External Investigation into the Case of J

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Acknowledgements

The External Review Panel wishes to thank all the staff at Northamptonshire Healthcare Foundation Trust who have willingly given their time to assist in providing an understanding of the care and management of the mental health service user J. All staff who were interviewed were clearly open to sharing information and their own reflections regarding the homicide that occurred in late 2006. Their contributions have assisted greatly in the production of this report. The Panel particularly wish to thank Des McMorrow, for arranging interviews and responding to our requests for information and documentation.

The External Review Panel extends their thanks to the co-operation and assistance provided by J's M and Uncle K, who assisted us in understanding and incorporating the carer and service user perspective into this investigation and report.

1 Executive Summary

1.1 Introduction

1.1.1 In 2007 J killed his maternal GM (GM) with a single stab wound to her neck. He was living with her and an uncle (L) and had been diagnosed as suffering from Paranoid Schizophrenia, complicated with persistent alcohol abuse. J pleaded Guilty to manslaughter and was made subject to a Hospital Order, under the Mental Health Act 1983, without limit of time. He is now detained in a secure psychiatric hospital.

1.1.2 J first came into contact with the services of Northamptonshire NHS Foundation Trust (the Trust) in April 2006 and was reported by his family as having been unwell for at least two years prior to this. J was predominately managed by a community based early intervention mental health team and his care was provided under the enhanced arrangements of the Care Programme Approach with oversight by a Consultant Psychiatrist and a Care Coordinator who was a Principal Community Psychiatric Nurse. Specialist counselling and support for his alcohol abuse was also provided by the Trust.

1.1.3 J had been living with his GM and Uncle L for the past year having left the home he shared with his M (Mother) and siblings with whom he had a difficult relationship. The extended family all lived in close proximity of each other.

1.1.4 Following the incident the Trust established an internal serious untoward incident investigation team who produced a report on its findings in April 2008. The report generated a number of recommendations which were subsequently adopted by the Trust and incorporated into an Action Plan.

1.1.5 This report sets out the findings of the External Review Panel. The Panel reviewed the Trust's internal serious untoward incident report into the care and treatment of J. In addition the external review report was further informed by interviews of key stakeholders, a review of J's health record (for which consent was provided), and a review of appropriate Trust documentation including relevant policies and procedures.

1.2 Purpose

1.2.1 The independent investigation was commissioned by NHS East Midlands. An independent investigation is required when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the event. The purpose is to examine all the circumstances surrounding the care and treatment provided and in each case to identify any errors or shortfalls in the quality of the service and to make recommendations for improvement as necessary.

1.2.2 The External Review Panel was required to address Terms of Reference agreed by the NHS East Midlands and key stakeholders, set out in full in Section Two of this report.

1.3 Methodology

1.3.1 The independent investigation process was informed by:

- Interviews with members of J's extended family:
  - Mother
  - Uncle K
- Interviews with key staff:
  - Consultant Psychiatrist
  - Care Coordinator
  - Consultant Forensic Psychiatrist, current Responsible Clinician for J
  - Trust Head of Risk Management
- A review and analysis of J's health record,
- A review and analysis of the Trust's internal report and appendices (April 2008)

1.3.2 The Panel were unable to interview J, as he declined to meet the Panel on arrival at the hospital where he is now placed.

1.3.4 J signed a consent form in February 2010 which allows the External Review Panel to access his personal information, including health records, court case records and associated papers. Consent was given on the understanding that some information may become public through publication of the investigation report.

1.3.5 The Panel utilised the Root Cause Analysis approach in carrying out this investigation

1.4 Findings of the External Review Panel

1.4.1 Overall, the Panel did not identify significant contributory factors which had not already been identified by the internal review. J's behaviour suggested the existence of a developing schizophrenic illness when of school leaving age and used alcohol as a way of managing his symptoms. His paranoid symptoms led to guarded behaviour and suspiciousness, making engagement more difficult for staff of both the Community Mental Health Team (CMHT) and Early Intervention Psychosis Service (EIS).

1.4.2 In the context of many other cases dealt with by the Early Intervention Team and others operating within the Trust J presented as a less challenging person. The Panel heard from the Consultant Psychiatrist of service users who were far more of a risk that J was deemed to be.

1.4.3 Had the information and experiences of J's GM been shared there was, on the balance of probabilities, a likelihood that J would have been recommended for admission to hospital where it is further likely he would have been easier to assess, alcohol free, and establish a consistent medication regime much more quickly. However, the Panel believe that such an admission would have had to be compulsory.

1.4.4 He was without doubt a risk to his M, with whom he had a difficult relationship, and why this was so was never determined. His sister and younger brother also figured in his expressed wish to cause them harm. There should have been an assessment of the children's welfare, even when he had moved, as he went home regularly.

1.4.5 It is unclear why J was retained as a service user of the CMHT in the first instance and not referred to the EIS given that he was referred with symptoms of a psychotic illness and was within the appropriate age group for EIS services. However, when the referral was made, both CMHT and EIS worked appropriately in jointly managing the transfer of his care.

1.4.6 Construction, recording and reviewing of his Care Plan was weak, although there was a clear understanding of J's needs between the Consultant and Care Coordinator. The Panel were assured this had improved. The GP was kept informed about his patient's treatment.

1.4.7 A number of occasions were identified when there were weaknesses in the risk assessment and management process,

1.4.8 In attempting to engage with complex young people this can only be safely achieved within a framework of clear risk information; this was not achieved with J within the Trust's time-frames. Consequently the model of practice within the EIS needs to closely reflect the needs of the services users it cares for. Offering a 'light touch' for fear of alienating a service user is only defendable when the risks are known. Therefore there should be a review of the model of practice of the EIS to ensure that there is sufficient flexibility in the levels of support offered and that firmer interventions are readily available to the service when requested.

1.4.9 The Trust's Consultant Psychiatrist and in particular the Care Coordinator made all reasonable attempts to engage with J and acted in a professional, thoughtful and caring manner towards him. The actions they took, with the information they had, were appropriate and proportionate. They were persistent and consistent in their contact with J.

1.4.10 The formulation and documentation of the Care Plan for J and its review were unacceptable within the time frame they were achieved.

1.4.11 A thorough initial review of the family history would have aided the formulation of a resulting Care Plan and Risk Assessment and commenced the Carer Assessment process. This assessment should have determined the interests of the extended family who lived in close proximity. Had this been conducted prior to a more thorough relationship developing with J then future issues of confidentiality concerning his ongoing treatment could have been controlled. His unacceptable behaviour was of a wider concern and needed to be discussed with those affected.

1.4.12 The internal review undertaken by the Trust and its main findings are supported by the Independent Investigation Panel. The Panel concluded that the recommendations made were appropriate and, in the main, have been implemented.

1.4.13 **The Panel were specifically required in the Terms of Reference given to, *"identify whether there was any aspect of care and management that could have altered or prevented the***

events of 2007." **The Panel concluded, with the information available to the Trust at that time, the tragic events could not have been predicted and therefore prevented.**

1.5 Recommendations

1.5.1 The Trust should commission the production of a procedure and process for taking a thorough social history and combine with this a review of the involvement of families and the sharing of information with them.

1.5.2 Service users and families should be given a clearly written and easily understandable description of the service and supporting information which covers issues of confidentiality and responsibilities to share information in order for the Trust's staff to support the service user.

1.5.3 The 'Interim Core Care Plan' resulting in first stage Care Plan and Risk Assessments should be audited to ensure they are formulated within the Trust's required second visit criteria.

1.5.4 The Trust should undertake a review of the model practiced by the EIS to ensure that there is sufficient flexibility in the levels of support offered and that firmer interventions are available when these are required.

1.5.5 Safeguarding children should be at the forefront of staff working in service users homes where there are children. The Trust should ensure that all service users families are offered a carers assessment and where children are involved this must be done factoring in any of the safeguarding concerns or needs as they arise.

1.5.6 The Trust should devise and undertake an audit of the Early Intervention Service to assure itself that it is adhering to the requirements of the Care Programme Approach and the Trust's Risk Assessments, including their quality, paying particular attention to review date adherence.

2 Terms of Reference and Principles of the Investigation

2.1 Terms of Reference

To undertake a systematic review of the care and treatment provided to J by the Trust to identify whether there was any aspect of care and management that could have altered or prevented the events of 2007.

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

- To review the quality of the health and social care provided by the Trust and whether this adhered to Trust policy and procedure, including:
  - To identify whether the Care Programme Approach (CPA) had been followed by the Trust with respect to J;
  - To identify whether the risk assessments of J were timely, appropriate and followed by appropriate action;
  - To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;
  - The Mental Health Act assessment process (if appropriate).
- To examine the role of the care coordinator and the interrelationship between the various teams within the Trust with whom he had contact with and the appropriateness of their involvement; e.g. CMHT, Early Intervention Services and Drug and Alcohol Services.
- To establish whether the recommendations identified in the Trust's internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the Trust in response these recommendations.
- To identify any learning from this investigation through applying Root Cause Analysis (RCA) tools and techniques as applicable.
- To report the findings of this investigation to East Midlands Strategic Health Authority.

2.2 Principles of the Investigation

2.2.1 **Approach** The investigation will not duplicate the earlier internal investigations; this work is being commissioned to build upon the internal investigations. Should the reviewers identify a serious cause for concern, this should be notified to the SHA and the trust immediately.

2.2.2 **Publication** The outcome of the review will be made public. East Midlands Strategic Health Authority will determine the nature and form of publication. The decision on publication will take into account the view of the chair of the investigation panel, relatives and other interested parties.

2.2.3 **Data Protection** The completed investigation reports contain details of the clinical care and treatment the service user received and is therefore subject to the Data Protection Act and if made public could also breach the Human Rights Act. It is the responsibility of NHS East Midlands to ensure that there is a balance within the report that would protect the rights of those individuals involved in the incident whilst also discharging its duty to publish what is deemed to be in the public interest.

2.2.4 **NHS East Midlands Policy for Managing and Investigating the Most Serious Events in Mental Health Services** This specific policy indicates that a key reason for commissioning an independent investigation is to ensure that lessons are learned, that the quality and effectiveness of services are continually improved and that the public and patients have confidence in its services. In achieving this objective the independent investigation team has to ensure that there is openness and transparency in the investigation process and that the public interest is served by this process. However the NHS has a duty to maintain and protect the rights of patients and their families to confidentiality. The independent investigation therefore needed to fully explore the relevant facts, documents and records without compromising those rights.

2.2.5 **Support to Victims, Perpetrator, Families and Carers** When an incident leading to death or serious harm occurs, the needs of those affected need to be of primary concern to the Foundation Trust, Strategic Health Authority and the independent investigation panel. This should be reflected through the principals of the NPSA guidance, which are:

- the principle of acknowledgement,
- principles of truthfulness, timeliness and clarity of communication,
- the principle of apology.

2.2.6 The families of the victims and perpetrator within this process were contacted and were offered a meeting with the independent investigation panel. In general families wish to:

- know what happened?
- know why it happened?
- know how it happened?
- know what can be done to stop it from happening to anyone else?; and,
- tell their account of events.

2.2.7 It is important that the debate on the matters of public concern which arise from this case are grounded on an accurate and full account of the facts which have hitherto been denied to the public.

2.2.8 **Procedure** All inquiries have to consider what procedure is appropriate for the particular issues to be considered. The objectives must be to conduct an inquiry which as far as is practicable:

- investigates the matters within the terms of reference thoroughly;
- ensures objectivity;
- ensures all the relevant information is considered;

- is fair to those who are under scrutiny;
- recognises the position and interests of all those concerned with the events which led to the inquiry.

2.2.9 Principles The independent investigation panel believes that at the core of any mental health service delivered to people with a mental disorder there must be four principles:

- clarity in current diagnosis, objectives, needs, changing the diagnosis, needs and risk assessment and the strategies to clarify and deal with them;
- coordination of the delivery of service, sharing of information and action;
- checking on the outcome of service provision by regular review;
- changes in the diagnosis needs and risk assessments, and service provision in light of the review.

3 Methodology

3.1 Data Collection and Analysis

3.1.1 **Consent** Signed consent was obtained from J following a conversation with his current Responsible Clinician on the 1st of February 2010. Of note the consent to access health records was also granted on the understanding that, *"information about myself in these documents may become public knowledge through publication of the investigation report."* The consent gives access to a schedule of documents, including health records.

3.1.2 Information about the scope of the investigation, its Terms of Reference and procedures, and information about the panel members were sent to members of J's extended family and staff who were invited to interview. In addition, each member of staff was sent a list of the areas the Panel wished to discuss and how the Panel intended to proceed with witnesses. All staff witnesses were interviewed in a neutral venue. A verbatim transcript was made available to those who had attended and they were encouraged to add to, or further explain, any points they wished to expand or clarify.

3.1.3 Staff invited to be interviewed by the panel did so voluntarily and were open and helpful in their contribution to this independent investigation and we thank them for their candid help.

3.1.4 Relatives were interviewed in their homes. They were his M (daughter of the victim) and an uncle (K).

3.1.5 The Lead Investigator and Medical Member attended the secure hospital to interview J, as had been agreed. In the event he declined to be seen.

3.1.6 Two key staff involved in J's care and treatment were interviewed. The Trust Head of Risk Management was interviewed, and helped the Panel considerably regarding Trust policy and operational documents, as well as the Trust's progress in implementing the recommendations of the internal review. In addition, J's current Responsible Clinician was interviewed (details in Appendix One). Written statements had been made to the internal review team and these were also taken into account.

3.1.7 The documentation viewed was significant in volume (details in Appendix One) and the Panel, in producing this report, has gleaned from it that which it considered to be important to the key questions it had to resolve.

3.1.8 **The Principles of Root Case Analysis** Root Cause Analysis (RCA) seeks to identify the origin of a problem. It uses a specific set of steps to find the primary cause of the incident or problem to determine what happened; determine why it happened and what to do to reduce the likelihood that it will happen again. RCA assumes that systems and events are interrelated. Basic types of causes are:

Human causes – People did something wrong, or did not do something that was needed.

Organisational causes – A system, process, or policy that people use to make decisions or do their work was faulty.

3.1.9 RCA helps discover specific actions that contributed to the incident under scrutiny. This often means that RCA reveals more than one root cause and helps identify what is the real reason the problem occurred.

3.1.10 The Panel utilised this approach in analysing documentation and information from interviews. The Panel did not consider that, in this case, such fundamental underlying factors could be identified.

3.2 Membership of the External Review Panel

3.2.1 The Panel consisted of three senior and experienced mental health professionals, Dr Colin Dale, Mr Peter Green and Dr Michael Rosenberg (details in Appendix Two).

3.2.2 All three members of the investigation team are independent of any of the organisations involved with the homicide and have had no involvement in any of the investigations to date.

3.2.3 This Level 3 (independent) review was commissioned by NHS East Midlands, from Caring Solutions UK Ltd. The investigation commenced in December 2009 and is expected to be completed in July 2011.

4 Introduction

4.1 Summary of the Incident

4.1.1 J was living with his GM at the time of the incident, although he also spent time each day at his M's. He had been living with his GM and his Uncle, L, for some 12 months' after he had been asked to leave his M's house because of his abusive and aggressive behaviour. On the day of the incident (May 2007), J and his Uncle L had been drinking, J was drunk and argumentative towards his GM. Later that night, she was stabbed in the neck and died on the way to hospital. J was arrested on suspicion of murder in the early hours of the following day.

4.1.2 J was then charged with the murder of GM: he pleaded Guilty to a charge of manslaughter on the grounds of diminished responsibility. He was made subject to a Hospital Order, under Section 37/41 of the Mental Health Act 1983.

4.2 Background and Context: J's Early History

4.2.1 J was born and brought up in the same town. His parents divorced when he was eleven and at the time of the homicide he had a younger sister and a much younger half brother. Up to his mid-teens J was progressing reasonably well at school. In his final year he became somewhat angry and the school attempted to access help with anger management via his GP. He became isolated socially, started drinking and remained in his room for much of the time. His behaviour continued to deteriorate: by his late teens he had become a heavy drinker. He used recreational drugs to a limited extent.

4.2.2 In 2003 he went to stay with his father for a year, returning to his M's when his father moved away. Due to his increasingly aggressive behaviour his relationship with his M became strained and his M had to contact the police due to her not being able to manage him at home and his domestic violence. On occasions she was concerned for the safety of her young children in his presence. His situation became untenable and he moved to live with his GM. His GP and the Early Intervention Service reported that his GM had a positive relationship with him and was a calming influence on him. The extended family lived close to one another and, prior to the incident, kept in close contact. Members of the extended family referred to in this report are:

- GM – J's grandmother and the victim of the homicide
- M – J's mother
- Uncle L – J's uncle/ M's brother who lived with J's grandmother/L's mother
- Uncle K – J's uncle, also his mother's brother who lived separately.
- J also had a younger sister and much younger half-brother who lived with their mother

4.3 Background and Context: The Early Intervention Psychosis Service (EIS)

4.3.1 This service is provided for those aged between 14 and 25 with a first presentation of psychotic symptoms and are within the first three years of a psychotic illness. The service includes people with co-morbid substance misuse, personality disorder and forensic needs.

4.3.2 The objectives of the EIS are to facilitate early identification and treatment of psychosis and therefore reduce the disruption to the young person's life. Without early intervention there is often a period of two to three years when problems intensify. The service aims to reduce this period of disruption.

4.3.3 Younger service users have particular needs from the service and some are, for example: attention to confidentiality and agreement of arrangements for communication with families. They may be deterred from using services through their being perceived as similar to school and other agencies with negative associations. *"Successful engagement is important in optimising outcomes. Encouraging engagement will mean close attention to making services not just acceptable but also inviting, prioritising things that are important and fostering strong therapeutic relationships".*

4.3.4 The 2010 document describing the services states. *"A core care plan will be established as soon as the referral is accepted into the service. It will cover crisis plan, arrangements for any medication and identification of the Care Coordinator. There is an expectation that this will be completed by the second visit."*

4.3.5 The service takes on some eighty plus cases per year and facilitates seven thousand face to face contacts with a total case load of some two hundred and thirty per year.

4.3.6 The Consultant Psychiatrist (CP) for the service informed the Panel that the EIS team is often faced with somebody who's been unwell for some time and rarely just have a psychotic illness. It is very unusual therefore to present purely with symptoms of psychosis and be polite and amenable and compliant with medication. Usually the team sees lots of people with particularly undiagnosed developmental disorders, some with Autistic Spectrum traits which complicate their management. Many have social anxiety, most of them are male, unemployed, and the vast majority of them will have either drug or alcohol problems. This group amounts to some 60 or 70% of people who come to the attention of the team. They are a very difficult and challenging client group to work with. .

4.3.7 In the context of many other cases dealt with by the Early Intervention team and others operating within the Trust, J presented as a less challenging client. The Panel heard from the CP about service users who were far more at risk than J was considered to be, on the basis of the information available.

5 Chronology

5.1 J was in contact with NFHT just over 1 year prior to the incident. A brief summary of the key events of that period are as follows:

- **08 March 2006** J's first contact with NHFT, self-referring to the Council on Addictions Northamptonshire (CAN), following advice to his M (M) from the police CAN advised J to see his GP and request a referral to CMHT. This was done but J failed to attend the initial appointment: contact was made directly by M who was concerned that her son's mental health was deteriorating.
- **23 March 2006** J arrested for damage to property at M's home
- **3 April 2006** Reported that J had moved to live with his GM, where there would be less opportunity for J's irritability and aggression towards his M. J's M and GM lived close by: J visited M on most days and was sometimes visited by mental health professionals whilst there.
- **5 April 2006** J was arrested for alleged breach of the peace.
- **13 May 2006** J was arrested for domestic violence, remaining in custody for two days. M later dropped the charges.
- **12 June 2006** J was accepted by EIS and allocated a Care Coordinator (CC). His CPA status was changed from Standard to Enhanced. Risk assessments were carried out and care/treatment plans were developed. J remained under the care of the EIS until the incident.
- **May 2007** The homicide was committed. J was convicted of manslaughter and sentenced to a hospital order without limit of time.

5. 2 The following contains a more detailed chronology of events and indicates the source of information provided. The overall picture shows periods of cooperation and engagement by J and periods of non-cooperation/disengagement. He was prescribed medication to control his symptoms of hallucinations, paranoia and irritability. Risk factors identified included: physical abuse and aggression, particularly towards his M; excessive binge drinking for a few days every two weeks following receipt of welfare benefits; social isolation; missed appointments due to paranoia; possible intermittent compliance with medication. Care/treatment plans included medication, support to family members, alcohol reduction.

Date/Time	Event	Source
08.03.06	J. self-referred to CAN; CAN staff felt a referral to mental health services was required and suggested he visit his GP to ask for a referral to CMHT**.**	Clinical records
15.3.06	Referral from GP to CMHT requesting an urgent appointment for J following his attendance at the surgery, presenting with auditory hallucinations. The referral indicated a number of presenting problems, including aggressive and destructive behaviour at home (the police had been involved on a number of occasions); binge drinking (on receipt of welfare benefits); isolated; hallucinations.	Clinical records
22.03.06	J did not attend appointment with CMHT; further appointment made for 5/4/06.	Clinical records
23.03.06	J was arrested charged for 'criminal damage' to property following an incident that occurred at his M's address the incident was witnessed by his younger sister.	Clinical records
03.04.06	Telephone call from J's M to CPN1; she was concerned that J's mental state is deteriorating. Home visit was requested, and arranged for 4/4/06 at his M's address where J was residing at the time. J's M expressed concern about J's ongoing behaviour and the potential impact on his much younger half-brother. Telephone call to J's M by CPN1 in response to message left by M indicating she was not able to be present for the appointment arranged on 4/4/06 J's M reported J had been verbally aggressive towards her, which resulted in her calling the Police. She reported J who had moved to his GM's address and could be visited there. ASW and CPN1 visited J at his GM's address. Visit to his M's address, J was there but not willing to discuss situation. He stated that he had forgotten the original appointment.	Clinical records
04.04.06 9:30	Home visit to assess J following telephone call from his M. Due to J's resistance, and apparent paranoia, it was deemed difficult to assess him at that time and he was given a further appointment to attend Clinic the next day.	Clinical record

11:00 15:30	ASW visited J at his M's address again to hand deliver letter with appointment arranged for next day at Clinic. J confirmed he would attend and knew where to attend. Telephone call received from J's M by ASW enquiring about the assessment earlier, M confirmed J has been asked to leave her address due to his ongoing abusive and verbally aggressive behaviour and that he was now at his GM's address. This was following the incidents involving the Police on 03.04.06.	
05.04.06	J attended appointment, assessed by CPN1 and ASW. He presented as frustrated by his hallucinations, he was irritable, unsettled and argumentative, and reported feelings became worse following drinking. Even without drinking he was still experiencing reduced concentration, auditory hallucinations and paranoia. J reported as socially isolated, having difficulty initiating and sustaining friendships. J was seen By a staff grade psychiatrist and prescribed medication. J was arrested during the evening for alleged breach of the peace. Earlier in the day J had pushed his younger half-brother, then fled the property leaving his brother upset but unharmed. J then went to a friend's house where he consumed alcohol. He became aggressive towards his M when confronted about the earlier incident. J remained in custody until 7.30 am until the 6th April.	Clinical records
06.04.06	Discussion held with J's M regarding the safety of his siblings in relation to J's behaviour. J's M advised that her younger children were not left unaccompanied with J.	Clinical records
07.04.06	J was seen at Clinic by CPN1 accompanied by his GM, appears calmer and less irritable, and has taken his prescribed medication last night. J happy to continue taking one medication but was concerned that it makes him drowsy. CPN1 explained that it was a low dosage and he agreed to take it for a short period when feeling irritable. His GM seen and interviewed separately. Provision of more support was discussed but it was agreed that at the moment J was manageable at home and that J may find more intensive	Clinical record

	support threatening and become suspicious. Treatment discussed with GM who was happy with current arrangements.	
10.04.06	CPN1 reported J to be less paranoid, continuing to take medication, which is helping him to sleep. No further incidents involving the Police.	Clinical records
13.04.06	Telephone call CPN1, to inform her that J was unable to attend appointment, as he was still asleep. Telephone call to GM by CPN1 to check situation, informed situation remains the same, J had not slept much the previous night. A further appointment arranged for the following week (20.4.06) and out of hours duty telephone number was given to the GM.	Clinical records
28.04.06	CPN1 visited J at home who was drunk at the time of the visit therefore difficult to assess. Uncle L reported J had stopped taking his medication, he agreed to re-start his medication. Further appointment arranged for next week at Clinic. Mother agreed to manage J at home, Crisis telephone numbers given, no risks identified.	Clinical records
02.05.06	Entry in the notes by CPN1, J still not taking medication, now appears to be at his GM's house. No record of assessment of J's mental state or medical review. Risk screening assessment form has been completed which indicated GM and M consulted with a copy to the GP. Risks recorded, in relation to his presentation and behaviour in particular his verbal aggression, abuse towards his M and others including alcohol misuse. The initial management plan included, CMHT continuing to see and engage with J, to understand relationship between paranoia and alcohol, to continue contact with M to monitor progress and any change in risk factors. To see J on a weekly contact basis to review risk factors and ongoing consideration re the options of CRHT or admission.	Clinical records

	Plan to review on 15/5/06	
15.05.06	CPN1 received telephone call from J's M advising that J had been in Police custody for two days, following arrest for domestic violence. His GM was with him as the appropriate adult and requested a member of the CMHT to also attend. SW contacted the Police who informed her that J was refusing to be interviewed. He had been released on bail to his GM's address for one month, when he was due to attend at the Police station. CPN1 contacted GM who confirmed she was happy for J to remain at her address, a follow-up appointment arranged for 16/5/06. Risk review scheduled for this date, but no entries other than CPN1's signature	Clinical records
16.05.06	CPN1 visited J's GM's address for appointment with J as planned. J not present. GM reported improvement in J's mental state since taking medication and his violent outbursts triggered by alcohol intake. Plan to refer to EIS. Joint assessment arranged for 22.5.06. J considered suitable for transfer following good response to medication at that time.	Clinical records Witness statement
22.05.06	Home visit by CPN1 and new Care Coordinator (CC). J not seen as he was in bed. GM reported increase in J's drinking, with his behaviour becoming more erratic and argumentative. No physical violence reported. GM also reported J may not have been taking his medication regularly she has observed him talking to himself. She felt confident J could be managed at home. Plan for further joint assessment in two days time.	Clinical record s
24.05.06	J seen at Clinic by CPN1 and CC for a joint assessment. He presented with paranoia, agitation and difficultly in concentration, denied any hallucinatory experiences although body language indicated he was distracted at times.	Clinical records

	Plan to continue with prescribed medication and review the following week.	
02.06.06	Telephone call from GM to CPN1, J unable to keep arranged appointment, reason unclear. No change in his mental state, no further incidents of violence, continues to laugh to himself and remains irritable. Clinical record indicates that J had not requested a repeat prescription but another two weeks supply was obtained. Appointment rearranged for 8/6/06.	Clinical records
08.06.06	J failed to attend follow-up assessment appointment with CPN1 and CC at Clinic.	Clinical records
12.06.06	Accepted by EIS as meeting their inclusion criteria. CPA status changed from Standard to Enhanced.	Clinical records
14.06.06	Joint assessment undertaken by CPN1 and CC at Clinic. J reported compliance with medication which was helping to control hallucinations and paranoid illness. J appeared willing to engage with the team. Follow up appointment to be arranged and seen at GM's house. Call made to GP regarding prescription which was ready for collection.	Clinical records
15.06.06	J's GM advised that he did not want to remain at her house for much longer. GM indicated there would be greater friction between J and his M: in the past this has led to violence and damage to property. GM felt J would not see the Team at home but would more than likely see the Team at the Clinic.	Clinical records
21.06.06	Telephone call by CC to J's GM, who reported continued friction and verbal abuse to M by J. M has now dropped charges for previous physical aggression. J spending long periods in his room staring at the TV whether on or off. Concerns raised about his increase in weight. Follow up appointment on the 26/6/06 and Out Patient's Appointment with Consultant Psychiatrist of the EIS (CP).	Clinical record

23.06.06	Telephone call from GM to CC, advising J may be returning to M's address next week. Repeated concerns regarding his behaviour	Clinical records
26.06.06	Call from J to CC apologising for missing yesterday's appointment. J stated that he found the prospect too stressful. No further action - Out Patient' Appointment already arranged with CP on 5/7/06, which J stated he would attend.	Clinical records
04.07.06	Telephone call made to GM, who confirmed that J would attend the appointment due on the next day with CP. GM concerned over J's weight gain and stated that J's eating habit was becoming out of control. J's GM concerned because of the family history of heart attacks, which had been the cause of death for many of J's senior relatives.	Clinical record
05.07.06	J did not attend appointment with CP and CC. Call to GM by CC, reported J had been drinking. CP wrote to J's GP – J difficult to engage but has symptoms of first episode psychosis, possibly related to alcohol abuse. CC to remain in contact with J.	Clinical record
10.07.06	Call from J requesting new prescription for medication. J apologised for missing yesterday's appointment, follow-up appointment arranged for 20/7/06.	Clinical record
12.07.06	Risk assessment tool completed by CC. Risks identified included excessive alcohol intake, physical aggression towards M, missed appointments due to paranoia. **Initial management plan:** To further assess after each contact, liaise with GM regarding families' risk concerns, warning risk indicator on clinical record.	Clinical record
20.07.06	J seen by CC at Clinic, reported improvement in mental state, but did appear to respond to voices during interview. J stated that he was happy staying at GMs house and compliant with medication.	Clinical record

	Follow up appointment arranged for 3/8/06.	
04.08.06	J seen by CC and CPN3 (for Criminal Justice Team (CJT) at Clinic, reported still feeling paranoid. CPN3 recommended court diversion relating to last offence. CPN3 highlighted J was abusing alcohol heavily to suppress his mental health symptoms. No further involvement by CPN3 due to the fact that J was already linked in with appropriate services.	Clinical records
16.08.06	J seen at Clinic by CC. His first care plan was completed, agreed and signed by J. J still presenting with psychotic symptoms and has been binge drinking heavily to help control his symptoms. The care plan summarises knowledge and information collected to date, including mental health needs, relationship issues, accommodation needs, physical health, education and employment. CPA 2 form signed by service user.	Clinical records
05.09.06	Telephone call to GM from CC. J remained agitated, with occasional verbal aggression towards M He was still responding to auditory hallucinations. CC offered further support and education to GM and M and suggested they attend 'Friends & Family Psycho-education' sessions. They did not take up this offer.	Clinical records
06.09.06	J attended out patient's appointment with CP and CC at Clinic, seen alone by CP. J reported: compliance with medication, reduction in previous mental health symptoms. J still felt paranoid, feeling angry and resentful, particularly if in a group of more than two people. J acknowledged he requires help with his alcohol problem. **Management/Treatment Plan Agreed**: • On-going EIS involvement • To remain on enhanced CPA • Increase anti-psychotic medication.	Clinical records

	• To continue to obtain personal and social history • To carry out a psychosis assessment in the future and possibly a psychological assessment. • Refer to Complex Needs Coordinator re alcohol and mental health problems. • Further review in one month by CP	
18.09.06	J seen for joint assessment by CC and Complex Needs Coordinator (CNC) at Clinic. J presented with difficulty in concentration, he recognised his alcohol problem and was concerned not to jeopardise his accommodation at his GM's due to alcohol intake. The CNC confirmed J was drinking very heavily for three to four days in succession following receipt of his benefit cheque on a fortnightly basis. J was showing no signs of alcohol withdrawal and appeared to have an obvious tolerance to these excessive binges. J confirmed he has absences of memory when intoxicated to high levels and has got into fights in the past when under the influence of alcohol, not when sober. **Treatment Plan**: • Interventions for harm reduction techniques, education and alternatives to alcohol • Motivational scale completed – demonstrated ambivalence to change, given a diary to record amounts of alcohol. • Follow-up appointments arranged.	Clinical record
03.10.06	J attended appointment with CNC, apologized for missing appointment on 26.09.06. Alcohol diary completed, a pattern of drinking heavily over three to four days confirmed. J still wishing to reduce his alcohol consumption, education given re effects of alcohol and change process required. Treatment plan: • Further alcohol diary given • Plan to see in two weeks	Witness statement

18.10.06	J attended Clinic for appointment with CNC, apologised for missing three appointments. GM forgot to remind him to attend. Alcohol diaries completed; demonstrated reduction in alcohol intake over two weeks, Treatment Plan: • Further advice and education • To continue alcohol diaries • Encourage self control • To attend appointments consistently • Further appointments agreed.	Clinical records
13.11.06	Telephone call from GM to CC concerned about J's eating pattern and excessive weight gain. Plan to see at Clinic with CP on 29th November 2006.	Clinical records
15.11.06	Telephone call to J by CNC re missed appointments, J no longer wished to see CNC felt he had control of his alcohol intake. Advised can make contact in the future.	Clinical records
22.11.06	CNC informed CC that J's case was closed.	Witness statement
29.11.06	J seen at Clinic by CP and CC. J could not recall meeting CP in September. J presented with continued paranoid ideation and auditory hallucinations. J attended alone and resisted offers of home visits. J much more relaxed however has gained four stone in weight. Diagnosis of Paranoid Schizophrenia possible, complicated by excessive alcohol use. Treatment Plan: • Change medication to address excessive weight gain following discussion with family by CC regarding clinical risks and benefits of switching medication.	Clinical record

06.12.06	CC visited J's GM to complete a carer's assessment; there is no recorded outcome and the Carer's Support Plan remained incomplete.	Clinical record
19.12.06	CC telephoned GM who reported J appeared unsettled. No further action documented, J had missed his appointment arranged for 12/12/06, however no follow-up documented.	Clinical record
20.12.06	J's new medication increased.	Clinical record
02.01.07	CC telephoned GM J presenting more subdued in mood since change of medication, not sleeping well and eating less.	Clinical record
04.01.07	J visited at home, routine visit, reports not sleeping very well and feels new medication not as effective as previous.. J has lost half a stone in weight.	Clinical record
11.01.07	J visited at home by CC. Increase in medication, letter to J's GP confirming increase dated 9/1/07. J reluctant to take increase until written confirmation received. Plan to provide written confirmation to J.	Clinical record
19.01.07	CC visited J at GM's home, family report sleeping better, gradually losing weight, no change in mental state, continues to feel paranoid and responding to outside noises. J still drinking very excessively. Next visit planned for 25th January.	Clinical record
25.01.07	CC visited J at home visible improvement in mental state documented.	Clinical record
02.02.07	CC visited J at home, reports continued paranoid ideation and hearing voices, requesting extra medication to help him through the day. J reports drinking less..	Clinical record

09.02.07	Home visit by CC, J not sleeping well at night continues to have some paranoid thoughts and auditory hallucinations. Weight loss maintained and continues to drink minimal amounts of alcohol. Medication increased.	Clinical record
21.02.07	J seen at GM's home by CP and CC, he was suspicious and guarded, and was interviewed whilst standing in a doorway. He agreed that medication was helping him and was agreeable to a further increase in medication. CP and CC were able to speak directly with J's GM and Uncle L. They provided his history, including paranoia, auditory hallucinations and probable delusions of reference from the T.V. and radio. He had damaged property and been suspicious and paranoid of his family, and in particular his M. He had been less aggressive since living at his GM's and a little more socially active. His presentation remained complicated by periodic excessive use of alcohol and possibly intermittent compliance with medication. **Treatment Plan:** • Ongoing EIS involvement • Increase in medication. • Support the family, including advice and emergency contact numbers. **Crisis Plan / Access to Services:** • Contact key worker in first instance. • If key worker is unavailable to make contact with another member of the EIS team. • Out of hours and in an emergency access services in the usual way. Plan for CP to review J in six weeks time.	Clinical record
13.03.07	J seen at GM's home by CC. J reported being less paranoid, and sleep less of a problem. Had one heavy drinking bout in the past two weeks. Care Plan, discussed and signed by J and his GM.	Clinical record
27.03.07	CC visited J at GM's home. J reported to be coping well. Plan for next visit on 10.04.07.	Clinical record

16.04.07	J damaged property at his M's house after suspecting she was in the house and hiding from him: in fact she was out.	Clinical record
23.04.07	CC telephoned GM to confirm plan for CP to visit on 25th April 07. GM reported that since last visit on 13.03.07. J has been paranoid on some days,	Clinical record
25.04.07	J seen at GM's house by CP and CC. GM present. J reported having lost one stone in weight and was pleased with this. Presented as co-operative, slightly unsettled, then admitted to still being slightly suspicious, particularly at night. J not willing to discuss recent damage to property, but said doesn't regret it as he "hates his M". CP has recorded J was no risk to self, but risk to others, especially M. Plan: • Ongoing EIS involvement • Medication to remain the same • Friends to be invited to 'Family and Friends' psycho-education sessions	Clinical record
30.04.07	Discussed at EIS team meeting as risk alert.	Clinical record
02.05.07	Risk indicator pack revisited and reviewed. Dated and signed by CC. The risk document includes property damage and also highlights that J was compliant with medication.	Clinical record
09.05.07	Telephone call to GM from CC to rearrange visit. She informed CC that J had damaged property in his bedroom. J appeared shocked and felt guilty afterwards. Plan for CC to visit on 10.5.07.	Clinical record
10.05.07	CC visited J at GM's home. J asleep in bed throughout. No new concerns raised by GM, reported that J remained paranoid but no increase in alcohol consumption identified at this time. An increase of medication was proposed. CC discussed J's presentation with CP, medication	

	increased. A letter was sent to J to confirm the new medication regime.	
17.05.07	CC visited J at GM's home. Described as being very talkative. J tried to not take any of his medication for one night could not get to sleep and paranoid ideas had become worse. Stated that he understands that he does not cope without medication and will need to continue to take it. Talked about the latest property damage. Appeared embarrassed talking about it, expressing a degree of regret for his actions, as he had not meant it. CC discussed with J the possibility of a further change of medication. J talked about how bored he feels. Discussed activities available. J did not feel ready at this time but appeared reassured that he would be welcome when he feels up to it. Talked to GM, no new concerns raised. Discussed next visit. Two further visits planned.	Clinical record Witness statement
May 2007	J's GM taken to hospital after being stabbed at home. She died before arrival.	Clinical record

6 Findings – Contributory Factors

6.1 The findings of this investigation are presented under the headings of the Terms of Reference. The overall objective of the investigation was to undertake a systematic review of the care and treatment provided to J by the Trust, to identify whether there was any aspect of care and management that could have altered or prevented the events of late 2006. The investigation addressed the following specific points:

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

6.2.1 To identify whether the Care Programme Approach (CPA) had been followed by the Trust with respect to J.

6.2.1.1 A thorough initial review of the family history would have aided the formulation of a resulting Care Plan and Risk Assessment and commenced the Carer Assessment process. This assessment should have determined the interests of the extended family who lived in close proximity. Had this been conducted prior to a more thorough relationship developing with J then future issues of confidentiality concerning his ongoing treatment could have been controlled. His unacceptable behaviour was of a wider concern and needed to be discussed with those affected.

6.2.1.2 In the event, J had expressly requested his CC not to talk to his M about his situation. CC had informed his M that he could not discuss J's situation without his permission.

6.2.1.3 In December 2009, some 9 months after his initial contact with the services, a CPN from the EIS visited J's GM to complete a 'Carer's Assessment'. There is no recorded outcome for this assessment and the Carer's Support Plan remained incomplete.

6.2.2 To identify whether the risk assessments of J were timely, appropriate and followed by appropriate action;

6.2.2.1 He was without doubt a risk to his M, with whom he had a difficult relationship, and why this was so was never determined. His sister and younger brother also figured in his expressed wish to cause them harm and there had been relatively minor incidents which had involved them (e.g. J pushing, removing a toy from a sibling). Discussion was held with J's M regarding his behaviour around his siblings: health care professionals were assured that the younger child was not left alone with J. Despite this, there is no documented evidence of a safeguarding children assessment being considered. There should have been an assessment of the children's welfare, even after he had moved, as he went to his M's home regularly.

6.2.2.2 In attempting to engage with this complex group of young people this can only be safely achieved within a framework of clear risk information; this was not achieved with J within the Trust's time-frames. Consequently the model of practice within the EIS needs to closely reflect the needs of the services users it cares for. Offering a 'light touch' for fear of alienating a service user is only defendable when the risks are known. Therefore there

should be a review of the model of practice of the EIS to ensure that there is sufficient flexibility in the levels of support offered and that firmer and more challenging interventions are readily available to the service when required.

6.2.2.3 A risk screening in early May 2006 identified his verbal aggression and abuse towards his M and others in the family: if the risks were assessed to be escalating in the future, options to be considered were involving the Crisis Resolution Home Team (CRHT) or hospital admission.

6.2.2.4 The Panel were assured that the team has improved in demonstrating risk assessment through the use of current documentation.

6.2.2.5 J's treatment plan was modified in November 2006 but there is no evidence of further risk assessment.

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

6.2.3.1 Construction, recording and reviewing of his Care Plan was weak, although there was a clear understanding of J's needs between the Consultant and Care Coordinator. The Panel were assured this had improved. The GP was kept informed about his patient's treatment.

6.2.3.2 The Trust's Consultant Psychiatrist and in particular the Care Coordinator made all reasonable attempts to engage with J and acted in a professional, thoughtful and caring manner towards him. The actions they took, with the information they had, were appropriate and proportionate.

6.2.3.3 Although there were concerns regarding J's compliance with medication at times, evidence was provided by his GM that suggested he was compliant, to some degree. Asked if he had considered prescribing a depot injection, J's EIS CP considered that J was more amenable to taking medication in tablet form. The EIS CP intended to establish a therapeutic dose of his current medication then introduce the idea of commencing a new anti-psychotic drug. He considered that this medication might have improved J's insight and enabled him to engage in social activities, taking exercise and reducing alcohol and drugs. The Panel considered that this was an appropriate plan. Unfortunately its implementation was overtaken by the homicide.

6.2.3.4 The formulation and documentation of the Care Plan for J and its review were unacceptable within the time frame they were achieved. Examples include:

- The Management Treatment Plan agreed with J in September 2006 had sufficient detail, but the Panel identified that there were no timescales for completing the further assessments which had been specified.
- On a number of occasions, a multi-disciplinary review of his complex needs and his care and treatment plans would have been appropriate. These did not happen. For example,
    - In May 2006 his non-compliance with medication was noted, along with his alcohol abuse, verbal and physical aggression towards members of his family. No multi-disciplinary review was planned

- In November 2006, J informed the CNC that he no longer wished to see him as he had control of his alcohol intake. Despite the fact that alcohol was a known contributing factor to J's behaviour, violence and aggression, there still had not been a multi-disciplinary review meeting to discuss his care, despite him being on Enhanced CPA.

6.2.3.5 Later that same month J's treatment plan was modified, but the Care Plan was not reviewed in the light of those changes.

6.3 To examine the role of the care coordinator and the interrelationship between the various teams within the Trust with whom he had contact with and the appropriateness of their involvement; e.g. CMHT, Early Intervention Services and Drug and Alcohol Services.

6.3.1 The Care Coordinator from EIS (CC) was highly experienced and the Consultant Psychiatrist had confidence in that experience. He worked well at engaging with J and thought he was making progress in developing a relationship where J was disclosing more about his symptoms and concerns. He maintained weekly contact with J, as shown in the clinical records. Unfortunately CC was not fully aware of the facts of J's behavior and was therefore unable to make fully informed decisions about J's treatment and care.

6.3.2 CC also worked appropriately to develop a supportive relationship with J's GM, as his main carer. Appropriate support was offered by CC, including provision of out-of-hours and emergency numbers, and an invitation to the family support group offered by EIS. Family members reported that they were happy with the support offered. Again, CC considered that he was establishing a sound professional relationship with GM. It was discovered after the homicide that she did not perceive health care professionals in an entirely positive light, being particularly concerned that J should not be admitted to hospital, with the consequence that she was not as open with CC as he had assumed.

6.3.3 The CMHT and EIS worked appropriately in transferring J's care and treatment, including joint visits and assessments prior to handover. It is unclear, however, why referral from the CMHT to EIS did not take place sooner. It was clear from the GP referral letter, as well as from information provided by the family, that he had been displaying symptoms of psychosis for up to two years prior to initial referral to mental health services. This was inconsistent with the Trust's policy and practice.

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

6.4.1 The panel was chaired by the Director of Nursing, a Consultant Psychiatrist, the countywide Mentally Disordered Offenders Manager, and were supported by a Locality General Manager. The final report was produced on the 19 April 2008.

6.4.2 The internal investigation report identified a number of care and service delivery problems, and made comments on the care and treatment provided. These are summarised here:

- There was no comprehensive history taken at first CMHT contact;
- There was a delay in referring J to the EIS, despite indications of psychotic illness having been present for up to 2 years previously
- Opportunities for carrying out risk assessments, risk management plans, care plans, and to review care plans, were sometimes missed; assessments and plans were not always robust – e.g. did not include timeframe for implementation
- Insufficiently robust response to J's limited engagement with services, including failure to keep appointments and withdrawing from CNC input.
- Failure to complete Carer's assessments
- Failure to offer assistance to J in handling his benefits, given known tendency to binge drink on receipt of same, and known risks associated with excessive alcohol consumption
- Lack of CPA reviews and of multi-disciplinary meetings to assess risk and plan care for this young man with complex needs
- Records not always appropriately completed
- J had two younger siblings – he either resided in the same house or visited their home regularly. There was no documented evidence that a safeguarding children assessment had been considered.

6.4.3 The internal review report concluded that, *"on balance the panel believes that his care was maintained within the expected national standards for Early Intervention Service and although there were shortfalls in his case these did not contribute to the death of J's GM."* The External Review Panel concurs with this conclusion.

6.4.4 The internal review report made thirteen recommendations. On the basis of the care and service delivery problems summarised above, the Panel considered that these recommendations were appropriate. In the table below the Panel comments on implementation of these recommendation, in the light of documentary evidence provided to them in the key areas requiring action. These were:

Recommendation	**Comment**
1. The internal review team believes there is a need to have specialist skills and expertise in working with dual diagnosis within the team, therefore need to employ a small number of workers to that end.	Two posts of 'Lead Practitioner/Dual Diagnosis Worker' were appointed in April 2009 to the Assertive Outreach Team. The policy for 'Dual Diagnosis' dated June 2008 is underpinned with the adoption of Department of Health policy implementation guide and NICE guidance for schizophrenia.
2. CMHT operational policy to be reviewed to clarify the role of initial screening, assessment and duration of contact.	In February 2008 a clear 'Policy for Screening and the Short Term Intervention Team' was produced.

3. All services to ensure that a thorough history is obtained from the service user and family involved / carers.	The Independent Investigation panel makes a specific recommendation concerning this area of work. (Para 7.1)
4. The Trust's staff to record objective measurements of compliance of medication informed by carer feedback	Ongoing review
5. Services to undertake a combined risk assessment for service users.	The Trust produced in April 2009 an operational policy document entitled, 'Working with Risk' which is underpinned by a clinical tool. This was subject to a positive Clinical Audit in October 2009 to establish a base line of practice throughout the Trust.
6. Guidance on when patients disengage from service.	A Disengagement Protocol is now located in the thorough 'Operational Policy and Clinical Standards – Early Intervention Psychosis Service', ratified on the 8th of February 2010.
7. Services to use HoNOS across all services and transfer information throughout the patients care pathway when transferring from one team to another. 8. All services within NHT to utilise the Single Clinical Record. There should be no separate records within the Trust. The Trust urgently should address the parallel process of the single care record and e-PEX and move to an electronic patient record. 9. Comprehensive risk assessments and risk management tools to be available on e PEX, in order to ensure that the risk profile is accessible to all staff / services	Recommendations 7, 8 and 9 are covered by the 'Health Records Policy – Single Clinical Record' which is underpinned by the electronic system. This policy was implemented in May 2008.
10. That CPA guidelines are adhered to for care planning, coordination and multidisciplinary review meetings at regular intervals. 11. Retraining on CPA and risk assessments for CMHT and EIS 12. Put in place policy guidance for staff when conflicts arise on confidentiality. 13. All patients on EIS upon referral to be placed on enhanced CPA	Recommendations 10 to 13 have been addressed by the production of a revised 'Care Programme Approach Policy' in December 2009. Following the review of CPA the Department of Health issued new guidance to be implemented in October 2008 and following this service users of EIS are subject to the new CPA arrangements. Of note is the audit of Carers Assessments completed. This was undertaken in August

	2009 and found 55% were completed; 26% were refused by the carer or there was no carer, and 10% needed completion.

6.5 Overall Conclusions

6.5.1 Overall, the Panel did not identify significant contributory factors which had not already been identified by the internal review. J's behaviour suggested the existence of a developing schizophrenic illness when of school leaving age and used alcohol as a way of managing his symptoms. His paranoid symptoms led to guarded behaviour and suspiciousness, making engagement more difficult for staff of both the CMHT and EIS.

6.5.2 In the context of many other cases dealt with the Early Intervention Team and others operating within the Trust J presented as a less challenging person. The Panel heard from the Consultant Psychiatrist of service users who were far more of a risk that J was deemed to be.

6.5.3 There was some resistance by his family to the idea of J being admitted to hospital. This led to reluctance by both his M and GM to disclose the full extent of the violence and abuse perpetrated by J against them. Had the family members who were directly involved with J informed the Care Coordinator and Consultant Psychiatrist of the true nature of J's actions and described all their experiences accurately then more informed decisions could have been made for his future assessment, treatment and care. Both J's Consultant Psychiatrist and Care Coordinator for the EIS indicated that, had they known about J's violence towards his GM, they would have considered hospital admission, including, if necessary, compulsory detention.

6.5.4 Had the information and experiences of J's GM been shared there was, on the balance of probabilities, a likelihood that J would have been recommended for admission to hospital where it is further likely he would have been easier to assess, alcohol free, and establish a consistent medication regime much more quickly. However, the Panel believe that such an admission would have had to be compulsory.

7 Recommendations

7.1 The Trust should commission the production of a procedure and process for taking a thorough social history and combine with this a review of the involvement of families and the sharing of information with them.

7.2 Service users and families should be given a clearly written and easily understandable description of the service and supporting information which covers issues of confidentiality and responsibilities to share information in order for the Trust's staff to support the service user and them.

7.3 The 'Interim Core Care Plan' resulting in first stage Care Plan and Risk Assessments should be audited to ensure they are formulated within the Trust's required second visit criteria.

7.4 The Trust should undertake a review of the model practiced by the EIS to ensure that there is sufficient flexibility in the levels of support offered and that firmer interventions are available when these are required.

7.5 Safeguarding children should be at the forefront of staff working in service users homes where there are children. The Trust should ensure that all service users families are offered a carers assessment and where children are involved this should be mandatory factoring in any of the safeguarding concerns or needs as they arise.

7.6 The Trust should devise and undertake an audit of the Early Intervention Service to assure itself that it is adhering to the requirements of the Care Programme Approach and the Trust's Risk Assessments, including the quality of them, paying particular attention to review date adherence.

8 Appendices

Appendix One: Relatives and Staff Interviewed and Documentation Reviewed

The following were interviewed:

Relatives
J's Mother (M)
J's Uncle (K)
Staff
J's Consultant Psychiatrist (CP), EIS
J's Care Coordinator (CC), EIS
NFHT Head of Risk Management
J's Current Responsible Clinician

The following documentation was reviewed

The National Framework for Reporting and Learning from Serious Incidents Requiring Investigation', National Patient Safety Agency, (NPSA)
'Review into the Care and Treatment of J', STEIS Ref 2007/4987, NHS Foundation Trust, updated 19th of April 2008
The full clinical notes and correspondence held by the NHS Foundation Trust.
The clinical records and correspondence concerning J held by the two centres for secure forensic mental health.
The Trust's relevant policies on the Care Programme Approach, Risk Assessment and the, 'Operational Policy and Clinical Services Standards (Early Intervention Psychosis Service)', February 2010.

Appendix Two: Members of the External Review Panel

Dr. Colin Dale has been an Executive Nurse in three NHS Trusts; has worked as a professional adviser to the Royal College of Nursing (RCN), National Institute for Mental Health in England (NIME), National Patient Safety Agency (NPSA) and the Dept of Health. He has successfully worked on a large number of projects in recent years. He is currently the Vice Chairman of a NHS mental health foundation trust and has functioned as an executive Director of Nursing with three previous NHS Trusts for a period spanning 11 years. He continues to work on a freelance basis as an independent Nurse Consultant and expert witness, combining this work with research and writing. He has worked on several previous mental health inquiries.

Dr Michael Rosenberg was previously the Consultant Psychiatrist, Inpatient Triage, South Downs Health NHS Trust (a new post involving the assessment and care of newly admitted patients for the first seven days of their care episode). Between 2003 and 2006 Michael was the Chief Executive and Honorary Consultant Psychiatrist South Downs Health NHS Trust; a Trust where he had previously been the Medical Director between 1998 and 2003. Michael was responsible for the Psychiatric Intensive Care Unit at Mill View Hospital from 1999 to 2005 (a modern 10-bedded unit caring for acutely mentally ill patients, requiring short-term intensive treatment). He is approved under Section 12(2) of the Mental Health Act 1983. Michael has extensive experience of the investigation of critical incidents and advised on the management of complaints in his Trust. He was the lead director for the Trust Patients' Advisory Forum and responsible for developing the Trust Strategy for Patient and Public Involvement.

Peter Green is a qualified psychiatric social worker and general manager with significant experience as a senior executive in local government, the National Health Service, the Mental Health Act Commission and latterly independent psychiatric hospital provision and consultancy. Peter was the principal social worker at St. James's University Teaching Hospital, Leeds and has worked in all three high security hospitals, as a senior practitioner at Rampton Hospital, the head of social work services at Broadmoor Hospital and the Director of Rehabilitation and General Manager at Ashworth Hospital. He has considerable expertise in the assessment of mentally disordered offenders and evaluation of service delivery. He has aided the administration of two public inquiries.

Appendix Three: The Care Programme Approach

One of the Terms of Reference was to consider this cornerstone of practice within mental health services.

The Care Programme Approach (CPA) was introduced in 1990 as the framework of care for people with mental health needs, originally intended to be implemented by April, 1991 and to run in parallel with the Local Authority Care Management system.

The CPA was revised and integrated with Care Management in 1999 to be used by health and social care in all settings, including inpatient care.

Two tiers of CPA were established: Standard and Enhanced.

Standard was described as being for those people whose needs could be met by one agency or professional worker.

People on Enhanced CPA have multiple needs which are more likely to be met by inter-agency co-ordination and co-operation. There is likely to be a higher element of risk and disengagement from services. A Care Plan was to be developed to address those needs. A key worker or Care Coordinator was to be appointed and regular review was to take place making changes to the plan to reflect changing need.

A new system for conducting CPA was implemented in October, 2008. Although this was not within the time frame of J, it restated that the role of the Care Coordinator was vital.

Appendix Four: Abbreviations and Descriptions

Organisational	
CAN	Council on Addictions Northamptonshire (CAN is CAN is an independent regional agency, first established in 1972. CAN provide a range of drug, alcohol and homelessness services throughout Northamptonshire and Bedfordshire.)
CMHT	Community Mental Health Team
CNC	Complex Needs Coordinator
CPA	Care Programme Approach (See Appendix Three for details)
CRHT	Crisis Resolution Home Team
EIS	Early Intervention Psychosis Service
NHFT	Northamptonshire Hospital Foundation Trust
Personnel	
CC	J's Care Coordinator from the EIS, a Community Psychiatric Nurse,
CP	Consultant Psychiatrist, Early Intervention Psychosis Service
CPN1	Community Psychiatric Nurse, allocated to J from the CMHT.
GM	J's GrandM
M	J's Mother
Uncle K	J's uncle/his M's brother who lived separately
Uncle L	J's uncle/his M's brother who lived with his M/J's GM.