system of referral called S.P.O.R (Single Point of Referral)[3].The referral was not seen by a Consultant Psychiatrist.

7.9 **28th AUGUST 2008** He was offered an appointment with the Community Mental Health Team (CMHT) but he declined and rescheduled for the 1st September 2008.

7.10 **1st SEPTEMBER 2008** He declined the appointment and rescheduled for the 11th September 2008.

7.11 **11th SEPTEMBER 2008** He was seen by Social Worker One and Community Psychiatric Nurse One and the assessment was completed. The outcome of the assessment was to continue with the prescription of medication that had been prescribed by his GP, to try to attend the gym, as he had been working long hours, and to attend an anxiety management group. The assessment at this time was of a poor standard, the outcome of the assessment was not discussed with the Consultant Psychiatrist or multi-disciplinary team and no attempt had been made to consider fully the information in the comprehensive GP referral or the additional information that was said to have been included in the GP letter.

7.12 **25th NOVEMBER 2008** GP One re-referred JMcF requesting Consultant assessment.

7.13 **28th NOVEMBER 2008** JMcF declined appointment and rescheduled.

[3] A Single Point of Referral (S.P.O.R) was in operation at the time of the incident. The S.P.O.R considered all referrals which had been received by the CMHTs and the CRHTTs and allocated the referrals out to the most appropriate team members without the patient being seen.

7.14 **4th DECEMBER 2008** JMcF declined appointment with the Consultant and rescheduled for the 13th January 2009.

7.15 **13th JANUARY 2009** JMcF attended and was assessed by Consultant Psychiatrist One. The assessment was thorough; there was a clear plan of care which was appropriate given JMcF's presentation. A recommendation was made for JMcF to self-refer into Improving Access to Psychological Therapies (IAPT) services. He did so in order to be able to receive cognitive behaviour therapy. This is good practice as required by national guidelines.

7.16 **28th JANUARY 2009** JMcF self-referred to IAPT.

7.17 **17th FEBUARY 2009** JMcF attended his first appointment. He was assessed and offered step 2 care[4] after specifically requesting face to face cognitive behavioural therapy.

7.18 **3rd MARCH 2009** JMcF did not attend this appointment.

7.19 **10th MARCH 2009** JMcF did not attend this appointment. A letter was written to JMcF to offer him another appointment for 27th March 2009.

7.20 **10th MARCH 2009** JMcF attended for an initial assessment with Private Therapist One. There were indicators of risk to self but no indication that JMcF was a risk to others. An integrative approach was adopted with elements of cognitive behaviour therapy in order to keep JMcF engaged. This was appropriate. JMcF wrote a letter of complaint (undated) to the IAPT service complaining that his request for cognitive behaviour therapy had been unmet by IAPT.

7.21 **23rd MARCH 2009** IAPT contacted JMcF about his complaint. Friend One had signposted him to private therapy.

7.22 **26th MARCH 2009** JMcF attended second private therapy session.

7.23 **4th APRIL 2009** IAPT services contacted JMcF who wished to continue with private therapy and he was discharged from IAPT.

7.24 **20th APRIL 2009** JMcF attended his third private therapy session. He was engaged with an experienced therapist at this time who was able to contain his difficulties.

7.25 **23rd APRIL 2009** JMcF attended his GP, GP Two, with Friend One. GP Two made a telephone referral to the Crisis Home Resolution Treatment Team (CRHTT) as his mental state was deteriorating and he was reported to have active suicidal thoughts. He was planning on leaving his wife that day. He was assessed that day, thought to have a reasonable plan of how to spend the rest of the day, was supported by Friend One, and had insight into his difficulties. The risk assessment was of a good standard.

[4] Step 2: is a low intensity service of the stepped care model, watchful waiting and guided self help. Please see Appendix four Access to Psychological Therapies

Comment

7.26 It is regrettable that there was no communication between Private Therapist One and the CRHTT. The ability for any one health professional to collect an overall picture of JMcF's mental state was lost. This could have been overcome by asking JMcF to give consent for professionals to share clinical details without fear of breaching confidentiality.

7.27 JMcF had made it clear that he did not want any health or social care professional to liaise with any members of his family; making it even more important to try and build a picture of his presentation to health and social care professionals.

7.28 **24th APRIL 2009** JMcF stayed with Friend's One and Two until and including the 28th April 2009.

7.29 **29th APRIL 2009** JMcF stayed at MG's house on the sofa until and including the 30th April 2009. MG hurt her knee on the 30th April whilst teaching body combat.

7.30 **1st MAY 2009** JMcF stayed with Friends One and Two.

7.31 **2nd MAY 2009** Friend Two assisted JMcF in moving his belongings out of the marital home. On interview Friend Two reported that JMcF was upset and swearing. There was no evidence that this information was available to clinicians at the time of the assessment. JMcF attended MG's house and was angry at the prospect of MG's ex boyfriend returning to the house to assist her following her knee injury. There were a series of texts between Friend One and MG highlighting concern over JMcF's behaviour.

7.32 **3rd MAY 2009** JMcF attempted to hang himself at the farm where he worked. JMcF text Friend One notifying of his intention. Friend One and Two intervene, remove him to their home and then to Accident & Emergency (A&E). He was seen by the Crisis Resolution Home Treatment Team (CRHTT) at 06:40. The CRHTT assessed him and offered admission. This was declined by JMcF. The CRHTT felt that he would benefit from a period of assessment in hospital and requested to speak with an Approved Mental Health Practitioner with a view to organising a Mental Health Act Assessment. This was appropriate. Whilst waiting for the assessment JMcF left A&E and was later returned by the police. Staff in A&E were unaware that he had left the department. There are a number of recommendations made in relation to this aspect of care in paragraph 15.86

7.33 **3rd MAY 2009** The Mental Health Act assessment took place at 10:30. There are detailed notes and a very comprehensive assessment was done that took over two hours. The predominant consideration was risk to self. No evidence of mental disorder was elicited and it was felt that his suicide attempt was secondary to relationship difficulties. JMcF spoke of his plans for the future and was willing to engage with the CRHTT. A plan was made for a work colleague to spend the night with him with some supervision from friends.

Comment

7.34 The decision at this point not to detain him under the Mental Health Act was a reasonable one based on the information available at the time of the assessment. There does not appear to be any indication from his past history that he constituted a significant risk to others. However, there are no written notes in the clinical records to indicate that the professionals who conducted the Mental Health Act assessment considered JMcF's occupation and access to farm machinery and firearms in their assessment.

7.35 **4th MAY 2009** He was visited by the CRHTT. He was found working at the farm. JMcF informed the CRHTT that he was being supported by friends and his private therapist. He was assessed and found on that day not to be a risk to himself or others. There was a plan made for an appointment to be made for review by Consultant Psychiatrist Two on the 5th May 2009.

7.36 **5th MAY 2009.** JMcF contacted the CRHTT and informed them that he was anxious about the fact that his friends were not responding to his texts and emails. His employer called the CRHTT and expressed concern about him. An arrangement was made for JMcF to be seen by Consultant Psychiatrist Two at 14:00. Prior to the Consultant meeting with JMcF he had a detailed conversation with one of the doctors who had performed the Mental Health Act assessment. The Consultant was surprised that JMcF could maintain small talk. He concluded that he was not morbidly anxious or clinically depressed. He concluded that he was not suffering from mental disorder. He felt it appropriate that CRHTT continue to offer support over the coming days and made an appointment to see him again on the 14th May 2009.

Comment

7.37 A number of different professionals assessed JMcF on a "one off" basis and this did not allow for a therapeutic relationship to develop. JMcF's employer raised a concern regarding his occupation and that he was due to slaughter animals. This occupation was not taken into consideration when assessing risk. That said, there were still no indications of risk of harm to others.

7.38 **6th MAY 2009** In the early hours of the 6th May 2009 disturbing texts were received by the farm manager from JMcF. The farm manager immediately contacted the CRHTT who immediately contacted JMcF on his mobile phone to try and ascertain his whereabouts. The emergency services were called and the police notified the CRHTT that an incident had occurred. It later became apparent that JMcF had reported a break-in at the farm just before he broke into MG's house, cut the electricity and murdered her with a bolt gun. On interview JMcF had no recollection of the offence beyond being outside in the street with MG after she had been attacked. Her children witnessed the offence and one was injured in the attack. JMcF made an attempt on his own life and received medical treatment. He was then assessed on the 7th May 2009 and detained under section 3 of the Mental Health Act 1983.

7.39 JMcF subsequently pleaded guilty to the murder of MG and is currently serving a life sentence with a minimum term of thirty years.

7.40 As can be seen from the diagrammatic representation on pages 46 and 47 there were five separate referral points across all services. There were nine occasions where JMcF engaged and disengaged with services, with JMcF having a general avoidance for admittance to hospital. On interview[5], JMcF had said that admission to hospital was not an option for him.

7.41 MANAGEMENT OF RISK

7.42 All the risk assessments were of a reasonable standard apart from one in September 2008 (paragraph 7.11 above) which was sub-optimal.

7.43 JMcF was a risk to himself as identified in the risk assessments on the 23rd April 2009 and the 3rd May 2009. Both risk assessments were of a reasonable standard. The intention to manage JMcF outside the hospital setting was a reasonable one given his mental state at the time of the

[5] Transcript of interview with JMcF 13th October 2010

assessments. This approach is in keeping with the national guidance where the emphasis is to manage patients in the community with the support of crisis/home treatment services.

7.44 MANAGEMENT OF RISK TO OTHERS

7.45 Negative findings regarding risk to others is mentioned briefly in two of the risk assessments but does not appear to have been explored in any detail by any of the professionals who had contact with JMcF. The Investigation Team have found little to suggest in his past history that risk to others was an issue of concern which required detailed investigation. The action of the professionals with regard to the assessment and risk to others does not therefore appear to have been unreasonable given the information available at the time.

7.46 At the time of assessment on the 23rd April 2009 the risk screen asked the following question in relation to risk to children. *"Child protection/welfare issues. Include child's date of birth, school and GP. Indicate where there is sufficient information:* ***Please consider:*** *Evidence of past current neglect/violence/sexual abuse/emotional abuse; any concerns about the welfare of children; young carers involvement in the care of an adult; other reports or evidence of risk to children."*

7.47 The field completed was documented as *Not applicable* on the 23rd April 2009, on the basis that JMcF did not have any children.

Comment

7.48 It is the Investigation Team view that the risk screen in use at the time did not specifically identify persons potentially at risk. The amended risk screen in use at Suffolk Mental Health Partnership Trust now specifically leads the assessor to consider risk to self, partner/spouse, parent, staff member, general public and child. Specifically, is there a dependent child? yes or no, and other.[6] It is the Investigation Team view that the risk to children could be further strengthened by asking the question "Does the user have contact with or access to children? Answer yes or no".

7.49 MENTAL HEALTH ACT ASSESSMENT

7.50 The decision not to detain JMcF under the Mental Health Act on the 3rd May 2009 was a reasonable one based on the information available at the time of the assessment.[7] He was assessed by two experienced doctors in A&E who both formed the view that JMcF did not meet the criteria for detention.[8] At the time of the Mental Health Act assessment his mental state appeared to have settled considerably. No clear symptoms of a treatable mental disorder were elicited. He agreed to engage with the aftercare and follow-up from the Crisis Resolution Home Treatment Team. Although he had an address to go to and supervision from friends, the Investigation Team have concerns about the adequacy of the level of support which appeared available to him in the community.

[6] Suffolk Mental Health Partnership NHS Trust 5th August 2009.
[7] Great Britain. *Mental Health Act 1983. s.1 (*c.20)
[8] That is to say he did not have a diagnosable mental disorder, was not of arrested or incomplete development of mind, did not have a psychopathic disorder or any other disability of mind, or it was not of a nature or degree to warrant his formal detention, and/or that his assessed level of risk at that time to himself or others was not perceived to be sufficiently high to warrant detention. See Appendix 5 for full details.

7.51 DIAGNOSIS

7.52 The Investigation Team felt it important to provide clarity in so far as possible on the issue of diagnosis. JMcF had been seen by a large number of mental health professionals both before and after the incident. Looking at several points in JMcF's contact with mental health services there appears initially to be a lack of consistency and agreement.

7.53 In psychiatry, diagnosis is often complex and thus classification systems are used to help clinicians in obtaining a diagnosis and to communicate between individuals and systems. In addition, it would be reasonable to state that diagnosis in psychiatry is often different between professionals and also that a patient's diagnosis is capable of change and evolution. Depression is a good example of a condition which has a lay and professional meaning. Most individuals would be able to identify in themselves times when they had felt depressed or down but this may be completely different from a condition which has a clinical significance.

7.54 Assessment of risk in this instance was complicated by the lack of diagnosis. The diagnosis in the 24 hours before the offence seems to have been the clearest in terms of stating that JMcF did not have a depressive disorder. Looking at the other comments and diagnoses, they point to JMcF having repeated periods in his life when he had felt depressed and some clinicians appear to have categorised this as being part of an illness that required treatment. A definitive diagnosis was never made.

7.55 The feelings of depression seem to have been clearly related to external events.

7.56 The evidence base informs us that the most successful approach would have been likely to be a combination of medication, psychological approaches and of course addressing the event that was provoking the depression.[9]

7.57 FORENSIC REVIEW

7.58 JMcF had no relevant forensic history. There was an escalation in risk to himself in the run up to the offence.

7.59 RESOURCES

7.60 Appendix three presents an analysis of information provided to the Investigation Team in relation to the performance and allocation of resources of Suffolk Mental Health Partnership Trust in the build up to the events of the May Bank Holiday weekend in 2009.

7.61 The question was raised by the family of MG whether or not beds were available on the weekend leading up to MG's murder. On the information that was given to the Investigation Team the analysis conducted by Niche indicates that should it have been clinically necessary to admit JMcF formally or informally there were sufficient beds and sufficient numbers of staff to do so.

[9] National Institute for Health and Clinical Excellence (2009) *Depression: The treatment and management of depression in adults* (update) [CG 90]

7.62 REVIEW OF THE EFFECTIVENESS OF JMcF'S CARE PLAN

7.63 Whilst under the care of and on the case load of the CRHTT, JMcF was not being cared for under the Care Programme Approach (CPA). It is the Core Panel's view that this was appropriate. CPA is for people with more complex needs. The decision whether or not to place a service user onto CPA is discretionary. The Department of Health has published clear guidance which informs clinicians in the making of this decision[10]. Staff within the CRHTT were at the stage of establishing rapport with JMcF and were trying to assess his mental state and needs. It is possible that the CRHTT may have placed JMcF on CPA at a later date once they had conducted a fuller assessment.

7.64 JMcF did not have a care plan or a nominated Care Co-ordinator/Key Worker whilst under the care of and on the caseload of the CRHTT from the 23rd April 2009. A number of different mental health professionals assessed and reviewed JMcF whilst he was under the care of the CRHTT. Almost each time he was seen by the CRHTT, he was seen by someone different. It is the Core Panel's view that it would have been difficult to detect small changes in JMcF's mental state if staff were assessing on a one-off basis as appeared to be the case. There was a lack of communication between the various health care professionals that JMcF accessed.

7.65 PROVISION OF IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)

7.66 Section 5.14 of the Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit states "*Appropriate care pathways integrated with existing psychological therapies and other mental health services, with a smooth transition between steps, will ensure that the patient experience is not disjointed and the population's range of needs is met*." [11] Establishing an integrated pathway with existing services is challenging to IAPT services.

7.67 In this case it is evident that Consultant Psychiatrist One discharged JMcF so that a referral to IAPT could be made. It is the view of the Investigation Team that JMcF would have benefited from psychological therapy (CBT) and continued psychiatric oversight. In terms of an integrated pathway it would appear that artificial boundaries between primary and secondary care precluded the extent to which an integrated pathway existed.

7.68 Section 5.21 of the IAPT Commissioning Toolkit emphasises the value of self referral and the importance of choice. The IAPT service locally already had self referral in place which is to be commended as many services fail to achieve this target nationally. Further consideration to the request of a patient self-referring and the requests of other qualified mental health professionals need more emphasis in an IAPT initial screening process. Improved formal communications between secondary care services and the IAPT service need to be agreed and protocols for patients being able to access both secondary care and primary care mental health services simultaneously when required/requested.

7.69 LEARNING THE LESSONS

7.70 Whilst it has been established that the Trust has a number of policies and procedures in place, on this occasion some policies were not formalised and there was a lack of clarity on some points. The care and service delivery problems with contributory factors are represented diagrammatically in the fishbone diagram in section 23.

[10] Department of Health (2008) *Refocusing Care Programme Approach: Policy and positive guidance*
[11] Department of Health (2007) *Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit*

7.71 This analysis follows National Patient Safety Agency guidance on root-cause analysis. In essence, an attempt has been made to identify root causes in organisational process, how those may have directly resulted in specific care and service delivery problems and how those may lead to the documented actual or potential effect on the outcome.

7.72 The issues identified in this analysis identify sub-optimal processes using this technique. These issues are not causative but are highlighted for organisational learning.

7.73 It has been established that the Trust investigation process was sub-optimal. The Trust was overwhelmed by other Serious Incidents at the time and applying for Foundation Trust status. The processes were not robust, staff felt out of their depth and a robust Serious Untoward Incident Investigation was hampered by lack of multi-agency working with Suffolk Police.

7.74 The Trust Investigation was limited in its scope and makes limited recommendations. The Trust did not communicate effectively with the family of MG. The Trust did not communicate adequately with its own staff.

7.75 There are a number of recommendations made as a result of this Independent Investigation. These are detailed in Appendix two subdivided under the following headings:

- National Learning
- Multi-agency Working/Organisational Boundaries Between:
  - The Interface between Health and Suffolk Police
  - The Interface between Health and Social Care
  - Communication between Acute and Mental Health Trusts
- Organisational, Governance and Serious Untoward Incident Process
  - Commissioners
  - Suffolk Mental Health Partnership Trust
- The Care Pathway/Operational Policy:
  - The Referral Process
  - The Community Mental Health Trust Operational Policy
  - The Crisis Resolution Home Treatment Team
- Access to Psychological Therapies
- Private Therapy
- Risk Assessments
- Data Collection/Equipment

7.76 The Investigation Team are aware of a number of homicides that occurred in the Suffolk area in 2009. The reader is reminded that this investigation is limited to the Investigation into the Care & Treatment of JMcF. The separate external review of patient safety that was commissioned jointly by the Trust and the PCT was published in May 2011.[12] It contains a number of recommendations to improve patient safety and governance within Suffolk Mental Health NHS Trust Partnership.

[12] Rae, M., Colgan, S., Doyle, M. & Fletcher, S. (2011) *Report of External Review of Safety and Clinical Governance Arrangements within the Suffolk Mental Health Partnership Trust December 2010-January 2011*. Revisions made to correct inaccuracies 9th May 2011

7.77 POLICE INVOLVEMENT IN THE INCIDENT

7.78 The amendment of Suffolk Police grading policy[13] to take into consideration mental health issues on grading calls is an appropriate one.

7.79 INTERFACE BETWEEN HEALTH AND SOCIAL CARE

7.80 The Investigation Team recommend that there be an immediate review of the Section 75 agreement[14] as to its current and future utility, with a new agreement developed in a more appropriate form that makes explicit the respective roles, responsibilities, required resources and outcome measures for each party.

7.81 MULTI-AGENCY WORKING POST INCIDENT

7.82 The lack of multi-agency working and the appreciation of the need for the Trust to run its own Serious Untoward Investigation into the Care and Treatment of JMcF, caused the Trust staff to think that a police statement requested and supplied by some, in so far as the murder of MG was concerned, would be sufficient for the purposes of this Independent Investigation into the Care and Treatment of JMcF.

7.83 Whilst it is understood that investigations of this nature are stressful for all concerned, a significant learning point for all is to ensure that all co-operate with investigations of this nature to learn the lessons for the future.

7.84 All organisations should ensure that sufficient support is in place to ensure staff affected by events such as these are supported appropriately.

7.85 NATIONAL LEARNING

7.86 The National Confidential Inquiry Into Suicide and Homicide by People with Mental Illness in their report *Independent Investigations after Homicide by People Receiving Mental Health Care*[15] analysed a number of Independent Investigation reports between 2006 and 2009 with the aim of collating key themes emerging from the recommendations in those reports. Below follows the key clinical messages identified that are relevant to this Independent Investigation:

- *"Mental Health Trusts should ensure (a) full implementation of the CPA by all clinical teams (b) robust risk management processes are in place for all service users (c) information about risk is shared between all individuals, professionals and agencies, based on protocol approved by the Trust."*[16]

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[13] Suffolk Constabulary – Grading Policy and Response to Calls Strategy and Procedure – amended November 2009

[14] Section 75 of the Health Service Act 2006. A 'Section 75 agreement' relates to a formal partnership agreement between health and local authority agencies that enable joint decision making and the pooling of budgets and resources for more effective local delivery of services. The term relates to Section 75 of the Health Service Act 2006. This Act superseded the NHS Act 1977 (Sections 28 and 28) and the Health Act 1999 (section 31) where similar powers were enacted. Agreements vary from locality to locality subject to local need and strategic priorities. Each agreement should clearly define roles, responsibilities, funding streams, governance arrangements, risk management issues, levels of delegated authority and powers, and the agreement should be reviewed on a regular basis to ensure its enduring relevance and validity

[15] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2010) *Independent Investigations after Homicide by People Receiving Mental Health Care*

[16] id p3

- *"Whilst respecting service-user confidentiality, Mental Health Trusts should encourage and support family carer involvement. Carers should receive an assessment of their own needs"*

7.87 With the benefit of hindsight, more weight should be given to the content of what is posted in texts and on social networking sites. The fact that communication by modern media is at arm's length should not diminish the content and the actions that may be required.

7.88 Risk assessment should be person-centred.

7.89 It has already been agreed that the Core Panel will facilitate a learning event following the publication of this report. It is a recommendation of this Investigation that the Core Panel should assist the SHA further in the monitoring of the recommendations made and supports the Trust and other interested parties in moving forward with a detailed joint action plan for improvement.

7.90 CONCLUSION

7.91 It is the conclusion of the Investigation Team, based on the evidence available, that whilst there are areas identified for improvement, the tragic murder of MG was not predictable. The events leading up to her murder were fast moving and the murder could not have been foreseen.

7.92 Although admission to hospital to manage the risk that JMcF presented to himself would most likely have prevented the offence at that time, this could not have been identified at anytime by the various mental health professionals.

8.0 THE INDEPENDENT INVESTIGATION TEAM

8.1 This Investigation was undertaken by the following panel of healthcare professionals who are independent of the healthcare services provided by Suffolk Mental Health Partnership Trust ("the Trust").

The Investigation Team consisted of a core panel:

Core Panel:

Mr Len Wilson	Chair, Associate Director Niche Health & Social Care Consulting
Mrs Sian Wicks	Lead Investigator and Report Author, Deputy Director Patient Safety Niche Health & Social Care Consulting
Dr Mark Potter	Consultant Psychiatrist
Mrs Sue Salas	Senior Consultant Mental Health Nurse

8.2 With a group of professionals with the relevant expertise in the following areas:

Additional Panel Members

Dr Paul Alford	General Practitioner
Mr Tim Cate	Associate Director of Psychology & Psychological Therapies. Acting Operations Director for North Yorkshire
Dr Ian Cummings	Consultant Forensic Psychiatrist
Mr Andrew Keefe	Principal Consultant Niche Health & Social Care Consulting, Social worker

Support to the Investigation Team

Mr Nick Moor	Director Niche Health & Social Care Consulting
Mr Tony Ingham	Senior Analyst Niche Health & Social Care Consulting
Mrs Samantha McAntagart	Administrator Niche Health & Social Care Consulting
Ms Sarah Blanch	Research Librarian Niche Health & Social Care Consulting

Independent Advice to the Panel

Ms Kiran Bhogal	Partner, Weightmans Solicitors

8.3 Full curriculum vitae of the Investigation Team are in Appendix nine.

9.0 INVESTIGATION METHODOLOGY

9.1 This investigation follows national guidance.[17] The investigation commenced on the 21st June 2010.

9.2 CONSENT

9.3 Consent was obtained from JMcF by the East of England Strategic Health Authority (SHA). The Chair and Lead Investigator visited JMcF in prison to inform him of the Terms of Reference for the Investigation and seek his consent for an interview with the forensic psychiatrist. JMcF agreed and gave consent for records to be released from his legal representative which greatly assisted the investigation process.

9.4 The Lead Investigator and Consultant Forensic Psychiatrist interviewed JMcF in October 2010.

9.5 COMMUNICATION WITH VICTIMS

9.6 The Lead Investigator at the outset of the investigation process made contact with the victim's family. The Chair and the Lead Investigator visited the family and heard their views and requests. The Lead Investigator offered to meet with the litigation friend of the three children; however this was declined, with the preference of communicating through legal representatives. The Terms of Reference were sent to all parties. Early on, there was a request from both contacts that the Investigation Team specifically note that the offence occurred at the end of a May Bank Holiday, and ascertain whether or not this had any bearing on the clinical decisions made. This was felt to be a very important aspect to investigate thoroughly not least because the families had requested it. The SHA agreed further work to be undertaken to enable this.

9.7 COMMUNICATION WITH THE PERPETRATOR'S FAMILY

9.8 At the inception of this investigation it was made clear by the Strategic Health Authority that JMcF's family did not wish to be involved in the investigation process.

9.9 COMMUNICATION WITH SUFFOLK MENTAL HEALTH PARTNERSHIP TRUST

9.10 The Chair and Lead Investigator met with the Chief Executive and Deputy Chief Executive /Director of Nursing of the Trust. The purpose of this meeting was to commence introductions, give the detail of the expectations, identify a lead liaison person at the Trust and establish effective communication.

9.11 COMMUNICATION WITH THE INDEPENDENT POLICE COMPLAINTS AUTHORITY

9.12 The Lead Investigator was granted interested party status early on to consider the findings of the Independent Police Complaints Commission (IPCC) investigation in so far as these impacted on the care and treatment of JMcF. Permission was sought for the Core Panel to have interested parties' status to consider the Lead Investigator's findings. The Core Panel would like to thank the IPCC for its assistance.

[17] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*

9.13 COMMUNICATION WITH SUFFOLK POLICE

9.14 The East of England Strategic Health Authority and the Lead Investigator from Niche have attempted to effectively communicate with Suffolk Police. However, the response from Suffolk Police has been poor. A letter written to the Chief Constable of Suffolk has never been directly responded to, despite further communication from the Lead Investigator and assistance from the Suffolk Police legal representative. Key documentation was received, but late. Requests for Suffolk Police to assist in regard to the Trust's response to the incident have been provided late. There appears to have been a misunderstanding between Suffolk Police and the Trust in relation to post event multi-agency working.

9.15 WITNESSES CALLED BY THE INVESTIGATION TEAM

9.16 The Investigation Team interviewed the staff involved, making reference to the national investigation interview guidance.[18] The list of staff titles of those interviewed is detailed in Appendix eight. Niche Health & Social Care Consulting adopts Salmon Principles[19]. The Lead Investigator made herself accessible to all to facilitate effective communication and clarification. She has had access, via JMcF's solicitor, to all the police statements taken at the time in relation to the murder of MG and has considered all those statements in so far as they were relevant to the care and treatment of JMcF. Similarly, there were some staff identified who had not provided a police statement but whose views were considered important for the purposes of investigating the care and treatment of JMcF.

9.17 Thirty eight members of staff, friends and ex-employers of JMcF were contacted in regard to this investigation. Members of staff were each asked to provide a statement in respect of the care and treatment of JMcF. Three professionals had moved on and despite efforts were uncontactable. Thirty two people were interviewed for the purposes of this investigation. Each interview was recorded and a transcript prepared. All had an opportunity to check for factual accuracy and to add additional information to it.

9.18 PANEL MEETINGS

9.19 The Core Panel met, with co-opted team members as appropriate, on a total of eleven occasions.

10th September 2010:	First full team meeting and commenced stage 1 of the investigation.
7th November 2010:	Interview panel meeting**.**
8th November 2010:	Interview day
9th November 2010:	Interview day
15th November 2010:	Interview panel meeting
16th November 2010:	Interview day
17th November 2010:	Interview day
7th December 2010:	Interview day
1st March 2011:	Interview panel meeting
2nd March 2011:	Final Interview day.
12th May 2011:	Final panel meeting to agree draft final report.

[18] National Patient Safety Agency (2008) *Root Cause Analysis Investigation Tools: Investigation interview guidance*

[19] *The Salmon process is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of The 1996 Royal Commission on Tribunals of Inquiry whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere.*

9.20 Throughout, the Investigation Team were in communication with each other and worked on areas of the investigation that were relevant to their level of expertise.

9.21 ROOT-CAUSE ANALYSIS

9.22 This report was written with reference to the National Patient Safety Agency (NPSA) Good Practice Guide for Independent Investigations of Serious Patient Safety Incidents in Mental Health Services.[20] The methodology used to analyse the information gathered was by the use of Root Cause Analysis (RCA). Root Cause Analysis is a retrospective multi-disciplinary approach designed to identify the sequence of events that led to the incident. It is a systematic way of conducting an investigation and looks beyond individuals and seeks to understand the underlying system features and the environmental context in which the incident happens.[21] However, if any one individual through the process is identified as a concern this is communicated to the employer.

9.23 **Techniques used:**

1. **The "Fish Bone" along with the "4 Ps"**: Place, Procedure, People and Policies were used to assist in identifying the influencing factors which led to the incident. This is represented diagrammatically in section 23.
2. **The Control Analysis** was used as a problem solving technique that required the critical analysis of the measures that were in place to preserve patient safety in terms of their effectiveness. The controls in this case were the policies and procedures that were in place to promote patient safety.[22]

9.24 A literature review of best practice and national policy guidance for patient safety in mental health services was performed in conjunction with review of Trust documents.

9.25 The Trust's Serious Untoward Incident report was benchmarked against the National Patient Safety Agency's "*investigation credibility & thoroughness criteria*"[23] and the results analysed.

9.26 The Investigation Team made reference to Department of Health Guidance: HSG (94) 27 *Independent Investigation of Adverse Events in Mental Health Services*[24]and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness *Independent Investigations after Homicide by People Receiving Mental Health Care*[25]

10.0 SOURCES OF INFORMATION

10.1 The sources of information were many. The Lead Investigator engaged those members of the family that wished to be involved, throughout this investigation. Reference was made to the patient records at Suffolk Mental Health Partnership Trust, patient records from previous trusts and establishments from JMcF's first point of contact with mental health services; Suffolk Mental Health Partnership Trust's own internal investigation report, staff statements, and current Trust policies and procedures; Records from JMcF's solicitors, that included all police statements taken at the time, copies of text messages and other material relevant to the homicide.

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[20] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*
[21] id p38
[22] National Patient Safety Agency (2008) *Root Cause Analysis Investigation Tool: Investigation interview guidance*
[23] id
[24] Department of Health (1994) *HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care*
[25] National Confidential Inquiry into Suicide and homicide by People with Mental Illness (2010) *Independent Investigations after Homicide by People Receiving Mental Health Care*

11.0 PROFILE OF JMCF

11.1 At the time of the offence, JMcF was 41 years old. He was born and brought up in the North of England with an alcoholic father, JMcF's parents separated when he was eight. His mother subsequently began a new relationship and in time he was exposed to violence from his stepfather. JMcF's behaviour began to deteriorate and in his teenage years he went into care - he was largely placed in institutional settings until he was sixteen. His schooling and academic progress was affected by this and, apart from a period when he tried and failed at being a driving instructor, for most of his adult life he was a farm worker and in the last decade before the offence, in the East of England. Though he was often happy JMcF has described a solitary lifestyle as a farm worker with limited interests outside work.

11.2 At the time of the offence, JMcF had recently separated from his wife whom he had been with for around thirteen years. JMcF had lived with his wife and her parents for most of this period and he had borrowed and spent money to increase the size of the property. It would appear that JMcF had lost interest in the relationship and the two had had different opinions on having children.

11.3 JMcF had in the years before the offence developed a small circle of friends outside of the farm whilst working part time as a fitness instructor. It was here that he met the victim who was also a fitness instructor. Information suggests that JMcF had interpreted the relationship with the victim in a more romantic way and a short time before the offence she had made her feelings clear to him, which JMcF coped badly with.

11.4 In addition to some childhood contact with mental health services for his behaviour, JMcF had been involved with mental health services for around fifteen years but largely in three discrete episodes. There was similarity in the episodes in that the key issue was around coping and self harm following on from stressful events. In the first episode in 1993 he was admitted to a psychiatric unit in Yorkshire after calling his GP and being found unconscious, having cut his wrist and with a noose nearby. JMcF was admitted to a psychiatric unit at that time and although there was some suggestion of psychotic symptoms this was never repeated in later assessments. The second episode occurred several years later after a brief foray to become a driving instructor where he had again become depressed and had suicidal thoughts.

11.5 JMcF had not had any relevant history of offending or violence. The third episode before the offence was again in the context of lowered mood and poor coping and with a general perception from services that the main risk was once more around self harm.

12.0 PROFILE OF SUFFOLK MENTAL HEALTH SERVICES

12.1 Suffolk Mental Health Partnership NHS Trust (SMHPT) provides specialist mental health services to a population of approximately 580,000, principally those living in the county of Suffolk, but also reaching into part of Norfolk. It employs staff in 1,693 whole-time equivalent posts; 47% of the workforce are in nursing posts (including support workers), 5% are medical staff and 10% are in allied health professions with the remaining staff employed in non-clinical roles.

12.2 Mental health services for adults are delivered in hospital and community settings, from 60 sites across the catchment area. In-patient services for the East of Suffolk are located in Ipswich at the General Hospital and St Clements Hospital, and for West Suffolk at the general hospital in Bury St Edmunds.

12.3 As at May 2009, NHS Suffolk commissioned mental health services for adults on a "stepped care" model, delivered through primary care mental health and specialist secondary mental health provision. Services at steps 1 to 3 are delivered in primary health care and community settings and include Improving Access to Psychological Therapies (IAPT) provision; care at steps 4 and 5 is delivered from SMHPT's specialist secondary services.

12.4 GPs' referral pathway gives access directly to IAPT services for appropriate individuals with mild to moderate problems. Also to the Crisis Resolution and Home Treatment Team (CRHTT) for more urgent cases, to the Link worker for the Community Mental Health Team (CMHT) for routine and non-urgent cases including those which may need access to secondary services.

- The IAPT Service Specification for NHS Suffolk's commissioning of IAPT services indicates that referrals should be accepted from primary care, secondary mental health services and self-referral; the IAPT service is expected to provide assessment for psychological therapy within 10 days of the date of referral and should be responsible for case management which includes "step up/down", as appropriate, and referral when appropriate, to other parts of the local network of mental health care, including CMHTs and assessment for in-patient care.
- Access to specialist mental health services (typically for those who present with apparent psychoses or with mild to moderate mental disorders which have failed to respond to initial treatment) is routed through the Single Point of Referral (S.P.O.R). Referrals by fax, e-mail or letter are seen by a multidisciplinary group and allocated for assessment within 21 working days for routine referrals; cases referred as "urgent" with explanatory information are prioritised and receive a response within 3 to 5 days. Crisis referrals which are likely to result in admission for in-patient care are passed to the CRHTT. Referrals which are inappropriate for allocation to CMHTs are passed back through the Link worker for the referring GP for re-routeing to an appropriate part of the local network of mental health care services.
- The CRHTT (which for West Suffolk is based at Wedgwood House in Bury St Edmunds) provides seven-day around the clock urgent access to intensive assessment and treatment as an alternative to admission for in-patient care; the CRHTT also "gate-keep" admission to in-patient beds, i.e. normally no one will be admitted to in-patient care without having been assessed by the CRHTT services. The CRHTT are expected to respond to a referral within 4 hours of receipt of the referral, which should be via a dedicated telephone line, supported by faxed or secure e-mailed information.

12.5 Overall operational management responsibility for SMHPT's mental health services rests with the Director of Mental Health and Social Care; this is an Executive Team post within the Trust's management structure. Within the Directorate, five service management lines cover the range of services delivered by the Trust:

- an Acute Service Manager is responsible for the overall management of the in-patient services and the CRHTT Teams
- CMHTs are under a Community Service Manager
- IAPT services fall within the group of services managed overall by a Service Development and Business Manager.

12.6 Monitoring of compliance with standards, guidance, policies and procedures in the delivery of the Trust's care and treatment services is coordinated by the Centre for Service Excellence, the Head of the Centre being managerially accountable to the Deputy Chief Executive, who is also the Director of Nursing. Key responsibilities of the Centre include:

- communicating and coordinating the process of risk management throughout the Trust
- managing the Trust's system for reporting incidents and "near misses" and encouraging reporting of all incidents
- supporting the review of incident trends and feedback of information on incident trends and learning to relevant committees (Governance Groups, Audit Committee and Directorate meetings)
- co-ordinating the investigation of serious incidents in line with the Trust's Adverse Incident Reporting Policy, where appropriate facilitating a root cause analysis
- reporting of Serious Untoward Incidents (SUIs) to the Strategic Health Authority and providing progress reports regarding investigation and learning
- ensuring that appropriate audit processes are in place and that results and recommendations coming from clinical audit are incorporated into the clinical governance agenda of directorates and have their implementation monitored.

12.7 The Trust's governance structure has the reporting of compliance routed through an Audit Committee, then to the Trust Board. Non-compliance is flagged to the Trust Executive Team via a risk register.

12.8 The Care Quality Commission's (CQC) Annual Health Check for 2008/09 gave the Trust an overall performance rating of "fair" for quality of services (CQC ratings are on a weak/fair/good/excellent scale). However, the Trust declared itself non-compliant with five standards. The CQC undertook a random review of the Trust in July 2009. Remedial action in time to ensure compliance for 2009/2010 was not possible.[26] The 2009 assessment by the National Health Service Litigation Authority (NHSLA) rated the Trust as compliant overall with the NHSLA Level 1 standards for risk management; the key findings and recommendations in the NHSLA report include specific reference to the need for the Trust to improve the aggregation of data on incidents in order to facilitate effective learning and to promote improvements in practice.

12.9 At the time of interview in December 2010, the investigation panel were informed that the Trust and PCT had commissioned an external review of patient safety at SMHPT following the issue of an improvement notice by the PCT. This review was completed in January 2011 and published in

[26] Care Quality Commission Core Standards Declaration Suffolk Mental Health Partnership Trust Declaration December 2009/2010.

May 2011. The report made a number of recommendations to improve patient safety and governance within Suffolk Mental Health NHS Trust Partnership.[27]

12.10 Following the decision that SMHPT should not pursue Foundation Trust status as a stand-alone organisation, the Board of the Trust agreed in July 2010 to proceed with a proposal to merge with Norfolk and Waveney Mental Health NHS Foundation Trust. At that time, the anticipated date of the merger was April 1st 2011; however, Monitor (the independent regulator for Foundation Trusts), was unable to give approval to the merger by that date, having received a report from the Cooperation and Competition Panel indicating that the merger would, in the Competition Panel's view, be anti-competitive, and therefore could not be recommended to Monitor and the Department of Health. The earliest SMHPT Trust now expects approval to be given is September 2011. SMHPT Trust Board appointed the Chief Executive of Norfolk and Waveney Mental Health NHS Foundation Trust as Chief Executive in March 2011.

[27] Rae, M., Colgan, S., Doyle, M. & Fletcher, S. (2011) *Report of External Review of Safety and Clinical Governance Arrangements within the Suffolk Mental Health Partnership Trust December 2010-January 2011*. Revisions made to correct inaccuracies 9th May 2011

13.0 CHRONOLOGY

13.1 Background

13.2 This chronology is as accurate as possible on the information available. It has been written with the aid of JMcF's clinical records, written statements produced by clinical staff for this Investigation and also the police statements produced by clinical staff and other key stakeholders. The chronology is set out with an opinion where appropriate, followed by patient safety recommendations, again where appropriate.

13.3 **In August 1982** JMcF was referred to a Consultant in Child & Adolescent Psychiatry in view of the sporadic and unpredictable nature of his minor youth offending. JMcF was thirteen years old at the time.

13.4 Following assessment the Consultant Child & Adolescent Psychiatrist concluded that JMcF's early development had possibly been hampered by under-stimulation and insecurity because of his father's unpredictability. His father was an alcoholic. When JMcF was eight years old his parents separated. He was left with his father and was uncared for and intimidated during this time. It was reported that he was now in a more supportive family living with his mother and step father. The reported stealing was likely to be related to poor parental modelling rather than any emotional conflicts.

13.5 **On 8th May 1992** JMcF attended the Accident & Emergency Department in Northallerton with a laceration to the abdomen. This was treated with steri strips and sutured.

13.6 **On 22nd January 1993** JMcF was found in the street having allegedly been assaulted. He was taken to Accident & Emergency Department in York. He sustained a superficial stab wound to his abdomen and was subsequently admitted to York District Hospital.

13.7 **On 28th January 1993** he was brought to the Accident Emergency Department, York District Hospital by friends who were concerned about him. He was intoxicated having consumed a bottle of whisky. JMcF was taking prescribed antibiotics at the time.

13.8 According to his medical records, JMcF was first referred to mental health services on 31st January 1993. His GP in Harrogate had arrived home to find a message on his answering machine from JMcF stating he was going to kill himself. At the time JMcF was living in Ripon. The GP attended and found JMcF unconscious with a laceration to the left wrist. A noose was found lying on the floor beside him, a blood stained knife and a drill set. It had been cut down from the rafter. No drugs or medication were found at JMcF's home but JMcF stated he had taken *paracetamol* but he denied taking an overdose. He had no past history of self-harming. The previous week he had been admitted to York District Hospital with an abdominal stab wound. The circumstances surrounding the stab wound were unknown.

13.9 **On the 31st January 1993** Upon admission to hospital, JMcF refused to talk to staff but the team managed to ascertain from other sources that his nine year old sister had been admitted with keto-acidosis at Christmas time and that the family had been told she might die. At the time of his admission she had recovered. During the month prior to his admission, JMcF had been unable to sleep. On New Year's Eve 1992, he had a car accident. At the end of January 1993, he was stabbed in York. JMcF stated that he had been stabbed but there were no witnesses to the incident. Four days prior to his admission to hospital, his mother began divorce proceedings against his father.

At the time of his admission he was single, working on a birthing unit for pigs and living alone in a cottage on the farm estate.

13.10 **On the 1st February 1993** a psychiatric assessment was carried out at Harrogate Health Care Trust. Following this assessment JMcF was transferred to Cedar Ward, Briary Unit. A drug screen was requested.

13.11 He was admitted to hospital under Section 2 of the Mental Health Act 1983

13.12 JMcF was commenced on *Zuclopenthixol*. He is reported as having been brighter as a result[28]. There were concerns that he had some underlying psychotic features. Whilst on the ward he was found in possession of razor blades. The staff were unclear how he had obtained them.

13.13 **On the 26th February 1993** JMcF was discharged. He was discharged on *Lofepramine* 70mg once a day, *Procyclidine* 5mg bd and *Chlorpromazine* 50mg bd with 100mg nocte[29]. The Discharge Summary stated that JMcF's exact diagnosis remained unclear:

13.14 *"...though is categorised as a suicidal attempt with an underlying possible psychosis".*

13.15 A Discharge Summary dated 8th March 1993 was sent to JMcF's General Practitioner ("GP"). The GP stated that JMcF had been suffering from insomnia for a month prior to admission. The Discharge Summary[30] states:

13.16 *"An initial differential diagnosis was of 1) schizophrenia, 2) A drug-related episode, 3) Depression".*

13.17 JMcF was referred to the Community Mental Health Team on discharge and offered a first appointment on 15th March 1993.

13.18 JMcF was reviewed as an outpatient as planned, on 15th March 1993 and continued to take medication at this time.

13.19 He was encouraged to take *Chlorpromazin*e 50mg tds on a regular basis and to continue to take *Procyclidine* 5mg bd. He was advised to cease taking *Lofepramine* as it appeared to be having limited effect. The Consultant Psychiatrist arranged to see JMcF two weeks later and asked for continued Community Psychiatric Nurse involvement.

13.20 **On 26th April 1993** he was reviewed again by the Consultant Psychiatrist. He was discharged from his care as JMcF was about to start a new job in Suffolk. The Consultant Psychiatrist advised him to get a new General Practitioner and to ask them to liaise with regard to obtaining copies of medical notes.

13.21 **On 1st August 1993** JMcF sustained a superficial pig bite to his right flank. He fell over and banged his head but was not knocked unconscious. However, he later became drowsy and difficult to rouse. A CT scan was conducted which showed no evidence of intra-cranial bleeding. He was given *Metronidazole* and *Flucloxacillin* for the pig bite. There were no other recorded episodes of access to mental health services at this point.

[28] Discharge Summary dated 8 March 1993
[29] Id,page 1
[30] id, page 1

13.22 **In 1994** JMcF was prescribed *Dothiepin* for depression.

13.23 **September 2000** He was rarely seen by his previous GP until he presented himself to his GP on 26th September 2000. At that time he was working as a driving instructor which he was finding very stressful. He had sleep disturbance and difficulty concentrating. He was finding working as a driving instructor too much and did not care if his pupils crashed the car. He admitted to wishing they would crash the car. He reported worrying about his pupils all the time, being unable to sleep and finding the responsibility of the job too much. He was very keen to return to farming but was in a contractual arrangement with a driving instruction company.

13.24 JMcF was by this time married and living with his wife's parents. He admitted to drinking one bottle of wine a night. He denied feeling suicidal and did not think he needed anti depressants. He admitted to feeling like he had in 1993 when he had been an inpatient.

13.25 The previous GP wrote to the driving instruction company stating that he did not think he was fit to teach driving. He reviewed JMcF a week later who reported that he had given up being a driving instructor and returned to farming, but was still waiting to hear whether he would be released from his contract with the driving instruction company.

13.26 **On 18th October 2000** JMcF was referred urgently by his previous GP to the Newmarket Mental Health Team in Suffolk. The GP reported, in his referral letter, that JMcF had been tense during his meeting with him and was suffering from a disturbed sleep pattern. JMcF denied feeling suicidal but admitted that he could not be bothered to eat and having lost one and three quarters of a stone in three weeks.

13.27 In response to the referral, JMcF was seen by a Community Psychiatric Nurse (CPN), at Newmarket Community Mental Health Team on 21st October 2000 for an initial assessment.

13.28 In his assessment the CPN stated that JMcF acknowledged he was suffering from a recurrence of depressive symptoms after a three month period of stress; having always liked driving, he had signed up for a two year contract with a school of motoring in May that year. However, he later felt pressurised as he was expected to have seventy hours road contact per week. JMcF admitted that this was too much for him and he often wanted to get away from his pupils. He "gambled" at road conditions to have accidents in order to have time off. He had also begun to increase his alcohol consumption. At the time of the assessment he had left the driving school and returned to farming work. JMcF had increased his alcohol intake in order to manage his stress, but had stopped drinking alcohol at the time of assessment. He reported that his depressive symptoms had settled since returning to farming work although he was still suffering from sleep problems with intermittent waking and early morning waking. He was also suffering from a lack of appetite and had lost weight. He reported having poor concentration and a lack of interest in anything. JMcF made it clear he did not wish his wife or family to know about his history of mental health problems and declined further follow-up as he was afraid they may find out.

13.29 Following his assessment, the CPN recommended that JMcF commence a prophylactic course of anti-depressants and stated in his assessment notes that he would liaise with the GP about support options.

13.30 **On 6th November 2000.** The Driving Academy Limited wrote to the GP regarding JMcF stating that on his application to become a driving instructor JMcF had crossed out the section that requested information about mental or other illnesses. He also stated that he had only missed a few days

work due to illness in the last five years. JMcF was subsequently accepted onto the driving instructor training programme. JMcF then took almost a year to complete his training. He was subsequently signed up by The Driving Academy on a two year contract. The Driving Academy expressed the view that JMcF's application form was misleading and consideration was given to instigating court proceedings.

13.31 A claim was subsequently made by the Driving Academy for arrears in excess of £4,400 and also a separate claim relating to training fees. A request was made that the GP specifically comment on JMcF's ability to work as a driving instructor.

13.32 The report submitted by the previous GP stated that from 26th September 2000 until 14th November 2000 JMcF was unable to work as a driving instructor because of the stress that the job was causing him. The GP stated that in his opinion the driving instructor job had caused JMcF to have a depressive episode. He also stated that he thought that it would be dangerous for his health and his pupils for him to continue driving. This matter appeared to be resolved and there were no other entries. There was no further traceable contact with mental health services.

13.33 **On 13th August 2008**. The GP, GP One, referred JMcF urgently to a Consultant Psychiatrist for a mental health assessment. The referral was addressed to a Consultant Psychiatrist, West Suffolk Hospital. In the referral letter, GP One highlighted the fact that JMcF had a long history of mental health problems[31]. The letter outlined that he had been admitted to hospital in York for depression and psychotic episodes when he was twenty three years old. The referral alerted the Consultant Psychiatrist to JMcF's previous psychiatric history, highlighting the fact that he had been found at home by his previous GP, unconscious with weapons of self-harm including a noose, a bloodstained knife and a drill set in 1993.

13.34 In the referral letter GP One listed as enclosures: letters from previous GP surgeries and letters from the Harrogate Health Centre which outlined more information about his previous psychiatric history. The letter states that JMcF had been suffering from low mood, racing thoughts, hyperactivity and feelings of recklessness for four weeks. GP One stated that the patient was denying any feelings of self harm but admitted to having an image of himself hanging. GP One was clear in his referral that JMcF was deteriorating and that JMcF was keen not to:

13.35 "*go down the same route as his previous episodes".*

13.36 GP One had started the patient on *Fluoxetine* two weeks previously but was now changing him over to *Venlafaxine. Temazepam* had also been prescribed in order to help with his sleep but this was noted to be making JMcF groggy in the mornings so it was discontinued. Finally, GP One highlighted that JMcF did not want his wife to know about his problems.

13.37 Team Leader One (Clinical Team Leader) at Suffolk Mental Health Partnership Trust wrote back to GP One on 19th August 2008, stating that the referral had been discussed and had been faxed onto the Bury St Edmunds Community Mental Health Team for an assessment of JMcF.

13.38 **On 21st August 2008** an appointment letter was sent out by Bury St Edmunds Community Mental Health Team to JMcF offering him an appointment to meet with the mental health services on 28th August 2008 at 15:00.

[31] Referral letter written by GP One to Consultant Psychiatrist, West Suffolk Hospital dated 13 August 2008

13.39 Community Psychiatric Nurse, Bury St Edmunds CMHT (CPN One) called GP One to ask whether this appointment was soon enough or whether she wanted JMcF to be seen sooner. GP One is noted to have indicated that that would be alright but gave the CPN JMcF's number. CPN One left a message for JMcF about the 28th August 2008 appointment and said he could be seen sooner if he wished. JMcF requested an alternative appointment and another appointment letter was sent out to him inviting him to attend on the 1st September 2008 at 15:00. However, JMcF was not seen on the 1st September 2008 as he cancelled that appointment too. He was contacted by telephone and offered a further appointment on 11th September 2008 at 15:00.

13.40 **On 11th September 2008** JMcF was assessed by Social Worker One (Approved Social Worker) and CPN One (JMcF was not seen by a Consultant Psychiatrist as had been requested by GP One. Consultant Psychiatrist One (Consultant Psychiatrist) Bury St Edmunds Community Mental Health Team has no recollection of being made aware of this referral[32]. During the assessment on 11th September 2008, CPN One asked most of the questions, whilst Social Worker One wrote up the assessment[33]. This was normal practice within the CMHT.

13.41 No reference is made in the documentation completed by Social Worker One following the assessment to the contents or information provided by GP One in the referral letter dated 13th August 2008. Both Social Worker One [34] and CPN One [35] have since confirmed that they did see a copy of GP One's referral letter.

13.42 In the referral letter GP One listed as enclosures letters from the Harrogate Health Centre in order to provide Bury St Edmunds Community Mental Health Team with some information with regard to JMcF's previous psychiatric admissions. No reference is made to this information either. Social Worker One (ASW) completed a Risk Screen[36] as part of the assessment. Under the category "Behaviours that cause concern" he recorded "nil". Under the section on "Cognition/physical health" the term "nil" has also been used. The Action Plan section of the Risk Screen had been left blank.

Comment

13.43 No record of the information regarding JMcF's previous psychiatric history can be found in the clinical records kept by the Bury St Edmunds Community Mental Health Team. There was no system in place at that time to record documentation received by the team.

13.44 During the assessment, JMcF reported feeling self-conscious and concerned about people being upset by him. He also reported feeling anxious since returning from holiday in July. It had been harvest time which meant he had had to work long hours and had been unable to attend the gym. JMcF reported that the prescribed medication was helping his symptoms.

13.45 CPN One and Social Worker One agreed with JMcF that he should continue taking the anti-depressants he had been prescribed by GP One, try to attend the gym and to discuss with the GP attendance at an Anxiety Management Group.

[32] Interview with Consultant Psychiatrist One on 9 November 2010
[33] Interview with CPN One on 9 November 2010
[34] Interview with Social Worker One on 16 November 2010
[35] Interview with CPN One on 9 November 2010
[36] Risk Screen completed by Social Worker One, ASW, dated 11 September 2008

13.46 Social Worker One wrote to JMcF summarising the outcome of the assessment and their agreed plan of action[37]. Social Worker One and CPN One did not discuss the assessment and the outcome at the subsequent Team Meeting[38] Social Worker One, (ASW) wrote to GP One on 11th September 2008 enclosing a copy of the assessment schedule completed[39].

Comment

13.47 A Single Point of Referral (S.P.O.R) was in operation at the time of the incident. The S.P.O.R considered all referrals which had been received by the CMHTs and the CRHTTs and allocated the referrals out to the most appropriate team. GP One's initial letter of referral dated 13th August 2008 was addressed to a "Consultant Psychiatrist". However, Consultant Psychiatrist One, Bury St Edmunds CMHT was not informed about the referral.

13.48 There was no system in place within the Bury St Edmunds CMHT at the time of the incident to record receipt of any information received from referees or anyone else by the team. Both CPN One and Social Worker One who conducted an assessment of JMcF in response to the referral make no reference to this information in their clinical notes following their assessment of JMcF. It is unclear whether or not the information was actually sent by GP One and whether or not CPN One and Social Worker One received and read the information prior to their assessment of JMcF.

13.49 Whilst there were minimum agreed standards in place at the time of the offence around how swiftly an emergency, urgent and routine referral would be seen, there was and is currently no regular monitoring and reporting of Bury St Edmunds CMHT's performance against these standards. The standards state that an urgent referral will be seen within five days. GP One's letter of referral was dated 13th August 2008. The letter was acknowledged by the S.P.O.R on 19th August 2008, which was already six days after the initial urgent referral.

13.50 At the time of the offence and at present, there is no formal system in place for the Team Manager to monitor the quality of assessments, including risk assessments being conducted by members of the Bury St Edmunds CMHT.

Opinion

13.51 The referral made by GP One to a "Consultant Psychiatrist" was appropriate given JMcF's presentation at that time. GP One's letter of referral was comprehensive and of a high standard.

13.52 The referral letter dated 13th August 2008 was addressed to a Consultant Psychiatrist. The Core Panel are of the opinion that this indicates that the GP was seeking an assessment of JMcF by a Consultant Psychiatrist.

13.53 The assessment of JMcF undertaken by Social Worker One and CPN One was of a superficial and poor standard given their experience of working in mental health. The initial risk assessment conducted by Social Worker One and CPN One was also of a poor standard. No consideration was given to the information provided in the letter of referral. Both Social Worker One and CPN One thought that JMcF's mental health had improved since the letter of referral from the GP.

13.54 Having completed an assessment of JMcF Social Worker One and CPN One did not discuss or feedback the outcome of their assessment with either Consultant Psychiatrist One or the multi-

[37] Letter to JMcF from Social Worker One, ASW dated 19 September 2008 outlining the outcome of the assessment
[38] Written statement from Social Worker and Team Leader One, Team Manager, Bury St Edmunds CMHT dated 1 February 2011
[39] Assessment Schedule completed by Social Worker One dated 11 September 2008

disciplinary team. Given that JMcF's GP had specifically made a referral to a Consultant Psychiatrist this was also poor practice.

13.55 During the course of interviewing staff, the Core Panel felt that some of the staff interviewed were of the opinion that GPs "panic and want all patients seen urgently". However, GP One's referral was comprehensive. The request for an urgent assessment was not acted upon as soon as we would expect given the agreed team standards for the time-frame within which urgent referrals were meant to be seen. The fact that the referral letter was addressed to a Consultant Psychiatrist was ignored. JMcF was not seen by a Consultant Psychiatrist as requested. No attempt was made by anyone to discuss the request for a Consultant Psychiatrist with GP One.

1. *Recommendations to improve Patient Safety*

The CMHT operational policy should state how all referrals to the team will be managed. The policy should provide staff with guidance around how quickly referrals should be seen and by whom.

When in receipt of a new referral, staff allocated to conduct an initial assessment of the patient should ensure that they read and have access to the referral letter and any additional information sent in by the referrer at the time of assessment.

Where a patient is known to have a past psychiatric history, attempts should be made prior to the assessment to obtain a discharge summary from the service which has previously assessed the patient.

At the time of the offence and currently, there are standards set in the East & West Suffolk Community Adult Mental Health Teams Operational Protocol (2010) around how quickly the CMHT will assess emergency, urgent and also routine referrals. It is recommended that the Team Manager, CMHT, regularly audits, monitors and reports to the Service Director on the performance of the team against these agreed minimum standards.

Where a referral is received by the CMHT from a GP for an assessment by a Consultant Psychiatrist, the referral should be brought to the attention of the Consultant Psychiatrist and agreement reached regarding who should assess the patient. If the Consultant Psychiatrist agrees that it is appropriate for other team members to assess a new referral, the staff who subsequently assess the patient should ensure that they feed back the outcome of their assessment to the Consultant Psychiatrist and the rest of the multi disciplinary team via the Team Meeting. Staff should ensure that this communication is minuted in the minutes of the Team Meeting and documented in the patient's notes.

Social Worker One and CPN One to access training and regular supervision on undertaking comprehensive assessments of new referrals.

Social Worker One and CPN One to access training and regular supervision on undertaking risk assessments.

The frequency of clinical supervision provided to Social Worker One and CPN One should be increased. Clinical supervision sessions should be used to discuss individual cases and to monitor the standard of their assessments including their record keeping.

A robust system should be introduced in Bury St Edmunds CMHT to ensure that all documentation coming into the CMHT is recorded.

A formal system should be introduced for the Team Manager to monitor the quality of assessments, including risk assessments being conducted by each individual member of the Bury St Edmunds CMHT.

13.56 **On 25th November 2008** GP One re-referred JMcF to a Consultant Psychiatrist Suffolk Mental Health Partnership Trust. The letter of referral[40] stated that although the request had been made for him to be assessed by a Consultant Psychiatrist he had in fact been assessed by one of the Social Workers. In this second referral letter sent to the Consultant Psychiatrist, the GP states:

13.57 "*I don't feel that he had enough of an input and I am re-referring him*".

13.58 The letter highlights the fact that JMcF feels his mood is getting *"lower and lower".* In this re-referral, the letter states that JMcF is no longer taking any prescribed medication, denies any thoughts of self-harm but did admit to taking more risks when driving.

13.59 **On 28th November 2008** an appointment letter[41] was sent to JMcF inviting him to an appointment with Consultant Psychiatrist One on 4th December 2008. JMcF cancelled this appointment.

13.60 **On 2nd December 2008** Team Leader One (Clinical Team Leader) wrote to GP One confirming receipt of the referral letter for JMcF and stating that the referral had been faxed on to the Bury St Edmunds Community Mental Health Team.

13.61 **On 4th December 2008** a revised appointment letter was sent out to JMcF. A revised appointment with Consultant Psychiatrist One (Consultant Psychiatrist) was sent out to him for the 13th January 2009 at 14:30. On 8th December 2008 a further revised appointment letter was sent out to JMcF. A letter of apology was written for having to change the appointment time on the 13th January 2009 to 13:30.

13.62 **On 13th January 2009** JMcF was assessed by Consultant Psychiatrist One. Consultant Psychiatrist One was able to elicit more information from JMcF at the assessment about his childhood and family life. The clinical records state[42]:

13.63 *"...is one of 3 children. His father died six years ago following lifelong problems with alcoholism. He was only in his early sixties. His father never had another relationship after separation from JMcF's mother. JMcF's mother had a new relationship and has since had further children with her new partner. At the time of divorce JMcF was twelve years old. He has a two year older sister and a six year younger brother. He recalls that at the time, mother decided to spend Christmas with*

[40] Re-referral letter from, GP to Consultant Psychiatrist, Bloomfield House dated 25 November 2008
[41] Acknowledgment of receipt of referral letter. Letter sent by Team Leader One, Clinical Team Manager to GP Two dated 2 December 2008
[42] Letter from Consultant Psychiatrist One to GP One dated 14 January 2009

her new partner, taking her youngest son with her. JMcF and his sister were left in the care of father. Rather than look after the two children he spent most of his time in the pub"

13.64 *"JMcF had blamed his father for everything that was wrong with the family. When his parents split up his sister lived with their father though later she was more or less fostered by a local family she used to baby sit for. JMcF together with his little brother stayed with mother. For reasons he does not quite know he was moved to a children's home where he remained the rest of his teenage years. The last three years he lived in a boarding school for boys near Scarborough. He recalls often running away to get some attention with everyone wanting to know where he had been on his return"*

13.65 Consultant Psychiatrist One's impression[43] was that JMcF had become depressed and had problems sleeping and episodes of suicidal ideation. She felt he would benefit from anti-depressants but JMcF was reluctant to take medication preferring to access Cognitive Behavioural Therapy (CBT). She concluded that JMcF would benefit from CBT via Improving Access to Psychological Therapies Service (IAPT). She arranged for him to have access to the Crisis Resolution & Home Treatment Team (CRHTT) at anytime as she identified that he had times during which he felt very low and suicidal. She prescribed *Trazodone* 150 mgs nocte prn.

Opinion

13.66 It was appropriate for GP One to re refer JMcF for an assessment by a Consultant Psychiatrist.

13.67 Consultant Psychiatrist One conducted a thorough assessment of JMcF. The notes of this assessment are very detailed and are of a high standard. There is a clear plan of care documented in the notes. A detailed summary of the assessment of JMcF was sent to GP One in response to the referral.

13.68 The plan of care suggested by Consultant Psychiatrist One was appropriate given JMcF's presentation. Self referral into IAPT was already in operation within Suffolk IAPT and self-referral is considered to be good practice and within the national guidelines for accessing psychological therapies.

13.69 **On 28th January 2009** JMcF self referred to IAPT following a recommendation made by Consultant Psychiatrist One (who saw JMcF on 13th January 2009). Consultant Psychiatrist One had suggested that JMcF refer himself to IAPT in order to be able to access CBT. GP One also referred JMcF to IAPT on the same day.

13.70 **On 17th February 2009** JMcF was subsequently assessed by IAPT Worker One (Low Intensity IAPT Worker); Suffolk IAPT Service Appropriate screening tools Patient Health Questionnaire (PHQ9)[44] and Generalised Anxiety Disorder (GAD7)[45] were administered. IAPT Worker One took JMcF's case to case management supervision for two main reasons – JMcF reportedly presented with low self-esteem rather than low mood, and also because he was specifically requesting face to face CBT.

[43] Interview with Consultant Psychiatrist One on 9 November 2010

[44] From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

[45] The GAD-7 originates from Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. GAD-7 © Pfizer Inc. all rights reserved; used with permission

JMcF was subsequently offered low intensity interventions by IAPT as part of a stepped care treatment plan.

13.71 **On 20th February 2009** IAPT Worker One sent JMcF self-help forms and two diaries for him to start completing. His next appointment with IAPT Worker One was scheduled for 3rd March 2009.

13.72 The patient wrote a letter to IAPT Worker One (undated)[46] which stated that he felt that he needed more than was being offered to him via IAPT. He was keen to receive CBT as recommended by Consultant Psychiatrist One and was disappointed to have not been offered CBT sessions. IAPT Worker One did not however receive the letter written by the patient until later as it had been misplaced within the service[47]. When JMcF did not attend for his appointment with her on 10th March 2009, she wrote to him offering him a further appointment on the 27th March 2009.

13.73 Consultant Psychologist One, Suffolk IAPT Service had a telephone discussion with JMcF following his letter of complaint regarding being offered low intensity support as opposed to CBT. JMcF told Consultant Psychologist One that Consultant Psychiatrist One had said he needed fairly long term CBT. He said that since he had written the letter he had had a private assessment with a private CBT therapist, Private CBT Therapist One. Friend One suggested JMcF contact the service Private CBT Therapist One worked in. JMcF said he was unsure of how to proceed. Consultant Psychologist One agreed with him she would talk to Consultant Psychiatrist One and contact him within two weeks.

13.74 **On 4th April 2009** Consultant Psychologist One telephoned JMcF again. JMcF stated he wished to continue seeing the private therapist and would contact IAPT if needed to in future. He was discharged from IAPT.

13.75 JMcF saw Private CBT Therapist One for an initial assessment on 10th March 2009 and then subsequently for three further sessions. JMcF was thought to be suffering from moderate to severe depression with suicidal or para-suicidal ideation at that time. Whilst there were indicators of risk to self there was no indication that JMcF was a risk to others. Private CBT Therapist One adopted an integrative approach with elements of CBT with JMcF in order to keep him engaged.

Comment

13.76 Consultant Psychiatrist One's recommendation that JMcF access CBT and JMcF's request for CBT was not met by IAPT.

13.77 At no point does there appear to have been communication between IAPT Worker One, (IAPT) and Private CBT Therapist One, (Private CBT therapist) or between Private CBT Therapist One and Consultant Psychiatrist One or the GP.

13.78 JMcF wrote a letter of complaint about the fact that his request for CBT had not been met by IAPT. His letter of complaint was misplaced and once found was not handled as per the Trust policy on the management of complaints.

13.79 JMcF accessed CBT via a private therapist when he could not access CBT via the NHS.

[46] Undated letter from JMcF to IAPT Worker One. Stamped as being received on 3 March 2009
[47] Interview with IAPT Worker One on 8 November 2010

13.80 The Core Panel heard that staff working within the IAPT have limited access to private office space within which to conduct 1:1 meetings and supervision.

Opinion

13.81 JMcF's scores on the Patient Health Questionnaire and the Generalised Anxiety Disorder indicated a level at the moderate to severe end. Whilst accepting that the scores alone cannot determine levels of intervention, further consideration should have been given to Consultant Psychiatrist One's recommendation and JMcF's request for CBT. Supervisor CBT One, IAPT Worker One's supervisor has no recollection of JMcF being discussed with her in case supervision[48]. There are no notes available from case supervision until 4th March 2009.

13.82 During the course of undertaking this investigation, it came to the Core Panel's attention that there are practical problems in the provision of supervision to workers working within IAPT. The team office is open plan and the availability of more private areas for supervision is restricted.

13.83 Private CBT Therapist One is an experienced therapist. She adopted an integrative approach when working with JMcF. It is unlikely that a purely CBT approach would have been effective.

13.84 Unfortunately, communication was minimal between the health professionals who assessed and treated JMcF. As a result, there was no means of being able to collect an "overall" picture of JMcF's mental state and his needs. JMcF was clear that he did not want any health or social care professional to liaise with any members of his family. As a result, the need to try and build a picture of JMcF via his presentation to health and social care professionals became even more important. Perhaps individual members of health and social care staff were reluctant to share information with one another for fear of breaching confidentiality. However, this could have been addressed directly by asking JMcF for his consent to share clinical details with health and social care professionals who had assessed him previously.

13.85 Private CBT Therapist One's own private process notes of her sessions with JMcF were scrutinised by the Core Panel. The writing was illegible in parts. Overall the notes were difficult to read. Records kept by psychologists should, according to the Generic Professional Practice Guidelines[49], be:

- Systematic and appropriately detailed
- In clear language/format
- Accurate
- Up to date and
- Relevant to professional work

13.86 Private CBT Therapist One's notes did not meet these minimum requirements.

[48] Written statement from Supervisor CBT One, Qualified Cognitive Behavioural Psychotherapist dated 31 January 2011
[49] British Psychological Society (2008) *Generic Professional Practice Guidelines*

2. Recommendations to improve Patient Safety

We recommend that a patient's wishes regarding accessing psychological therapies be taken into consideration when deciding what treatment to offer a patient.

We recommend that the professional opinion of mental health professionals who have recently assessed any patients being assessed by IAPT is considered when deciding what treatment to offer the patient.
Private CBT Therapist One should be reminded that it is important to ensure that her process notes are legible to ensure effective written communication.

Providers should consider the implementation of national policies to ensure that they do not inhibit access to multiple services where that is necessary.

All complaints received by Trust staff should be dealt with via the Trust policy on managing complaints.

A review of the office space occupied by and made available to the IAPT service should be conducted with a particular focus on the extent to which private space is available for staff to conduct supervision sessions.

13.87 **On 23rd April 2009** JMcF went to see GP Two. Friend One accompanied him and suggested to the GP that JMcF be referred to the Crisis Resolution Home Treatment Team (CRHTT)[50].

13.88 **On 23rd April 2009** a telephone referral was made by the GP to the CRHTT. His GP reported that JMcF's mental state was deteriorating and that JMcF had active suicidal thoughts and plans.

13.89 **At 12.30pm on 23rd April 2009** JMcF was contacted by a Community Psychiatric Nurse (CPN) from the CRHTT. JMcF reported he was not feeling good and had thoughts of self harm. He was not taking his anti-depressants. He declined a home visit but agreed to be seen at Wedgwood House at Suffolk Mental Health Partnership Trust.

13.90 **At 2.30pm on 23rd April 2009** JMcF was assessed by CRHTT Nurse Two and CRHTT Nurse Three from the CRHTT. JMcF had been referred to the CRHTT by GP Two who reported he was low in mood, suffering from suicidal ideation and had marital difficulties. By this time JMcF had commenced CBT privately. Both CRHTT Nurse Two and CRHTT Nurse Three were aware that JMcF had been seen previously by Consultant Psychiatrist One and had access to and read the notes of the assessment she conducted on 13th January 2009.

13.91 JMcF was assessed at Wedgewood. He attended the assessment with Friend One who was present throughout the whole assessment. At the time of assessment JMcF was considering ending his marriage and was overwhelmed by an argument he had had the night before with his wife. He reported having suicidal thoughts and plans to cut his wrists or hang himself. He had called Friend One for help who went with him to the GP appointment and the appointment with staff from the CRHTT. The two staff assessing him from the CRHTT did not consider that JMcF was an imminent suicide risk, nor did they think he needed to be admitted to hospital. Both nurses assessing JMcF thought that he had reasonable plans around how he was going to spend the rest

[50] Transcript of Police interview with JMcF dated 16th June 2009

of his day and some insight into the difficulties he was experiencing. They did not think that JMcF required hospital admission or home treatment. They recommended he visit his GP for a prescription for *Trazadone* as recommended by Consultant Psychiatrist One and continue CBT with his private therapist.

13.92 Neither nurse considered having Consultant Psychiatrist One review JMcF and neither communicated to Consultant Psychiatrist One[51] the fact that they had assessed JMcF that afternoon in response to a referral to the CRHTT from his GP. Nor did either nurse communicate with Consultant Psychiatrist Two (Consultant Psychiatrist for the CRHTT) about the referral and their assessment of JMcF. Both nurses did however have access to the notes written by Consultant Psychiatrist One following her assessment of JMcF on 13th January 2008. Neither nurse asked JMcF for his consent to liaise with his private CBT therapist regarding his mental state. Neither nurse made any attempt, nor thought about contacting his private CBT therapist for more information or to update her[52].

Opinion

13.93 The assessment conducted by CRHTT Nurse Three and CRHTT Nurse Two in itself was acceptable. Consideration was given to risk to self and others. Neither nurse felt he was a suicide risk at that time or a risk to others. Details of JMcFs past psychiatric history are documented on the risk assessment form.

13.94 It is regrettable that neither nurse informed Consultant Psychiatrist One of the outcome of their assessment of JMcF. It is also regrettable that they did not feed back the outcome of their assessment of JMcF to Consultant Psychiatrist Two, for the CRHTT within which they were working. Neither nurse made any attempt to seek consent from JMcF to communicate with JMcF's private therapist. Overall, both nurses did not communicate as well as we would have expected following their assessment of JMcF.

13.95 Given the events to this point in time the Core Panel consider that it is quite possible that JMcF would not have been able to access mental health services had Friend One not sign-posted him to services.

3. Recommendations to improve Patient Safety

CRHTT staff to be reminded of the importance of communicating effectively with other colleagues.

CRHTT staff to be reminded of the importance of communicating effectively with other healthcare staff involved in any patient's care.

13.96 **On 23rd April 2009** JMcF left his wife. On 24th April JMcF went to stay with Friend One and Friend Two who are husband and wife. Friend One was a Trainee Clinical Psychologist at the time. Friend One told JMcF he could stay with them for two weeks.

13.97 **On 25th April 2009** Friend One and MG held a 40th Birthday party for JMcF.

[51] Interview with CRHTT Nurse Three on 9 November 2010 and interview with CRHTT Nurse Two on 16 November 2010

[52] Interview with CRHTT Nurse Two on 16 November 2010

13.98 JMcF stayed with Friend One and Friend Two until 28th April 2009. They both had a friend coming over from America to stay. Friend One knew JMcF's employer was supportive and that he could stay with his employer if need be. JMcF did not stay with Friend One and Friend Two on 29th and 30th April 2009. Friend One thought he had stayed on the farm but JMcF said he had slept on the sofa at MG's home. However, it has not been possible to verify this statement with anyone else.

13.99 **On 30th April 2009** MG hurt her knee whilst teaching Body Combat. JMcF took her to Accident & Emergency. He stayed at Friend One and Friend Two's home on 1st May 2009.

13.100 **On 2nd May 2009** Friend Two helped JMcF move his belongings out of the marital home. Friend Two stated JMcF was swearing and upset on the way back to his home. JMcF then went over to MG's home. JMcF was angry at the prospect of MG's ex-boyfriend returning to her home. Friend One received a text from MG at 20:14 on 2nd May 2009 which said:

13.101 *"Hi JMcF's behaviour is scaring me [redacted]. I'm with the girls so can't call u but wanted to tell u".*

13.102 Friend One and MG then exchanged a number of texts that evening. At 21:49 MG sent Friend One a text which said:

13.103 *"Between u and I [redacted] JMcF despite the facade is to me not so stable. I am feeling uncomfortable with him. ....."*

13.104 **On 3rd May 2009** JMcF called Friend One. He had left a message on Facebook saying something about all good things come to an end[53] and sent a text to her stating:

13.105 *"You and [redacted] have been great. It's not your fault".*

13.106 Friend One and Friend Two were at home when Friend One received the text. They were both concerned that he may try and kill himself by taking *Zopiclone* and by using a rope[54]. They both got in their car. Friend One called JMcF on his mobile and asked him where he was. He confirmed he was at the farm. When Friend One and Friend Two got to the farm they found JMcF in the barn. He was at the top of a forklift truck which was raised to the rafters. There was a rope hanging down. JMcF was standing beside the rope. Friend One asked JMcF to come down which he did. Friend Two suggested driving back to their home and putting JMcF to bed, which they did. Shortly after, Friend One did not think this was appropriate given JMcF's actions, so she called the on-call GP service for advice. An ambulance then came and took JMcF to hospital.

Comment

13.107 The first time MG is known to have expressed fear of JMcF appears to have been in her text to Friend One on 2nd May 2009.

13.108 CRHTT Nurse One, the Lead on Call for the CRHTT was contacted by a doctor in the Accident & Emergency Department between 03:00 and 03:15. The doctor requested a mental health assessment to be carried out on JMcF. CRHTT Nurse One contacted her colleague CRHTT Nurse Three (Charge Nurse, CRHTT) and requested that they carry out a joint assessment of JMcF in Accident & Emergency. CRHTT Nurse One and CRHTT Nurse Three both met at A&E at around

[53] Interview with Friend One on 8 November 2010
[54] id.

04:00. They checked JMcF's electronic record entries on EPEX. CRHTT Nurse Three recalled JMcF having previously assessed him on 23rd April 2009.

13.109 Whilst awaiting the arrival of CRHTT Nurse One and CRHTT Nurse Three, JMcF left the Accident & Emergency Department, West Suffolk Hospital Trust. Staff working in the Accident & Emergency Department had no idea that JMcF had left the department and only became aware of this fact when JMcF rang the reception in the Accident & Emergency Department and spoke to a receptionist[55]. He stated that he was on his way to his place of work to kill himself.[56] Staff in the Accident & Emergency Department, initiated a departmental search and an area was searched outside, and then subsequently contacted the police at 04:30[57] and circulated him as a missing person as prompted by CRHTT Nurse One and Nurse Three.

13.110 When both CRHTT Nurse One and CRHTT Nurse Three arrived at the Accident & Emergency Department they were advised by the staff in Accident & Emergency that JMcF had left the department. Both nurses requested that A&E report JMcF as a missing person to the police and requested that they were contacted immediately on JMcF's return. They then left the department and went home.

13.111 Between 05:00 and 05:30 CRHTT Nurse One received a telephone call from a doctor (she is unable to recall the doctor's name) informing her that the police had called JMcF on his mobile; he had answered and told them his location. The police had then located JMcF and brought JMcF back to Accident & Emergency on an informal basis. JMcF was returned to the A&E department and registered at 05:22, and the CRHTT contacted at 05:45.[58]CRHTT Nurse One then contacted CRHTT Nurse Three again and they both met up in Accident & Emergency at 06:00 in order to assess JMcF.

13.112 When CRHTT Nurse One and CRHTT Nurse Three assessed JMcF he said he had not slept for four nights. He appeared "*unsettled*"[59] to CRHTT Nurse Three in contrast to his previous presentation to her. He had previously presented as a good historian. On this occasion both nurses found it difficult to take a history from him. The trigger for his suicide attempt had been the fact that the previous evening he had returned to his wife to collect his belongings. His wife helped him pack his bags and seemed to show no signs of being upset about his leaving.

13.113 With JMcF's consent, CRHTT Nurse Three called Friend One. Friend One explained to her[60] that JMcF had just left his wife and had been staying with Friend One and Friend Two for a few days. JMcF was described as "*more manic*"[61]. It was said that JMcF would be unable to stay much longer as they were expecting a friend to stay from America. JMcF had as yet not made any firm arrangements to stay anywhere else but had been spending time at MG's house.

13.114 CRHTT Nurse One and CRHTT Nurse Three decided that admission to hospital was appropriate for JMcF. They both felt that he would benefit from a period of assessment in hospital. Neither felt JMcF could give a clear account about the events which had occurred the night before. They did not think it was safe (in as far as they thought that he continued to be at risk of self harm) to

[55] Written statement from A&E Consultant One, Consultant in Accident &Emergency Medicine dated 3 February 2011
[56] id
[57] id
[58] id
[59] Interview with CRHTT Nurse Three on 9 November 2010
[60] id
[61] id

allow JMcF to leave the Accident & Emergency Department. He declined admission. He stated that he had a combat class to run and that he had work to do, for example animals on the farm to feed.

13.115 CRHTT Nurse One contacted Customer First, Suffolk County Council at 08:20 and requested to speak to an Approved Mental Health Practitioner with a view to organising for a Mental Health Act assessment to be carried out.

13.116 Social Worker Two (Approved Mental Health Professional) was called at 08:30, Section 12 Doctor One at 08:50 and Section 12 Doctor Two, GP at 09:00. Social Worker Two contacted the police at 09:30 to alert them to the fact that a Mental Health Act assessment was going to take place in the Accident & Emergency Department and they may need police assistance.

13.117 Section 12 Doctor One arrived on site at 09:45 then spent time liaising with staff from the Mental Health Trust regarding bed availability. At the time of the incident, four adult mental health wards served the locality as follows:

- Northgate – 21 beds
- Southgate – 20 beds
- Mistley – 24 beds
- Playford – 24 beds

13.118 Bed occupancy levels across all four wards for the period Jan 2009 to May 2009 varied between 70% to 91%, averaging at 81%. On 3rd May 2009, there were a total of five beds available across all four wards. See Appendix three for further information regarding our benchmarking of bed numbers, bed availability and staffing levels.

Comment

13.119 There was no indication in the clinical notes of what level of nursing observations JMcF should be placed on whilst waiting in the Accident & Emergency Department for a) an assessment by the CRHTT and b) a Mental Health Act assessment.

13.120 There are no written notes in the clinical records to indicate that the professionals who conducted the Mental Health Act assessment considered JMcF's occupation and access to farm machinery and firearms in their assessment.

13.121 As per good practice, Section 12 Doctor One checked bed availability prior to commencing a Mental Health Act assessment on JMcF on 3rd May 2009.

13.122 There were acute psychiatric beds available into which JMcF could have been admitted informally had he agreed to be admitted or formally under Mental Health Act 1983 had he been detained.

13.123 **On 3rd May 2009**, whilst in Accident & Emergency awaiting the arrival of two members of staff from the CRHTT, JMcF left the department. The staff in Accident & Emergency were unaware he had left the department until JMcF rang reception and told them so[62]. Having realised JMcF had left the department the staff circulated his details to the police. He was later found and returned to Accident & Emergency with police assistance on an informal basis. CRHTT Nurse One and CRHTT Nurse Three from the CRHTT were then contacted and returned to Accident & Emergency

[62] Written statement from A&E Consultant One, Consultant in Emergency Medicine dated 3 February 2011.

to assess him. Having completed their assessment both nurses then left JMcF in Accident & Emergency at around 06:30 in order to go and organise a Mental Health Act assessment. JMcF did not leave the department but remained there until the three members of staff conducting the Mental Health Act assessment arrived at around 10:00.

Opinion

13.124 Staff in the Accident & Emergency Department had a duty of care towards JMcF from the time he arrived in the department via ambulance. He was referred to the CRHTT for a mental health assessment at 03:28. Staff in the Accident & Emergency Department were unaware that JMcF had left their department whilst awaiting the arrival of mental health professionals. Staff only became aware that JMcF had left their department when JMcF called reception in Accident & Emergency. Given that JMcF was attending the department having made a serious attempt to take his own life we would have expected that the staff in Accident & Emergency would have considered and taken steps to ensure that JMcF was closely supervised by nursing staff whilst he was in their department. JMcF was brought back to the Accident & Emergency Department by police at 05:22. At 05:45 staff from the CRHTT called Accident & Emergency staff to say that they would be in attendance within the hour. They documented the outcome of their assessment at 06:40.

13.125 There were beds into which JMcF could have been admitted. The Core Panel are of the opinion that bed availability did not have an influence on the decision not to section JMcF under the Mental Health Act 1983 at that point in time.

13.126 In hindsight, it would have been preferable for the staff conducting the Mental Health Act assessment to have contacted Friend One and Farm Manager One regarding securing a suitable place for JMcF to stay upon discharge. JMcF's consent could probably have been obtained to contact them. Both Friend One and Farm Manager One felt it would have been preferable for a member of staff to contact them directly without JMcF being present. Farm Manager One felt pressured to agree to JMcF staying with him since it was JMcF that called him and made this request. Farm Manager One subsequently called Section 12 Doctor One once he had got JMcF back to the farm to express his concerns about him staying at the farm.

4. Recommendations to improve Patient Safety

Ensure that there is an operational policy in place between Suffolk NHS Mental Health Partnership NHS Trust and West Suffolk NHS Trust regarding the management and care of patients presenting with mental health problems in Accident & Emergency.

The operational policy should clearly state the arrangements around the care and treatment of patients in the Accident & Emergency Department who are awaiting mental health assessment.

Minimum standards around waiting times should be agreed, monitored and reported to the Mental Health Liaison Group on a regular e.g. bi-monthly basis.

The operational policy should offer clarity around the duty of care by staff from either the Acute or Mental Health Trust for any patient awaiting a mental health assessment.

The operational policy should also include guidance around the supervision and management of patients awaiting assessment.

13.127 A Mental Health Act Assessment commenced at 10:30 and was conducted by Section 12 Doctor One, Section 12 Doctor Two and Social Worker Two (Approved Mental Health Practitioner) on 3rd May 2009.

13.128 The three clinicians made their way to Accident & Emergency and commenced their joint assessment at 10:30. Prior to commencing their assessment, Section 12 Doctor One confirmed with the Mental Health Trust that there was a bed available for JMcF should one be required. All three clinicians had access to and sight of clinical records relating to JMcF's previous assessments by mental health staff including the assessment by Consultant Psychiatrist One and also assessment undertaken by staff in the CRHTT. They also had sight of the risk assessment previously completed by staff in the CRHTT.

13.129 A member of the Mental Health Act assessment team as identified in paragraph 13.127 telephoned Friend One prior to commencing the assessment of JMcF. She reassured Friend One and said "*We'll look at him*"[63].

13.130 When JMcF was seen by the three clinicians, he said he had been taken aback by the calm reaction of his wife when he had gone to collect his belongings. This was despite the fact that they had been married for thirteen years. He had expected his wife to be upset about him leaving her. He had also recently received a telephone call from his mother enquiring about his separation from his wife. He had not heard from his mother for one and a half years. He also reported being upset that he thought that his friend MG had accepted her ex partner back. He was upset about that as he felt her children were afraid of MG's ex partner. This made him angry. He left and drove to the farm and set up the equipment required to take his life.

13.131 The assessment team carried out what the Core Panel consider to be a thorough assessment lasting two hours. They could find no evidence of mental disorder. From the clinical records the assessment team knew that there was no history of violence towards others. During the assessment JMcF made no threats towards others. Risk to others does not appear to have been raised specifically in the assessment. The focus was understandably on his risk to himself given that his attendance at A&E had been precipitated by the attempt to hang himself. There does not appear to be any indication from his past history that he constituted a significant risk to others and it does not appear therefore that this was a significant omission by the assessing team. There was no evidence that he was a risk to others.

13.132 JMcF made arrangements to find someone to stay with whilst he was with the assessment team. He contacted Friend One first who declined to have him back to stay. Section 12 Doctor One also spoke to Friend One and asked if Friend One and Friend Two were prepared to have JMcF stay again. Friend One became angry at this suggestion and asked him whether or not he had heard everything that was said about him. Friend One could not believe Section 12 Doctor one was considering discharging JMcF. Friend One felt that JMcF should be detained in hospital under the Mental Health Act 2007. Friend One did not think that Section 12 Doctor One was listening to the concerns raised[64].

13.133 JMcF then contacted Farm Manager One. He was away at the time but agreed that JMcF could stay with him on the farm and made his way back to the farm. JMcF was collected by Farm Manager One from Accident & Emergency and taken by to the farm.

[63] Transcript from interview with Friend One conducted on 8 November 2010
[64] Transcript from interview with Friend One conducted on 8 November 2010

13.134 Whilst Section 12 Doctor One was still in Accident & Emergency he received a telephone call from Farm Manager One expressing doubts about having JMcF staying with him and back on the farm[65]. After a discussion with Section 12 Doctor One, Farm Manager One reluctantly agreed to the initial plan.

Comment

13.135 All three clinicians who conducted the Mental Health Act assessment on JMcF on 3rd May 2009 did not think JMcF had a mental disorder or was detainable under the Mental Health Act 1983. They did however recommend that he be discharged under the care of the CRHTT to afford the opportunity of continued assessment and support.

Opinion

13.136 Having interviewed and read the clinical records completed by the three clinicians who assessed JMcF under the Mental Health Act 1983, the Core Panel support the decision not to detain JMcF under the Mental Health Act 1983. In our opinion they collectively conducted a very thorough and detailed assessment of JMcF. In their view, the crisis had passed and JMcF seemed much calmer following his suicide attempt the previous evening. It should also be noted that JMcF had alerted the police to his location having left the Accident & Emergency Department.

13.137 The clinicians who conducted a Mental Health Act assessment of JMcF worked with JMcF to arrange and agree a package of care upon his discharge from Accident & Emergency. JMcF contacted his Friend One who declined to have him stay at her home as she was expecting visitors. Farm Manager One subsequently agreed to JMcF staying with him on the farm. However, it should be noted, that in both instances Friend One and Farm Manager One were perhaps faced with some pressure to accept JMcF since it was he, rather than a clinician, who called them requesting a place for him to stay.

13.138 The Core Panel considered in some depth the fact that the team who conducted the Mental Health Act assessment did not detain JMcF under the Mental Health Act 1983. The Panel believe that JMcF would have benefited from an admission to hospital at that time. An admission to hospital would have allowed a full assessment of JMcF's mental state to be undertaken. However, the Panel agree with the decision reached not to detain JMcF under Mental Health Act 1983 and do not consider having regard to the information available and the assessment that JMcF was detainable at that point in time. The Core Panel note that Friend One was of the opinion that JMcF should be detained in hospital. The Core Panel were unable to ascertain with certainty whether the assessment team considered this fact but they decided ultimately not to detain JMcF.

13.139 The Core Panel also considered the fact that JMcF was discharged into the care of the CRHTT despite having been considered to show no evidence of a mental disorder. The Core Panel reviewed the CRHTT referral criteria and are of the view that JMcF met the criteria for treatment by the CRHTT.

13.140 **At 07:30 on 4th May 2009** JMcF's employer called the CRHTT to express concern about JMcF. Concern was expressed as JMcF was talking about going into Bury St Edmunds to meet up with some friends. CRHTT Nurse Four (Charge Nurse, CRHTT) contacted JMcF and told him that his

[65] Clinical records written by Section 12 Doctor One dated 3 May 2009

employer had called the team to express her concerns. JMcF said he felt safe and confirmed he planned to meet up for coffee with friends. CRHTT Nurse Four advised JMcF that he would call him at 13:30 to see how he was. CRHTT Nurse Four made this call as planned and arranged to meet JMcF on the farm at 14:30.

13.141 CRHTT Nurse Four met JMcF on the farm as planned on the afternoon of 4th May 2009. CRHTT Nurse Four asked JMcF about his recent suicide attempt. He confirmed that one of the triggers had been his wife's lack of emotion when he went to collect his belongings. JMcF said his friends and his private CBT therapist were all being very supportive. CRHTT Nurse Four tried to ascertain the degree to which JMcF was a risk to himself. His police statement states:

13.142 "*I was given no suggestion that he harboured any plans to harm himself or anyone else*". [66]

13.143 CRHTT Nurse Four agreed with JMcF that he would make an appointment for the Consultant Psychiatrist Two to review him.

13.144 **On 4th May 2009** JMcF put a letter through MG's door.

Comment

13.145 JMcF was first referred to the CRHTT by his GP on 23rd April 2009. JMcF was first assessed by Consultant Psychiatrist Two, for the CRHTT on 5th May 2009. The Core Panel tried but were unable to ascertain the extent to which JMcF was discussed with any members of the medical team including Consultant Psychiatrist Two from the time he was first referred to the CRHTT on 23rd April 2009 prior to being seen by Consultant Psychiatrist Two on 5th May 2009.

Opinion

13.146 As per good practice a member of the CRHTT made contact with JMcF soon after his discharge from Accident & Emergency. CRHTT Nurse Four who assessed JMcF considered whether JMcF was a risk to himself or others. He did not think on the basis of his assessment of JMcF that he was a risk to either himself or others. It was appropriate for CRHTT Nurse Four to arrange for JMcF to be assessed by a member of the medical team.

13.147 The Core Panel remain unclear about the extent to which medical staff in the CRHTT were involved in the care of JMcF aside from Consultant Psychiatrist Two who saw JMcF on 5th May 2009.

13.148 The Core Panel found that, overall, health and social care professionals involved in the care of JMcF focused on JMcF's risk to self to a greater extent than on his risk to others. The rationale for doing so was the fact that JMcF had made an attempt to harm himself whereas he had not made any previous statements about wishing to harm others, including MG or her children. It should be noted that the first time MG is known to have expressed any concerns about being afraid of JMcF was on the 2nd May 2009, the day he made a serious self harm attempt and the day prior to the Mental Health Act assessment, in a text to Friend One. This was not known to staff.

13.149 **On 5th May 2010** JMcF paged the CRHTT. He spoke to Team Leader One (Modern Matron, CRHTT). He said he had had a bad night. He stated that his thoughts were racing and he felt very anxious. He had been up that morning checking to see whether anyone had responded to his

[66] Police statement from CRHTT Nurse Four dated 12 May 2009

previous emails and texts. He was disturbed to find no one had responded to him. Team Leader One suggested to JMcF that it would be good for him to be assessed and have his medication reviewed by a member of medical staff later that day. Team Leader One said a member of staff would be in contact later to advise him of a time to come in to see the doctor later that day.

13.150 **On 5th May 2010** Consultant Psychiatrist Two (Consultant Psychiatrist, CRHTT) was made aware of JMcF. This was the first time that Consultant Psychiatrist Two had heard of JMcF. Consultant Psychiatrist Two arranged for CRHTT Nurse One (Charge Nurse, CRHTT) to contact JMcF to offer him an appointment to see Consultant Psychiatrist Two that day at 14:00. Prior to meeting JMcF Consultant Psychiatrist Two received a call from Section 12 Doctor One who had been one of the two doctors who had carried out an assessment on JMcF for possible detention under the Mental Health Act on 3rd May 2009. Both doctors discussed JMcF in detail prior to Consultant Psychiatrist Two, meeting and assessing him.

13.151 Consultant Psychiatrist Two saw JMcF as planned on 5th May 2009. Consultant Psychiatrist Two was surprised at how well JMcF was able to engage in "*small talk*[67]". When asked what he wanted from the CRHTT and the session, JMcF said he wanted medication to quieten his thoughts around why people were not responding to his texts and emails. Consultant Psychiatrist Two responded by stating there was no medication that could achieve that and suggested he write things down rather than use social media .

13.152 Consultant Psychiatrist Two offered JMcF an appointment to see him again on 14th May 2009. He concluded that JMcF was not morbidly anxious or clinically depressed. He also concluded that he was not suffering from mental disorder. He felt it was appropriate that the CRHTT continue to offer JMcF support for the coming few days.

13.153 Between 15:00 and 18:10 JMcF sent texts to a number of people (except MG) from his work telephone. The texts suggested he had been having an affair with MG. At 17:30 MG replied to a message JMcF had posted on Facebook. At 18:00 MG called the police to say that JMcF was harassing her. She said he was calling and texting her and she was frightened.

Opinion

13.154 It was appropriate for Team Leader One to refer JMcF to be assessed by Consultant Psychiatrist Two.

13.155 Section 12 Doctor One contacted Consultant Psychiatrist Two (in order to discuss JMcF's presentation with him and to find out how JMcF was doing.) This is in line with good practice.

13.156 The assessment Consultant Psychiatrist Two (conducted on JMcF on 5th May 2009) was adequate.

13.157 A number of different clinicians had contact with and assessed JMcF whilst he was under the care of the CRHTT. This is unfortunate as this did not allow for a therapeutic relationship to develop between JMcF and one or more members of the team. In the Core Panel's opinion, this was detrimental to his care as there was no continuity of care by the same members of the CRHTT. Each professional assessed JMcF almost on a "one-off" basis.

[67] Interview with Consultant Psychiatrist Two on 17 November 2010

13.158 There was uncertainty about JMcF's diagnosis. The Core Panel believe that JMcF was clearly undergoing a personal crisis precipitated by his decision to leave his wife, her apparent indifference to this decision and also possibly by the fact that his mother had got in contact again with him after some time. JMcF was clearly keen to enter into a relationship with MG and felt rejected when his feelings were not reciprocated by MG. JMcF would have benefited from a short admission to hospital but this was not possible as he declined admission and was not detainable. He was discharged into the care of the CRHTT who would have worked intensively with him, if he engaged with them over a period of days. During this time a clearer understanding of JMcF's mental state and needs would have hopefully have developed.

13.159 **On 5th May 2009 at 17.30** CRHTT Nurse Five, (Community Mental Health Nurse, CRHTT) received a call from JMcF's employer expressing concern about the fact that JMcF was going to be slaughtering animals the next day. CRHTT Nurse Five said she could not comment as she had not met JMcF but could liaise with Consultant Psychiatrist Two as he had seen JMcF earlier in the day. The employer did not feel this was necessary. CRHTT Nurse Five advised her to discuss her concerns directly with JMcF.

13.160 Ultimately, following discussion with JMcF, the employer organised for another member of staff to undertake the slaughtering of the animals the next day as opposed to JMcF.

Opinion

13.161 Staff conducting the Mental Health Act assessment and those caring for JMcF within the CRHTT should have taken into consideration and explored JMcF's occupation prior to discharging him to the farm where he worked. JMcF had only hours earlier made a serious suicide attempt on the farm using farm machinery. It was left to his employer to raise concerns about JMcF slaughtering animals at work using a bolt gun, rather than the staff who conducted the Mental Health Act assessment or staff in the CRHTT initiating a discussion about this issue with JMcF and his employer.

13.162 The Core Panel are of the opinion that having received the telephone call from his employer CRHTT Nurse Five should have contacted Consultant Psychiatrist Two to discuss her concerns with him about JMcF slaughtering animals the next day. CRHTT Nurse Five left the employer to make the decision about whether or not she should contact Consultant Psychiatrist Two in response to her query and ultimately left the employer to liaise with JMcF about the matter. She could have been more supportive of the employer and offered more direct advice. We recognise she had not met JMcF which is why it would have been appropriate for her to contact Consultant Psychiatrist Two regarding the question the employer was asking.

5. Recommendations to improve Patient Safety

Clinicians should be reminded to explore information about the patient's occupation if the patient is in employment and to consider the patient's occupation, and access to firearms when undertaking risk assessments.

13.163 **On 6th May 2009 at 02.50** Farm Manager One called the CRHTT as he had received a disturbing text from JMcF. CRHTT Nurse Five was on call for the CRHTT and called him back. Farm Manager One expressed concern about the content of a text he had just received from JMcF. He read the text out to CRHTT Nurse Five. He said he had taken the bolt gun used by JMcF to slaughter

animals away from him but he was now going to look for the spare bolt gun (as he was afraid JMcF might have it).

13.164 **At around 03.00** CRHTT Nurse Five called JMcF and advised him that Farm Manager One had contacted her. JMcF said:

13.165 *"You're too late. I've lost most of my blood. I'm going to sleep now"*

13.166 CRHTT Nurse Five managed to get JMcF to confirm his whereabouts. He was in his friend's, Friend One and Friend Two's, back garden. CRHTT Nurse Five contacted the ambulance and police services after this. She requested they attend the address JMcF had given her. She requested police attendance as she was unsure whether or not JMcF would co-operate with the ambulance crew.

13.167 **At 03.00** CRHTT Nurse Five contacted Farm Manager One to confirm the contents of the text Farm Manager One he had received from JMcF. The text said:

13.168 *"Oh to be a good Manager, where is the spare bolt gun, not to mention axe? I will spare the mother but not the three beautiful daughters".*

13.169 **At 03.00** on 6th May 2009, it is documented in the clinical notes that CRHTT Nurse Five called Farm Manager One again to confirm that the police had been made aware of the content of the text

13.170 **At 03.10** CRHTT Nurse Five documented in the clinical notes that she contacted Suffolk Police Control Room to alert them to the reference to the bolt gun, axe and the three daughters in the text sent by JMcF to Farm Manager One. The police advised her that they were dealing with JMcF at the time and would get back to her.

13.171 **At 03.20** CRHTT Nurse Five documented in the clinical notes that she rang the employer and made her aware of the content of the text.

13.172 **At 04.40** on 6th May 2009 the employer rang CRHTT Nurse Five for an update. The CRHTT had no further information at this point.

13.173 **At 04.50** on 6th May 2009 CRHTT Nurse Five contacted the police for an update. The police advised her that they were dealing with a serious incident

13.174 **At 04.55** on 6th May 2009 CRHTT Nurse Five called Employer One again to inform him that the police had stated they were dealing with a serious incident.

13.175 **At 05.20** on 6th May 2009 CRHTT Nurse Five received a telephone call from a Specialist Registrar. He contacted the CRHTT to inform them he had been advised by Accident & Emergency that there had been a serious incident. He had been advised that a patient had stabbed a woman who had subsequently died. He also said that the patient had harmed himself but was alive.

13.176 **At 05.40** on 6th May 2009 CRHTT Nurse Five advised Consultant Psychiatrist Two of the events as known.

13.177 **At 06.00** on 6th May 2009 CRHTT Nurse Five advised Manager One (On Call Manager) of the events. They in turn contacted Director One (Director on call). The latter requested a time line and a report regarding the serious incident as soon as possible.

13.178 **At 09.00** on 6th May 2009 the administrative staff in the CRHTT picked up a telephone message on the team ansaphone. The message had been left the night before by Friend One. The message raised concerns about JMcF's behaviour which had become increasingly erratic. He was sending text messages and Facebook messages which were harassing in nature about Friend One and MG (these were unknown to mental health staff at the time). Friend One had left her contact details on the message and asked the CRHTT to call her to discuss her concerns.

Opinion

13.179 Carers, family or friends involved in a patient's care should have a telephone number to call should they wish to make contact with the CRHTT at any time during the day or night. Friend One was a trainee Clinical Psychologist at the time of the incident and had been working within the Trust. Friend One had met JMcF through the gym. Friend One left this message on the ansaphone for the CRHTT using a number known to staff. The CRHTT ansaphone should have also had a message on it advising callers how to contact the team out of hours.

13.180 CRHTT Nurse Five started to liaise with JMcF from 3am but did not inform Consultant Psychiatrist Two until 05:40.

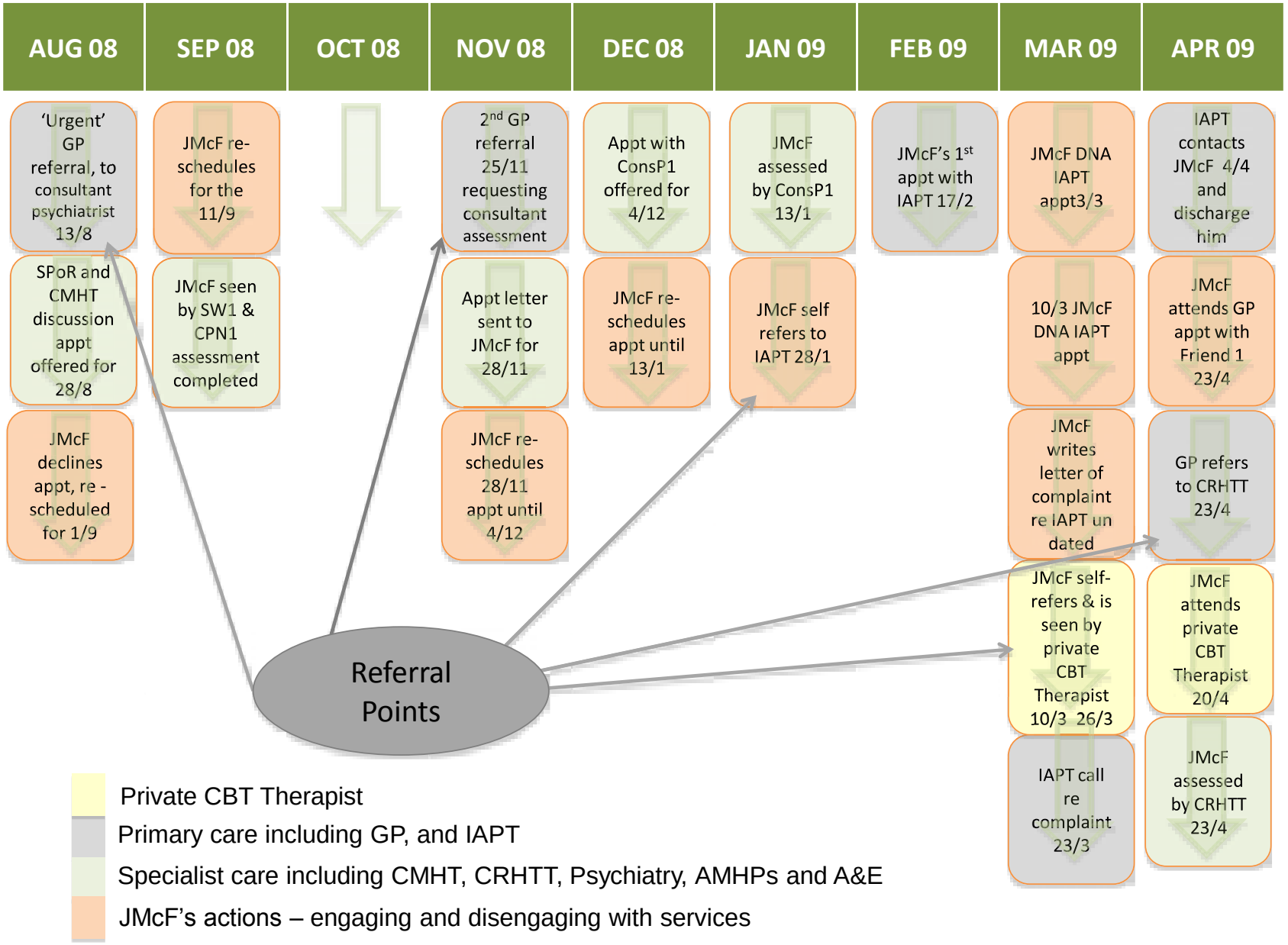
13.181 At 09:15 on 6th May 2010 Team Leader One took a telephone call from the employer who had heard on the news that a local person had been arrested and wanted to know whether it was JMcF. Team Leader One was unable to give the employer any information at that point.

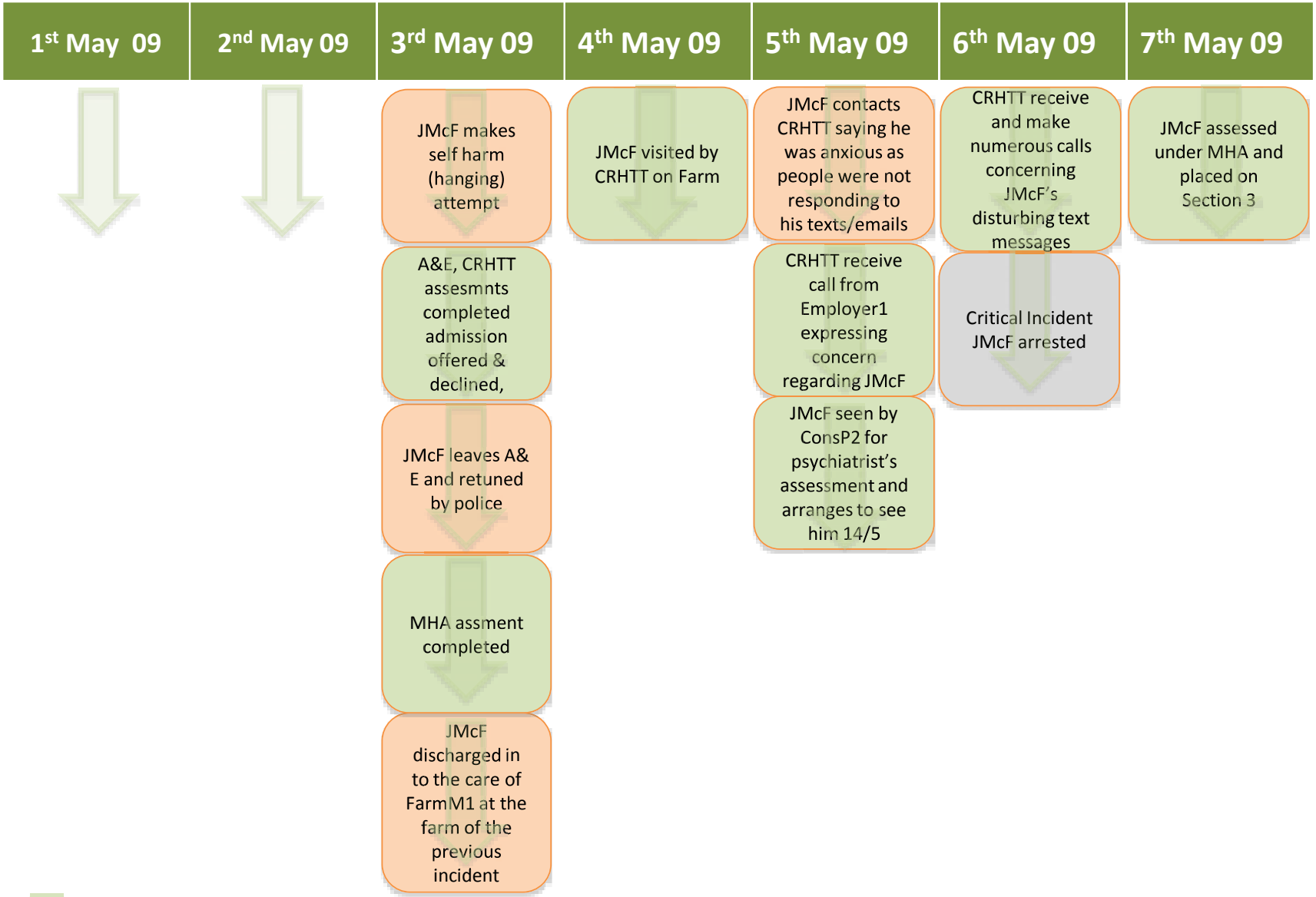
13.182 Shortly after 09:15 Team Leader One contacted Director One (Director of Mental Health Services) to inform her of the latest developments. She advised Team Leader One to liaise with the Police.

13.183 It subsequently came to light through the police investigation that there was a call made to the police notifying them of a break in at the farm. It also became apparent that the electricity had been cut in MG's home. On interview, JMcF's first recollection after the offence was being outside in the street with MG after she had been attacked.

13.184 As can be seen from the diagrammatic representation overleaf there were five separate referral points across all services. There were nine occasions where JMcF engaged and disengaged with services, with JMcF having a general avoidance for admittance to hospital. On interview[68], JMcF had said that admission to hospital was not an option.

[68] Transcript of interview with JMcF 13th October 2010


AUG 08
SEP 08
OCT 08
NOV 08
DEC 08
JAN 09
FEB 09
MAR 09
APR 09
'Urgent' GP referral, to consultant psychiatrist 13/8
SPoR and CMHT discussion appt offered for 28/8
JMcF declines appt, re - scheduled for 1/9
JMcF re-schedules for the 11/9
JMcF seen by SW1 & CPN1 assessment completed
2nd GP referral 25/11 requesting consultant assessment
Appt letter sent to JMcF for 28/11
JMcF re-schedules 28/11 appt until 4/12
Appt with ConsP1 offered for 4/12
JMcF re-schedules appt until 13/1
JMcF assessed by ConsP1 13/1
JMcF self refers to IAPT 28/1
JMcF's 1st appt with IAPT 17/2
JMcF DNA IAPT appt3/3
10/3 JMcF DNA IAPT appt
JMcF writes letter of complaint re IAPT un dated
JMcF self-refers & is seen by private CBT Therapist 10/3 26/3
IAPT call re complaint 23/3
IAPT contacts JMcF 4/4 and discharge him
JMcF attends GP appt with Friend 1 23/4
GP refers to CRHTT 23/4
JMcF attends private CBT Therapist 20/4
JMcF assessed by CRHTT 23/4
Referral Points
Private CBT Therapist
Primary care including GP, and IAPT
Specialist care including CMHT, CRHTT, Psychiatry, AMHPs and A&E
JMcF's actions – engaging and disengaging with services


1st May 09
2nd May 09
3rd May 09
4th May 09
5th May 09
6th May 09
7th May 09
JMcF makes self harm (hanging) attempt
A&E, CRHTT assesmnts completed admission offered & declined,
JMcF leaves A& E and retuned by police
MHA assment completed
JMcF discharged in to the care of FarmM1 at the farm of the previous incident
JMcF visited by CRHTT on Farm
JMcF contacts CRHTT saying he was anxious as people were not responding to his texts/emails
CRHTT receive call from Employer1 expressing concern regarding JMcF
JMcF seen by ConsP2 for psychiatrist's assessment and arranges to see him 14/5
CRHTT receive and make numerous calls concerning JMcF's disturbing text messages
Critical Incident JMcF arrested
JMcF assessed under MHA and placed on Section 3
Specialist care including CMHT, CRHTT, Psychiatry, AMHPs and A&E
JMcF's actions – engaging and disengaging with services

14.0 FORENSIC REVIEW

14.1 Purpose of report

1. *The Consultant Forensic Psychiatrist for the core panel conducted a forensic analysis into the care and treatment of JMcF. The analysis draws upon a large body of information and it also draws upon an interview with JMcF at Norwich Prison on 13th October 2010.*

14.2 Forensic issues

2. *"In the main the key issue is whether or not JMcF could have been identified by mental health services or another agency as being a risk to the victim. From a review of all of the records I have not seen any historical issues which could have identified JMcF as being a risk in terms of violence to the victim. Thus there is no history of violent incidents, assaults, fights and so forth.*

3. *Concern was raised within the farm around the appropriateness of having access to farm implements. I noted that there were two bolt guns at the farm. A number of people had license to slaughter and use of the gun; JMcF was identified as the main slaughter man and largely this role was left to him. The two bolt guns consisted of one main one which worked well and a second one which was less reliable and acted as a backup. They were located within a specific area in the farm where the animals were slaughtered. JMcF was identified as being technically minded and able to disassemble and assemble the guns if necessary. From my review of the records this was not specifically communicated to mental health services and more reflected concern about the appropriateness of JMcF being/working at the farm and the risk that he presented to himself.*

4. *There is an identified risk of harm to himself. This includes:*

5. *Attempt upon his life in 1993: JMcF had identified this as being a 'cry for help' - of note is that the presence of a blood stained noose and drill set suggested a more violent approach to taking his own life. In that incident his GP had arrived home to find a message on his answering phone from JMcF saying that he was going to kill himself. The GP subsequently went to his home and there found JMcF unconscious and with a laceration to his left wrist and a noose on the floor (later this was noted to be hanging from the rafters). It was also commented that he had sustained an abdominal wound/been stabbed the week before but this was not explored. I noted that there was some similarity between the incident in 1993 and the events when he tried or considered hanging himself from the rafters of the barn shortly before the offence. The incident at that time in 1993 was resolved via an admission to hospital where he remained for a number of weeks.*

6. *October 2000: JMcF had told his GP that (whilst working as a driving instructor) that he was 'entering a do not care state when he felt that he would not care if his pupils crashed the car and he almost wished it to happen.' In a letter from November 2001 it was also noted that JMcF had thoughts of driving with his lights off whilst randomly crossing a junction to cause an accident.*

7. *There are also references in the letter from his current GP on 14.1.2009 that JMcF had ended trying to kill himself some 20 years before and after the end of a relationship - JMcF had*

tried to cut his wrists and hang himself but was noticed by a housemate who called for help (presumably the same episode to the incident in 1993).

8. *Self harm issues in the months before the offence*

- *13.8.2008: in the initial GP referral it is noted that JMcF had had a mental image of hanging from the farm barn. I noted that this was not explored in the assessment with Social Worker One on 11.09.2008. I also noted that Social Worker One had agreed that the previous behaviour & risk of self harm had not been noted in that assessment (or recorded as nil).*

- *25.11.2008: letter from GP in which it was noted that JMcF was taking more risks when driving.*

- *14.1.2009: letter from Consultant Psychiatrist One where it was noted that 'he feels really low to the point of considering suicide.' Also in that letter it was noted that in November 2008 he had for 'several days felt uncomfortable getting near a barn on the farm he works at having mental images of hanging himself which made him feel unsafe.' It was also noted that 'he has reached the stage of 'starting to tidy up his possessions in a kind of preparation of killing himself.' It was also noted that at the farm he had easy access to guns and exceedingly sharp knives.'*

- *23.4.2009: noted in the MHT assessment that he had suicidal thoughts and plans to cut his wrists and hang himself following an argument with his wife the night before. Also noted that 'he began he would be better off killing himself as this would not be so painful for his wife.' It was also noted that 'his suicidal thinking is usually worse in the morning if he has been awake all night ruminating about things.'*

- *2.5.2009: noted events around the self harm incident on that day at the farm and involving his Friends One and Two. A&E assessment noted that JMcF had said that he was unsure whether he wanted to kill himself or to take his revenge and make others around him feel guilty. It was noted that JMcF had made preparations and had flattened batteries to prevent the machinery being accessed (presumably relating to the nature of the suicidal action). It was noted that he had answered calls from friends and police and did not try to leave.*

14.3 Management of risk

9. *I noted that despite a seeming escalation in risk to himself in the run up to the offence there was a general avoidance of admission to hospital. Admission to hospital to manage the risk that JMcF presented to himself would most likely have prevented the offence at that time though this could not have been identified at any time by the various mental health professionals.*

10. *Risk to others was not raised specifically at any time in the professionals assessments in the days before the offence; this was not something that was identified as an issue that needed exploring due to a lack of such behaviour in the past there is no reason to suggest that this was a potential avenue that JMcF would progress. JMcF has himself identified that his plans to the victim were not well formed and he would likely not have admitted this if for some reason he had been asked. He has admitted that he had felt anger towards the victim but beyond the letter, texts and Facebook traffic this was raised as a specific issue on only one occasion (see below) to mental health professionals.*

11. *I noted that in the assessment summary from the night of the self harm incident at the farm, it was noted that Friend One had informed services that 'when her x partner came to the house he 'flew' at him in rage. This is out of character for him according to Friend One and MG was afraid of him.'*

12. *MG was concerned and this is the thrust of her contacting the police. There seems no clear reason to suggest that this should have led to the involvement with mental health - it is possible that if she had seen a police representative (beyond the telephone contact) that her knowledge of JMcF's involvement with mental health services might have been flagged up to the police. The time frame however in this period is very compressed and outside of the normal working week.*

13. *In terms of risk to himself this was complicated by diagnosis. General practice colleagues appear to have considered that JMcF had a depressive episode and thus felt that there was a need to involve secondary services for both an opinion, management of risk and for treatment itself. Neither primary care nor JMcF himself felt that the psychological approach that was later offered addressed the clinical need. JMcF had felt benefit from the private therapy that he had sought out himself and this appears to have reinforced secondary service's response as matters began to escalate.*

14. *Overall secondary services began to firm up the view that JMcF did not have a mental illness in the form of a depressive illness. Although at the initial time of his contact with primary care there were no clear precipitants to a change in his mood state this was not the case as matters progressed when it was identified that his relationship had ended. It is possible that this was always at the heart of his mental state though it is also possible that the breakdown in his marriage and the loss that this stability and support structure brought was a consequence of being depressed. This is likely to remain a chicken and egg argument.*

15. *I have looked in some detail at the mental health act assessment which took place the weekend before the offence and after JMcF had made an attempt upon his life. There was certainly a change in direction from an expected outcome of compulsory admission towards discharge home with support from the CRHTT. A number of key factors were important here:*

    - *Lack of diagnosis in the form of JMcF not having a mental illness*
    - *Lack of evidence of ongoing suicidal intent*
    - *Not thought to be detainable*
    - *JMcF generally functioning well - i.e. 'having two jobs, keeping busy, concentrating well, enjoying life'.*
    - *That JMcF appeared calm, rational and forward planning - noted that the assessment commented that his 'risk of self harm was reduced.'*
    - *JMcF reluctance to go to hospital (in the interview with Section 12 Doctor Two JMcF had said that he would go into hospital voluntarily but wanted to feed the lambs and had a class of MG's that he wanted to do).*
    - *JMcF's reassurance and solution in the form of accommodation and support at the farm following his telephone call to Farm Manager One*

16. *There appears also to be a paradox in that Section 12 Doctor One did not determine a diagnosable mental disorder to allow his admission to hospital but nevertheless facilitated after care. This conveys a mixed message.*

17. *On the day before the offence he was seen by Consultant Psychiatrist Two and after JMcF had phoned Team Leader One in a state of distress. In the interview with Team Leader One he recalled that there was 'some sort of anger' though this was not explored and later moved on to issues around medication and thus a referral to see Consultant Psychiatrist Two later that day.*

18. *In his interview Consultant Psychiatrist Two noted that he had explored the events at the farm and the risk that JMcF presented to himself. He also noted that JMcF had wanted something to help calm himself down though this was declined by Consultant Psychiatrist Two. Although I can appreciate the difficulties around dependency, drugs such as benzodiazepines are licensed for the management of agitation and could have been effective in the short term. In his interview Consultant Psychiatrist Two had informed the panel that he had had intelligence, post event, that JMcF had been using cocaine and that this might have been an explanation for his changes in behaviour and mental state. There is however no indication that Consultant Psychiatrist Two knew this at the time of his assessment or that the information is correct".* The panel could find no evidence to support this. JMcF states that he has never taken illegal drugs.

15.0 CARE PATHWAY

Access to secondary care

15.1 PRIMARY CARE

15.2 The Core Panel General Practitioner examined the General Practitioner notes and considered the appropriateness of the management of JMcF in primary care and the subsequent referral into secondary care.

15.3 He found that JMcF's general practitioner undertook a mental health review on the 16th March 2007 which corresponds to a recommendation that all patients with severe mental health problems (or a past history of them) are reviewed at least annually. However, there is a lack of detail in respect of current history and mental state examination but the documentation details that JMcF is stable.

15.4 JMcF's GP One undertook a review of JMcF.

15.5 The Panel General Practitioner is of the opinion that the interactions were entirely appropriate between GP One and JMcF and that the care was of a good standard.

Opinion

15.6 GP Two responded to JMcF's needs appropriately.

15.7 JMcF: Received high quality and clinically sound care in his primary care interactions.

15.8 There are however a number of recommendations in regard to documentation in clinical records:

6. Recommendations to improve Patient Safety
Detailed mental state examinations should be included in examination records

Assessment of severity scoring e.g. PHQ-9, Hospital Anxiety and Depression Score should be part of reviews.

The rationale for urgent referral for assessment under the MHA should always be clearly documented.

The SUI review should detail the need for GPs to include the assessment of risk to himself/herself and others in future mental health reviews

15.9 IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT) NHS SUFFOLK IAPT SERVICE

15.10 The NHS Suffolk IAPT service is a wave one service commissioned in October 2008 and the background to IAPT and Suffolk service specification can be found in Appendix four. The specification describes an IAPT service in detail and contains an illustrative care pathway which indicates that all referrals will go through step 2 other than cases with post traumatic stress disorder (PTSD), obsessive compulsive disorders (OCD), and those with language difficulties. The

illustrative care pathway does not show a mechanism of referral into step 3 for any other reason. The service specification also describes elements of step 4 interventions but it is unclear as to what elements and does not clarify the interface with step 4 (which is normally secondary care provision). This is an unusual configuration for a service specification for IAPT services. The staffing and performance targets laid out in the specification are what would be expected for the size, type and nature of provision and is in line with the national context set out above.

15.11 Service provision at the time of the offence

15.12 As a wave one site the service was at a stage of establishing itself. Approximately six months into delivery, as with many if not all IAPT services embedding into local service provision and agreeing interface with other services in particular secondary care services proves for many to be a challenging process. With the majority of both low intensity workers (LIs) (now called psychological wellbeing practitioners) and high intensity workers (HIs) attending university courses and requiring high levels of supervision to meet course and British Association for Behavioural and Cognitive Psychotherapies (BABCP) accreditation criteria, many services are in the first year under immense pressure to deliver in all aspects and to meet targets set in terms of performance.

15.13 The impression gained from the information shared is that with the Suffolk IAPT service many of these issues were present.

15.14 PROVISION OF IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT) TO JMcF

15.15 JMcF self referred to the IAPT service on the 28th of January 2009 following a recommendation by a Consultant Psychiatrist (seen on the 13th of January 2009) and he did so to be able to receive CBT for depression.

15.16 A face to face initial screening on the 17th of February 2009 by a low intensity worker took place. The appropriate screening tools (PHQ9 and GAD7) were administered. As a new case the LI took the case to case management supervision for two main reasons. JMcF reportedly presented with low self esteem rather than low mood and was specifically requesting face to face CBT.

15.17 During the course of supervision it was decided that step 2 interventions would be offered to JMcF and a standard pack was sent out to JMcF for step 2 interventions on the 20th of February 2009. A further letter offering a face to face intervention was sent offering an appointment on the 3rd of March 2009. A letter of complaint was received on the 3rd of March 2009. This letter was misplaced (placed in wrong pigeon hole) and was not retrieved for a further three weeks. In this time a further appointment was sent out for JMcF.

15.18 When the letter of complaint was retrieved it was passed to the Clinical Lead of the service. The Clinical Lead contacted JMcF and discussed the situation. JMcF informed the Clinical Lead that the services of a private therapist had now been employed and that input from the IAPT service was no longer required. The Clinical Lead informed JMcF that if in the future he required the services of IAPT then he could contact the service. The case was then closed.

Opinion

15.19 Self referral to the IAPT service was already in operation which is good practice as required by the national guidelines.

15.20 The service, whilst following the protocol as laid out by the service specification, did not appear to respond to an individual's expressed request and choice for face to face CBT.

15.21 The scores on the PHQ9 and the GAD7 indicated a level at the moderate to severe end. Whilst accepting that the scores alone cannot determine level of intervention, further consideration should have been given to this request. It is not clear as to whether this specific request was discussed in case supervision at the time, nor does there appear to be a record of the supervision reflecting this. The overall process of supervision appears to face challenges in terms of space and privacy. The office area was described as being open plan, but the availability of more private areas for supervision seems restricted. The supervision in this case was recalled to be in a quiet area but overall this appears to be an issue for the service in particular LI workers. There appears to be an information governance issue that needs to be addressed.

15.22 The letter of complaint was placed in the wrong pigeon hole by administration staff. (It was placed into a member of staff's pigeon hole who had the same first name as the LI worker). Apparently all mail was, and continues to be, opened by administration staff. The letter was misplaced and when found handed to the Clinical Lead to deal with the complaint. Such practice does not follow the Trust's policy on dealing with complaints procedure.

15.23 Private Therapy

15.24 Following JMcF's experience with IAPT, the services of a private therapist were accessed at a small independent practice. JMcF requested CBT and had an initial appointment on the 10th of March 2009. JMcF attended for three more sessions during which time he was described as suffering from moderate to severe depression with suicidal and/or para-suicidal ideation. A further session was booked for the 5th of May 2009.

Opinion

15.25 JMcF was seen by an experienced therapist at this time who was able to engage with him and help him contain his difficulties. Whilst there were elements of CBT in the work done, it is apparent that an integrative approach was used to keep JMcF engaged. It is most likely that a pure CBT model would not have been effective with JMcF. Assessment indicated that there was a risk of harm to self but no indication of harm to others.

15.26 The significance of this input led to a greater understanding of JMcF's underlying difficulties. However this was not communicated by the therapist or requested by other agencies.

15.27 The input by the private therapist was the only time that JMcF was engaged sessionally and an understanding of his history and current difficulties reached. The notes taken in each session were difficult to follow and understand. These were said to be psychological process notes; however, the writing was poor and difficult to read.

15.28 Overview of Assessment and treatment

15.29 From the point of initial referral by GP One until JMcF engaged his own private therapist JMcF received a series of one off assessments which resulted in no clear overall coordination of input. When he saw Consultant Psychiatrist One in January 2009 a recommendation that he should receive CBT for depression was made. JMcF referred himself to the IAPT service where he was assessed and offered step 2 care after specifically requesting face to face CBT. JMcF complained

about this in writing but the complaint was lost for three weeks and not handled appropriately, during which time JMcF engaged a private therapist. At no point does there seem to have been communications formally or informally between the services involved.

15.30 Community Mental Health Teams (CMHTs)

15.31 CMHTs are multi-disciplinary teams which are responsible for:

15.32 "*Delivering and co-ordinating a specialised level of community based care for defined populations*[69]".

15.33 The Department of Health published an implementation guide for mental health services in 2002[70]. In relation to CMHTs, the implementation guide outlines the target population the CMHTs should be caring for, and the key functions of a CMHT.

15.34 The guidance states that most patients treated by the CMHT will have time limited disorders and will be referred back to their GP after a period of weeks or months (an average of 5 – 6 contacts[71]) when their condition has improved. A substantial minority will, however, remain with the team for ongoing treatment, care and monitoring for periods of several years. They will include specialist care for:

- Severe and persistent mental disorders associated with significant disability, predominately psychoses such as schizophrenia and bipolar disorder
- Longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow up
- Any disorder where there is significant risk of self harm or harm to others or where the level of support required exceeds that which primary care can offer
- Disorders requiring skilled or intensive treatments not available in primary care, complex problems
- Complex problems of management and engagement such as presented by patients requiring interventions under the Mental Health Act 1983, except where these have been accepted by the assertive outreach team
- Severe disorders of personality where it can be shown they will benefit by continued contact...." [72]

15.35 Three specific functions were identified for CMHTs which are as follows:

- Assessment and advice on the management of patients being treated in primary care
- The provision of care and treatment for time limited disorders which are more complex or severe than those treatable in primary care
- The provision of care and treatment for those with severe and enduring mental health problems

[69] Carpenter, J., Schneider, J., Brandon, T. & Woof, D. (2003). Working in multi disciplinary community mental health teams: The impact on social works and health professionals of integrated mental health care. *British Journal of Social Work*, vol 33, pp 1081 - 1103

[70] Department of Health (2002) *Mental Health Implementation Guide: Community Mental Health Teams*

[71] Burns, T., Raferty, J., Beadsmoore, A., McGuigan, S. & Dickson, M. (1993). A controlled trial of home based acute psychiatric services 11: Treatment patterns and costs. *British Journal of Psychiatry*, vol 163, pp 55 - 61

[72] Department of Health (2002) *Mental Health Implementation Guide: Community Mental Health Teams*

15.36 In relation to the question: "*What should CMHTs do?"* the good practice guidance states that they should[73]:

- Provide support and advice to primary care services
- Provide joint educational facilities for all members of the primary health care team
- Prompt and expert assessment of people with mental health problems
- Provide effective, evidence based treatments to reduce and shorten distress and suffering and in the process ensure that inappropriate or unnecessary treatments are avoided.
- Establish a detailed understanding of all local resources relevant to support of individuals with mental health problems and promote effective interagency working.
- Assist patients and carers in accessing such support, both to reduce distress but also to maximise personal development and fulfilment.
- Provide advice and support to service users, families and carers.
- Gain a detailed understanding of the local population, its mental health needs and priorities, and provide a service that is sensitive to this and religious and gender needs.
- Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign Language

15.37 CMHTs vary considerably in their size and the composition of the team. The good practice guidance states that the optimum staffing for a standard CMHT is one full time Consultant Psychiatrist, one to one and a half non Consultant Psychiatrists and eight whole time equivalent Care Co-ordinators.

15.38 Great variations have been found around which patients GPs refer to CMHTs[74]. Previous studies have shown that fewer than 50% of people with mental health problems will be identified by GPs[75]. A rate of 20% disagreement in referrals from primary care to CMHTs has previously been reported[76]. It has been suggested that the blurred boundaries between social pathology and mental illness at a primary care level can lead to inappropriate demands being made to mental health services[77].

15.39 In a recent qualitative study[78] conducted within a randomised controlled trial of primary care and CMHTs in Manchester and Croydon, the tensions around the primary-secondary care interface were studied. GPs, psychiatrists and clinical leads were interviewed. GPs reported wanting access to specialist knowledge which they felt could best be provided via access to a psychiatrist. Referral to a CMHT was perceived as not facilitating this access. GPs described a perceived threat to their professional autonomy in decision making about referrals by having to negotiate with CMHTs about them. Different GPs were found to have personal thresholds for referring patients to secondary care. The conclusions arising from this study included a need to facilitate doctor to doctor communication without marginalising other team members; and that poor communication and arguments about referral criteria can have a negative effect on patient care.

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[73] Department of Health (2002) *Mental Health Implementation Guide. Community Mental Health Teams*

[74] Walker, P., Haeney, O. G. & Naik, P. C. (2005) Attitudes to referral to community mental health teams. *Psychiatric Bulletin*, Vol 29, pp 213 – 214

[75] Slade, M., Gask, L., Leese, M., McGrone, P., Montana, C., Powell, R., Stewart, M. & Chew-Graham, C. (2008) Failure to improve appropriateness of referrals to adult community mental health services – lessons from a multi site randomized controlled trial. *Family Practice*, 25 (3), pp 181 – 190

[76] Slade, M., Cahill, S., Kelsey, W., Powell, R., Strathdee, G. (2002) Threshold 2: The reliability, validity and sensitivity to change of the Threshold Assessment Grid (TAG). *Acta Psychiatr Scand*, 106, pp 453 - 460

[77] Singh, S. P. (2003) Running an effective community mental health team. *Advances in Psychiatric Treatment*, 6, pp 414 - 422

[78] Chew-Graham, C., Slade, M., Montana, C., Stewart, M & Gask, L. (2008) Loss of doctor-to-doctor communication: Lessons from the reconfiguration of mental health services in England. *Journal Health Services Research & Policy*, Vol 13, pp 6 - 12

15.40 CMHTs should be able to provide a range of treatment interventions[79]. They should:

- Offer evidence based interventions
- All staff within CMHTs should be trained in psychological therapies and psychosocial interventions
- Provide types A and B of NHS classification of psychological interventions and some form of type C. Type A consists of psychological treatment as part of a programme of healthcare, type B consists of counselling and eclectic interventions such as cognitive behavioural therapy and type C consists of formal psychotherapies such as psychoanalysis[80]
- Provide pharmacotherapy and assess for the side effects of drugs
- Ensure that outcome measures used include social, vocational and leisure pursuits
- Offer comprehensive assessment and support in relation to substance misuse
- Offer basic monitoring of physical health
- Offer family, carer support and education

15.41 REFERRAL TO A CONSULTANT PSYCHIATRIST

15.42 JMcF was referred to the Consultant Psychiatrist, West Suffolk Hospital by GP One on 13th August 2008. The comprehensive referral letter stated that the referral was "urgent". A summary of JMcF's previous psychiatric history was stated and current concerns were outlined. It was also stated that additional information relating to his previous psychiatric history was enclosed.

15.43 At the time, there was no system in place to monitor documents being received by the CMHT. It is unclear as to whether or not the documents referred to in GP One's letter were ever received by the CMHT.

15.44 A Single Point of Referral (S.P.O.R) was operating at the time GP One made the referral. The referral was acknowledged by letter by Team Leader One, Single Point of Referral on 19th August 2008. GP One's referral was not shared or discussed with Consultant Psychiatrist One, Bury St Edmunds Community Mental Health Team[81]. The referral was allocated to Community Psychiatric Nurse One (CPN One) and Social Worker One. There was no written guidance in place at the time for the team to refer to regarding the allocation of new referrals and how decisions around which team member/s and discipline should assess which patients.

15.45 CPN One contacted GP One by telephone that day after her urgent referral on 22nd August 2008 to clarify how urgent the referral was and the degree to which she wanted JMcF to be assessed swiftly. GP One requested that CPN One contact JMcF directly to arrange an appointment which she did. A message was left on his mobile advising him that his appointment was for 28th August 2008, but he could be seen sooner if he wished. On 22nd August 2008 JMcF cancelled his scheduled appointment for the 28th August 2008. He was offered an alternative appointment on 1st September 2008 which JMcF also cancelled. He was then offered an appointment on 11th September 2008 which he attended.

15.46 JMcF attended an appointment with CPN One and Social Worker One on 11th September 2008. When interviewed by the Core Panel both CPN One and Social Worker One stated that they had access to the letter of referral from GP One prior to assessing JMcF on that day. However, the Risk Assessment form completed by Social Worker One makes no reference to JMcF's previous self

[79] Burns, T. (2004) Community Mental Health Teams. *Psychiatry,* 3(9), pp 11 – 15
[80] Department of Health (2002) *Mental Health Implementation Guide. Community Mental Health Teams*
[81] Interview with Consultant Psychiatrist One on 9 November 2010

harm attempts, his previous admission to a psychiatric hospital under Section 2 of the Mental Health Act 1983 or to the fact that he was complaining of racing thoughts.

15.47 Social Worker One and CPN One agreed a plan of care with JMcF. He was to continue to take the antidepressant which had been prescribed by his GP, to continue going to the gym and to liaise with his GP about accessing an anxiety management group. Social Worker One subsequently wrote to GP One summarising the outcome of the assessment undertaken. Neither Social Worker One nor CPN One fed back the outcome of their assessment of JMcF to Consultant Psychiatrist One or to the multi disciplinary team via the Team Meeting.

15.48 GP One subsequently re referred JMcF back to a Consultant Psychiatrist on 25th November 2008. JMcF was assessed by Consultant Psychiatrist One on 13th January 2009. Consultant Psychiatrist One conducted a thorough mental state examination of JMcF. She subsequently wrote a detailed letter to GP One outlining her impressions of and recommendations regarding the care and treatment of JMcF. The letter was copied to JMcF.

Opinion

15.49 GP One's urgent referral of JMcF to the Consultant Psychiatrist was appropriate. The referral letter was comprehensive. The concerns about JMcF were clearly outlined along with JMcF's previous psychiatric history including his history of self harm and his previous admission to an inpatient psychiatric unit. Additional information was enclosed.

15.50 CPN One's telephone call to GP One to clarify the urgency of the referral is in line with good practice. The response time for urgent referrals to S.P.O.R at the time of the incident was three to five days. Routine referrals were seen within twenty one days. JMcF was seen almost a month after the referral by staff working in the CMHT. We would expect any urgent referral to have been seen sooner than that. However, it should be noted that CPN One contacted JMcF by telephone and offered him an earlier appointment if he wished. It should also be noted that he cancelled two appointments prior to being seen on the 11th September 2008.

15.51 JMcF was assessed by CPN One and Social Worker One on 11th September 2008. They both failed to take into consideration some of the important information shared with them by GP One in her referral letter. The risk assessment form completed by Social Worker One makes no reference to JMcF's previous self harm attempts. At interview[82] Social Worker One was unable to explain why he had written "*nil*"[83] under the section *"Behaviours that cause concern"*[84]. It would appear that CPN One and Social Worker One conducted a superficial assessment which did not take into consideration key information around previous psychiatric history, previous self harm attempts and JMcF's occupation; had they taken this information into consideration, the care plan they would have agreed with JMcF could have been different.

15.52 Neither CPN One nor Social Worker One could recall whether or not they had fed back the outcome of their assessment to either members of the CMHT or to Consultant Psychiatrist One. Consultant Psychiatrist One informed the panel that she had not been made aware of JMcF's referral until GP One made the re referral for a Consultant Psychiatrist to assess JMcF.

[82] Interview with Social Worker One 16 November 2010
[83] Risk Assessment on JMcF completed by Social Worker One on 11 September 2008
[84] id

15.53 GP One was not satisfied with the outcome of the assessment of JMcF by CPN One and Social Worker One. She continued to have serious concerns about the mental state of JMcF and re referred him to a Consultant Psychiatrist. We are of the opinion that this was the correct course of action for her to have taken.

15.54 JMcF was finally assessed by Consultant Psychiatrist One on 13th January 2009. Her assessment of JMcF was very detailed and thorough.

15.55 Following her assessment of JMcF Consultant Psychiatrist One concluded that JMcF was not severely clinically depressed and that he could continue to be managed safely in primary care. She recommended that he commence Cognitive Behavioural Therapy via the Improving Access to Psychological Therapies Service. She was aware that patients cannot access therapy via IAPT if they are under the care of secondary mental health services. She also suggested that JMcF access the Crisis Resolution & Home Treatment Team via his GP, in recognition of the fact that he may feel very low at times. She also recommended he commence *Trazadone* 150mgs at night as required. JMcF was not taken onto the CMHT caseload.

Opinion

15.56 The panel are of the opinion that Consultant Psychiatrist One conducted a very thorough assessment of JMcF which she communicated to GP One in a very detailed written report. We believe that her treatment plan for JMcF was appropriate.

7. Recommendations

Ensure that there is a system in place to record receipt of all letters/documents which have been received by the CMHT

Draft a protocol to support clinical staff in relation how new referrals for assessment are allocated to team members.

Ensure that there is a robust system in place for staff to feed back the outcome of any new referrals and outcome of any new assessments undertaken to the team

Ensure that there are standards in place to monitor and report the standards in place around how soon an emergency, urgent and routine referral should be seen.

Social Worker One and CPN One to attend (further) assessment and risk assessment training.

Both to receive more frequent clinical and also managerial supervision (At present managerial supervision is four to six weekly).

Trust to review risk assessment training for all staff across all teams.

15.57 CRISIS RESOLUTION & HOME TREATMENT TEAM

15.58 The introduction of Crisis Resolution & Home Treatment Teams (CRHTT) throughout England was required under the NHS Plan[85]. The purpose of Crisis Resolution & Home Treatment Teams is to

[85] Department of Health (2000) The NHS Plan

enhance access to mental health services and to reduce psychiatric bed usage[86]. Unlike Community Mental Health Teams, the team work 24 hours a day and can visit patients several times a day at home as required[87].

15.59 A Crisis Resolution & Home Treatment Team provides intensive support for people in mental health crisis in their own home, or other suitable alternative such as a crisis house. The crisis resolution team will stay involved until the problem is resolved. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. It will also act as a gatekeeper to other mental health services such as acute inpatient care, referring clients to other services if longer-term follow up is indicated. They enable some of the more social factors to be considered in relation to the assessment and treatment of people with mental illness.

15.60 The service is usually aimed at adults with severe mental illness. The Mental Health Implementation Guide[88] states that the service is for people:

15.61 *".....with an acute psychiatric crisis of such severity that without any involvement of the Crisis Resolution & Home Treatment Team hospitalisation would be necessary"*

15.62 In terms of whom the service is NOT appropriate for, the guidance states that the Crisis Resolution & Home Treatment Team is not usually appropriate for people with:

- Mild anxiety disorders
- A primary diagnosis of alcohol or other substance misuse
- Brain damage or other organic disorders including dementia
- Learning disabilities
- Exclusive diagnosis of personality disorder
- Recent history of self harm but not suffering from psychotic illness or severe depressive illness, and
- A crisis related solely to relationship issues

15.63 Crisis Resolution & Home Treatment Teams have the following characteristics:

- Consist of a multi-disciplinary team
- Are available to respond 24 hours a day, 7 days a week
- Staff in frequent contact with service users, often seeing them at least once on each shift
- Provide intensive contact over a short period of time, and
- Staff remain involved with the patient until the problem is resolved

15.64 Each Crisis Resolution & Home Treatment Team is likely to cover a population of 150,000 and have a case load of 20 to 30 patients at any one time[89]. However, demographic factors, health and social care boundaries and geographic location may affect these figures.

15.65 The Mental Health Implementation Guide suggests how a CRHTT should be staffed and is clear that any CRHTT should operate 24 hours a day and 7 days a week. Direct referrals from a wide

[86] Johnson, S. (2004) Crisis Resolution and Intensive Home Treatment Teams. *Psychiatry*, 3(9), pp 22 - 25
[87] id
[88] Department of Health (2001) *The Mental Health Policy Implementation Guide* p11
[89] Department of Health (2001) *The Mental Health Policy Implementation Guide*

range of sources including staff in Accident & Emergency Department, carers and staff in primary care are encouraged.

15.66 Previous research studies have explored the advantages of home treatment as opposed to inpatient admission and treatment. Studies have shown that home treatment can be safe, effective and feasible[90]. It was reported a decade ago that there was one homicide carried out by a patient over a period of twenty five years of providing home treatment[91].

15.67 The operational policy for the Crisis Resolution & Home Treatment Team operating in Suffolk Mental Health Partnership NHS Trust was still in draft form at the time of the incident. The operational policy which was in place at that time states[92] that the team will provide a service for people who are:

- *Experiencing an acute mental health problem/crisis which without the intervention of the Team would require inpatient care*
- *Aged 17 upwards*
- *Registered with a GP within the catchment area*

15.68 In addition the operational policy states:

"*With the expectation that[93]:*

a) The referrer has seen the service user within the previous 24 hours
b) The referrer, will be from secondary services during working hours, for example,
✓Link worker for service users not known to Mental Health Services
✓ Community Mental Health Teams
✓Early Intervention Service
✓ Assertive Outreach Teams
✓ Approved Mental Health Practitioners (AMHP's)
✓ Section 136 assessments
✓Service users who may benefit from early discharge from hospital
✓A&E

15.69 With regard to the inclusion criteria for the Crisis Resolution & Home Treatment Team the operational policy states[94]:

- *Has been assessed as deemed to require hospital admission.*
- *Clear evidence that the existing Community Care Programme is beginning to breakdown*
- *The person is experiencing an acute disruption to their ability to function adequately in the community primarily as a result of an acute mental health problem.*
- *Strong probability that a short term crisis intervention will allow the service user to maintain their community tenure with the ongoing intervention of the Community Teams.*
- *Service users will experience one or more of the following:*
  ✓Psychosis to a degree that impedes upon functions of daily living, inability of community services to manage

[90] Smyth, M. G., Hoult, J. (2000) The home treatment enigma. *British Medical Journal*, Vol 320, No 7230, pp 305-308
[91] id
[92] SMHPT Crisis Resolution / Home Treatment Team – Operational Policy Draft 6, p 4 -5
[93] id, p 5
[94] SMHPT Crisis Resolution /Home Treatment Team – Operational Policy Draft 6, p 5

✓*Unipolar /bipolar affective disorder*
✓*Obsessional compulsive disorders/phobias*
✓*Dual diagnosis (mental illness and substance misuse)*
✓*Borderline personality disorder*
✓*Psychopathic disorder (treatable or to prevent hospitalization)*
✓*Severe anxiety states – debilitating*

a) *Clear evidence that the Community Care Programme is beginning to breakdown and that a limited period of home treatment will avoid an admission to hospital and allow the service user to maintain their community tenure with the ongoing intervention of the CMHT, or,*
b) *There is a strong probability that a fixed-term package of assessment, care and treatment in the individuals home environment will not be appropriate, but facilitation of an early discharge from hospital will be possible*
c) *Service users will experience one of the following:*
✓*Psychosis to a degree that impedes upon functions of daily living, inability of community services to safely manage*
✓*Unipolar /biopolar affective disorder*
✓*Obsessional compulsive disorders/phobias*
✓*Dual diagnosis*
✓*Severe and debilitating anxiety states*

15.70 Consultant Psychiatrist One suggested to JMcF that he access the CRHTT whenever he was feeling very low via his GP[95]. JMcF was referred to the CRHTT on 23rd April 2009. He had been experiencing suicidal thoughts, planned to cut his wrists or hang himself following an argument with his wife the previous night. He called a friend for help and went to his GP for help. His GP Two referred him to the CRHTT the same day.

15.71 JMcF was assessed on 23rd April 2009 by CRHTT Nurse Three and CRHTT Nurse Two. JMcF attended the assessment with Friend One who encouraged him to seek help. Both nurses accessed a copy of Consultant Psychiatrist One's assessment of JMcF on 13th January 2009 and were aware of her impression and plan of care for JMcF.

15.72 JMcF described how he felt his suicidal thoughts were as a result of his marital difficulties. He was being treated privately and undergoing CBT which he felt was highlighting the problems in his marriage and making him aware that he would have to leave his wife. He stated he was sleeping around six hours a night and that a lack of sleep contributed to his low moods and negative feelings. His appetite was variable. He reported his concentration was poor although he was motivated to attend work and his fitness classes. He stated that his difficult childhood had affected his confidence and self esteem.

15.73 Both concluded that JMcF did not require admission to hospital. They did not think he was an active suicide risk[96]. They discussed medication with him and suggested he take *Trazedone* as suggested by Consultant Psychiatrist One, JMcF agreed to this suggestion, and to make an appointment with his GP.

[95] Consultant Psychiatrist One letter to GP One, GP dated 14 January 2009 following her assessment of JMcF on 13 January 2009
[96] CRHTT Nurse Two Police Statement dated 22nd July 2009

Opinion

15.74 JMcF met the referral criteria for the CRHTT on the 23rd April 2009 in as far as he was registered with a local GP and was experiencing suicidal ideation.

15.75 JMcF was referred a second time to the CRHTT by the Accident & Emergency staff at West Suffolk Hospital NHS Trust at approximately 03:00 on 3rd May 2009. JMcF had been taken to Accident & Emergency by Friend One following a suicide attempt at the farm.

15.76 Whilst waiting to be seen in Accident & Emergency by the CRHTT, JMcF left the department. The staff in the Accident & Emergency Department had a duty of care for Mr JMcF whilst he was in their department. At some point during the early hours the Accident & Emergency Department receptionist received a telephone call from JMcF to say he had left the department[97]. Staff in the Accident & Emergency Department were unaware that JMcF had left the department until he called them to tell them.

15.77 Staff in Accident & Emergency informed the police that JMcF had left. The police subsequently located and brought JMcF back to Accident & Emergency on an informal basis in the early hours of the morning. He was then assessed by CRHTT Nurse Three and CRHTT Nurse One.

15.78 Prior to assessing JMcF both accessed JMcF's electronic records. CRHTT Nurse Three recalled that she had previously assessed JMcF. JMcF was agitated when seen by them. He spoke about a female friend who he had spent time with and that he was upset that her previous partner had returned[98]. He said that there was some animosity between her ex partner and himself. He made no reference throughout the assessment of wishing to harm anyone. He was more focused on himself.

15.79 JMcF stated that the previous evening he had gone to the marital home to collect his belongings. He was upset that his wife helped him to pack and yet showed no signs of emotion about him leaving her. He said he had not slept for four nights.

15.80 CRHTT Nurse One and CRHTT Nurse Three sought and gained JMcF's consent to talk to Friend One who had brought him to the Accident & Emergency Department earlier that day.

15.81 Both nurses concluded that JMcF could benefit from a hospital admission in order to determine whether or not there was a diagnosable and treatable mental disorder.[99] JMcF was unwilling to be admitted to hospital and stated he had animals to feed in the morning on the farm. He was also concerned he might lose his keep fit classes if he missed any.

15.82 As a result of their concerns about JMcF's mental state both nurses set up a Mental Health Act assessment. They both left JMcF in the Accident & Emergency Department whilst they organised this. CRHTT Nurse One asked the Accident & Emergency staff to call the police should JMcF attempt to leave again from the department. There were not enough staff working within Accident & Emergency to allocate someone to remain with him, but he was agreeable to remaining in the department at that time.[100]

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[97] Written statement from A&E Consultant One, Consultant in Accident & Emergency Medicine dated 3 February 2011
[98] CRHTT Nurse One Police statement dated 29th June 2009
[99] Interview with CRHTT Nurse One 9 November 2010
[100] id

15.83 In her two assessments of JMcF, CRHTT Nurse Three reported that there was nothing in his presentations that indicated he was harbouring any thoughts of harming others.[101]

Opinion

15.84 Whilst waiting to be seen in the Accident & Emergency Department by staff from the CRHTT, JMcF left. Staff working in the Accident & Emergency Department were unaware that he had left the department until he rang reception to inform them. Staff in Accident & Emergency had a duty of care for JMcF during that time. It is unacceptable that a patient who had presented to their department following a serious suicide attempt had not only left their department but left without their knowledge.

15.85 The recommendation made by the two nurses from the CRHTT that JMcF be admitted to an inpatient psychiatric ward for a period of assessment was appropriate. An admission to hospital would have been appropriate course of action for JMcF at that time. It would have provided the opportunity for mental health professionals to undertake a more in depth assessment of JMcF's mental state. It would have also enabled them to collect information together from his previous admission to a psychiatric hospital and to make contact with some of his close friends providing JMcF consented to this. However, JMcF declined to be admitted on an informal basis.

15.86 Since JMcF declined to be admitted to hospital on an informal basis, a referral for a Mental Health Act assessment was an appropriate course of action for both nurses to have undertaken.

8. Recommendations to improve patient safety

An operational policy should be developed by and agreed between West Suffolk Hospital and Suffolk Mental Health Partnership NHS Trust regarding caring for patients who have presented with mental health problems in the Accident & Emergency Department, West Suffolk Hospital. The operational policy should cover:

- Minimum standards for response times by mental health professionals
- Clarity around the clinical responsibilities for staff working in each Trust
- How information about the patient can be accessed
- How information about the patient will be recorded
- Reporting arrangements and management structure
- How to contact senior staff for advice

The standards set out in the operational policy should be monitored and reported to the Accident & Emergency Psychiatric Liaison Meeting. An audit of a random sample of patient records to establish the response times of mental health professionals should be undertaken and reported on twice a year.

All staff working in Accident & Emergency should receive training on key considerations in respect of their duty to care, the initial assessment and observation of patients presenting with mental health problems

15.87 The Mental Health Act assessment was requested at 08:20 and commenced at 10:00. As a result JMcF had been in the Accident & Emergency Department for longer than four hours whereby he breached the four hour limit, which was in place at the time.

[101] CRHTT Nurse One's Police statement dated 29th June 2009

15.88 The Mental Health Act assessment was conducted by Section 12 Doctor Two, Section 12 Doctor One and Social Worker Two. All three clinicians conducted an in depth and very thorough assessment of JMcF together. Detailed notes are in the clinical records. They concluded that JMcF was not suffering from a mental disorder. The clinical records state:

15.89 *"No current suicidal ideation/wishes/planning. Says unsure whether he wanted to kill himself last night or just wanted to take his revenge and make those around him feel guilty. He made very careful preparation last night, setting up machinery and made up a noose. He also flattened the batteries so that the machinery could not be brought down. He however informed friends who found him – replied to phone calls....."*[102]

15.90 Also noted:

15.91 *"No evidence of psychosis"*[103]

15.92 There were no concerns about JMcF's risk to others. Under those circumstances they were unable to section/detain him in hospital. All three clinicians concluded that JMcF was not suffering from a mental disorder, but rather undergoing a crisis in his personal life. Section 12 Doctor One identified three main triggers; JMcF had recently left his wife who had made no attempts to ask him to stay. JMcF felt rejected by his wife as a result. He also felt rejected by his friend MG whom he had been supporting. They had an argument and he also felt rejected by her. Finally, he had received a telephone call from his mother. JMcF blamed his mother for a neglectful childhood.

15.93 Following an assessment for detention under the Mental Health Act, JMcF was discharged into the community. The three clinicians who conducted the Mental Health Act assessment supported JMcF to find somewhere to stay over the coming days. JMcF's friend, Friend One declined to have him staying with her again. However, JMcF's Farm Manager One, agreed to have him stay with him and to take care of him upon discharge from Accident & Emergency Department. Farm Manager One was away in Norfolk at the time and drove back to the farm to be with JMcF.

15.94 A few hours after JMcF had been discharged into the care of Farm Manager One, Farm Manager One rang Section 12 Doctor One. He rang at 13:00 and stated he was worried about having JMcF at home. Section 12 Doctor One reassured him and explained how he could contact the CRHTT.[104]

15.95 However, on discharge, JMcF did not stay with Farm Manager One, but rather his employer as she lives in the large farm house on the farm. Section 12 Doctor One organised for the CRHTT to follow JMcF up following discharge from the Accident & Emergency Department.

Opinion

15.96 The decision not to detain JMcF was taken following a comprehensive assessment by three experienced health professionals (two of whom are mental health professionals). They had access to JMcF's medical records from previous assessments conducted by mental health professionals. The assessment identified three specific triggers which had clearly upset JMcF and resulted in him making plans to make serious attempt to take his own life. However, at the time despite these meticulous plans, JMcF alerted his friends to the fact that he was about to take his own life. He

[102] Clinical notes written by Section 12 Doctor One on 3 May 2009, p 7
[103] id
[104] Clinical notes written by Section 12 Doctor One on 3 May 2009, p 9

also alerted them to his location having left Accident & Emergency. We support the decision not to detain JMcF under the Mental Health Act 1983.

15.97 We agree, however, that JMcF would ideally have been admitted to hospital at this point for a period of assessment. However, given that JMcF declined admission and was not detainable under the Mental Health Act 1983 the health professionals assessing JMcF at this time negotiated with him in order to agree an alternative plan of care. There was no legal mechanism to keep JMcF in hospital; therefore, the next best thing was to agree a plan of care for ongoing assessment. JMcF was agreeable to being cared for in the community by the CRHTT.

15.98 We support the decision taken to discharge JMcF into the care of the CRHTT. There was nothing in JMcF's presentation in Accident & Emergency or indeed his previous psychiatric history that indicated that he was a risk to others.

15.99 The three health professionals conducting the Mental Health Act assessment supported JMcF to make arrangements for somewhere to stay upon discharge. The Panel are not entirely clear about the extent to which JMcF's occupation was considered when organising discharge care by the health professionals conducting the assessment.

9. Recommendations for patient safety

As part of any mental health assessment, clinicians should explore a patient's occupation and consider the environment and situation within which they are discharging patients. Consideration should be given as to whether the patient's occupation could enhance their risk to themselves and/or others.

15.100 Following discharge from the Accident & Emergency Department on 3rd May 2009, JMcF was contacted by CRHTT Nurse Four on 4th May 2009. He contacted JMcF by telephone initially and made arrangements to visit him later the same day on the farm.

15.101 CRHTT Nurse Four visited JMcF on the farm on the afternoon of 4th May 2009. They discussed his recent suicide attempt and the triggers that he felt had led up to it. JMcF stated that he was finding seeing his private CBT therapist helpful but also that it had been:

15.102 *"A bit overwhelming"*[105]

15.103 CRHTT Nurse Four was given no suggestion by JMcF that he harboured any plans to harm himself or anyone else.[106]

15.104 CRHTT Nurse Four was given the impression by JMcF that he was willing to work with the CRHTT.

15.105 On 5th May 2009 JMcF paged the CRHTT at 05:15. Team Leader One called him back. JMcF stated he had not slept well. He said his thoughts were racing and he was feeling very anxious. JMcF said he had got up to see whether anyone had responded overnight to the e mail and text messages he had sent. He said people did not bother to respond to him and that this made him more anxious.[107]

[105] CRHTT Nurse Four Police Statement 12 May 2009, p 3
[106] Police Statement from CRHTT Nurse Four 12 May 2009
[107] Clinical record written by Team Leader One dated 5 May 2009

Opinion

15.106 A team member from the CRHTT visited JMcF on the farm the day after his suicide attempt. This is in line with good practice.

15.107 Consultant Psychiatrist Two first became aware of JMcF on 5th May 2009. JMcF had first been referred to the CRHTT on 23rd April 2008 but had not yet been assessed by a member of the medical team. Consultant Psychiatrist Two made arrangements to see JMcF on 5th May 2009 in response to JMcF's telephone call to the team stating his thoughts were racing and he was feeling anxious.

15.108 JMcF was assessed by Consultant Psychiatrist Two on 5th May 2009 as planned at Wedgewood House. Consultant Psychiatrist Two concluded that JMcF was not morbidly anxious or clinically depressed. He found no evidence of a mental disorder but was willing to have the CRHTT work with him for a few more days. He found no evidence that JMcF represented a risk of harm to anyone else[108]. Consultant Psychiatrist Two wrote a letter to JMcF's GP summarising his findings following the assessment. He did not communicate with JMcF's private therapist.

Opinion

15.109 A number of clinicians in the CRHTT saw and assessed JMcF. This is unfortunate as it did not facilitate the development of a therapeutic relationship between JMcF and one particular clinician. This also does not facilitate or support the principle of continuity of care. Despite the panel investigation it is unclear how involved medical staff in the CRHTT were in the care of JMcF. JMcF was assessed by Consultant Psychiatrist Two on 5th May 2009. The panel were unable to clarify the extent to which JMcF's case was discussed in the presence of other medical staff prior to this.

15.110 Consultant Psychiatrist Two communicated with JMcF's GP as per good practice. It would also have been good practice for him to have communicated with JMcF's private therapist having first secured JMcF's consent to do so.

10. Recommendations for patient safety

The CRHTT should introduce a Key Worker / Care Co-ordination system to facilitate continuation of care and support the development of a therapeutic relationship between acute patients on the team case load and named workers within the CRHTT.

Remind clinicians of the need to ensure that they communicate effectively with all health professionals involved in their care, seeking and documenting the patient's consent as necessary.

[108] Police Statement from Consultant Psychiatrist Two 21 May 2009

16.0 REVIEW OF THE ADEQUACY OF THE RISK ASSESSMENTS AND RISK MANAGEMENT INCLUDING SPECIFICALLY THE RISK OF THE SERVICE USER HARMING HIMSELF OR OTHERS

16.1 Prior to his most recent contacts with mental health services, JMcF had an identified history of risk of harm to himself. These incidents consist of (a) an attempt on his life in 1993 where he was found unconscious on the floor with a laceration to his left wrist and a noose close-by; (b) a report to his GP in October 2000, whilst working as a driving instructor, that he was entering a do not care state when he felt that he would not care if his pupils crashed his car and almost wanted it to happen.

16.2 The GP referral made by GP One dated 13th August 2008 details the self-harm attempt made in 1993 and notes that JMcF had had a recent mental image of hanging himself from the farm barn. The issue was not however discussed in the assessment with Social Worker One on the 11th September 2008 and the risk assessment completed at that time records behaviour that caused concern as nil. Neither Social Worker One nor CPN One who was also present at the assessment on the 11th September 2008, were able to give any explanation for this omission. This is clearly a serious individual error but JMcF's history of self-harm was picked up in subsequent contacts with services (the assessment by Consultant Psychiatrist One) and it therefore does not appear likely that it affected the subsequent management of JMcF within the service.

16.3 The assessment with Consultant Psychiatrist One on the 13th September 2009 is very comprehensive. Presence of suicidal ideation is explored in detail. Risk to others does not appear to have been specifically raised.

16.4 The assessment by CRHTT Nurse Three on the 23rd April 2009 identifies suicidal thoughts and plans to hang himself. It also identifies that the suicidal thoughts are worse in the morning. Risk assessment also identifies no previous history of aggression or violence. This risk assessment appears to have been of a good standard.

16.5 The risk assessment on the 3rd May 2009 again clearly documents a past history of self-harm and details the suicide attempt which had resulted in JMcF's attendance at A&E. No history of aggression or violence is also noted. Again this assessment appears to have been of a reasonable standard.

Opinion

1. The risk assessment completed on the 11th September 2008 contains a serious omission but the other risk assessments appear to be of a good standard. It would appear therefore that the poor risk assessment on the 11th September 2008 reflected individual clinician's error rather than systemic failure of risk assessment in this individual case.

2. The risk management plans formulated appear to have been reasonable. There appears to have been a general intention to manage JMcF outside of a hospital setting. This appears to have been reasonable in the light of mental state findings when he was assessed. It is also in keeping with the general policy in psychiatric care nationally which has an emphasis on trying to manage patients in the community with the support of Crisis Resolution Home Treatment Team services.

3. The Core Panel are in agreement that with the benefit of hindsight an admission to hospital to manage the risk that JMcF presented to himself would most likely have prevented the offence at that time, although this could not have been identified at any time by the various mental health professionals.

4. Negative findings regarding risk to others is mentioned briefly in two of the risk assessments but does not appear to have been explored in any detail by any of the professionals who had contact with JMcF. There was however little if anything to suggest in his past history that this was an issue of concern and that this therefore required detailed investigation. The action of the professionals with regard to the assessment and risk to others was therefore not unreasonable.

17.0 REVIEW OF THE MENTAL HEALTH ACT ASSESSMENTS

17.1 On the 3rd May 2009 JMcF was assessed at Accident & Emergency having been taken there by friends who had found him trying to hang himself. He had been found with a rope around his neck on the top of a forklift truck.

17.2 He was seen by the Crisis Team in Accident & Emergency at approximately 06:40. He was noted to be pressured in speech, thought disordered, described poor sleep and admitted to suicidal thoughts. He was offered informal admission to hospital but declined this and a Mental Health Act assessment was subsequently requested.

17.3 He was seen for the Mental Health Act assessment by three professionals all experienced in mental health. This assessment took place at approximately 10:30.

17.4 Section 12 Doctor One made very detailed notes of what appears to have been a comprehensive assessment lasting over two hours.

17.5 Evidence obtained from Section 12 Doctor One and Social Worker Two confirms that they were aware of the circumstances of JMcF's attendance at A&E and had considered risk issues, although the predominant focus was on risk to self (this appears reasonable since JMcF had attended A&E following a self-harm attempt).

17.6 No evidence of mental disorder was elicited and it was felt that his suicide attempt was secondary to relationship difficulties. JMcF spoke about his plans for the future and appeared willing to engage with follow-up from the Crisis Resolution Home Treatment Team. It was also confirmed that a work colleague was intending to spend the night with him.

Opinion

1. The decision not to detain JMcF under the Mental Health Act on the 3rd May 2009 was taken after a lengthy and comprehensive assessment of his recent history and current mental state. When initially assessed by members of the Crisis Resolution Home Treatment Team he had appeared pressured in speech and was expressing suicidal thoughts. However, by the time of the Mental Health Act assessment his mental state appears to have settled considerably. No clear symptoms suggestive of a mental disorder were elicited. JMcF agreed to engage with aftercare including follow-up from the Crisis Resolution Home Treatment Team. The professionals assessing him also confirmed that JMcF would have an

address to go to and some supervision from friends before they concluded their assessment.

2. The Mental Health Act assessment was carried out by three experienced clinicians. The assessment was comprehensive and the clinical notes made at the time of a high standard. The two doctors and approved mental health professional carrying out the assessment had obtained background information related to recent events and took steps to ensure that an aftercare plan was in place for JMcF as part of the decision making process regarding use of the Mental Health Act.

3. Risk to others does not appear to have been raised specifically in the assessment. The focus was understandably on his risk to himself given that his attendance at A&E had been precipitated by the attempt to hang himself. There does not appear to be any indication from his past history that he constituted a significant risk to others therefore this was not a significant omission by the assessing team.

17.7 The decision not to detain him under the Mental Health Act was a reasonable one based on the information available at the time of assessment. However the Investigation Team have concerns about the adequacy of the level of support which appeared available to him in the community at the point of discharge. The Investigation Team felt that it would be helpful to explain the criteria for Detention under Section 2 or Section 3 of the Mental Health Act 1983 and this information is contained in Appendix five.

18.0 REVIEW OF THE EFFECTIVENESS OF JMCF'S CARE PLAN INCLUDING THE INVOLVEMENT OF JMCF AND HIS FAMILY

18.1 JMcF's wishes were considered and incorporated into the care plan following his discharge from Accident & Emergency on 3rd May 2009. JMcF had declined to be admitted to hospital due to work commitments but was willing to engage with the CRHTT and to receive care in the community.

18.2 JMcF did not have a care plan or a nominated Care Co-ordinator/Key Worker whilst under the care of and on the caseload of the CRHTT from the 23rd April 2009. A number of different mental health professionals assessed and reviewed JMcF whilst he was under the care of the CRHTT. Almost each time he was seen by the CRHTT, he was seen by someone different. This was something which Consultant Psychiatrist Two regarded as beneficial[109]

18.3 *"I think that is possibly a strength. It meant that a number of very experienced clinicians carried out their own independent assessment"*

18.4 The panel do not support this view. This is not in keeping with the provision of continuity of care. In order to have a better understanding of JMcF's mental state, much could have been gained by one mental health professional acting as his Care Co-ordinator with a view to establishing a therapeutic relationship with him. In our opinion it would have been difficult for different mental health professions to detect small changes in JMcF's mental state if they were only assessing him on a one off basis.

18.5 JMcF did not want his wife to know about his contact with his GP or other health professionals. He did not consent to his GP or the mental health professionals involved in his care to enter into any discussions with her. JMcF's wishes with regards to the sharing of information by health professionals with his wife was adhered to by them.

18.6 JMcF blamed his mother for his neglectful childhood. She had contacted him prior to him planning to kill himself. JMcF had had little regular contact with his mother. In view of the fact that JMcF had recently left his wife and did not want her to know about his mental health problems, and also in view of the fact that he had little contact with his mother, Approved Mental Health Professional Two did not contact either as his nearest relative as part of the Mental Health Act assessment conducted on the 3rd May 2010.

18.7 JMcF's Friends One and Two supported and took JMcF into their home for a period of time. Friend One attended several of JMcF's appointments with health and mental health professionals. She was asked about her views of JMcF's mental state on several occasions by different health professionals[110]. The extent to which her views were listened to by health professionals varied.

18.8 Consultant Psychiatrist Two wrote to GP Two following his assessment of JMcF on 5th May 2009. This is in line with good practice.

18.9 No attempts were made by any of the staff in the CRHTT to contact the private CBT therapist JMcF was seeing. No member of the CRHTT asked JMcF for his consent to do so. Members of the CRHTT were aware that JMcF was seeing a private therapist yet they did not consider the fact that

[109] Interview with Consultant Psychiatrist Two on 17 November 2010
[110] Interview with Friend One on 8 November 2010

it might be beneficial to contact her to update her in terms of JMcF's recent suicide attempt, nor did they consider the fact that she might be able to share, with JMcF's consent, some background or other information she may have about JMcF to support them in establishing a view with regards to JMcF's mental state. This lack of communication is poor practice.

18.10 The staff within the CRHTT made no attempts to obtain JMcF's medical records from his previous contact with mental health services. This would have helped the team enhance their knowledge of JMcF in general and to compare his previous presentation and current presentation. This is poor practice.

11. Recommendations for patient safety

The importance of having an up-to-date, comprehensive care plan for all patients on the CRHTT case load should be highlighted to clinical staff working in the team. Regular audits should be undertaken to provide assurances that there are up to date comprehensive care plans in place.

Staff within the CRHTT should make attempts to contact other health professionals involved in the care of any patient they have on their caseload. The patient's consent should be secured in writing prior to doing so.

Staff within the CRHTT should be reminded to take into consideration the previous psychiatric history of any patient on their caseload. Attempts should be made to access previous medical records relating to previous contact with mental health services.

19.0 THE INTERFACE BETWEEN HEALTH AND SOCIAL CARE

19.1 SOCIAL CARE ISSUES

19.2 Social care staff, and more specifically Mental Health Social Workers, in the Bury St Edmunds locality were located in, and operated from, multi-disciplinary Community Mental Health Teams. This was not uncommon throughout the nation at the time in an attempt to provide more integrated (seamless) services between the health and social care domains. This was achieved via a Section 75 agreement[111] that enabled some mental health Local Authority staff, in the main social workers, to be seconded (rather than TUPE'd) into the Mental Health Trust. Again this was not an unusual situation at that time across the nation.

19.3 Social workers would work within these multi-disciplinary teams combining the roles of a generic mental health professional (completing assessments, managing a caseload and acting as a care co-ordinator) as well as bringing social work expertise, and where qualified to do so Approved Social Work (ASW) experience (later Approved Mental Health Professional - an AMHP).

[111] Section 75 of the Health Service Act 2006. A 'Section 75 agreement' relates to a formal partnership agreement between health and local authority agencies that enable joint decision making and the pooling of budgets and resources for more effective local delivery of services. The term relates to Section 75 of the Health Service Act 2006. This Act superseded the NHS Act 1977 (Sections 28 and 28) and the Health Act 1999 (section 31) where similar powers were enacted. Agreements vary from locality to locality subject to local need and strategic priorities. Each agreement should clearly define roles, responsibilities, funding streams, governance arrangements, risk management issues, levels of delegated authority and powers, and the agreement should be reviewed on a regular basis to ensure its enduring relevance and validity

19.4 Locally the management of these teams also adopted an integrated approach whereupon the Team Manager could be a nurse, social worker or other suitably qualified profession. The Community Team in question was managed by a Social Worker, Social Worker and Team Leader One, throughout the period under consideration.

19.5 Despite both social workers and social work managers working in a CMHT setting and having greater day to day interactions with the Mental Health Trust and its staff, none of the Local Authority's employment responsibilities in relation to professional standards were delegated. Similarly the individual social work professional would continue to be held to the General Social Care Council's codes of Professional Standards for their own practice. The Investigation Team are of the view that to some degree both social workers and their managers lost some of their independence as they were absorbed into the prevailing culture of the Trust: that of being a 'Health' rather than a social care focused organisation.

19.6 Each of the social workers that we interviewed had been qualified for a number of years, and each were ASW/AMHP qualified, and so they should have had sufficient confidence in themselves, their profession, and their legal obligations to voice any concerns or objections if they held any. There is little evidence that they ever did this.

19.7 The first significant contact by a social worker in the build up to JMcF's offence was on the 11th September the previous year (2008). JMcF had been referred by his GP (date 13th August 2008) who expressed concern that JMcF had a long history of mental health issues, including detailing significant risk issues, and that his mental state was deteriorating again. JMcF had declined/rescheduled at least two appointments before attending the one on the 11th September. Social Worker One completed the documentation for this assessment, but it was undertaken jointly with a nurse, CPN One. At interview, Social Worker One stated he had no recollection of the interview and so could not add anything to his written report of the interview and the supporting letter back to the GP. He could give no explanation why he had recorded 'Nil' in the report in response to the section regarding risk issues when clearly there was on record a history of risk alerting behaviours by JMcF. At interview Social Worker One acknowledged and expressed regret for this error. Social Worker One had no further contact with JMcF after the 11th September 2008.

19.8 Although there were significant events and milestones between this assessment and May 2009 there is no record of any social care inputs. The next significant contact by a social worker was that with Social Worker Two on Sunday morning 3rd May 2009. JMcF was in A&E declining the opportunity to be admitted to hospital after making an attempt on his life the previous night. It is useful at this point to return to the issue of multiple roles of social workers: for the purposes of this interview Social Worker Two was acting as an Approved Mental Health Professional under the terms of the Mental Health Act 1983. Social Worker Two was quite clear in his mind – and documented it accordingly – that he agreed with the medical opinion that JMcF was not detainable under the Act and so no application was made. We would not expect an AMHP to challenge a medical opinion just for the sake of doing so if they did not, on the evidence presented at interview, believe an admission was appropriate. Similarly, given no medical recommendations were made (to admit) there was no possibility of a formal admission being made and so there was no *obligation* to consult the nearest relative. Social Worker Two was quite right in this regard in relation to his role as AMHP under the Mental Health Act 1983.

19.9 However in his more general role as social worker the Investigation Team wondered if he should not have made more efforts to contact JMcF's family. Social Worker Two notes in his police

statement that he had been made aware that JMcF "had recently been traumatised by events in current relationships". These presumably included the fact JMcF had separated from his wife weeks before, he had left the family home that he had shared with his in-laws, and had recently spoken with his mother on the phone. There were a number of family members who could have been contacted and their views sought. All interviews with 'significant others' relating to JMcF appeared to be with people who had known JMcF for a comparatively short period of time. We feel this to be an omission, but one that is shared by the all the teams and at each point of intervention: JMcF was repeatedly presenting with conflicting messages and presentations and no individual professional stood back and saw the bigger picture or escalating pattern of behaviours.

19.10 Part of this construct is no doubt, in our minds, due to JMcF himself deliberately manipulating others by saying different things to different people at different times, (especially when being assessed formally and the threat of an admission to hospital was at stake). However, given the experience of Social Worker Two as both a social worker and ASW/AMHP, we feel this was a lost opportunity to recognise an escalating pattern of disturbing behaviours and respond by contacting longer standing significant others including family members. We cannot say if such action had been taken the outcome would have been different.

19.11 This point is further compounded when we consider the responsibilities of an AMHP, post assessment if an application is not made. The Code of Practice Mental Health Act 1983 (4-053, specifically 4.82) states where an application is not made "The decision should be supported, where necessary, by an alternative framework of care and treatment. AMHPs must decide how to pursue any actions which their assessment indicates are necessary to meet the needs of the patient". The 'alternative framework of care' that was developed for JMcF was flawed in many respects. It was a very temporary arrangement with a reluctant work colleague of JMcF who had to disrupt his bank holiday weekend to return to the farm to 'look after' JMcF. In the absence of more appropriate services we feel Farm Manger One acquiesced to the request to support JMcF overnight. JMcF was homeless and he was being discharged to his employer: the place where the following day he was scheduled to slaughter a large number of animals whilst in an erratic and depressed state of mind, and a place the night before he had made an apparent serious attempt upon his own life.

19.12 We fear this assessment, along with a number of other critical ones, suggests a prevailing culture of *'if the person is not sectionable they are therefore of sound mind and so fully responsible for their own actions and we have discharged our duties'*. This is a false assertion. Both as a social worker and as an AMHP there remains a duty on the social worker (and the wider care team) to assess need and develop appropriate plans to meet that need. This duty is just as valid – if not more so – when the assessment is performed out of normal service hours.

19.13 This same 'not our responsibility' approach seems to pervade each step of the provision of care and treatment of JMcF and is not exclusive to that of social care professionals. No one individual took responsibility for him (save for his GP) and so each intervention was seen as a separate event with little regard for the emerging pattern of missed and or rescheduled appointments, increasing concerns of those around him and his deteriorating mental state.

19.14 Similarly, there appeared to be a pattern of assessors only seeing what was presented to them at the time of assessment and not giving due weight to JMcFs history (e.g., Social Worker One recording 'nil' risk behaviours and Social Worker Two focussing upon JMcF's presentation at time of interview on the Sunday morning rather than the preceding days and weeks).

19.15 Additionally, along with everyone else that we interviewed who had assessed JMcF, Social Worker Two focused on JMcF's risk to himself and his suicidal intentions. Given subsequent events this clearly was another omission but not one that rests solely with social care staff. It is clear from our interviews with key clinicians and practitioners that lessons have already been learned in this regard but both the Trust and the Local Authority would benefit from further formal risk assessment training for their respective workforces.

19.16 Overall the responsibility for and provision of training (risk or otherwise) of the Local Authority's social care staff in practice appears to the investigating team to have been devolved to the Mental Health Trust. We heard from a number of social care professionals interviewed about the various forums and mechanisms of supervision and support AMHPs receive to enable them to fulfil their duty. However we were struck that there was so little emphasis placed on the mainstream social work role by both the Trust and especially the Local Authority. We believe this deficit should be addressed with a reassertion of the need for quality social care as well as mental health care assessments and interventions for all those who use mental health services in the locality.

19.17 This issue is in our minds indicative of the systemic relationship and cultural difficulties in the interface between health and social care: i.e., between the Mental Health Trust and the Local Authority. The Section 75 agreement for partnership appears to have been a historic document made for pragmatic and legal purposes rather than a living and dynamic relationship. Once Local Authority staff members were seconded into the Trust a new routine was established whereupon, to our minds, two damaging cultural constructs developed over time.

19.18 Firstly, that in practice the roles and key responsibilities of social care staff was distilled into all things pertaining to Mental Health Act(s) generally and the ASW/AMHP role specifically. Therefore AMHPs were recognised and supported with role specific supervision, forums, training, etc., at the expense of their (and others') generic social work role and responsibilities.

19.19 The second point compounds the first in that there appears to be a lack of clarity in practice of which agency was responsible for general social care and social work standards. It appears to us that each party believed the other party was responsible for the ongoing support, supervision, training and maintaining of social care quality standards. The Local Authority appears to have delegated this function to the Mental Health Trust and the Trust in turn continued as a predominantly health focused organisation absorbing social care secondees as they would any other health profession, expecting the Local Authority to fulfil all legal obligations in this regard.

19.20 This phenomenon of fulfilling one's legal duties and thereby absolving oneself of wider responsibilities is the same one that we witnessed at individual practitioner level: hitting the target and missing the point. This appears to be a systemic and cultural issue rather than one located in a single individual or team.

19.21 We therefore make the following recommendations.

12. Recommendations for patient safety

There be an immediate review of the Section 75 agreement as to its current and future utility, with a new agreement developed in a more appropriate form that makes explicit the respective roles, responsibilities, required resources and outcome measures for each party.

Social work and social care, beyond that of the AMHP role, be given a higher profile throughout the Trust with bespoke support, forums, training and Key Performance Indicator's for all social care staff who work within the MDT context.

That all mental health assessing staff within the Trust and Local Authority receive up to date Risk Assessment and Safe-guarding training on at least a yearly recurring basis. As a minimum we would expect at least a full day on each subject domain.

That all current and future AMHPs receive intensive risk assessment training that stresses the importance of previous history, appropriate alternative interventions and their responsibilities, and the need to consider homicide as well as suicide when considering harm to self and/or others.

20.0 POLICE INVOLVEMENT

20.1 The Lead Investigator and panel had sight of the IPCC report and have considered its findings only in relation to matters that may concern the care and treatment of JMcF.

20.2 Thought was given to the Terms of Reference to this inquiry specifically the Terms of Reference that ask the Investigation to:

- *"..examine the adequacy of the collaboration and effectiveness of communication between the service teams, other agencies, who may have been involved in the care and treatment*
- *.. consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a reoccurrence."*

20.3 There were four main areas that were considered relevant to this investigation:

A. Pre incident the consideration that the reported harassment may have been an indication of JMcF's deteriorating mental state. The Core Panel recognised that there had been a change in policy in Suffolk to take into consideration mental health issues on grading calls since the incident. However, the panel would have liked the opportunity to discuss the issue of information available to the police about JMcF at the time, communication and multi-agency working. In particular the finding *"Two police incident event logs had been created on the 3rd May concerning attendance at A&E which recorded that officers returned him to hospital when he left and were placed on standby prior to the MHA assessment of JMcF."* "This suggested that there was earlier intelligence concerning JMcF which could have been accessed by the relevant call taker and dispatcher on the 5th May 2009 which may not have been accessed when it should have been."[112]

[112] IPCC report redacted p.11 Para 17

B. The post event issue of multi-agency working, communication with Suffolk Mental Health Trust and any considerations in working within a Memorandum of Understanding[113]. Specifically the issue that the Trust raise, that they were allegedly prevented from completing a robust Internal Investigation by the police in that they were asked not to talk to staff or request statements in relation to the care & treatment of JMcF whilst the police investigation was ongoing. However, the police state that this was not the case. There appears to have been a misunderstanding between the police and the Trust and the Core Panel has not, in view of the late response on the part of the police, been able to investigate the position further.

C. Post event learning: the way forward with communication, the use of information and the impact of grading of calls.

D. The impact on this independent investigation because of the significant delay in receiving the police records of JMcF that were first requested in May 2010. The police statements were received in late September 2010. Some further limited information was received in February 2011 from Suffolk Police.

20.4 The Lead Investigator did ask to meet with Suffolk Police to discuss the matters indentified above but no direct response was received from Suffolk Police and the Investigation Team have not been able to verify or consider the interaction between the Trust and Suffolk Police any further.

20.5 During the course of this investigation the IPCC have reported on their investigation.[114]

20.6 One of the recommendations was that:
"Incidents involving people where mental health issues are a factor should be recorded on the CIS so that the information is available when grading incidents"[115]

20.7 This was relevant to point A and C. Suffolk Police have amended their grading policy since the incident. There has been a change in policy in Suffolk to take into consideration mental health issues on grading calls. This is an appropriate form of action.

20.8 In regard to point B the Core Panel is unable to explore this point further. In regard to Point D whilst it is acknowledge that Suffolk Police provided some information, it was provided late and this has meant that this contributed significantly to the delay in completing this investigation.

[113] Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006) *Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm.*
[114] Independent Police Complaints Authority Commissioner's Report *Suffolk Police Response to call from xx and her subsequent murder"* March 2011 p5
[115] id p8

21.0 COMMUNICATION AND SHARING OF INFORMATION

21.1 The Lead Investigator throughout this investigation has provided the East of England Strategic Health Authority with written monthly feedback detailing the progress of the investigation and constraints to completion. The Lead Investigator has also provided bi-monthly written feedback to all stakeholders involved in this investigation following the same communication template.

22.0 REVIEW OF THE TRUST'S INTERNAL INVESTIGATION

22.1 At the time of this incident the policy in place was the Serious Untoward Incident Policy and Procedures dated February 2004 with a review date of 2005.[116] Its purpose is to *"...describe the Trust's arrangements for the management of incidents and near misses. The aim is to promote a safe organisation, minimise injury to all, by ensuring that lessons are learnt."* [117] The policy defines a serious untoward incident (SUI) as *"any unexpected event, occurring on an NHS site or elsewhere whilst in NHS funded or regulated care involving NHS Patients, relatives or visitors... and which may or has caused death."*[118]

22.2 Section 8 of the above policy outlines the roles and responsibilities in implementation.

22.3 **The Trust Board** has overall responsibility for effective risk management in the Trust.

22.4 **The Chief Executive** is ultimately responsible for ensuring compliance with the Health & Safety at Work Act 1974.

22.5 **The Director of Nursing & Modernisation** has executive responsibility for risk management and reporting directly to the Board on the Trust's performance.

22.6 **The Head of the Centre for Service Excellence** is responsible for coordinating and supporting the development of risk management systems in the Trust.

22.7 **The Risk Manager** has responsibility for the day to day implementation of the policy.

22.8 When this incident occurred in the small hours of the 6th May 2009 the charge nurse at the time, whilst dealing with the incident as events were unfolding, also escalated the incident to the Acute Service Manager. The Executive Director On call was notified. The Policy states that witness statements are to be obtained.[119]

22.9 **Panel comment**

The Trust Policy is limited and out of date. It does not make reference to national guidance in particular the National Patient Safety Agency Guidance on *Being Open*[120] *and guidance on Root Cause Analysis tools*[121]*, techniques and report writing tools and templates.*[122] *Despite trying to*

[116] Suffolk Mental Health Partnership NHS Trust (February 2005) *Serious Untoward Incident Policy and Procedures*
[117] id p4 para 2.1
[118] id p5 section 5
[119] id p8 para 9.4
[120] National Patient Safety Agency (2004) *Being Open Guidance.(Updated Nov 2009)*
[121] National Patient Safety Agency (2004) *Root Cause Analysis Toolkit*
[122] National Patient Safety Agency (2008) *Root Cause Analysis Report writing Tools and Templates*

ascertain the reasons, it was not possible to ascertain why statements from all the staff involved in JMcF's Care and treatment were not requested to provide a statement at this point.

22.10 **7th May 2009** a multi-disciplinary team (MDT) review took place. 12 members of staff attended including the Modern Matron, Consultant Psychiatrist Two and the Approved Mental Health Practitioner. A timeline/chronology of events was compiled. Two issues/risks were identified at that time. These were related to the Crisis Home Treatment Team not having access to the electronic record (Epex) when working from home and the administration phone answer-phone message did not contain emergency contact numbers for out of hours contact. The MDT concluded at that time "*that the team provided timely assessments of high quality and updated risk assessments accordingly as each presentation necessitated*."[123]

22.11 **Panel Comment**

The immediate local issue identified was that on call CRHTT staff did not have access to Epex when working from home and that an anasphone message did not contain an emergency contact number on the administration phone. This was a complicated issue in that Friend One of JMcF was a trainee psychologist and an employee of the Trust at the time and when raising the alarm friend one used an internal number out of hours. Immediate action was taken by the Trust to ensure that all CRHTT ansaphone messages contain contact details for out of hours.

22.12 The Core Panel noted that Suffolk Police requested that the Trust do not contact JMcF's relatives. However, there is no comment as to whether or not any decision was made by the Trust in contacting MG's family.

22.13 The Core Panel noted that the MDT served as a team debriefing. One to one debrief was offered to all staff and staff were made aware of external support.[124]

22.14 **Panel Comment**

At this early stage, it would have been an appropriate course of action for all staff who were involved in the care and treatment of JMcF to have been requested to provide a statement to support the forthcoming internal investigation as stated in national guidance[125] and reflected in the Trust's own Policy.[126] It would have been appropriate for both the victim and perpetrator's family to have had a Trust contact and to have been made aware of the forthcoming Internal Investigation. It would have been appropriate for Suffolk Police and the Trust to draw up a Memorandum of Understanding as per national guidance.[127]

22.15 **15th May 2009** the Trust established a JMcF Incident oversight group which appears to be an Executive Group set up to manage the incident. The Head of the Centre for Service Excellence was responsible for liaising with the police and for managing the internal investigation process reporting to the Deputy Chief Executive.

[123] Suffolk Mental Health Partnership NHS Trust. *Multidisciplinary Team review JM* 1400 07/05/09
[124] id p3
[125] National Patient Safety Agency (2004) *Being Open Guidance. (Updated Nov 2009)*
[126] Suffolk Mental Health Partnership NHS Trust (February 2005) *Serious Untoward Incident Policy and Procedures.* Section 9, para 9.4 page 8
[127] Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006) *Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm*

22.16 **Panel Comment**

Later on *the Acute Services Manager became the contact for the victim's family*
There doesn't appear to have been any immediate identified learning in this initial process which is an opportunity lost, apart from a change to an answer phone message. On interview the Chief Executive stated that their internal investigation was hampered by Suffolk Police as the police specifically requested that the Trust avoid speaking with their staff or request a statement for the purposes of investigating the care and treatment of JMcF. The Chief Executive and the Deputy Chief Executive stated that they were unaware of the Memorandum of Understanding[128] and have subsequently become aware of it. Suffolk Police were given a number of opportunities to comment on their approach but to date have not co-operated with this request.

22.17 In September 2009 the Trust commissioned an external documentary review for one piece of work that included a review of six individual cases, one of which was JMcF[129], along with an overarching report of a cluster of homicides.[130]

22.18 **9th November 2009** the Trust completes its own internal investigation without staff statements[131].

22.19 **Panel Comment**

The Trust's internal investigation report was benchmarked using the National Patient Safety Agency's "*Investigation credibility and thoroughness criteria".* The Trust Internal Report scored 20.6%. This is a low score. The main reason for this was that the investigation was limited in its scope. It was a documentary review. The executive summary was a summary of the incident and did not contain information relating to the care and support of the victim's family or the perpetrators family. It did not refer to support and engagement of staff in the internal review. The care and service delivery problems, contributory factors, root causes, lessons learnt, a summary of the recommendations and the arrangements for shared learning are all absent from the executive summary. The main body of the report did not have the usual subheadings that one would expect. The chronology, although limited, was clear and was of a good standard. The recommendations were limited. The investigation outcome was poor. There was no identifiable action plan attached to the report. There was no comment on the implementation, monitoring and evaluation arrangements in the report. A comment is made that this internal report "will *also feed into a broader review by three external professionals, employed to support the Trust in completing a systemic review of a number of recent deaths involving service users in contact with SMHPT."*[132] The report was limited.

22.20 **3rd December 2009** The date of the final report was the 3rd December 2009[133]. The terms of reference specifically stated:

> "*The review team will have access to the clinical notes and the Trust Review documentation already existing in relation to the incident. The review lead will have a free hand in deciding what approach to use and who to talk to within the Trust and other agencies".*

[128] Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006) *Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm*
[129] Independent External Review Team *Review of the Case of JMcF*. 3rd December 2009
[130] Independent External Review Team *Cluster of Homicides in Suffolk between May and August 2009: Report from an external ,independent team, following a documentary review.* 18th December 2009
[131] Suffolk Mental Health Partnership NHS Trust. *Documentary Review of a Serious Untoward Incident JM* v1.7 09/11/09
[132] Suffolk Mental Health Partnership NHS. Trust *Documentary Review of a Serious Untoward Incident JM* v1.7 09/11/09
[133] Independent External Review Team *Review of the Case of JMcF* 3rd December 2009, page 3.

22.21 **Panel Comment**

This was an appropriate course of action to take and an example of good practice and demonstrates an openness and willingness to investigate further. The expectation of the Trust was that national guidance would be followed in relation to the formulation of the report including the use of root course analysis techniques. This was reasonable given that the proposal of works[134] submitted by the External Review Team outlined and makes reference to national guidance and the methodology of root cause analysis whilst agreeing that this was a documentary review as requested by the Trust.

22.22 This report appears to be finalised on the 3rd December 2009.

22.23 **Panel Comment**

The report was a documentary review.[135] The report made a number of recommendations in relation to waiting times, note keeping, further investigation in relation to bed availability and training.[136] *Notwithstanding the fact that the report was a documentary review, it does not follow NPSA guidance in relation to the suggested format for the writing of such reports.[137]It was accepted by both parties that interviewing would not occur. However, because of the perceived limitations of the documentary review on the part of the independent external reviewer inaccurate statements were included without validation. It should have been possible for the independent External Review Team to check for factual accuracy with the Trust if necessary within the context of a documentary review. The independent External Reviewer states that it was openly acknowledged by the SHA, PCT and the Trust that compliance to the NPSA approach would not be achieved. However, there is no evidence of this acknowledgment in the documentation between parties that the panel have seen.*

22.24 **Panel comment**

The report was limited in its scope and as such the findings and recommendations are limited.

22.25 **18th December 2009 is the date of the overarching report** "Systemic Review of Homicide Cluster in Suffolk between May and August"[138] by the same provider that was received by the Trust.

22.26 **Panel comment**

In respect of the case of JMcF, the overarching report (as opposed to the individual report in relation to JMcF) makes an error in reporting the correct victim.[139] In its conclusion the report makes recommendations in relation to updating policies and procedures, devising an action plan, and suggestions are made in relation to the management structure, identifying leads for *"substantial pieces of work that is required"*[140]. The report also states that *"deep thought must be given to the prevailing culture within the organisation and how this needs to be managed"*[141]

22.27 It is unfortunate that the Trust Board accepted the overarching report and failed to note the inaccuracy. The report with this inaccuracy was submitted to the SHA and PCT. On interview, the

[134] Independent External Review Team Formal Proposals for the Review page 3 September 2009
[135] Independent External Review Team *Review of the Case of JMcF* 3rd December 2009, page 3.
[136] id p7
[137] National Patient Safety Agency (2008) *Root Cause Analysis Report writing Tools and Templates.*
[138] Independent External Review Team *Cluster of Homicides in Suffolk between May and August 2009: Report from an external ,independent team, following a documentary review.* 18th December 2009
[139] id p18
[140] id p44
[141] id p44

Executive Team reported that they were inundated and occupied with the process regarding Foundation Trust Status and felt overwhelmed by the ongoing homicide investigations.

22.28 ASSESSMENT OF THE ADEQUACY OF THE TRUST'S FINDINGS, RECOMMENDATIONS AND ACTION PLAN

Opinion

22.29 The initial Trust report was limited in its scope and not completed within the specified time frame of 45 working days[142]. There were a number of other serious untoward incidents at the time and the Trust felt overwhelmed by the volume of serious untoward investigations to be undertaken. Lack of cooperation from the police hindered the Trust process and ability to run their own internal investigation. The Trust had identified for itself that its internal report was limited.[143] There was no documentary evidence to suggest direct input from a Non Executive Director, Medical Director or the Director responsible for the service.

22.30 There were limited recommendations made as follows:

- *"Explore options to modify the current model of service to improve continuity of the service user's experience."*
- *"Clarity should be established through either a Policy or a Protocol on what action is taken when people decline to attend appointments, to reflect particularly situations where a GP has made an urgent referral for assessment and advice versus a routine referral."*
- *"The operational policy should be finalised with an Equality Impact Assessment and provide guidance on consistent standards across both CRHTT services in SMHPT."*
- *"There must be greater clarity on what is an appropriate response to letters from GPs, including and timescales for response and the appropriate response where referral for a specific type of professional opinion is requested. This should be included in the operational policy or service specification for CMHTs."*
- *"There should be a review of the on-going training and educational needs for the CRHTT to ensure that they have the appropriate skills and competencies across the team and that these are kept up to date. It is suggested that particular notice should be taken of training on self harm, suicide prevention, risk assessment and the use of psychological interventions."*
- *"There should be clear guidance on what processes are in place, for making decisions on when and how clinical information on previous psychiatric treatment is obtained from previous providers of services."*
- *"The CHRTT should review how all information received by the team relating to referrals and /or transfer of records is recorded on arrival to confirm contents."*[144]

[142] East of England letter dated 8th May 2010 to PCT and SMHT from EOE.
[143] Suffolk Mental Health Partnership NHS Trust. *Documentary review of a Serious Untoward Incident involving JM.* 6th May 2009, p24
[144] id p25

22.31 These were then combined with the recommendations from the external investigation that the Trust commissioned. Again these were limited in their scope making recommendations in relation to access to a Consultant when specifically referred, record keeping, training, the interface of Crisis Resolution and Inpatient Services.[145]

22.32 REVIEW OF PROGRESS THE TRUST HAS MADE IN IMPLEMENTING THE ACTION PLAN

22.33 There was no individual Trust action plan dedicated to the findings of the internal and external investigation commissioned by the Trust for this serious incident. There was however, an overarching action plan that detailed the actions to be taken following a number of different Serious Untoward Incidents, including this one as the result of a thematic review[146] of a number of cases that were commissioned by the Trust.

22.34 It has been difficult to assess the progress that has been made in implementing the action plan as there are a number of different formats whereby information is displayed and the action plan doesn't include all the limited recommendations made from both previous investigations. Therefore the approach by the Trust has been disjointed with various professionals reviewing the incident with an unsystematic approach.

22.35 It is clear from the SUI progress reports to Suffolk PCT from the Trust[147] that the focus in the immediate aftermath of the incident was the Trust collaborating extensively with Suffolk Police on the murder investigation of MG and collaborating with the Independent Police Complaints Commission as they undertook their investigation.

Opinion

22.36 The focus was lost on the care and treatment of JMcF and the processes and actions that may have needed to be taken immediately. It should have been possible for all agencies to work together to ensure potentially the safety of others without compromising any ongoing police investigation. Suffolk Police have not taken up the opportunity afforded to them by the panel to clarify this point.

22.37 The organisation of the formulation of the Trust thematic action plans commenced September 2009. However there is a lack of recorded detail under JMcF as the Trust internal review and external review were not completed until 9th November and the 3rd December 2009 respectively. There was a special board meeting held on the 21st December 2009. An item on the agenda was the agreement of recommendations arising out of the investigation into JMcF. The Minutes are limited and do not capture the list of recommendations approved. The 19th February 2009 sees an improvement in the information captured on the *SUI Thematic Review Integrated Action Plan.* There are seven listed development areas identified arising out of the recommendations made. A number of actions were noted as completed and polices drafted and waiting for approval but no evidence of implementation of those action plans.

22.38 The Core Panel assessment of the implementation of recommendations is as follows:

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[145] Independent External Team *Review of the Case of JMcF.* 3rd December 2009

[146] Independent External Review Team *Cluster of Homicides in Suffolk between May and August 2009- allegedly involving people having an association with services offered by the Suffolk Mental Health Trust Partnership Trust* 18th December 2009.

[147] SMHPT SUI Progess report to Suffolk PCT dated 8th May 2009

22.39 Policy & Procedure

22.40 The Operational Policy for the Crisis Resolution Home Treatment Team[148] has been finalised.

22.41 In relation to continuity of care the Trust has considered the issue of continuity of care in the CRHTT Policy updated operational policies.

22.42 In relation to referrals:
"Clarity should be established through either a Policy or a Protocol on what action is taken when people decline to attend appointments, to reflect particularly situations where a GP has made an urgent referral for assessment and advice for a routine referral."

22.43 The CRHTT operational policy states:
"Service users will need to be able to co-operate with their treatment plan to be eligible to access the service" (p 8).

Opinion

22.44 Neither the CMHT service specification nor the CRHTT policy or the Community Adult Mental Health operational protocol cover the situation where a person declines to attend following a GP referral. No evidence in these documents that this issue had been considered and addressed.

22.45 The Single Point of Referral (S.P.O.R.) has been disbanded.

22.46 There are now standards in relation to the response time for GP referrals and audits are being undertaken on GP referrals.

22.47 The CRHTT operational policy now has written response times:
"*In some cases it may be appropriate for the response time to be negotiated with the referrer; however in all cases a response will be required within 24 hours*"

22.48 The appropriate response time to a request for a specific professional opinion in the CRHTT policy is not evident.

22.49 The Community Adult Mental Health Teams Operational Protocol now states that urgent referrals will be seen within 24 hours and non urgent referrals within 28 days.

22.50 Identified Link Workers to engage with GPs and act as the gateway into secondary services.

22.51 The Mental Health Trust are working with A&E to agree protocols around caring for people with mental health problems in A&E but at the time of writing are not formalised.

22.52 Standards have been agreed around the response time for responding to a request to conduct a Mental Health Act assessment in A&E.

22.53 There are now agreements with the PCT that the Mental Health Trust has to respond within three hours.

[148] SMHPT. Crisis Resolution Home Treatment Team Operational Policy dated November 2010

22.54 However, all will require careful monitoring of implementation. It is recommended that the Core Panel assist in monitoring the implementation and review the situation six months from publication of this report.

22.55 Supervision and training

22.56 The Core Panel were informed that the training itself and the recording of it for the workforce has been revised. Previously training was not being centrally recorded. The panel were informed that this has now been corrected. Attendance at training and compliance is centrally recorded now. Each team now has training priorities in place which are recorded by the Education Manager.

22.57 Clinical supervision arrangements have been agreed and are now in place for the A&E Psychiatric Liaison Nurse.

22.58 In addition, the revised operational policy for the CRHTT states the following:

"The training and development needs will be reviewed by the Team Manager through discussion and individual supervision/appraisal. This is to ensure team resource is used efficiently and focuses on the need to deliver an effective CRHTT Service and that all members of the team are equipped to carry out their role and responsibilities effectively at all times. All members of the CRHTT will be expected to undertake any identified mandatory training as required by the SMHPT and any relevant professional bodies and pertinent topics associated with CRHTT such as risk assessment and management. A learning and educational forum will be held two weekly within the team to discuss any new or pertinent issues related to the CRHTT service" (p21)

22.59 However, the revised operational policy for the CRHTT does not specifically state that staff should receive training in self harm, suicide prevention or formulation and psychological interventions. Only risk assessment and management was highlighted. This needs to be addressed.

22.60 The Service Specification for the CRHTT (undated) under "Staff Development & Training Expectations" states:

"It is expected that staff are trained, developed and supported, as appropriate to their individual needs identified through the appraisal and supervision processes, to achieve the Ten Shared Capabilities for mental health practice" (p5).

22.61 The CMHT service specification states "*It is expected that staff are trained, developed and supported as appropriate to their individual needs identified through the appraisal and supervision process to achieve the ten essential capabilities for mental health*".

22.62 The Adult Community Mental Health Teams operational protocol states regarding staff training: "*All staff are required to complete their mandatory training and be in receipt of management supervision to identify gaps in knowledge and skills which will be fed into PDRs and become objectives for them to meet" (p16).*

Opinion

22.63 The policies do not explicitly state that staff should receive training in self harm, suicide prevention and psychological interventions. Risk assessment and management was identified in

some policies. The larger question around how training transfers into practice is not addressed at all.

22.64 MANAGEMENT OF INFORMATION

22.65 There is a lack of evidence in the CRHTT operational policy or the CMHT service specification around confirming receipt or recording receipt of information from referees.

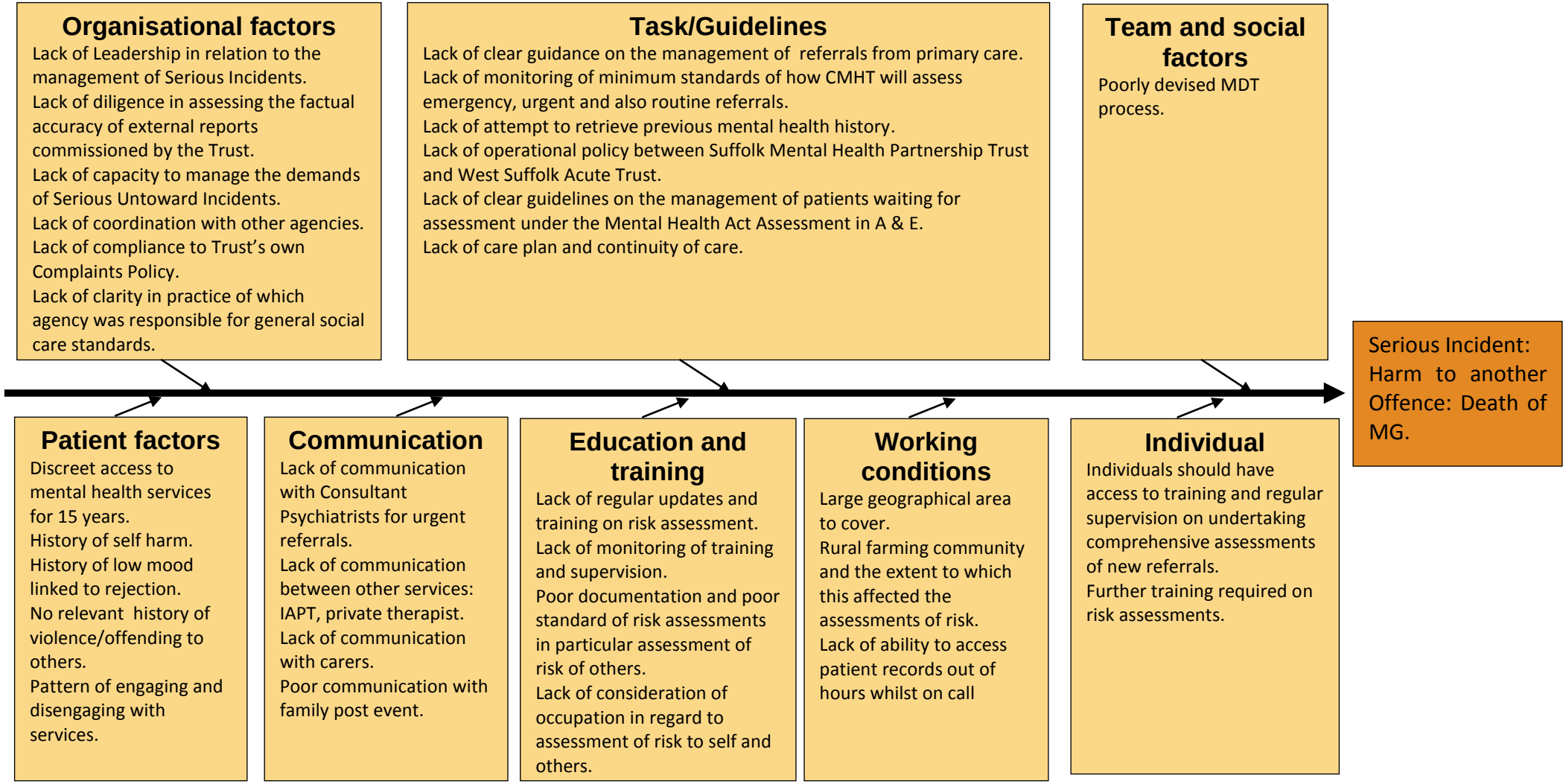
22.66 The Community Adult Mental Health Teams operational protocol places the responsibility on referees to provide the necessary information. The protocol states *"The referrer will be responsible for completing all requested information for the process of referral (for known service users, the last CPA Plan and up to date risk assessment should be included – recorded on the Trusts Electronic System)" (p8).* The protocol also states *"A full examination of previous documentation when service users are allocated to Care Co-ordinators either for assessment or intervention is essential" (p9).*

22.67 This does not fully address the issue of ensuring *as much information as possible to ensure an accurate assessment.* The Policy should be amended to ensure that the CMHT has a tracking system for receipt of enclosures that come with referrals and have a proactive approach in requesting previous records.

23.0 ROOT-CAUSE ANALYSIS

23.1 Whilst it has been established that the Trust has a number of policies and procedures in place, on this occasion some policies were not formalised and there was a lack of clarity on some points. The care and service delivery problems with contributory factors are represented diagrammatically in the adapted fishbone diagram below.

23.2 This analysis follows NPSA guidance. In essence, an attempt is made to identify root causes in organisational process, how those directly resulted in specific care and service delivery problems and how those led to the documented actual or potential effect on the outcome. The issues identified identify sub optimal processes as identified by using this technique. These issues are not causative but are highlighted for organisational learning.



24.0 LEARNING THE LESSONS

24.1 There are a number of lessons to be learnt that have come to light through this investigation process. In relation to responsiveness to referrals from primary care into secondary care, establishing previous history/access to mental health services, communication between professionals, the response to a service user that engages and disengages with the system, the assessment of risk to self and risk to others including children and consideration of occupation in the management of risk.

24.2 Following the offence, it has come to light that the organisational processes of the management of such serious incidents are sub-optimal; opportunities for effective communication with family members and the opportunity to identify systems issues that require immediate action were lost. The need for effective monitoring of training has been identified.

24.3 Effective multi-agency working was not apparent. It was apparent during the course of this investigation that the *Memorandum of Understanding Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006, was not clearly understood by the Trust or the police service. A high level discussion between the SHA and Suffolk Police needs to take place to avoid delays in the investigation process in the future.

24.4 The recommendations made as a result of this Independent Investigation are detailed in Appendix two subdivided under the following headings:

- National Learning.
- Multi-agency Working and Organisational Boundaries.
- The Interface between Health and Social Care.
- Organisational, Governance and Serious Untoward Incident Process.
- Communication between the Acute Trust and the Mental Health Trust.
- The Care Pathway.
- The Referral Process.
- Access to Psychological Therapies.
- Private Therapy.
- Crisis Resolution Home Treatment Team.
- Risk Assessments.
- Data Collection/Equipment.

24.5 This approach has been adapted to assist the Trust and SHA in devising a detailed action plan.

24.6 The Core Panel in the course of this investigation have had sight of the Facebook traffic and text messages sent. The panel felt compelled to pass this comment, with the benefit of hindsight. In a world where the use of social networking sites and mobile texting is frequent, this inevitably means that communication between two people is at arm's length and not face to face. More weight should be given to the content of what is posted in texts and on social networking sites. The fact that the communication is at arm's length should not diminish the content and the actions that may be required.

25.0 CONSIDERATION OF SIMILAR INDEPENDENT MENTAL HEALTH INVESTIGATION REPORTS IDENTIFYING ANY SIGNIFICANT COMMON FACTORS IF APPROPRIATE

25.1 The National Confidential Inquiry Into Suicide and Homicide by People with Mental Illness in their report *Independent Investigations after Homicide by People Receiving Mental Health Care*[149] analysed a number of Independent Investigation reports between 2006 and 2009 with the aim of collating key themes emerging from the recommendations in those reports. Below follows the key clinical messages identified that are relevant to this Independent Investigation:

- *"Mental Health Trusts should ensure (a) full implementation of the CPA by all clinical teams (b) robust risk management processes are in place for all service users(c) information about risk is shared between all individuals, professionals and agencies, based on protocol approved by the Trust."*[150]

- *"Whilst respecting service user confidentiality, mental health trusts should encourage and support family carer involvement. Carer's should receive an assessment of their own needs"*

25.2 It is a recommendation of this Investigation that the Core Panel assist the SHA in the monitoring of the recommendations made and supports the Trust in moving forward with an action plan for improvement and implementation of the recommendations.

26.0 NOTABLE PRACTICE

26.1 The Investigation Team considered this carefully. The following areas are highlighted:

26.2 The GP referral was of a good standard and JMcF was followed by his GP.

26.3 The subsequent risk assessments of 2009 were of a good standard limited to the format available at the time.

26.4 A number of mental health practitioners had done careful assessments in 2009.

26.5 Despite not being a finding of the Trust Internal Investigation, the Trust did amend and strengthen its Risk Profile.

27.0 INVOLVEMENT AND SUPPORT FOR STAFF

27.1 All available relevant staff involved were interviewed by the Investigation Team. It was clear that some staff members felt unsupported, since the offence, by the Trust and there was a culture where staff felt unable to discuss the event. Once the police investigation was complete, it should have been possible for the Trust to discuss the incident with their staff and complete a thorough investigation. Some staff at the beginning of this Independent Investigation did not willingly participate. Despite early communication with the Trust, the internal Trust communication was ineffective in relation to informing all the relevant staff of this Independent Investigation.

[149] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2010) *Independent Investigations after Homicide by People Receiving Mental Health Care*
[150] id p3

27.2 Once these initial difficulties were resolved, the available staff willingly engaged with the process and were open in their discussions surrounding the care and treatment of JMcF. Staff also commented on how best to manage processes in the future. All available staff demonstrated a willingness to improve practice and learn lessons for the future.

27.3 The Trust needs to ensure that there are appropriate support mechanisms in place to support staff when involved in a Serious Untoward Incident. The Trust needs to ensure that its staff follow the Trust policy in relation to documentation, note keeping and statement writing, some of which were sub-optimal on this occasion. The Trust needs to continue to audit compliance against this process.

27.4 In addition, the Trust should follow the National Patient Safety Agency's good practice guide on the use of the incident decision tree[151], which will assist the Trust in effectively managing the performance of staff should it fall short of the required standard.

28.0 COMMUNICATION STRATEGY

28.1 This report has been shared in advance with the family ahead of publication. This report has also been shared with the perpetrator in advance and relevant sections have been shared with relevant stakeholders ahead of finalisation and publication. The SHA have led on the communication strategy and engaged all in advance.

[151] National Patient Safety Agency (2004) *Incident Decision Tree*

29.0 CONCLUSION

29.1 JMcF had been involved with mental health services for around fifteen years but in three discrete episodes. The key issue identified being around coping and self harm, following on from stressful events.

29.2 There was no relevant history of violence or offending to others.

29.3 There were five separate referral points across all services: Primary care including GP and IAPT services; Specialist care including CMHT, CRHTT, Psychiatry, AMHPS and A&E. There were nine occasions where JMcF engaged and disengaged with services with JMcF generally avoiding admittance to hospital.

29.4 There was an escalation in risk to himself in the run up to the offence.

29.5 Risk to others was not raised specifically at any time in the professionals' assessments in the days before the offence. A risk not explored due to a lack of such behaviour in the past. There was no reason to suggest that this was a potential avenue that JMcF would progress and therefore a potential avenue that needed exploration by the professionals involved with his care.

29.6 JMcF admitted in his interview with the Consultant Forensic Psychiatrist that plans for MG were not well formed. He admitted that he felt anger towards her but beyond the letter, texts and Facebook traffic this was raised as a specific issue on only one occasion.

29.7 MG herself and her friends were concerned about his anger which they felt was out of character. MG was frightened by him. This was the thrust for MG in contacting the police. There is no clear reason to suggest that this should have led to the involvement with mental health services. It is possible that had she seen a police representative (beyond the telephone contact) that her knowledge of JMcF's involvement with mental health services might have been flagged up to the police. However, the time frame in this period is very compressed. We have not been able to explore this point with them.

29.8 Assessment of risk was complicated by a lack of diagnosis. The diagnosis in the 24 hours before the offence seems to be the clearest in terms of stating that JMcF did not have a depressive disorder. Looking at the other comments and diagnoses, they point to JMcF having repeated periods in his life when he had felt depressed and some clinicians appear to have categorised this as being part of a depressive illness an illness that required treatment.

29.9 The actions of the community team and crisis team in the period before the offence did not consider that medication should be the mainstay and identified the relationship to psychosocial issues. This resonates with the view from the records that his depression has usually occurred for a reason or following an issue in his life and perhaps hence why his depression was more severe after the offence.

29.10 There seems to be no evidence that he has been depressed at other times or of a nature or degree that directed him to seek help from either his GP or from mental health services.

29.11 The feelings of depression as far as we can ascertain have been clearly related to external events

29.12 The most successful approach would be a combination of medication, psychological approaches and of course addressing the event that was provoking the depression.

29.13 JMcF was a risk to himself as identified in the risk assessments on the 23rd April 2009 and the 3rd May 2009. Both risk assessments were of a reasonable standard. The intention to manage JMcF outside the hospital setting is a reasonable one given his mental state and clinical presentation at the time of the assessments. This approach is in keeping with the national policy[152] where the emphasis is to manage patients in the community with the support of crisis resolution/home treatment services.

29.14 The decision not to detain JMcF under the Mental Health Act on the 3rd May 2009 was taken after a lengthy, comprehensive assessment of his recent history and current mental state. At the time of the Mental Health Act Assessment, his mental state appeared to have settled considerably. He agreed to engage with the aftercare and follow up from the CRHTT. Although he had an address to go to and supervision from friends, the Investigation Team have concerns about the way in which support was arranged and the appropriateness of that support.

29.15 The decision not to detain JMcF under the Mental Health Act on the 3rd May 2009 was a reasonable one based on the information available at the time of the assessment.

29.16 The tragic murder of MG was not predictable and although with the benefit of hindsight, admission to hospital to manage the risk that JMcF presented to himself would most likely have prevented the offence at that time, this could not have been identified at anytime by the various mental health professionals.

[152] Department of Health (1999) *National Service Framework for Mental Health*